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Summary

Deposition of Michael B. First, M.D., In Re the Detention of William Davenport, aka William Cummings, Respondent. In the Superior Court of the State of Washington, in and for the County of Franklin, case no. 99-2-50349-2.

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Dr. First's Background	
9-10	I am a consultant to the American Psychiatric Association on DSM issues. I was the editor of the DSM-IV-TR (2000). I also edited the text and criteria of DSM-IV (1994). I was also involved in the final stages of the production of the DSM-III-R (1987).
The Focus of the DSM and its Relevance for Forensic Issues	
13	The primary use of the DSM is to help clinicians in making psychiatric diagnoses.
13	The DSM has been utilized in forensic arenas. It was not developed for that purpose at all. The DSM has several cautionary statements to make this point. These statements make it clear that the needs of the forensic community are not equivalent to the needs of the clinical community … the DSM was put together with the needs of the clinical community (in mind). (What were the most important of those needs?)
15	Forensic experts have cited certain disorders in the DSM as meeting SVP requirements when the disorders in and of themselves do not.
Organization of the DSM	
18	In DSM-III … the criteria were typically lettered (e.g., A, B, C …) … and under each letter there could be lists which were numbered (1, 2, 3 …).
Restrictions on Using the DSM	
20	The DSM is not to be used as a cookbook for (by?) a layperson to just open up the DSM, look at the list and basically apply them in making a diagnosis (what is the problem with this? The lay person does not have the requisite understanding of psychopathology, differential diagnosis, probabilistic reasoning, and health-care values that affect decision thresholds).
Changes to the DSM-IV-TR	
22	After 1994 … by the year 2000 … the text was not sufficiently out of date to justify a major revision in the text … except in a few extreme circumstances …the Paraphilia section of the DSM was one of the few sections in which there was a change in the criteria, because … an error was made in the DSM-IV that we felt needed to be corrected … the only other disorder I believe that there was a change was a Tic disorder … the error in the Tic disorder was similar to the errors in the Paraphilia section … because it had to do with … the clinical significance criterion … which was a requirement that … the individual disturbance has to cause either clinically significant distress or impairment.

Why Paraphilias are in the DSM	
24	The reason Paraphilias are in the DSM … (is that) historically psychiatrists have treated Paraphilias and have considered Paraphilias (as) evidence of psychopathology (Note: isn't this a result of social considerations regarding treatment needs?).
Conceptual Validity: Its Definition, and Relevance to Paraphilias and Forensic Practice	
26-27a	Conceptual validity in the clinical arena means whether something is real. We label something as a psychiatric disorder when it provides a useful function such as predicting whether someone will seek out treatment because of it. (Note. This implies an important point that is often overlooked - that is, that the development of the DSM stemmed primarily from a compassionate motivation to treat those who suffer from an illness and that forensic motives to protect the public were a secondary consideration. The clinical arena, in otherwords, sometimes tolerates a relatively high rate of false positives to maximize patient access to healthcare resources. The forensic arena, in contrast, is invested in keeping the rate of false positives low. On the average, false positives in a healthcare context receive benefits while false positives in a forensic context receive deprivations. Healthcare is about the allocation of benefits not the allocation of deprivations. A classification instrument developed in a healthcare context will therefore yield an unacceptably high rate of false positives when applied to a forensic context. These fundamental differences may explain why the APA has been so vociferous in asserting that SVP proceedings involve a misuse of psychiatry and why the use of the DSM in forensic settings falls outside its focus of convenience).
26-27b	Conceptual validity is relevant to Paraphilia. Homosexuality was a Paraphilia in DSM-II in the same sense (abnormal arousal) that Sadism is a Paraphilia today. It was removed in 1975 because so many felt it was not an abnormal sexual preference.
27	Other paraphilias have been questioned on the grounds that they are not pathological, but they've been retained because the evidence is not strict enough to prescribe their removal (Note. This policy fails the falsification test in the Federal Rules of Evidence; science requires proving that a construct exists, not proving that it doesn't; the usefulness concept in 26-27b provides a more defensible scientific perspective).
28	Regarding conceptual validity in the forensic arena, the forensic definition of a mental disorder may overlap the clinical definition, but they are absolutely not equivalent because (similar sounding) forensic terms are defined legislatively (and by the courts) (Unstated assertion: "while mental disorders in the DSM are defined by committees of health-care providers and researchers").
