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Diagnostic and Statistical Manual-III: A Perspective from Family Court

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ABSTRACT: The third edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM-III) is evaluated from the standpoint of forensic science experience in a family court setting. The importance of diagnosis in developing pertinent recommendations within an adversarial system is discussed, with particular emphasis on difficulties in coordinating the *Manual* with the mental disorders frequently found in such a population. The limitations of the current criteria of the developmental disabilities are noted, and problems of reconciling incest and child abuse with the nomenclature are investigated. Some inconsistencies in the conceptualization of the conduct disorders and antisocial personality disorder are explored in terms of the needs of the juvenile justice system. An additional coding procedure is proposed for DSM-III, in order to identify more easily prodromal or emerging disorders of clinical significance.

KEYWORDS: jurisprudence, psychiatry, *Diagnostic and Statistical Manual*, family relations

The Family Court of New York State has jurisdiction over most legal "family issues," including various types of delinquency and status offenses, custody and visitation suits, neglect and abuse cases, family offenses, and terminations of parental rights. Clinical forensic science responsibilities within the Family Court system—assigned to an independent Mental Health Services—are defined in a unique way. While most criminal forensic science work is undertaken pretrial or presentencing and centers on such activities as the assessment of competency and issues of "sanity," the bulk of the Family Court clinician's responsibility usually does not emerge until after a legal decision or determination of guilt ("fact finding") has been established by the court. At this point, Mental Health Services, which has an *amicus curiae* status, is requested to develop a diagnostic profile and recommendations for the best interests of the relevant parties at a separate dispositional hearing. The clinician makes use of all available material to present a report which will place the parties' legal concerns within the context of their relevant history, dynamics, and social interactions; he indicates, with conclusions drawn from the data, the possibility or necessity of treatment, the likeli-

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hood of recidivism, and so forth. Thus, the clinician's role is essentially that of a mental health consultant to the court, albeit one whose range of options extends beyond the usual gamut of mental health alternatives to such interventions as probationary supervision, Bureau of Child Welfare involvement, and various placement, custody, and visitation alternatives [*1*].

The court looks to the forensic science expert not only for a recommendation, but also for an understanding of the position of the relevant legal-social issue within the individual's overall functioning. The clinic report is composed with an awareness of the needs of the court and its increasing adversarial atmosphere. However, those parties who are involved in a given court case may still have difficulty in evaluating the clinician's report. The perceived value and reliability of the recommendations will often depend not only on their practicality and consonance with other sources of information to which the court has access, but on the report's own internal consistency, particularly that between the diagnosis and recommendation. Since contesting parties are likely to bring competing or conflicting solutions to the legal issues before the bench, the court's willingness to accept, modify, or reject the forensic science recommendations will often depend on the clinician's ability to defend his diagnosis—the basis of his recommendations—against intense probing both from adversarial interests and, at times, the bench itself.

The third edition of the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM-III) represents the most recent systematization of diagnostic thinking available in the mental health field; it has won general approbation for its specificity and comprehensiveness, although both its own authors and critics recognize, invariably, some areas of limitation and controversy [*2–4*]. Working within our framework, DSM-III has a special value. The clarity of the diagnostic criteria, a significant innovation in this new edition of the manual, allows even educated laypersons to evaluate objectively the basis for the clinician's diagnostic decision. DSM-III does limit its applicability and relevance, "... for nonclinical purpose, such as the determination of legal responsibility, competence or insanity ... (which) must be critically examined ... within the appropriate institutional context" [*5*]. As we have noted, however, our role is in many respects similar to that of other, nonforensic science consultants and diagnosticians, and well within the intended scope of the manual. While not every individual is before the court because of mental disorder, many of those whose legal problems are serious enough to merit the court's attention display a significant degree of maladjustment.

The Family Court affords us intensive exposure to disorders that are perhaps less frequently observed or recognized in other clinic settings. These disorders have repeatedly created diagnostic dilemmas for us as clinicians using DSM-III. Such difficulties obviously impact on our ability to present a meaningful understanding of the parties to the court. These ambiguities must also affect the communication between clinicians in other settings, and reflect a lingering lack of overall diagnostic organization with issues that are clinically prominant in our population. An exploration of some of the more significant areas of difficulty for us can increase the awareness of the court system as a whole to subtleties and complexities in some of the more frequently used diagnostic categories, and perhaps at the same time challenge forensic science professionals' thinking in these areas as well. We also hope to suggest areas of redefinition in DSM-IV which would be helpful to noncourt related clinicians and researchers who may encounter similar cases on a less frequent basis.

Developmental Disabilities

As forensic science clinicians in a family court setting, we encounter a higher percentage of youngsters with learning problems than are to be found in the juvenile population as a whole [*6*]. Given the rehabilitative goal of our system, the diagnosis of developmental disabilities and the assessment of their influence over the daily functioning of court clients can

be a critical issue at the dispositional hearing. For example, "learning disabilities" are often thought to be responsible for chronic school frustrations, which may be acted out with resulting delinquency; parties in such proceedings may be motivated to suggest the presence of such difficulties in juvenile respondents, with the implication that the youngster's misbehavior can be most expeditiously remediated by a change in class setting, instead of by more drastic interventions. Even when placement is clearly indicated, the court itself will remain concerned with the accuracy and appropriateness of such diagnoses. If the severity of the effect of the disability on the adolescent's behavior is overestimated, placement in settings with a primarily educative thrust will be ineffective for the youngster's actual problem. If the potency of significant disabilities is ignored or minimized, placement in more restrictive settings may violate the "least restrictive intervention" guidelines, with potential deleterious consequences.

