The New *Diagnostic and Statistical Manual of Mental Disorders, DSM-5*: Implications for Accommodations Requests

by Lawrence J. Lewandowski, Ph.D., and Benjamin J. Lovett, Ph.D.

Applicants who request accommodations on a bar exam are far more likely to have a mental disability (i.e., a learning, cognitive, or psychiatric disability) than a physical one. As such, their reported disabilities fall under the purview of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), updated periodically by the American Psychiatric Association (APA). In May 2013, the latest edition of the *DSM* (the *DSM-5*) was released.[1] Nineteen years had passed since the previous edition, so many changes were made to the statistical information about the disorders, such as how prevalent they are. More importantly from our perspective, many changes were also made to the criteria used to diagnose disorders, including the disorders most commonly seen in bar exam accommodations requests.

In this article, we discuss aspects of the *DSM-5* that are most relevant for bar examiners. We begin by covering general changes from the previous *DSM* edition and discussing some of the controversies that arose during the revision process. We then focus on selected specific disorders, some of whose criteria have changed substantially, and the implications for state bars reviewing requests for disability accommodations. We conclude by summarizing the *DSM*'s role in the overall context of the test accommodations process and by forecasting the general long-term impact of the *DSM-5* on bar exam accommodations.

General Changes in the *DSM-5*

Multiaxial System Eliminated

Psychiatrists, psychologists, and many other professionals became familiar with the *DSM*'s previous edition, the *DSM-IV*, published in 1994, and its mini-update in 2000 (the *DSM-IV-TR*).[2] These manuals plotted different disorders and other patient features on five different "axes" and asked diagnosticians to make a "multiaxial" diagnosis, for which clinicians would note not only major psychiatric disorders, but also personality disorders, general health conditions, social stressors, and the person's overall functioning. One major change in the *DSM-5* is that this multiaxial diagnosis system is gone. Instead, personality disorders have been moved into the same category as major psychiatric disorders, and the content from the other axes has been deleted entirely.

This change is a very significant one, in part because one of the deleted axes measured the person's overall functioning. This Global Assessment of Functioning (GAF) was a rating on a scale from 1 to 100, based on standardized guidelines, which indicated the person's level of functional impairment—the degree to which he or she had trouble functioning in real-world settings. Functional impairment is related to the definition of disability

under the Americans with Disabilities Act (ADA) ("a physical or mental impairment that substantially limits one or more major life activities"),[3] and so it is fair to say that the *DSM-5* has less explicit emphasis on functional impairment, since the GAF has been eliminated.

Given the elimination of the GAF, state bars should be reminded that a *DSM* diagnosis by itself does not mean that someone is disabled in a legal sense—which has always been the case, even before the elimination of the GAF. Indeed, as the *DSM-5* admits in a prefatory note:

> In most situations, the clinical diagnosis of a *DSM-5* mental disorder . . . does not imply that an individual with such a condition meets the legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the *DSM-5* diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.[4]

Disorder Groupings Changed

A second general change to the *DSM-5* has to do with the groupings of disorders. The *DSM-IV-TR* had a category called Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence, and it was this category that housed learning disabilities and Attention-Deficit/Hyperactivity Disorder (ADHD), along with conduct problems and separation anxiety. This category had no theme to the underlying nature of the disorders in its grouping; they were simply disorders that tended to be diagnosed in youth. In contrast, the *DSM-5* has an entirely new set of categories, and learning disabilities and ADHD fall under a new category, Neurodevelopmental Disorders.

We view this as a positive change, one that will hopefully remind diagnosticians that these disorders have clear biological underpinnings, and regardless of when the learning and attention problems are first diagnosed, they represent problems in the initial acquisition of cognitive and academic skills. Therefore, evidence from childhood is critical to making a valid diagnosis and establishing a developmental pattern of functional impairment.

Controversies and Criticisms of the *DSM-5* Revision Process

The *DSM-5* is the first edition to have been developed during the Internet age. Therefore, much of the discussion and debate over the *DSM-5* was open to the general public. Part of this was by design; the APA put drafts of proposed revisions on its website and accepted public comments on the proposals. In addition, newspapers and magazines ran articles during the revision process, some of them on specific controversies such as the changing criteria for autism that were said to be more stringent, potentially removing the label (and attendant services) from many children.[5]

Finally, many critics—some of them trained professionals, others not—took to weblogs and other Internet-based media to criticize every step of the revision process. One of the less expected critics, retired psychiatrist Allen Frances, had been in charge of the *DSM-IV* revision process. Frances penned column after column against the *DSM-5* throughout the revision process, eventually writing a

book, *Saving Normal*, which was published at almost the same time as the *DSM-5*.[6]

A Few Specific Criticisms

Several criticisms are worth noting briefly; most have been covered in Frances's work, and other commentators have noted most of these as well.