Theories and Procedures Underlying the Compilation of DSM-IV	
30	When we wrote the Paraphilia section we considered coming up with general criteria and putting them in a box that would apply to all Paraphilias so that each Paraphilia would be a subset (Note. This would probably look something like the section on Substance Dependence). We did it halfway. The text reflects some general criteria but they don't appear in a box.
30-31	The criteria that apply across the Paraphilias are Criterion A and B (Note. This implies that NOS Paraphilias must have an A criteriona and a B criterion).
31-32	Criterion A describes what a Paraphilia is: "recurrent, intense, sexually-arousing fantasies, urges, or behaviors … generally (but not in each specific case, see p. 33) involving (one the following three clauses) non-human objects, the suffering or humiliation of oneself or one's partner … or children or other non-consenting person that occur over a period of at least six months." In writing this compound sentence we attempted to … cover (formulate?) … the criteria under A … as they (with the idea in mind that we could?) … apply them to each of (include them in each of the boxes that

	describe?) … the eight specific disorders.
33	Non-human objects was meant to cover fetishism and transvestic fetishism … suffering or humiliation … was meant to cover sexual sadism or masochism … children or other non-consenting persons was there to cover exhibitionism, pedophilia, and voyeurism.
The Meaning of "Non-consenting Persons"	
33-34	So the phrase "children or other non-consenting persons," which has caused some confusion, was there to cover pedophilia … and (under) voyeurism … and exhibitionism … the phrase "unsuspecting stranger" is used … "the non-consenting person phrase was specifically trying to capture the objects of exhibitionism and voyeurism, and was not meant to mean anything else" (Note. Non-consenting therefore means no one else but children and unsuspecting persons).
34-35	The drafters of the DSM did not intend to imply that a rape victim was a non-consenting person. Non-consenting person was constructed (formulated?) to cover (some of) the specific Paraphilias. It was not an attempt to cover the hundreds of hundreds of Paraphilias covered under Paraphilia NOS (e.g., apotemnophilia or being aroused at the thought of being an amputee).
The Purpose of Paraphilia NOS, It's Application to Paraphilic Rapism, and More on Nonconsent	
36-37	The Paraphilia NOS category is for every other Paraphilia that exists in nature, one of which is Paraphilic Rapism, but is not tied to the use of the word non-consenting in Clause 3 of the general description of a Paraphilia. It would be inappropriate to assume that the use of the word "non-consent" in Clause 3 of the first sentence on page 566 of the DSM was in any way … connected to the issue of PR.
37	You can have PR under the NOS category but it's incorrect to say the DSM drafters were intending to include Paraphilic Rape in the DSM by using the word non-consenting.
38	The DSM is meant for clinicians. A doctor needs to come up with a diagnostic label for any patient that he or she sees in clinical practice. A specific diagnosis should be assigned if one applies. Otherwise, clinicians are told to use one of these "waste-basket categories" called NOS.
39	Paraphilia NOS applies if you, as a clinician, believe that the individual you are seeing meets the general principle of Paraphilia, yet is not one of the eight specific disorders.
The Meaning of Paraphilia NOS-Rape and the User's Responsibility for Its Validation	
41-42	If a clinician were to believe that Paraphilic Rape was a valid construct, and that a client suffered from it, Paraphilia NOS would apply. It's up to the user, however, to substantiate the validity of the category. Assigning a diagnosis of Paraphilia NOS is simply a declaration of belief, but it may or may not be valid. Insurance companies sometimes require doctors to provide justification for using a diagnosis.
Limits of the DSM and Values & Procedures that have Impacted its Content	
43-44	A cautionary statement in the DSM indicates that it reflects a consensus regarding current knowledge but does not encompass all the conditions for which people may be treated (this again points up the importance of treatment relative to public safety). Somewhere around DSM-III-R and DSM-IV a conscious decision was made to add only disorders for which there was a reasonably large body of empirical evidence. So some disorders are in the DSM because they were there before DSM-III-R (and there is no evidence for some of these disorders) while the newer ones are evidence-based.
46	The requirement for getting in the DSM is twofold: that there is a body of supportive evidence and that it is submitted for inclusion. It was easier to get in the DSM in the mid-80's. You were well on your way if you could convince Dr. Robert Spitzer, who

	directed the compilation of DSM-III, that a (favorite) category was worthwhile.