Thus, the evaluation of developmental anomalies will be a concern in all cases directly involving juveniles as offenders. Other types of cases will also require a similar awareness. In issues of competency or termination of parental rights based on mental retardation, we are rarely faced with a simple black-and-white decision, and the ability to indicate to the court specific areas of intellectual strength and weakness will help explain and justify our recommendation. Also, in any cases where children are involved as direct parties (for example, custody and visitation disputes and neglect or abuse cases), the clinician will be expected to alert the court to any relevant educational problems with such minors.

DSM-III has taken a major step in providing "diagnostic legitimacy" for such disabilities with its incorporation of "Specific Developmental Disabilities" into the psychiatric nomenclature. While we welcome the recognition of such cognitive deficits into a major diagnostic schema, the current organization of these disabilities appears to us as potentially confusing to the layman, and at the same time both overly specific and insufficiently conclusive for professional use. We do not perceive our requirements as different from those of other clinicians in nonforensic science settings. Our experience and subsequent reservations are derived from the frequency of our contact with such a population and by the rigorous standard of examination to which diagnostic decisions can be subjected in the judicial process.

"Learning disabilities" are evidenced by discrepancies between an individual's actual and expected achievement, when these discrepancies are not a result of limits in general intelligence, physical impairment, or motivational, emotional, or sociocultural factors. Although experts may disagree about the exact nature and etiology of such impairments, it is generally recognized that they reflect some interruption or deficiency in the processing of information [*7-9*]. This processing constitutes a chain of activities, from intially absorbing the material to storing it in memory, associating it with other similar material, and ultimately expressing it in coherent form. Learning disabilities may affect one or a number of the elements of the processing sequence. When a child suffers one or several learning disabilities, his or her functioning may show the effects of the impairment in many areas, such as poor reading or arithmetic skills, a faulty sense of direction, or impaired physical coordination.

DSM-III currently provides an array of developmental disabilities categories for the diagnostician to indicate the nature of the individual's limitation. However, the Developmental Disabilities subsection alternates between overly specific and perhaps artificially circumscribed diagnoses on the one hand (for example, Developmental Arithmetic Disorder), and vague or overinclusive labels on the other (Mixed or Atypical Specific Developmental Disabilities). While difficulties in reading or arithmetic may in fact be the most striking limitation of a child in this school-oriented society, the majority of children who experience even one area of difficulty as a learning disability usually also have other areas of vulnerability, such as left-right confusion, marginally poor coordination, or mild impulsivity [*8,10*].

The high and perhaps artificial level of specificity of DSM-III symptomatic diagnoses invites the court or other report user to focus too narrowly on a single element of a usually broader disorder, and to ignore associated relevant aspects of the learning problem. A lay-

person may understand a diagnosis such as "Developmental Reading Disorder" to suggest that, since reading is a visual activity, the individual has a visually based problem. In fact, reading difficulties can be caused by auditory processing problems (for example, problems in recognizing and matching sounds) in those with grossly intact visual skills. Further, such symptomatic labeling of the developmental disorder opens the door to an eventual profusion of other circumscribed learning disabilities (for example, Developmental Coordination Disorder and Developmental Abstracting Disorder).

Equally important for the clinician and the court, the current system is simply too cumbersome for ready use when one diagnoses a child with multiple learning handicaps, a common occurence in our population. In such cases, the final diagnosis on Axis II—even ignoring whatever personality disorders are to be listed—can easily become a hash of Developmental Disabilities listings, unlikely in its complexity to give the user the "flavor" of the actual underlying impairment. To be forced to list, for example, Developmental Reading Disorder, Developmental Arithmetic Disorder, and Atypical Developmental Disorder, all for a child with difficulties in abstract thinking, surely represents diagnostic overkill, yet is the mode of presentation currently required. The alternative with such a clumsy system, and one we fear often resorted to, is to either ignore the disabilities altogether, or to lump them uncritically in the "mixed" or "atypical" categories. In such situations the diagnosis, which should serve as the summary and keystone of clinical observation, becomes an area of confusion. The clinician will either ignore this at the peril of miscommunication, or will be forced to use the body of the report to anticipate the misunderstanding in a didactic manner.

The DSM-III presentation of learning disabilities is thus analogous in its limitation to an approach to schizophrenia that would diagnose individual symptoms (for example, "Auditory Hallucinatory Disorder") rather than more meaningful syndromes. The mainstream of thinking suggests that developmental disabilities are most cogently classified as to whether they affect the visual-motor or language channel of processing, although of course individuals can suffer limitation in both areas [*9, 11*]. To rationalize the current diagnostic dilemma, we would propose a schema more consistent with DSM-III's general syndromal approach to mental disability. A useful and economical classification of developmental disorders would include the following categories:

(1) Visual-Motor Developmental Disorder,
(2) Language-Processing Developmental Disorder,
(3) Developmental Articulation Disorder, and
(4) Mixed or Atypical Developmental Disorder.