- First, while placing proposed revisions on the APA website might seem transparent, the revision process was in fact highly secretive, and members of the working groups that made final proposed changes were required to sign confidentiality agreements, so it is unclear how some of the final decisions were made.
- Second, the final *DSM-5* document has a number of careless writing errors, so that the manual at times seems to contradict itself. As Frances notes, the manual was likely rushed to print and was in serious need of a general text editor.[7]
- Third, the diagnostic criteria and accompanying narrative descriptions of the disorders have a variety of "escape clauses," which appear to allow diagnosticians to make diagnoses even when the *DSM-5*'s own formal criteria for a disorder are not met.
- Finally, the *DSM-5* continues the tradition of having substantially more disorders than its predecessor (322 in the *DSM-IV*, 392 in the *DSM-5*), which could encourage overdiagnosis, unless we assume that the actual number of different mental disorders has substantially increased since 1994.

From our vantage point, the most troubling problems with the *DSM-5* are the careless writing errors, inconsistencies, and escape clauses, which we worry will all have the same effect: they will make diagnosis more subjective and permit clinicians to make diagnoses regardless of whether a patient meets official criteria. In fact, these problems serve as a caveat for everything that we say in this article about changes to the criteria for specific disorders. Indeed, the post-*DSM-5* era may see a rise in the number of lawsuits in which the presence of a disorder becomes a debated point, without even considering whether the disorder (if present) constitutes a disability.

A Look at Specific Disorders in the *DSM-5*

Learning Disabilities

Previous versions of the *DSM* have used terms such as Learning Disorders and Academic Skills Disorders to identify learning disabilities. In the *DSM-5,* the term has been changed to Specific Learning Disorder (SLD), which is a single overall diagnosis describing deficits in general academic skills, combining the previous separate diagnoses particular to reading, mathematics, and written expression. This modified diagnostic category now has four criteria (which we describe in this section), and the disorder may cause impairment in up to three domains: reading, mathematics, and written expression. Another diagnostic specifier in the recent version has to do with rating the severity of the disorder as mild, moderate, or severe.

As with previous definitions, SLD is still believed to be a biologically based developmental disorder that produces cognitive abnormalities which underlie learning deficiencies in reading, writing, and mathematics. The basis for the diagnosis, however, is not biological but rather a result of a synthesis of different types of evidence: developmental, edu-

cational, medical, and family histories, as well as school records and psychoeducational assessment.

Criterion A: Symptoms

One change to the diagnosis of learning disabilities from the *DSM-IV-TR* is the focus on symptoms of difficulties in learning fundamental academic skills (e.g., difficulty reading words, inaccurate spelling, excessive grammar or punctuation errors, problems applying math facts and solving math problems). This criterion (Criterion A) is much more detailed than it was under the *DSM-IV-TR*. The focus is on problems that can be observed, described, specified, and measured.

In this spirit, it should be noted that there is no longer a subcategory of Learning Disorder Not Otherwise Specified (LD-NOS). LD-NOS was a diagnosis (under the *DSM-IV-TR*) given to individuals who did not meet criteria for one of the specific learning disorders, although these individuals may have demonstrated mild problems in reading/language, math, and writing. This diagnosis was controversial for its lack of specificity and its openness to subjectivity. Learning disorders are now considered as *specific*, so there is no longer an option to diagnose a learning disorder based on, for example, processing speed, memory retention, or executive functioning, as was often the case under the *DSM-IV-TR.*

Criterion B: Academic Skills

The new SLD definition puts more emphasis on the impairment of academic skills (Criterion B). This criterion moves the *DSM-5* closer to the ADA standard for determining a disability. The *DSM-5* definition states that with SLD, "affected academic skills are substantially and quantifiably below those expected for the individual's chronological age . . . ."[8] This essentially is the "average person standard" that has been applied in disability law for years.[9] The *DSM-5* no longer takes the position that one's impairment is related to one's IQ or level of schooling. In other words, one does not compare one's academic achievement score to one's IQ score (the outdated discrepancy approach) or, in the law school setting, to the achievement of peers attending law school.