Events That Bear on the Marginal Status of PR in the DSM	
47-51	Dr. Spitzer told me before this deposition that some of the members of the sexual disorders work group thought that Paraphilic Rapism had some validity. This disorder, as well as Masochistic Personality Disorder and Late Luteal Phase Dysphoric Disorder, became the target of a lot of criticism by women's groups who felt that they might be harmful to women because they either blamed the victim (Masochistic Personality) or might allow sex offenders to evade criminal responsibility (Paraphilic Rapism). In contrast to the other disorders, Paraphilic Rapism was advanced by a very limited number of people who formulated it on the basis of clinical judgment. Given the weakness of the empirical base and the potentially explosive nature of Paraphilic Rapism, a decision was made to drop it completely. The other two disorders wound up in the Appendix that was included to encourage further research. They chose not to even put PR in the Appendix because it was so problematic.
51	No proposals were submitted for expanding the list of specific Paraphilic Disorders when the DSM-IV was compiled.
52-55	Little, if any, evidence has been collected as to the validity of PR. "It was more (that) some individuals had worked … I believe … I suspect they worked in treating Paraphilias" and (wanted to include PR) because they were working with rapists in their practice.
The Effect of Mistakes in the DSM on the Diagnosis of Paraphilia-NOS:DSM-II thru DSM-III-R	
56-61	I am aware of two mistakes that were made when the DSM was compiled. One has been corrected and the other has not. In the DSM-II the Paraphilias were conceptualized as a preferential state (and) that people with Paraphilias preferred this pattern of sexual attraction over others. This frame of reference was used to describe a couple of disorders (Pedophilia, Zoophilia) in DSM-III, which was characterized by the formulation of specified rather than conceptual criteria. Pedophilia, for example, was defined as the "act or fantasy of engaging in sexual activity with prepubertive children (that is) repeatedly preferred or the exclusive method of achieving sexual excitement. So the way that criteria were worded varied from disorder to disorder. This was corrected by including uniform wording in DSM-III-R. It was decided at this time that it was a mistake to require preferential attraction or exclusive gratification as criteria for diagnosing Paraphilias, so these concepts were dropped. So every Paraphilia was described as "over a period of at least six months, recurrent, intense sexual urges and sexually arousing fantasies involving (for example) sexual activity with a prepubescent child or children, generally age 13 or younger." They all had the same B criterion, which was the person either acted on these urges or was markedly distressed by them. To summarize, in order for you to get a Paraphilic Diagnos per DSM-III-R, you had the intense urges and fantasies, <u>and</u> you either acted on them or you were distressed by them.
The Effect of Mistakes in the DSM on the Diagnosis of Paraphilia-NOS: The DSM-IV Draft	
61-66	When we compiled DSM-IV the Paraphilia work group did not recommend any changes except to add a qualifier of Gender Dysphoria to Transvestic Fetishism and to move Telephone Scatologia up to Appendix Status rather than referring to it only as an NOS option. These recommendations were recorded for the non-committee members to review in what was called the Options Book, published by APA on 9.1.91. The DSM-IV draft criteria were disseminated on 3.1.93, six months before DSM-IV went to press. The content of the draft criteria were at this point consistent with the content of the Options Book regarding the Paraphilias. Each of them reiterated the DSM-III-R criteria.

The Effect of Mistakes on the Dx of P-NOS: Changes to the B Criterion in the DSM-IV Draft	
67-68	During the six months prior to publication Dr. Allen Frances and I decided to change the B criterion so that it "says the fantasies, urges and behaviors cause clearly significant distress or impairment in social, occupational or other important areas of functioning." We assumed that we were just standardizing the language of the B criterion so that it conformed to the language we used to describe the threshold for all disorders in the DSM, so we added this change without a lot of thought to its implications.