Specific criteria for each syndrome would be set forth, in accordance with the best available research. It is likely that definitive diagnoses here would involve neuropsychological testing, but such an approach is universally recognized as indispensable in such diagnoses, and DSM-III already requires limited psychological testing in the current system. After making the general diagnosis, the clinician would have the option of indicating in addition *whatever* number of specific symptoms of the processing impairment that impressed him as being significant at the time of the evalution. Thus, a child with difficulties in reading who was also encountering problems with gross motor skills as a result of his underlying visual-motor impairment would be diagnosed:

Axis II: Visual-motor Developmental Disorder
(Reading and Coordination problems primary)

We feel that such a system would offer an appropriate and theoretically secure view of the child to those coming into contact with the diagnostic material. Such a diagnosis would convey the admixture of specific impairment and diffuse disability more genuinely appropriate to the nature of these impairments.

Incest and Child Abuse

Problems of sexual behavior have been a major concern in professional mental health for the past century. While many controversies have flourished, surprisingly little has been written in a scholarly way about the topic of incest; whether or not incest itself is universally taboo, wide discussion of it certainly seems to be so. Even major reference works in forensic psychology and psychiatry relegate incest, when it is acknowledged, to little more than passing commentary in chapters on general sexual deviation [*12,13*].

In a family court setting, incest appears in our population more frequently than one would expect from perusing clinical texts, and our subjective impression of its prevalence is reinforced by the available statistics, which suggest upwards of 100 000 cases annually [*14*]. DSM-III, like most diagnostic publications, tends to avoid specific mention of this phenomenon. There is absolutely no reference to it in the Mini-D (the handbook version of DSM-III), and only the most cursory acknowledgement of it in the general manual, under the general category of "Pedophilia." However, because incestuous actions are not necessarily related to other sexual abuses against children, we do not find the label "pedophilia" useful; however disturbing and mentally disordered such actions, pedophilia carries too broad an implication for the actual scope of such deviance in many of our clients.

Incest is, redundantly, a phenomenon of family relationships. The pattern of family dynamics in incestuous situations is indeed viewed as a fairly consistent one by many authorities [*12,15,16*]. Incest is rarely solely between the violator-parent and a single sibling, and, in the majority of cases, all same-sex children are likely to become involved, to some degree, at one time or another. More significantly, it is generally felt that, in father-daughter incest, the mother is consciously aware of the relationship (although the awareness may be subject to denial), and she may have an active part in the evolution or maintenance of the incestuous tie.

It is often suggested that, because of the web of family dynamics associated with (though not demonstrably causative of) incest, such behavior falls within the range of miscarried interpersonal dynamics, rather than the individual mental disorders covered by DSM-III. The *Manual* notes that, within the universe of psychosexual disorders, "... the Paraphilias are characterized by arousal in response to sexual objects or situations that are not part of normative arousal patterns...." It goes on to clarify that in such disorders, "... unusual or bizarre imagery or acts are necessary for sexual excitement ... (and) tend to be insistantly and involuntarily repetitive...," involving, among other possibilities, "... repetitive sexual activity with nonconsenting partners" [*5*]. The available research on incest appears consistent with these criteria, and provides empirical and heuristic justification for the conclusion of incest as a paraphiliac act.

Incest generally appears, not as a sudden explosive incident, but as the outcome of a slowly developing relationship between parent and child which may date back to subtle but excessive stimulation during the toddler years [*17*]. At least two thirds of all estimated cases occur between fathers and daughters. Up to 75% of these fathers report concommitant alcohol abuse at the time of the incestuous episodes, at least until the daughter enters puberty [*18*]. Given the fact that the incestuous relationship tends to develop over time, with perhaps many years of diffuse stimulation before actual genital-genital contact, the frequent combination of alcohol and incest suggests that such fathers artificially alter their perceptions and inhibitions before engaging in the overt sexual act. (This would imply a somewhat different dynamic clinical picture from that of the sexually impulsive, nonincestuous pedophiliac; incestuous fathers for example, tend to be more likely to admit their guilt in incidents with relatively younger children than with older youths, while, in general, pedophiliacs reportedly have greater tendencies to deny their experiences with younger than with older minors) [*18*]. Recent research indicates that although the adult party is often an individual with characterological problems, his or her sexual offenses against family members will not

necessarily generalize beyond the family constellation. Heterosexually incestuous fathers seem to be more aroused, outside of the family, by age appropriate females than are the wider range of male heterosexual pedophiliacs [*19*]. Homosexually incestuous fathers, in contrast, do not seem to show evidence of other extrafamilial homosexual liasons [*20*].

The trend of this evidence is consistent with the well-defined, repetitive, and deviant arousal patterns of other paraphilias. The distinct path of the development of sexual engagement noted here also suggests that incestuous behavior is a specific form of sexual arousal and discharge, although of course an adult needs to be no more exclusively incestuous in his or her behavior than in other paraphilias. As a family-related disorder, both the associated interpersonal dynamics and the prevailing family treatment approach, may suggest its inappropriateness in a compendium of individual mental disorders. However, we would point out that incest is not by any means seen universally as caused by family dynamics [*21*]; since DSM-III states that it is, "atheoretical with regard to etiology or pathophysiological processes except for those disorders which are well established..." it seems premature and perhaps inconsistent to *exclude* incest as a paraphilia based upon a theory of its etiology. DSM-III is admittedly traditionally oriented in terms of which paraphilias it recognizes, and the general trend of historical precedent thus undoubtedly serves to establish a relatively conservative view of the range of sexual deviations within the *Manual*.