The SLD guidelines further suggest that academic skills that are well below average should be at least 1.5 standard deviations below the population mean (a standard score at or below 78, or a score below the seventh percentile). A more lenient threshold can be considered when "learning difficulties are supported by converging evidence from clinical assessment, academic history, school reports, or test scores"[10] (an escape clause). Moreover, for adults, "a documented history of impairing learning difficulties may be substituted" for a current assessment[11] (another escape clause).

The escape clauses notwithstanding, the changes regarding learning disabilities in the *DSM-5* uphold a more rigorous standard for diagnosis than is typically found in schools under the Individuals with Disabilities Education Act (IDEA).[12] Bar exam applicants seeking test accommodations often argue that their reading or writing, for example, is merely average while their intelligence is above average. Under previous discrepancy models for learning disabilities, applicants and clinicians could argue that this aptitude–achievement discrepancy constituted a learning disorder, and many state special education systems continue to permit this, since IDEA does not proscribe it. But the *DSM-5* SLD definition, similar to the ADA standard for determining a disability, has adopted an "average person" standard and indicates that average test scores do not constitute an impairment, no matter how high one's IQ. Clearly, there are many bar exam applicants who might have

qualified for a learning disability diagnosis based on a discrepancy model (which does not consider impairment relative to the average person) who will not qualify for an SLD diagnosis under the *DSM-5*.

Criterion C: Age of Onset

This new SLD definition also seems to put more emphasis on age of onset than previous *DSM* learning disability definitions, noting that learning difficulties must "begin during school-age years" (Criterion C).[13] The *DSM-IV-TR* criteria said nothing about the age when symptoms began. Unfortunately, there is yet another escape clause in the *DSM-5,* wherein the criterion states that the difficulties "may not become fully manifest" until academic demands increase.[14] Still, the narrative text accompanying the criterion states that "the learning difficulties are readily apparent in the early school years in most individuals."[15]

Typically, a learning disability has been viewed as a childhood disorder with an early onset. This has made it difficult for a previously undiagnosed law student to obtain a diagnosis during law school and begin establishing a need for test accommodations. It seems that the *DSM-5* is open to the idea of late diagnosis, particularly if mitigating measures (e.g., accommodations, tutoring) masked the learning disability until academic demands became overwhelming.

Criterion D: Exclusionary Criteria

Finally, SLD Criterion D essentially covers all "exclusionary criteria" in stating that the learning difficulties must not be "better accounted for" by such things as general low intelligence, sensory deficits, other medical or neurological conditions (e.g., pediatric stroke), lack of language proficiency, psychosocial adversity, or inadequate educational instruction.

Of most relevance to accommodations on the bar exam is the issue of language proficiency. There are a growing number of students in the United States for whom English is a second language. Many states now allow test accommodations for such students at the K–12 level. Recent research has shown that some of these students, particularly those with low language proficiency, are at risk on timed reading tasks similar to those on the bar exam.[16] Some of these students perform similarly to students with learning disabilities due to their language deficiencies, yet they do not qualify legally for test accommodations. Bar exam administrators may be seeing an upswing in accommodations applications from these students, who may be told or may believe that they have disabilities.

Sorting out applicants with bona fide learning disabilities from those with learning difficulties due to poor language proficiency can be a challenging task and one that is often overlooked by clinicians. Administrators must insist that test accommodations are considered only when a disability, not a language difference, accounts for low test performance. If an applicant truly has a learning disability, it should be present in English *and* in the student's primary language, and that should be documented.

DSM-5 *SLD Implications*

In summary, the new SLD definition seems to have implications for reviewing the documentation of applicants for accommodations on the bar exam. The *DSM-5* makes it clear that SLD must be specific to academic skill in the areas of reading, writing, or mathematics. No longer can clinicians diagnose learning disorders based on weaknesses in processing speed, memory retention, executive functioning, and so on.

Also, SLD should be denoted by significant impairment as measured objectively on standardized achievement tests (and/or a well-documented history of learning difficulties), and the impairment should be based on test scores that are below average as compared to one's age group. There is recognition that this impairment can be detected at any age, not necessarily in childhood.