The Effect of Mistakes on the Dx of P-NOS: Changes to the A Criterion in the DSM-IV Draft	
68-69	"It also turned out, and something I didn't realize until today, is the other thing we did is we actually also changed the wording of the A criterion, because we wanted to emphasize the idea that we're trying to capture the idea that the person acted on the urges … now it says over a period of at least six months there's recurrent and intense sexually-arousing fantasies, sexual urges, or behaviors involving blank, and the blank is whatever the Paraphilia was …"
The Effect of Mistakes on the Dx of P-NOS: Post-Publication Feedback re B Criterion Changes	
69-71	"It was pointed out to us after the DSM-IV came out that we may have made a mistake … people interpreted (the change in the B criterion) as us meaning that we were changing the threshold … (and) requiring (a) person (to be bothered) by urges … in fact, most people with Paraphilias are *not bothered* (by their urges) … so (our change) created a whole host of problems and confusion … we meant that, for disorders like Pedophilia and (other specified Paraphilias) that involved non-consenting individuals, that acting on it was supposed to be part of it … we ended up restoring the DSM-III-R wording for those disorders, for Pedophilia, Voyeurism, Sexual Sadism, Sexual Masochism, and Exhibitionism (in the DSM-IV-TR)
The Effect of Mistakes on the Dx of P-NOS: The Current A Criterion Misleads Evaluators	
71-78	"The other problem was I didn't realize until today (p. 71) that we had rewritten the A criterion (so that) it's being used by individuals … to mean that all you need to do is to focus on behaviors in order to meet the criteria for Paraphilia, without (considering) the issue of urges and fantasies … in any book ever written about Paraphilias … the construct (requires) a deviant pattern of sexual arousal … arousal is manifested in a number of different ways … fantasy … urges and behavior … the problem is the way that sentence is written, with an "or," people have mistakenly interpreted that all you need is behavior, and you don't have to worry about … urges and fantasies … and the problem with focusing on behavior is that … there are many different reasons (underlying behaviors that appear to be the same) … to understand (a behavior) you need to consider the (situational and psychological) context … (it's a dilemma because) it would have been illegitimate to say urges and fantasies and behaviors … because (it would eliminate the possibility of assigning a diagnosis) … what we probably should have done is to … what the DSM-III-R did is it required fantasies and urges … it should have been fantasies and urges are required, plus behavior, plus minus (the absence of?) behavior … (fantasies or urges must be present to diagnose a Paraphilia and you can't assign a Paraphilic Diagnosis if they are absent)." (Note: Overall, the wording from DSM-III-R seems to best reflect the concepts underlying Paraphilia).
Differential Diagnosis, the Prevalence of PR, and the Case of William Davenport	
80-83	You always have to think about alternative possibilities (in an evaluation) and rule them out in order to be able to make a diagnosis … that's the concept of differential diagnosis. Dr. Wheeler did not discuss differential diagnosis in his evaluation of Mr. Davenport and did not refer to any evidence other than behavior when he assigned the diagnosis of Paraphilia NOS or Rape to Mr. Davenport. This was inappropriate because

	the "diagnosis was based exclusively on inference that the behavior seen here … necessarily involved this arousal pattern … and there's no evidence to substantiate that … it's circular reasoning … you need to establish there's an arousal pattern before making that diagnosis."
83-85	Individual report is only one source of information (about arousal)… an obvious source of inquiry would have been to ask the spouse … it's common for someone who has a sexual deviation … to try to get the partner to participate in that fantasy … the PPG … other tests … (contextual factors such as) substance abuse.
86	"A small minority of people who commit rape may have a Paraphilic pattern that consists of being sexually turned on by participating in raping someone. That's the arousal pattern that is the essence PR or P-NOS. Rape is more often than not committed because it's an opportunity for someone to achieve sexual gratification from individuals who are convenient."
The Implications of a Diagnosis for Volitional Control	
87-90	A diagnosis does not in anyway allow an evaluator to conclude that a person lacks volitional control … it is true that some persons with Paraphilia are volitionally impaired … but it is not true that any of the diagnoses in the DSM necessarily indicates the presence of volitional impairment … it's fair to say that you need to look at what's going on in the person's mind that drives these behaviors … the MMPI would be helpful …
Diagnostic Reliability, Reliability Research on the DSM, and Reliability Research on Paraphilias	
93-96	Diagnostic reliability is the ability of two evaluators to agree on the same diagnosis when they see the same individual. When the DSM-III came out … they enlisted a number of clinicians in practice … evaluate the same patient … and they saw how well they agreed (I used NIMH materials and Spitzer's Schedule for Affective Disorders and Schizophrenia from 1980 to 1983 to train a group of research assistants to reliably diagnose DSM disorders as part of an NIMH grant). That was the last full reliability trial of the DSM. Not much thought was given to evaluating the Paraphilias because of they were infrequently encountered in clinical settings. Only a handful of Paraphilias were evaluated, too few to be able to draw any meaningful conclusions. The evaluators were also not asked to evaluate specific Paraphilias, but only whether a Paraphilia was present or absent. Given these limitations they were able to at least agree that a Paraphilia was present.