Establishing incest in the nomenclature should be helpful to all clinicians, but of special value in forensic science settings where the bulk of such cases is likely to appear. Incest, like other sexual deviations, cannot consistently be subsumed under personality disorders or Axis I categories. Since DSM-III is unclear about the status of incest as a disorder, it is likely that various clinicians are coding it idiosyncratically (for example, as Pedophilia, as an Atypical Paraphilial, or as the manifestation of various personality disorders), confounding the statistical and record keeping purposes of the diagnostic system. As a widespread mental health difficulty and a common judicial presenting problem, the lack of such an appropriate diagnosis creates an unnecessary discontinuity between the sexual deviation and any other diagnosis, which is neither the *raison d'etre* of the initial legal or mental health intervention, nor the focus of treatment.

Child abuse within the legal system presents somewhat different problems for the forensic clinician. While incest does indeed appear to us as a mental disturbance meeting the general diagnostic criteria of other paraphilias, the evidence indicates that child abuse is less a discrete mental disorder than an interpersonal and intercultural difficulty. We are not suggesting that abuse is an area of pure cultural relativism. Although historically children have been subjected to treatment which we would today view as bizarre or outrageous, there is little evidence of physical abuse and violence as a historical phenomenon [*22,23*].

Present information indicates that the pathology of child abuse is often associated with specific stimuli arising from the parent-child relationship. Such factors as illegitimacy, low birthweight, and neonatal health complications seem to be frequently related to episodes of child violence [*24*]. Parents who abuse also tend to have been abused as children. In spite of common opinion to the contrary, such adults do not generally present with the most severe personality disorders, although the evidence does suggest certain defects in character structure [*25*]. Nevertheless, an interactional model is not consistently applicable to child abusers in our population.

We are struck particularly by a group of adults who, "reasonable" and appropriately controlled on first interview, eventually demonstrate a massive level of denial (which appears to represent a *deficit* in psychic structure rather than a defense) and encapsulated areas of paranoid thinking not immediately obvious to the observer. Our observations are shared to some degree by research which details the so-called "sick but slick" pathology of these parents [*26*], and further work may conceivably create a dynamic profile leading to the formulation of a mental disorder specific to some child abusers. In any case the forensic science clinician must take special care in abuse cases to place the offense itself in the wider range of

social stressors and personality dynamics. Outside of this context an understanding of the abuse loses meaning. With this context in mind, characterologically paranoid parents will not be referred for "parent training skills," nor will a limited or immature parent be required to undergo inappropriate dynamic psychotherapy.

Conduct Disorders

The history of diagnostic thinking concerning the relationship between antisocial actions and the mental disorders thought to underlie such behaviors is a complex and at times contradictory one. It is perhaps worthwhile to note that agreement on the nature and definition of these disorders, particularly the antisocial personality, eluded even the DSM-III task force [*27*]. DSM-III offers the clinician four possible diagnostic options for individuals whose presenting problems primarily involve such behavior. The Conduct Disorders are meant generally for individuals under the age of 18 with repetitive behavior problems. The Antisocial Personality Disorder is the designation appropriate for an adult "psychopathic" or "sociopathic" personality. Adjustment Disorders describe transient or reactive episodes of misbehavior. Specific V-codes are also available to identify adults and juveniles whose actions are either isolated events or reflections of a "career crime orientation" (such as drug dealers motivated solely by profiteering).

However difficult it has been historically to elucidate the role of psychodynamic factors in adult antisocial behavior, the potential issues multiply alarmingly when one attempts to extend the antisocial construct to youngsters and adolescents. Already potent intellectual and sociolegal concerns become further enmeshed with emotionally laden issues such as the effects of "labeling" on young people, as well as with suspicions or hopes that antisocial activities, like so much else in childhood, will be modified in the process of development [*28,29*]. We will limit our discussion to two areas of special forensic science interest, the anomaly of the "socialized" conduct disorder and the relationship of age factors to the conduct disorders as a whole.

"Socialized" Conduct Disorders

The identification of youths as "conduct disordered" is without question the most frequent diagnosis in delinquency and status offender cases. DSM-III allows for a fourfold subclassification of the general Conduct Disorder diagnosis, based on the presence or absence of aggressive actions, and of putative socialization skills. A residual category is reserved for atypical cases. Since the conduct disorders may be viewed as potential precursors of the adult Antisocial Personality Disorder, there is obvious interest in distinguishing between an "undersocialized" conduct disorder (presumably already displaying the lack of empathy or common social concern characterizing antisocial adults), and a "socialized" conduct disorder, potentially or hypothetically more amenable to reciprocal human interaction. To this end, DSM-III lists five attitudes or behaviors that serve as criteria for judging whether or not a conduct disorder is in fact "socialized" [*30*]. These criteria are (1) one or more peer group friendships lasting over six months, (2) extending oneself for others, (3) guilt or remorse when appropriate, (4) avoiding blaming or informing on others, and (5) concern for the welfare of companions. A juvenile displaying two or more of these characteristics is described as "socialized", while the youth who shows none or only one of these traits is labeled as "undersocialized."