It would appear that these changes should narrow the definition of learning disabilities slightly. By making the diagnosis more specific, objective, and based on impairment relative to the average person, these changes should make it easier for documentation reviewers to decide whether an applicant qualifies for accommodations based on a learning disability.

Attention-Deficit/Hyperactivity Disorder

ADHD is still considered to be a persistent disorder that interferes with one's development and functioning. However, there have been a number of changes in the *DSM-5* definition of ADHD, some of them quite significant in making test accommodations decisions. In particular, the *DSM-5* has gone to greater lengths to differentiate adult and child diagnostic criteria.

Criterion A: Symptoms

ADHD diagnosis in the *DSM-5* is largely based on the 18 symptoms (Criterion A) that have been carried over from previous *DSM* versions with a few wording changes. To receive a diagnosis of ADHD, a person must have at least six or more symptoms of inattention, or six or more symptoms of hyperactivity and impulsivity (or six in both categories). The *DSM-5* lowers the threshold to five symptoms for those 17 years of age/and older. (See later section on ADHD Specifiers.) The symptoms must negatively impact social, academic, or occupational activities. (The *DSM-IV-TR,* on the other hand, stated that the symptoms must be "maladaptive and inconsistent with developmental level."[17]) There is little guidance as to what constitutes a negative impact, and administrators responsible for reviewing accommodations applications will certainly be presented with personal statements in which applicants claim to have symptoms that impact these life activities. In a sense, this wording in the *DSM-5* seems to liberalize the assessment of who may have ADHD symptoms.

Criterion B: Age of Onset

Criterion B, which stipulates age of onset of symptoms, has long been controversial. In the *DSM-5,* the age of onset has been changed from 7 to 12 years of age. The definition now states that "several" symptoms have to be present before age 12. This relaxes the previous age of onset, which many felt was too strict. It is believed that a person with ADHD should manifest "several" of the symptoms by age 12, and that there should be a "substantial clinical presentation during childhood."[18]

Criterion C: Settings

Criterion C did not change in the *DSM-5.* It stipulates that symptoms must be present in two or more settings (e.g., school, home, and work). This is sometimes an issue in the documentation provided by applicants for test accommodations. Often the evaluators make an ADHD diagnosis based on test results obtained during a clinical assessment at one point in time, or based on the reports of *only* a parent or *only* a teacher. A more comprehensive approach would be to elicit clinical information from multiple informants in multiple settings (e.g., parents at home and teachers at school).

Ostensibly this criterion assures that the individual with suspected ADHD does not merely manifest symptoms in specific situations (e.g., high-stakes

exams, competitive situations, certain task demands). ADHD symptoms should be pervasive and persistent, being present in multiple settings and across time.

Criterion D: Impairment

Criterion D, known as the impairment criterion for ADHD, has been reworded as follows: "There is clear evidence that the symptoms interfere with, or reduce the quality of social, academic, or occupational functioning."[19] This is contrasted to the *DSM-IV-TR* wording of Criterion D: "There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning."[20] It appears that in the *DSM-5* the impairment criterion has been liberalized. The language in this criterion does not mention "clinically significant impairment" or a "substantial limitation." (Interestingly, the *DSM-5* raised the bar on demonstrating impairment for learning disabilities with its SLD definition, but it appears that it has clearly lowered the bar with respect to the ADHD definition.)

Criterion E: Exclusionary Criteria

Criterion E ensures that the symptoms are not better explained by other disorders, such as psychotic, anxiety, and mood disorders, as well as dissociative, personality, and substance disorders. Because ADHD symptoms (especially inattention symptoms) are so common and overlap with conditions such as anxiety, depression, and concussion, for example, it is important that evaluators perform a careful differential diagnosis.

Bar exam administrators may receive accommodations applications that claim multiple disorders, or only one disorder despite an evaluation that lists multiple diagnoses. The determination of qualification for accommodations becomes complicated by this diagnostic uncertainty. With ADHD in particular, it is crucial to have a recent comprehensive and competent clinical assessment that teases out ADHD from other conditions.