The Relative Importance of High Reliability in the Forsensic versus Healthcare Arenas	
96-98	Reliability is probably more important in the forensic arena … decisions with respect to individuals' liberty and other issues like that are involved … so there's a requirement of systematic nature of evaluations … in clinical work, we try to help the clinicians make a diagnosis … so … reliability is a little less important probably … validity is … certainly very important in the forensic arena … (agrees with attorney Thompson that in a clinical setting it is possible to change a person's diagnosis and treatment whereas a diagnosis that is rendered within the context of a forensic setting tends to be retained; he then goes on to say:) "I guess if you put it that way, certainly the impact of a wrong diagnosis in a forensic setting will be much larger than the impact of a wrong diagnosis in a clinical setting."
The Validity and Reliability of NOS Diagnoses in General	
99-101	"The NOS categories by definition aren't really categories … they're holding places to allow clinicians to have a code for their work … if you say (a person's) diagnosis is NOS, all you said is that their diagnosis doesn't meet the criteria for any specific categories … you're not really saying much about what the person actually has … if you

	look at any study, the NOS categories have much lower reliability than specific categories … because they're undefined … they're just vague descriptions of the kinds of things that might fit in … take the concept of PR … there are no accepted diagnostic criteria as far as I'm aware that have been published … without a standardized definition, it can't possibly (be as reliable as) the specified DSM disorders …
How to Enhance Reliability; Group Promotion Without Evidence Does Validate P-NOS	
101-105	"You create reliability by … constraining an (evaluator's) ability to idiosyncratically apply their own way of looking at things … those who (make a diagnosis of P-NOS without being able to support that diagnosis) are working on tenuous grounds … in an area where the implication of using a diagnosis has such a great effect … for a group of people to simply dictate that because we do it, it's reliable (doesn't provide proof of reliability)."
The DSM Was Designed for Clinical Rather Than Forensic Practice	
107-108	"The DSM … was created as a clinical document, period … that was the constituency … we became aware that, because the DSM is an official publication of the American Psychiatric Association, there was the potential for it being used as an indicator as some kind of standard … outside the DSM …we felt it was crucial to explicitly indicate the limitations of the DSM (in) settings outside of the clinical setting" (this is why the warning on use of the DSM in forensic settings was included) …
A P-NOS Diagnosis May Falsely Imply An Adequate Level of Reliability	
109	"There seems to be a sleight of hand where .. because the term (P-NOS) … happens to appear in the DSM for clinical reasons … (and) … because the book is a scientific document … (that) the validity and reliability that is generally present for most of the (DSM) disorders … would apply to that category … it's a sleight of hand because absolutely there's no connection with the use of the phrase P-NOS and any kind of reliability that applies to other elements of the book."
The Definition of Volitional Control and the Implications of a Diagnosis for Volitional Control	
111-113	"Volitional control is the ability to make decisions and act according to the decisions you make … (paraphilias could have the ability to override volitional control of an individual; some individuals with some personality disorders might have an aspect of impairment of volitional control) … (impulsivity is a criterion for Borderline Personality and Reckless Driving, but) the issue of volitional control is not in any of the criteria, that's for sure …"
Research on the Amelioration of Personality Disorders Over Time	
114-120	"It used to be standard thinking that, once you have a personality disorder, you have it for life … (it) is becoming clear that's not the case … one of the surprising results of (the CLIPS) study is that personality disorder is not anywhere near as stable as people thought … I would say that the criteria as stated in the DSM-IV-TR (are) probably overly pathological … many personality disorders, Borderline and Antisocial are two … mitigate with age … (as one becomes more mature, perhaps physiologically as well as emotionally, any perceived personality disorder that you may have had may mitigate or subside over time) … at least ten (papers from the CLIPS study, a multi-site project directed by Dr. Andrew Skodol) have been published … the study is really raising major questions in everybody's mind (as to) what people understood."