This definition of socialization, in our experience, leads to three significant difficulties both for the forensic science field and the broader range of clinical practice. First, we would question the appropriateness of employing the adjectives "socialized" and "undersocialized" to describe the five criteria cited in the manual. There is likely to be a distortion in communication when a layperson unfamiliar with the actual diagnostic criteria assumes that

DSM-III's "socialized" delinquent necessarily participates in commonly understood social-community behavior. As a matter of fact, a 16-year-old chronic delinquent who has engaged in repeated rapes and assaults, but who relates intimately with several members of his family and does not, or will not, "rat" on his coperpetrator ("avoiding informing on others") will be judged faute de mieux as "socialized," while an otherwise similar coperpetrator, who does inform on his accomplice (for whatever reasons) will be assessed as being "undersocialized." (Part of the difficulty here lies in the fact that a difference quantitatively of only one behavior or attitude makes for a significant and deceptive difference qualitatively between the two labels. Statistically, this is not a commendable procedure.)

Secondly, one must ask whether the five attributes enumerated in the *Manual* are adequately reflective or predictive of commonly understood adult "social" development. Several of the most careful studies demonstrate that there is no single factor or discrete cluster of behaviors that consistently identifies those who will *not* develop such disorders as adults. In fact, a rather wide range of youthful behaviors exists from which antisocial adults may emerge [*31*]. Again, assessing a youngster's social development on the basis of whether or not he or she avoids "blaming or informing" on others seems to us highly questionable. In the real world, one has to consider such factors as the motivation for avoiding blaming others, and even, in fact, who the others are, and what their values and goals are. Marohn [*32*], citing Kohut, notes that it is pointless to discuss such bonds without assessing their quality.

Finally, there is a generally disturbing normative implication in the diagnostic use of the term "socialized." The history of the study of human behavior makes clear that people of good faith often have much more difficulty in agreeing on criteria of normality than pathology [*33*]. It is questionable, on theoretical and ethical grounds, as to whether psychodiagnosticians should have the option to delineate necessary and sufficient conditions for normative behavior [*34*]. Surely, the task force merely meant to juxtapose an extremely deviant social attitude ("undersocialized") with one relatively less deviant. A more judicious choice of descriptors would perhaps have conveyed a more appropriate sense of the matter to those not intimately aware of the details of the evaluative process.

For the court, the socialization-undersocialization dichotomy certainly conveys a suggestion of potential differences in pathology, prognosis, and treatment. DSM-III itself seems to be ambivalent about the bifurcation it has created, acknowledging the impression it wishes to make while warning that, "the validity of these diagnostic subtypes ... is controversial," [*5*, p. 45] and noting parenthetically in an appendix to the manual that, "... the prognostic implications are still unclear" [*5*, p. 385].

In a practical sense, then, the clinician is required to make a differential diagnosis of admittedly doubtful value; our experience, almost without exception, is that this dimension is irrelevant in terms of our own recommendations to the court, and to the court's subsequent decisions. If these specific subcategories are not meaningful in our system, given the deliberate inclusion of behaviors that are specifically related to legal definitions of status offenders and delinquents, they can have only superficial validity elsewhere.

Age Factors in Conduct Disorders

As we have already noted, DSM-III makes it impossible to indicate that an individual under the age of 18 demonstrates any type of antisocial personality orientation more serious than that of a conduct disorder. As the system now stands, the most chronic 17-year-old delinquent must be placed in the same general category of mental disorder as the latency aged youngster who has only recently established a pattern of "acting up" at school or at home. There is no question that DSM-III recognizes that children who chronically violate social norms are vulnerable for future personality disorders. We challenge, however, the reluctance of DSM-III to identify genuine antisocial personality elements where they do exist

in adolescents, and we advocate some mechanism by which psychodiagnosticians can identify actual personality (as opposed to behavioral) distortions in those juveniles.

The abrupt forced discontinuity between adolescent conduct disorders and the adult antisocial personality is not unique to DSM-III. Many major authors in the field make use of a similar dichotomy [*29,31,35*]. Recognizing that we are simplifying for exposition's sake what are complex arguments, we note three rationales commonly used for limiting the "antisocial" label to adults. First, there is a fear that such labeling may prejudice the possibilities for treatment and rehabilitation for youths so identified. Second, the child's behavior is not viewed as fixed, and may change in the course of development. Not all delinquent minors become antisocial adults. Finally, the argument has been advanced that the behaviors needed to demonstrate genuine antisocial attitudes are only available to adults in this society.

We share a justified fear of "labeling," but the fact is that *all* professional diagnoses must be used with caution, and understood in their proper context. Any label, even a laudatory one, can be harmful if it is misused or misunderstood. We do recognize that children exist in a process of dynamic development. It has been estimated that up to 90% of all adolescents become involved in at least one action for which they could be legally culpable at some point in their youth, and a recently published longitudinal study from an urban area found that almost half of all delinquents convicted of a first offense had no further juvenile court contacts [*36*]. Nonetheless, a significant number of young offenders do go on to establish adult criminal careers. The fact that one cannot absolutely predict the eventual adult personality structure from the childhood or adolescent orientation to antisociality is no reason to avoid recognizing the personality distortions that may in fact exist in a given juvenile. DSM-III certainly allows the clinician to diagnose other distortions of personality (for example, Schizoid and Avoidant Disorders of Childhood and Adolescence) in youngsters, even though there is no more clear evidence that such difficulties are more stable in the individual's development than antisociality.