ADHD Specifiers

As with other new definitions in the *DSM-5,* several "specifiers" are now used to sharpen an ADHD diagnosis. One specifier has to do with presentations (formerly called subtypes) of ADHD. The current criteria define three presentations of ADHD similar to the subtypes stated in the *DSM-IV-TR*:

- Predominantly Inattentive (I) (six or more I symptoms),
- Predominantly Hyperactive/Impulsive (H/I) (six or more H/I symptoms), and
- Combined presentation (six or more I and H/I symptoms).

Also, there are two special categories called Other Specified ADHD and Unspecified ADHD. The former refers to a case in which the individual does not meet full criteria for any of the presentations yet experiences significant distress or impairment, and the clinician states the reason that the presentations do not meet criteria. The latter category is essentially the same case, but the clinician does not specify a reason why the criteria are not met.

These last two categories are new in the *DSM-5* and are sure to be confusing and controversial. These categories, coupled with language changes in Criterion A and Criterion D, seem to significantly liberalize the ADHD diagnosis. Everyone has ADHD symptoms to a degree (e.g., distractibility), many will feel that these symptoms interfere with their functioning, and many will qualify for a diagnosis even if they do not meet full criteria for a specific ADHD presentation.

DSM-5 *ADHD Implications*

Documentation reviewers and administrators responsible for making accommodations decisions will likely be challenged when interpreting the changes in the ADHD definition. Contrary to the new SLD definition, the ADHD definition has become less specific, less objective, and less rigorous. Determining who is substantially limited by ADHD and really in need of accommodations to take the exam will continue to be a challenging task, and the *DSM-5* definition for ADHD only makes the task more difficult.

Autism Spectrum Disorder

Another neurodevelopmental disorder that bar examiners encounter occasionally is Autism Spectrum Disorder (ASD). Individuals with this disorder who complete law school tend to be those known formerly as having "high-functioning autism" or Asperger's Syndrome. In a controversial and debated decision, the *DSM-5* included Asperger's Syndrome, along with the three other previously separate disorders, under the new umbrella of ASD, no longer giving Asperger's Syndrome a separate category. Although individuals in the current pipeline will still have the Asperger's Syndrome diagnosis, this change may, in the long run, increase the number of ASD claims.

Criteria A–E

Briefly, ASD is defined by two main criteria: persistent deficits in social communication and interaction (Criterion A); and restricted or repetitive patterns of behavior, interests, or activities (Criterion B). As with most other neurodevelopmental disorders, the symptoms must be present early in development (Criterion C), cause significant clinical impairment (Criterion D), and not be better explained by another disorder such as intellectual disability (Criterion E).

DSM-5 *ASD Implications*

A daylong bar exam in a room with hundreds of other tense examinees is a novel, unpredictable, and stressful situation for anyone, but especially for a person with ASD. A person with ASD might make odd noises or movements while others are working in close proximity, which could be distracting to other examinees. Then, of course, for the person with ASD, the exam setting creates the possibility of distraction, sensitivity to stimuli, preoccupations with things other than the test, faulty communication with the exam proctor, repetitive behaviors (e.g., playing with a pencil), and even perseverating on a test question.

It is important to conduct a thorough evaluation of any applicant with ASD. The evaluator should make the diagnosis based on all five *DSM* criteria, as well as on a detailed history, observations, interview, reports from other informants, and rating scales known to be sensitive to ASD. The evaluator also should carefully describe the unique symptoms of the individual with ASD so that the accommodations decision makers can assess the type and degree of impairment as well as the specific accommodation needs.

In many cases, it may be best to grant a request for a separate room to a person with ASD. This accommodation may avoid an exacerbation of symptoms and provide a more flexible setting to allow breaks, extend testing time, or deal with both relevant and irrelevant questions from the examinee. Another plausible accommodation would be extended time, especially if the individual routinely gets distracted and spends time on unessential, stereotypic behaviors (e.g., counting every comma in a reading passage). The challenge is to determine how much extra time to give a person who, by nature of the ASD condition, may spend test time on

irrelevant activities, especially when there is no way to predict how much time might be squandered.

Clearly, providing accommodations to examinees with ASD might be more a matter of educated guessing and preserving the integrity of the testing conditions for all examinees, rather than following a formula based on psychological test scores. Unfortunately, there is no research to guide accommodations decisions for individuals with ASD. Decision makers will need to make determinations on a case-by-case basis using their knowledge of the test and the test setting, as well as the characteristics and needs of the examinee. In general, we would recommend being more liberal in providing accommodations that are unlikely to confer an unfair advantage (e.g., a separate room) and more rigorous in evaluating requests for accommodations that nondisabled examinees would also want (e.g., extended time).