DSM Diagnoses Were Never Meant to Inform Opinions about Volitional Control	
121-122	"Most of the (SVP) statutes require the presence of an abnormal personality disorder … that impairs … volition … and therefore results in being dangerous … the DSM was never meant to inform that judgment … the DSM says nothing about the nature of volitional impairment as it applies to particular disorders … so an error … people are

	making (is) that because somebody has Disorder X … by definition that in and of itself is enough evidence to say that … there's volitional impairment …"
Dangerousness Does Not Necessarily Stem From Mental Disorder or Volitional Impairment	
122-123	"There are many reasons why someone could be dangerous … many criminals, once they're released … remain dangerous because they're bad people … that is not the same as having a … mental disorder that is the cause of the dangerousness … and none of the DSM categories are inherently connected with dangerousness … there's no question that there's no diagnosis in the DSM that by necessity has volitional impairment … anyone who makes a claim like that … it's a misuse of the way the diagnostic labels were intended."
Definitions of Mental Disorder, Clinically Significant Distress, Psychotic, Enduring, Pervasive, Inflexible; The Importance of Cross-Situational Consistency for Diagnosing Personality Disorder	
129-132	"There is no definition of the word 'mental disorder' … 'clinically significant' distress or impairment means that it's the amount of distress or impairment that seems enough to justify clinical care … there's no good empirical way as of yet to be able to make a definition …
147-153	"In clinical settings, it's commonly said that the most common personality disorder is Personality Disorder NOS … so, like with the P-NOS … if you are seeing a patient … and they have Personality Disorder NOS … it becomes a mish-mash … whatever mish-mash you're seeing in only valid insofar as you're labeling it a personality disorder and nothing else … the concept of ASPD … was proposed by Lee Robbins of Washington University … the disorder got created by virtue of the fact that this is the outcome of children with conduct disorders … God knows what is true for individuals with Personality Disorder, anti-social type, because it's not ASPD … you certainly can't draw any conclusions (it would be wrong to render a diagnosis of PD-NOS-Antisocial and then cite to research on ASPD) … there is a V code in the back of the DSM called Adult Anti-social Behavior, to recognize the fact that mental health professionals often have to deal with individuals who don't have any mental disorders, but just have anti-social behavior …"
154-155	Psychotic disorder is fairly well-defined … mental illness is an amorphous term (that you have some illness that due to some problem with your brain) … they're not equivalent …
157	Enduring means that "something needs to last a relatively long period of time to label (it) as a personality disorder … it's to emphasize that all personality disorders (are characterized by) chronicity …
158-160	"Pervasive means it's not occurring only in one situation … you carry your personality into every situation … if you're doing an assessment of personality disorder, and you see a trait present inconsistently across situations, that raises questions about its validity as evidence of personality disorder … inflexible, similar thing … what makes personality disorder rather than personality is (that) you don't roll with the punches … it's not adaptable …"
164	"The nature of personality disorder is even the most impulsive person is not so impulsive that they can't control their actions to conform to the laws of society … (regarding Pedophilia and volitional control), they … might try to (imply that) a situation-specific volitional impairment that is directly related to (the affected person's) arousal pattern …"
167-172	(There is a problem in diagnosing personality disorder when somebody has a substance abuse problem) "because … personality disorders stem from personality traits that are maladaptive … there are two (ways that) substance abuse can cloud the picture for a

	personality disorder … one (arises when) how you behave under the influence of a substance is different than your normal trait behavior … the second which arises is that … someone who is addicted to (illegal) drugs has to engage in illegal behavior … to procure those drugs … that can look a lot like ASPD … people with ASPD also like to take drugs, so a little bit of a chicken and egg problem (may exist in such cases) … if somebody is an alcoholic, (he or she might not) fulfill financial responsibilities, (which) is a criterion for ASPD … somebody might mistake that for ASPD … so that's why (a fair differential diagnosis) is important … I try to find periods of time in the peson's life where they weren't so heavily using alcohol … if they really have ASPD, you would expect those anti-social traits to appear even when they're not using alcohol … that's the way you always do the differential diagnosis with substance use and any other disorders … (I did not see any discussion of the use of these procedures in Dr. Wheeler's report on Mr. Davenport; it is an error to diagnose somebody with PD-NOS without ruling out that alcohol might be the cause) … Dr. Wheeler concluded he didn't meet the conduct disorder criterion, so he's already on potentially false positive grounds …"
Incarceration, Psychopathology, and Paraphilic Behavior	
173-175	(The fact that a person gets incarcerated doesn't show anything about the inner workings of pathology in the person; a person's underlying psychological functioning can sometimes be changed for the better as a result of incarceration). "I recently was involved in a case of a young man who was inappropriately imprisoned at 17 for rape … it was my opinion that the incarceration actually allowed him to mature … we got him over the highest vulnerability, which is probably late teens-early 20s, and now he's in his 30s … it … probably improved him."