We demur from the position that the behaviors necessary to establish the accuracy of the antisocial orientation as a formal diagnosis are available only to adults; the diagnosis can and should be made more on general attitudinal and personality elements of the syndrome (for example, disregard for the truth and recklessness) than on its behavioral aspects. In any case, our forensic science practice shows that delinquency is not necessarily different in style or content from adult crime. Children and adolescents today encounter a wider range of experiences, opportunity, and independence than their parents did only a generation earlier. Everything from the voting age to the age of first menstruation has dropped in the past few decades. Our own intensive clinical experience has exposed us to many youths who simply show all the attitudinal (and often many of the behavioral) attributes of the antisocial adult. For these individuals, a "conduct disorder" is a grossly inadequate diagnosis. Its overuse creates distortion of expectation for courts and social agencies, and its adoption with such hardened individuals must invariably penalize the benign delinquent who must share the identical rubric. From Marohn [*32*] we also derive the interesting implication that the reluctance of the *Manual* to recognize such potent disturbances in adolescent development may reflect an overall professional failure to appreciate the generally unique qualities of adolescents.

Finally, we note that psychiatric diagnosis of "Psychopathy" has always had a strong relationship to whatever assumptions about criminality and individual responsibility were prominent in the zeitgeist of the times. Today's legal system is moving increasingly in the direction of recognizing that juveniles as young as 13 may be as responsible for their actions as if they were adults [*37,38*]. Individual clinician's value judgments may not be consonant with such changes, but a diagnostic system that does not allow for greater flexibility of professional judgment in this regard, when the society itself is beginning to encourage such legal flexibility, risks anachronism.

We believe that the "conduct disorder" remains valuable for many young people, and we would maintain a distinction of some type between "aggressive" and "nonaggressive" subtypes. We would, however, eliminate altogether the dimension of socialization, and add an Antisocial Disorder of Adolescence which makes use of attitudinal and internal psychic traits corresponding to those used with adults. Thus, a child could be diagnosed as a conduct disorder without any assumptions or implications about deeper lying pathology; the juvenile could also be diagnosed when appropriate with the adolescent antisocial label. We would also recommend that the age at which the Adult Antisocial Personality Disorder can be applied be modified to incorporate some leeway for considered judgment. For example, one might be able to employ the full adult designation in those cases where a minor had been out of the custody or broad control of his parents for a significant period of time. We feel strongly that modifications in these diagnoses, along the lines that we have proposed, would make the evaluation process more meaningful and consistant with reality in those settings where such diagnoses have their greatest use and significance.

The Reliability of Diagnostic Judgment

While justification of the diagnostic process rests on a generally accepted accumulation of scientific data and clinical observation, the degree of reliability for any diagnosis will vary along a continuum ranging from the tentativeness of an intuitive "hunch" to unqualified confidence in the results of a highly formalized assessment. The accuracy which the clinician attributes to his evaluation will depend on such factors as the conditions under which the evaluation was undertaken and the degree of cooperation offered by the client. Within the body of the diagnostician's report, there are usually both overt and covert indicators of such factors.

Currently, DSM-III provides several alternatives to indicate that a final diagnostic judgment has not been achieved. The phrase "rule out" (or R/O), followed by a specific mental disorder, demonstrates that the diagnosis reflects limited information at the clinician's disposal. "Atypical" may suggest the clinician is confident of the general category within which the individual's disorder falls, although the assessment picture is clouded as to which specific subcategory will be appropriate; unfortunately, "atypical" is also employed, in certain circumstances, merely to indicate that DSM-III provides no specific label for the disorder, even when the diagnostic picture is in fact clear. Such would be the case when one was dealing with a statistically rare but nonetheless clearly defined disorder. Finally, the statement "diagnosis deferred" is available when no conclusion at all can be reached, within the context of the examination, as to the presence or absence of any impairment.

All of these options are helpful in communicating the limitations of diagnoses. However, while the *Manual* has provided some welcome flexibility in judgment, the structure of DSM-III—its detailing of requirements for each diagnosis—engenders a potential set of new difficulties. In most cases, a client must demonstrate an invariant number or sequence of behaviors to be placed within a specific category; generally, the clinical picture must have existed for a fixed length of time before the diagnosis can be established. However, individual psychopathology is viewed almost universally as the outcome of a dynamic process, whether that process is defined as reflecting behavioral, psychodynamic, interpersonal, or neurogenetic assumptions of human development. Syndromes rarely appear "full blown," but emerge with varying degrees of definition over time. A contradiction is inherent between the necessarily static and formalized definitions of any diagnostic schema and the actual flux of life itself.