Anxiety Disorders

For the most part, the types and definitions of anxiety disorders have not changed substantially in the *DSM-5,* at least in a manner that would drastically affect a bar exam administrator's role. The *DSM-5* defines anxiety in terms of one's response to an anticipated or future threat, in contrast with fear, which it defines as the emotional response to a real or perceived imminent threat. The symptoms associated with both fear and anxiety include physiological (e.g., perspiring, increased heart rate), behavioral (e.g., freeze, flee, or fight), and cognitive (e.g., worry, intrusive thoughts) feelings and responses.

Typical nondisabled applicants to the bar exam are likely to be anxious and experience versions of these symptoms due to the anticipated consequences, both occupational and social, of failing the exam. So the determination of who actually has an anxiety disorder is often a matter of symptom intensity, frequency, and duration. In contrast to ADHD and SLD, anxiety disorders are not developmental, and the onset of an anxiety disorder might occur in law school, making it hard to produce evidence that anxiety has affected the applicant's performance on prior academic or standardized tests.

Various types of anxiety disorders are covered in the *DSM-5,* including Generalized Anxiety Disorder (GAD), Panic Disorder, Specific Phobia, and Social Anxiety Disorder. As consultants who review documentation for several test agencies, we have seen cases with each of these diagnoses. (It should be noted that even in this recent *DSM* version, there is no specific mention or definition of test anxiety.)

Applicants with GAD

Typically, applicants who request test accommodations claim to have GAD, a diagnosis based on excessive amounts of worry which has generalized to an array of circumstances. The claim is that the anxiety interferes with concentration and mental processing and causes fatigue, sleep disturbance, restlessness, and other symptoms. Applicants with GAD might argue that their anxiety is exacerbated by a high-stakes exam, thus interfering with their ability to perform similarly to other examinees.

There are at least two problems with this argument. One is that most people have elevated worry and arousal regarding high-stakes tests. As for the other problem, it should be noted that the report of anxiety, including symptoms and how they impair functioning, essentially comes from the person seeking accommodations, a rather subjective and individualistic perspective (e.g., "I worry about lots of things, including tests. The bar exam will make me very anxious. I don't think I can perform well when

I am so anxious. I need extra time to take some of the pressure off."). Consequently, the disability consultants and accommodations decision makers must determine the extent to which the individual is truly impaired by the anxiety, how this impairment restricts access to the exam, and what can be done about it.

Typically, these individuals do not perform differently from other examinees on psychoeducational tests (i.e., IQ, achievement, neuropsychological, etc.). It may be that their anxiety is not triggered in a clinical evaluation setting but might be triggered in the setting of a high-stakes exam. A person who claims that it is the bar exam in particular that causes excessive anxiety yet has an outstanding academic record and good SAT and LSAT scores (all obtained without accommodations) is not likely to need test accommodations. This may be referred to descriptively as test anxiety; however, test anxiety is not recognized as a *DSM-5* disorder. Rather, an applicant for accommodations should have a diagnosis of an anxiety disorder such as Panic Disorder and should be able to demonstrate persistent and significant distress due to the condition that impairs his or her ability to access a high-stakes exam. For a person with intense anxiety that *is* persistent and impairing, the issue becomes what accommodation is appropriate.

The majority of applicants with anxiety disorders request extended time, usually arguing that more time will reduce stress and cause less worry, thus allowing them to perform their best. But how much time is needed or deserved? Is it fair to allay one person's discomfort and worry but not another's? How do we know for certain that anxiety would in fact interfere with test performance if the exam were taken under standard time conditions? The answer to these questions is that there is no answer.

Each case must be judged individually and carefully but ultimately decided by objective and quantifiable evidence of significant impairment that can be mitigated by a specific amount of time. We would want to see credible, objective evidence that the individual is both (1) impaired in real-world situations outside of tests and (2) impaired in test performance due to anxiety when not given accommodations. In our experience, few GAD cases provide such a data-based rationale for extended time.