175-179	(A prison setting alone would be able to stop Paraphilic behavior). A small minority of Pedophiles are Child Molesters (did he get this backwards?) … the legality of child pornography is finally creating an opportunity to have … pedophiles be arrested who are, in fact, child molesters.
Background Information on a Case History of PR Titled "The Perfect Relationship"	
179	(The DSM case book that included the case history called "The Perfect Relationship" was a private (NOT APA) venture. I was one of the co-authors. It was not an official document. It got in there because Dr. Robert Spitzer, who had written the DSM-III, had an interest in Paraphilic Coercive Disorders. That book substantiates at least one case … that's a real case. The only thing you can conclude from that is that this is evidence that at least one case of this thing exists. The fact that it was included in no way influences the validity of that or anything. It is very clear that books that are published by the press represent the opinions of the authors and not the association. In fact, on the front of every one of those books on the copyright page is a statement of that.)
The Significance of Being Positive on All Criteria for Differential Diagnosis	
190-193	"When the entire picture is present … that allows you to make a conclusion … within medical certainty … that this person has a major depressive disorder … rather than … everyday depression …"
193-194	"To apply that (the above) situation to a Paraphilia, the essence of a Paraphilia is the internal state in which somebody has a deviant sexual arousal pattern … a behavior that's a criminal act … could be due to Paraphilia, or might be due to the fact the person's a criminal and has no regard for anybody else's needs … the way you would differentiate the two is (by) getting some evidence to support the idea that internally the person has the abnormal arousal pattern … to use the example … about child molestation versus Pedophilia … you need to figure out does that person have an attraction to children specifically, as opposed to that the child was present, and out of

	convenience or availability that child was molested …
Definition of the Concept of PR	
195-197	"The construct of Paraphilic Rape is fairly straightforward … when this was proposed for DSM-III-R … the concept was that there can exist … people (who) are aroused specifically by fantasies and images of rape … to differentiate … an individual who's just taking advantage someone … versus … a Paraphilia, you would have to come up with evidence that that person has an arousal pattern in which raping was the stimulus that created the arousal (a person's report that 'I raped somebody five times" would not be sufficient to make affirmatively infer that he suffers from PR) … you can't deduce backwards … the presence of repetitive behavior doesn't mean the only explanation for that is a Paraphilia.
The Relevance of the Scientific Method to SVP Evaluations	
198-199	(Scientific thought and methodology should be pertinent to SVP evaluations because determining whether a mental abnormality exists requires a diagnostic assessment, which is a scientific endeavor, and determining risk requires a risk assessment, which is also a scientific endeavor. There is nothing about this domain of assessment that would obviate its requirement that it conform to the principles of science.
The Relevance of the Null Hypothesis Concept to Psychiatric Diagnosis	
199-201	"In the world of psychiatric diagnosis, we wouldn't actually probably use the phrase null hypothesis, but conceptually, that's what one is doing … (in differential diagnosis), the requirement … is to prove that a certain observation is attributable to one thing versus another … without the evidence there, you cannot make that differentiation … I believe that would be an application of the null hypothesis … it requires some scientific endeavor to differentiate one hypothesis from another … the null hypothesis always is (that), without knowing otherwise, you have to assume that it's equally likely that a particular behavior would be attributable … to whatever the range of possible explanations there are…"
201-207	(I saw absolutely no effort by Drs. Wheeler or Yannisch in their reports to rule out alternative hypotheses for Mr. Davenport's behavior. The first time I saw alternative hypotheses considered was when Dr. Wheeler answered questions that the AG asked him at trial. I didn't think that Dr. Wheeler made a legitimate attempt to do a differential diagnosis in that setting.)
The Relevance of "Risk Assessment" Versus "Prediction" for SVP Evaluations	
209-210	(Regarding Doren's article titled "Inaccurate Arguments of Sex Offender Civil Commitment Proceedings"), I could not differentiate (his use of the term "risk assessment" from his use of the term "prediction") … he was making a whole big deal about how they weren't the same, and I didn't find any of his examples … persuasive … it made no sense.