An individual may display many of the characteristics associated with a disorder without yet manifesting the full set of criteria articulated by DSM-III. For example, a dysthymic disorder (neurotic depression) in an adult must have continued for two years before the actual diagnostic label would be applied. If the clinician could only document one and a half

years of depression, he or she could not use that diagnosis, and would have to rely upon other options, technically correct, which might provide a less meaningful reflection of the individual.

The tension between the evolving nature of most mental disorders and the rigid requirements of DSM-III creates a quandry for clinicians. The dilemma exists for the author of a report, and perhaps even more so for the "consumer," who may experience difficulty reconciling the mental state captured in the diagnosis with the actual presenting picture. Such difficulties will be highlighted in an adversarial forum. We do not believe that the forensic science proceeding, particularly at the dispositional phase, is incompatible with the exercise of diagnostic judgment. On the contrary, such settings, with their emphasis on accuracy and clarity of communication between clinicians and educated but properly skeptical laypersons, are in fact rigorous and appropriate tests of the value of diagnostic systems.

We would therefore suggest an addition to alternatives for noting a qualified level of diagnostic certainty. Greater flexibility would be possible if one were able to indicate the indefinite or evolving quality of the client's disorder. The term "provisional" is currently used by DSM-III in conjunction with "rule out," as noted above. In situations where the clinical picture was already well organized along the lines of a discrete disorder, but lacked some major criterion of the formal diagnosis, we would propose a prefix of "P" (for provisional) immediately before the diagnosis to indicate that, in the professional's best judgment, *all* of the formal criteria of the disorder were in fact likely to emerge within six months of the date of the evaluation. To insure that "P-diagnoses" did not become excuses for sloppy clinical thinking or observation, we would insist that no more than one of the final criteria be absent from the clinical picture at the time of the assessment. We would also recommend that the P-diagnosis be valid for no more than a six-month period following the diagnosis. If a follow-up evaluation at the end of that period still did not substantiate the clinician's previous impression, a different diagnosis would have to be used; if an examination were not conducted by the end of the six months, the P-diagnosis would automatically be invalidated, a recognition on the limitations on the level of reliability of the procedure.

Our proposal, which may admittedly seem somewhat complex, offers advantages for all those involved with assessment. It limits the frequency with which the clinician is forced to use the "atypical" categories when they do not really apply. A P-diagnosis is distinguished in function from "diagnosis deferred" and "rule out" in that the latter two terms indicate that insufficient clinical material is available to the clinician, while the P-diagnosis signifies that the clinical picture is established, but is temporarily discrepant with a specific diagnostic criterion. For research purposes, a provisional diagnosis provides a simple quantification for a qualitative observation. The clinician, and those who use his services in and out of the court setting, will profit from the opportunity to extend the range of understanding with this controlled but potent option.

Conclusions

DSM-III represents a significant advance in the formulation and tabulation of diagnostic knowledge and, as it stands, is a useful tool in the family court setting. We have attempted here to indicate certain areas where, however, the *Manual* either falls short of, or is somewhat at odds with, our experience as clinicians in an urban juvenile court setting. We have tried to present material that can offer court personnel a broader awareness of how the generally accepted nomenclature relates to some of the unique characteristics of a family court caseload. We have suggested as well directions for possible modifications in the diagnostic schema which would allow it to be both more inclusive, and more specific, for the individuals whom we see. Eventually, perhaps, the wider range of family-based disturbances and psychopathology will be researched and established as meaningful diagnostic entities.

We hope that our efforts here will promote a greater awareness of the value of the in-

formed diagnostician within the legal system. Since some of our ideas are admittedly controversial, we also hope to encourage our colleagues to respond to our observations from the context of their own forensic science experiences. We will feel satisfied if we have added something to the continuing intellectual dialogue that makes participation in the diagnostic activity so stimulating and gratifying.

References

[1] Schuster, R. and Guggenheim, P., "Focus of Clerical Practice in a Family Court Mental Health Service," in *Critical Issues in American Psychiatry and the Law*, R. Rosner, Ed., Charles C Thomas, Springfield, IL, 1982.

[2] Lyskowski, J. and Tsuang, M., "Precautions in Treating DSM-III Borderline Personality Disorders," *American Journal of Psychiatry*, Vol. 137, No. 1, Jan. 1980, pp. 521-525.

[3] Schacht, T. and Nathan, P., "But Is It Good for Psychologists?" *American Psychologist*, Vol. 32, 1977, pp. 1017-1025.

[4] Spitzer, R., Williams, J., and Skodol, A., "DSM-III: The Major Achievements and an Overview," *American Journal of Psychiatry*, Vol. 137, No. 2, Feb. 1980, pp. 151-164.

[5] *Diagnostic and Statistical Manual of Mental Disorders*, (DSM-III), 3rd ed., The American Psychiatric Association, Washington, DC, 1980.

[6] Schuster, R. and Guggenheim, P., "An Investigation of the Intellectual Capabilities of Juvenile Offenders," *Journal of Forensic Sciences*, Vol. 27, No. 2, April 1982, pp. 393-400.

[7] Bryan, I. and Bryan, J., "Learning Disorders," in *Handbook of Minimal Brain Dysfunction: A Critical View*, H. Rie and E. Rie, Eds., John Wiley and Sons, New York, 1980.

[8] Meier, J., *Developmental and Learning Disabilities*, University Park Press, Baltimore, 1976.