Applicants with Other Anxiety Disorders

The issues presented by other anxiety disorders (e.g., Panic Disorder, Specific Phobia, Social Anxiety Disorder) are similar. Clinicians and applicants may claim that the exam, either as a phobic stimulus or as a social evaluation of performance, creates a threat to the individual that causes stress, worry, physiologic arousal, and mental interference. In extremely stressful situations, an individual might have a panic attack (i.e., a surge of intense fear or discomfort that usually includes a host of physical symptoms), perhaps due to Panic Disorder with a history of attacks. These are real conditions that vary in degree and can be quite disabling.

What needs to be determined once again is the extent to which the anxiety impairs one's ability to fully access the bar exam. In the rare cases where access is clearly limited, it makes sense to test the examinee in a separate room and to prepare the proctor for every possibility. Some conditions will require medication, possibly accompanied by water and a light snack. Extra breaks could be helpful in allowing an individual time to relax and use self-coping strategies.

Once again, the most difficult decision pertains to extended time. Most likely, extended time will reduce a person's worry about time pressure on a high-stakes exam. This should reduce anxiety symptoms and allow the examinee to perform, perhaps, with better concentration and clarity of thought. Then again, who wouldn't want the time pressure removed?

DSM-5 *Anxiety Disorders Implications*

Accommodations decision makers must determine who is significantly impaired by anxiety and truly restricted in exam access, versus who might be relatively anxious yet perform reasonably well despite some anxiety. This decision will require extensive information from a comprehensive assessment that carefully measures test-taking performance and performance on high-stakes exams, especially those taken without accommodations. It is fair to say that those involved with accommodations requests will continue to see a high volume of requests based on anxiety, even though test anxiety is not a disorder.

Conclusions

The *DSM-5*'s Role in the Test Accommodations Process

The *DSM-5,* as with previous editions, is a document composed of reports from committees. In this sense, it is a patchwork quilt that has its share of inconsistencies, errors, and ambiguities. It is an imperfect document that will continue to change, but it is the diagnostic manual followed by the majority of mental health professionals in the United States.

Even though the *DSM-5* will be heavily utilized when making test accommodations determinations (and some states specifically request a *DSM* diagnosis in their guidelines), we must keep in mind that it is merely a diagnostic manual, and diagnosis is only the starting point in the accommodations process. Diagnosis is a necessary step but not a sufficient one to qualify for accommodations. In addition, consultants and decision makers must determine whether or not the individual with a diagnosis also is substantially limited in a major life activity as compared to most people, and whether or not the limitation restricts the individual's access to the bar exam. The *DSM-5* does not clearly address these other issues.

As noted earlier, the *DSM-5* definition for SLD has explicit criteria as to what constitutes impairment, and it is consistent with ADA language. Yet the other definitions of disorders do not provide the same level of guidance on impairment. Consequently, the *DSM-5* will continue to serve as a guide for making formal diagnoses but will have little impact on determining a substantial limitation, restriction of access to a test, or the specific test accommodation that may be warranted in a certain case. These decisions will need to be made on a case-by-case basis with the help of external consultants in each diagnostic area who can carefully review the objective evidence of functional impairment and make recommendations to the state law boards.[21]

Test Accommodations Practices in the Future

Despite the limitations of the *DSM-5,* and the partial role that diagnosis plays in the test accommodations decision process, there is a growing body of research that is starting to inform test accommodations practices. Research is beginning to offer insights about the validity and effectiveness of certain accommodations, the reliability of self-reported information, the possibility of malingering in the presence of incentives, the potential for evaluator bias in advocacy situations, the role of speed in various exams, and the growth of universal design principles applied to examinations (designing tests in such a way that almost everyone could access the test in a given for-

mat; for example, a test administered on a computer with relaxed time limits, clear presentation of materials, and the simplest response method).[22]

The *DSM-5*'s Possible Long-Term Impact on Bar Exam Accommodations

If we had to guess about the longer-term impact of the *DSM-5* on bar exam accommodations, we would probably say that it will only have an impact on diagnosis, the first component in determining eligibility for test accommodations. With regard to this component, we can envision the numbers of cases decreasing for SLD and increasing for ADHD and other psychiatric categories. Because some of the diagnostic categories have become more ambiguous, liberal, and general (e.g., ADHD), there will be a greater need for documentation of a person's functional impairment and how this impairment restricts access to the bar exam.

It is our hope that mental health clinicians will heed the suggestions in this article and provide documentation that includes detailed histories, careful differential diagnoses, objective evidence of substantial limitations, and a data-based rationale for specific accommodations requests. Regardless of how wide the *DSM-5* casts the diagnostic net, accommodations decisions still will come down to proof of a substantial limitation that restricts access to the bar exam.