The Relevance of Bayes's Theorem for Diagnostic Assessment and Making Decisions	
211-214	(Regarding Bayes's Theorem), "it's a basic, established statistical method for looking at conditional probability … it's not an arcane, left-field methodology that somebody came up with in the last ten years for a particular point … it's been around for an extremely long time, and it's well- established in the whole world of clinical decision-making and predictive power … the only possible reason why (Bayes's Theorem couldn't be used in the SVP arena is that) … you need to have certain data, and if the data doesn't exist, it would be difficult to use it, but there's nothing about the theorem itself … it's used in medicine all the time … what we're talking about here is a process very similar to diagnostic considerations in medicine … there's absolutely no reason why (in) this arena that Bayes's Theorem wouldn't apply as well, assuming you had the data to use it … it's

	completely useful … (if we are diagnosing Paraphilias, and have the right body of information, we could use Bayes's Theorem … not only for prediction of diagnosis, but also that could carry over if you have the right information in predictions of risk … there is no particular reason why it shouldn't apply in this particular field unless) somebody could make the case that … the data is not of high enough quality to allows its application, but … all of the aspects of Bayes's Theorem apply given … that the data is available … there is nothing (then) that would justify the claim that Bayes's Theorem is not applicable … the fact that … there is already lots of work on actuarial tables, a lot of the date that's used in that should be useable for Bayes's Theorem as well … I would actually be dubious on the claim that the not (of) sufficient quality, because in fact it's used all the time actuarially.
215-216	(Regarding assigning a P-NOS diagnosis, the person who makes the diagnosis must come forth with … evidence … and that would be the same sort of evidence that one could utilize if it was available for Bayes's Theorem. It doesn't make any sense on the surface to argue that a diagnosis could be made without any empirical information and then to argue that empirical information can't be used for the purpose of Bayes's Theorem)… "the idea that … a clinical judgment call somehow is the only way to make a diagnosis, and that a method such as Bayes's Theorem would not be applicable … doesn't make any sense … the only limitation in the use of Bayes's Theorem in medicine is limitations in the data available to allow you to use it, but there's absolutely nothing procedurally suspect about the principle of using this as a way of enhancing your accuracy…"
Pseudo-science and the Scientific Merit of Group Promotion of a Practice Without Evidence	
217-221	"The phrase pseudo-science … means to make it look like there's scientific principles being used, when in fact the underlying basis behind the assertions have no basis of true science … (the fact that a group of individuals got together and said … 'this is how we're going to do it … and we don't think the null hypothesis and Bayes's Theorem are applicable because we just don't think they're applicable' isn't science) … let's say they had an argument … then it's conceivably possible … since it is counter-intuitive to say that Bayes's Theorem doesn't apply, I think the burden of evidence should be on somebody claiming that it doesn't apply, to demonstrate why it doesn't apply … the statement that 'because we do it this way, that's why we do it' is pseudo-science … it's consensus … that's not science … it's an outrageous statement…"
Age and its Effect on Paraphilic Behavior and Personality Disorder	
221-224	"Paraphilic behavior … declines with age … if the intensity of urges and fantasies goes down, then .. the behaviors would go down, because the behaviors are driven by the urges and fantasies … of course there are always going to be individuals where that's not true … but that's the exception to the rule … one would expect that over time the risk of someone acting out Paraphilic fantasies would decline, simply because of a lessening desire … yes, age is a relevant factor … my understanding from reading the articles that were presented to me (is that) actuarial data backs up the idea that age is an important factor in risk of re-offense…"
225-229	(The severity of personality disorders also decreases with age) … "it's well-known that anti-social criminal … you know, individuals with that personality often 'burn out' when they get older, and the amount of anti-social behaviors decline … the mellowing out phenomenon reflects the age effect … over time … these disorders become less intense … if you're attracted to children at age 13, you're going to be attracted to children at age 70 … so the … focus of your arousal remains constant … the percentage of time you would think about that would decline … the time you spend masturbating

	thinking about that will go down, and the actual paraphilic behaviors go down … but the core of the Paraphilia is present for life … (you could get those with a Paraphilia to develop other attractions or to lower the intensity of their attraction) … but it's very difficult to reprogram someone's sexual attraction.
229	(Regarding the treatment of Paraphilias), this is a little beyond my area of expertise.