[9] Waugh, K. and Bush, W., *Diagnosing Learning Disorders*, Charles E. Merrill, Columbus, OH, 1971.

[10] Frierson, E. C. and Walter, B., Eds., *Children with Learning Disabilities*, Appleton-Century Crofts, New York, 1967.

[11] Rie, E., "Effect of MBD on Learning, Intellective Functions, and Achievement," in *Handbook of Minimal Brain Dysfunction: A Critical View*, H. Rie and E. Rie, Eds., John Wiley and Sons, New York, 1980.

[12] Bromberg, W., *The Uses of Psychiatry in the Law*, Quorum Books, Westport, CT, 1979.

[13] MacDonald, J., *Psychiatry and the Criminal*, Charles C Thomas, Springfield, IL, 1976.

[14] Kempe, C. and Helfer, R., Eds., *The Battered Child*, 3rd ed., University of Chicago, Chicago, 1980.

[15] Renvoize, J., *Uses of Violence*, Routledge and Kegan Paul, Boston, 1978.

[16] Rosen, I., *Sexual Deviation*, 2nd ed., Oxford University Press, Oxford, 1979.

[17] Walters, D., *Physical and Sexual Abuse of Children*, University of Indiana Press, Bloomington, IN, 1975.

[18] Gebhard, P., Gagnon, J., Pomeroy, W., and Christianson, C., *Sex Offenders*, Harper and Row, New York, 1965.

[19] Quinsey, V., Chapin, T., and Carrigan, W., "Sexual Preferences among Incestuous and Nonincestuous Child Molesters," *Behavior Therapy*, Vol. 10, No. 4, 1978, pp. 562-565.

[20] Dixon, K., Arnold, K., and Calestro, K., "Father-Son Incest: Underreported Pyschiatric Problem?" *American Journal of Psychiatry*, Vol. 135, No. 7, July 1978, pp. 835-836.

[21] Scott, W., "Attachment and Child Abuse: A Study of Social History Indicators among Mothers of Abused Children," in *Traumatic Abuse and Neglect of Children at Home*, G. Williams and J. Money, Eds., Johns Hopkins University, Baltimore, 1980.

[22] Aries, P., *Centuries of Childhood*, Vintage Books, New York, 1962.

[23] Korbin, J., "The Cross Cultural Context of Child Abuse," in *The Battered Child*, 3rd ed., C. Kempe and R. Helfer, Eds., University of Chicago Press, Chicago, 1980.

[24] Steele, B., "Psychodynamic Factors in Child Abuse," in *The Battered Child*, 3rd ed., C. Kempe and R. Helfer, Eds., University of Chicago Press, Chicago, 1980.

[25] Spinetta, J. and Rigles, D., "The Child Abusing Parent: A Psychological Review," in *Traumatic Abuse and Neglect of Children at Home*, G. Williams and J. Money, Eds., Johns Hopkins University, Baltimore, 1980.

[26] Wright, L., "The 'Sick but Slick' Syndrome as a Personality Component of Parents of Battered Children," in *Traumatic Abuse and Neglect of Children at Home*, G. Williams and J. Money, Eds., Johns Hopkins Press, Baltimore, 1980.

[27] Millon, T., *Disorders of Personality*, John Wiley and Sons, New York, 1981.

[28] Lewis, D. O. and Balla, D., "'Sociopathy' and its Symptoms: Inappropriate Diagnosis in Child Psychiatry," *American Journal of Psychiatry*, Vol. 132, No. 7, July 1975, pp. 720–722.
[29] Jenkins, R., *Behavior Disorders in Childhood and Adolescence*, Charles C Thomas, Springfield, Illinois, 1973.
[30] Robins, L., "Sturdy Childhood Predictors of Adult Outcome: Replications from Longitudinal Studies," *Psychological Medicine*, Vol. 8, 1978, pp. 611–622.
[31] Robins, L., "Aetiological Implications in Studies of Childhood Histories Relating to Antisocial Personality," in *Psychopathic Behavior: Approaches to Research*, R. Here and D. Schalling, Eds., John Wiley and Sons, Chichester, England, 1978.
[32] Marohn, R., "Personality Disorders and Adolescence," in *Personality Disorders*, 2nd ed., J. Lion, Ed., Williams and Wilkins, Baltimore, 1981.
[33] Neubauer, P., "Normal Development in Children," in *Manual of Child Psychopathology*, B. Wolman, Ed., McGraw-Hill, New York, 1972.
[34] Halleck, S., *The Politics of Therapy*, Science House, New York, 1971.
[35] Reid, W., "The Antisocial Personality and Related Symptoms," in *Personality Disorders*, 2nd ed., J. Lion, Ed., Williams and Wilkins, Baltimore, 1981.
[36] Wolfgang, M., "Seriousness of Crime and a Policy of Juvenile Justice," in *Delinquency, Crime, and Society*, J. Short, Ed., University of Chicago Press, Chicago, 1976.
[37] Guggenheim, P., "Juvenile Justice—Changes in the N.Y.S. Law," *The Bulletin*, Vol. 22, No. 1, 1979, pp. 2–7.
[38] Guggenheim, P., "The Juvenile Offender Law," *The Bulletin*, Vol. 25, No. 6, 1981, pp. 1–3.

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