NOTES

1. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-5) (American Psychiatric Association, 5th ed. 2013). The APA's decision to switch from the previous use of roman numerals to the arabic numeral 5 in the latest edition reflects its intention to publish incremental updates (e.g., *DSM-5.1,* etc.) between new editions.
2. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV) (American Psychiatric Association, 4th ed. 1994); AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV-TR) (American Psychiatric Association, 4th ed., text rev. 2000).
3. Americans with Disabilities Act of 1990, as Amended, 42 U.S.C. § 12102(1)(A) (2008).
4. *Supra* note 1, at 25.
5. *E.g.,* Benedict Carey, *New Definition of Autism Will Exclude Many, Study Suggests,* NEW YORK TIMES, Jan. 20, 2012.
6. ALLEN FRANCES, SAVING NORMAL: AN INSIDER'S REVOLT AGAINST OUT-OF-CONTROL PSYCHIATRIC DIAGNOSIS, *DSM-5,* BIG PHARMA, AND THE MEDICALIZATION OF ORDINARY LIFE (HarperCollins 2013).
7. Allen Frances, *DSM-5 Writing Mistakes Will Cause Great Confusion,* The Huffington Post, June 11, 2013, http://www.huffingtonpost.com/allen-frances/dsm5-writing-mistakes-wil_b_3419747.html.
8. *Supra* note 1, at 67.
9. The "average person standard" is derived from the Equal Employment Opportunity Commission's Title I employment regulations under the ADA, which state that an impairment is a disability if it "substantially limits the ability of an individual to perform a major life activity as compared to most people in the general population." 29 C.F.R. § 1630.2(j)(1)(ii) (2010).
10. *Supra* note 1, at 69.
11. *Id.*
12. The Individuals with Disabilities Education Act is a law enacted by the United States federal government in 1990 governing how states and public agencies provide early intervention, special education, and related services to children with disabilities. (It replaced the Education for All Handicapped Children Act of 1975.)
13. *Supra* note 1, at 67.
14. *Id.*
15. *Supra* note 1, at 69.
16. J. Abedi, M. Courtney & S. Leon, *Research-Supported Accommodation for English Language Learners in NAEP,* CSE Technical Report 586, Center for the Study of Evaluation, National Center for Research on Evaluation, Standards, and Student Testing, Graduate School of Education & Information Studies, University of California, Los Angeles (Jan. 2003); K.M. Hendricks, Reading and Test Taking in College English as a Second Language Students (2013) (doctoral dissertation, Syracuse University).
17. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV-TR) 83 (American Psychiatric Association, 4th ed., text rev. 2000).
18. *Supra* note 1, at 61.
19. *Supra* note 1, at 60.
20. *Supra* note 17, at 84.
21. For a helpful overview of this consultation process, *see* M. Gordon, Ph.D., *How to Optimize the Use of Outside Consultants for ADA Documentation Reviews,* 81(3) THE BAR EXAMINER 16–24 (September 2012).

22. For more information on current research findings related to test accommodations, *see* S. Bolt & A.T. Roach, Inclusive Assessment and Accountability: A Guide to Accommodations for Students with Diverse Needs (Guilford Press 2009); B.J. Lovett & L. Lewandowski, Testing Accommodations for Students with Disabilities: Research-Based Practice (American Psychological Association, in press).

Lawrence J. Lewandowski, Ph.D., is a Professor of Psychology and a Laura J. and Douglas Meredith Professor for Teaching Excellence at Syracuse University. He also holds an appointment as Clinical Professor in the Department of Psychiatry at the Upstate Medical University. Lewandowski is a licensed psychologist who has many years of experience as a reviewer for ADA test accommodations. He received a B.A. in psychology from Northwestern University and an M.A. in psychology and a Ph.D. in educational psychology from the University of Michigan.

Benjamin J. Lovett, Ph.D., is an Associate Professor of Psychology at Elmira College in Elmira, New York, where he teaches courses on psychological testing and childhood psychological disorders. He has consulted for a variety of testing agencies and educational institutions on testing accommodations issues. Lovett holds a B.A. in psychology from Pennsylvania State University and an M.S. in psychology and a Ph.D. in school psychology from Syracuse University.