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IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF FRANKLIN

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In Re the Detention of:
WILLIAM DAVENPORT, aka William Cummings,
Respondent.

NO.: 99-2-50349-2

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722 West 168th Street
New York, New York

December 11, 2006
12:30 p.m.

DEPOSITION of MICHAEL B. FIRST, M.D., a non-party witness herein, pursuant to Civil Rule 26, before Ronald A. Marx, a Notary Public of the State of New York.

A P P E A R A N C E S:

ROBERT J. THOMPSON, ESQ.
Attorney for Respondent
504 W. Margaret Street
Pasco, Washington 99301
PHONE 509.547.4011
E-MAIL rthompson@clearwire.net

JENNIFER KAROL, Assistant Attorney General
JODY CRAWFORD, Assistant Attorney General
Appearing via telephone
Attorney for the State of Washington
800 Fifth Avenue, Suite 2000
Seattle, Washington 98104
PHONE 206.389.2004

ALSO PRESENT:
ROBERT L. HALON, Ph.D

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----------TESTIMONY----------

----------EXHIBITS----------

(EXHIBITS ATTACHED)

P R O C E E D I N G S

(Exhibit 1, Curriculum Vitae, was marked for identification, as of this date.)

(Exhibit 2, report dated 2/10/96, was marked for identification, as of this date.)

(Exhibit 3, special committee center annual review 10/03-10/05, was marked for identification, as of this date.)

(Exhibit 4, article, was marked for identification, as of this date.)

(Exhibit 5, article, was marked for identification, as of this date.)

MR. THOMPSON: Jennifer, are you ready?

MS. KAROL: I am.

MR. THOMPSON: It's going to be difficult for us to hear your objections, so scream if you have to, okay?

This is Attorney Robert Thompson, and we are here in re the -- in re Davenport as a cause number coming out of Franklin County, Washington.

We're here for the duly-noted deposition of Michael B. First. In the office we have the court reporter. We have Dr. Robert Halon who is present, and we have Dr. First.

Jennifer, could you state your name for the record, please? We can't hear you.

We are here to finally get the deposition of Michael B. First. This is -- cause number is contained in re Davenport of a Franklin County matter.

This is Bob Thompson. I'm here with Dr. Robert Halon, Dr. Michael B. First, and the court reporter.

Jennifer, could you give us who you're with and where you're at?

MS. KAROL: This is Jennifer Karol, assistant attorney general in behalf of the State of Washington.

I also have Jody Crawford in my office. He's also an assistant attorney general with our office. We're here at Seattle, Washington this morning.

MR. THOMPSON: Could you give us your mailing address as well?

MS. KAROL: Sure. It's 800 Fifth Avenue, Suite 2000, Seattle, Washington 98104.

MR. THOMPSON: Jennifer, can we have the normal rules in regards to reserving your objections, with the exception of the form of the question and any privileged matters?

MS. KAROL: Absolutely. Mr. Thompson, I just want to put on a

brief objection just for the record, that the state reserves the right to seek the suppression of the contents of this deposition for reasons stated in the state's motion to strike the deposition.

It's my understanding that that motion was brought by Assistant Attorney General Todd Bowers, and it was unable to be heard prior to this deposition because of the judge's illness.

So I just want to put that on the record. And any other stipulations are fine. We can go ahead with it.

MR. THOMPSON: And just to complete the record, the Respondent's position is different than that of counsel's.

The matter was duly noted. The state made some procedural errors in

regards to the timing of its objections, and as a result were denied the opportunity to address the concern that they wish to raise.

With that I think we're ready to go. I was wondering if we could have the doctor sworn.

M I C H A E L B. F I R S T, M. D., a non-party witness herein, 1051 Riverside Drive, Unit 60, New York, New York 10032, having been duly sworn by a Notary Public of the State of New York, upon being examined, testified as follows:

DIRECT EXAMINATION BY MR. THOMPSON:

Q Doctor, could you spell your last name for the record, please?

A First, F-I-R-S-T.

Q And Mr. First, what is your business address?

A It's 1051 Riverside Drive, Unit 60, New York, New York 10032.

Q All right. Doctor, what is it that you do?

A I'm a psychiatrist. I work part time in private practice, but I have a full-time faculty appointment at Columbia University, and my title is professor of clinical psychiatry.

I'm also a research psychiatrist at the New York State Psychiatric Institute, and I'm also a consultant to the American Psychiatric Association on DSM issues.

Q All right. The DSM, could you explain that to us for the record?

A DSM is the diagnostic and statistical manual of mental disorders. The current version is called the DSM-IV-TR, indicating it's the fourth edition, text revision. I was the editor of the DSM-IV-TR. DSM-IV-TR was published in the year 2000.

I was also the editor of the text and criteria of its immediate predecessor, which was the DSM-IV. That was published in 1994.

I was also involved in the final

stages of the production of the DSM-III-TR, which was published in 1987.

The DSM, the diagnostic and statistical manual of mental disorders, is the manual used by all mental health professionals practicing in the United States for the purpose of guiding them in making psychiatric diagnoses.

Q Now, Doctor, in order to get to where you are in regards to your practice, you had to get a certain amount of education.

Could you briefly describe your education and any relevance in regards to the DSM?

A I went to medical school and graduated from the University of Pittsburgh Medical School in 1983.

I then completed a residency in psychiatry at Columbia University, which I graduated in 1988 -- actually 1987.

I also did a fellowship in biometrics. And biometrics research, that's a department at Columbia University which is

headed by Dr. Robert Spitzer, is the department that produced the DSM-III and DSM-III-R. So I essentially apprenticed with the creator of the DSM-III and the DSM-III-R.

I then was -- took a position with the biometrics research department in 1988, which I've held up to the current period of time.

During that time I was appointed as editor of text and criteria to the DSM-IV, which was headed by Dr. Allen Frances.

So probably from 1989 up through 1994 I was working 50 percent time with Dr. Frances, and being paid for by the American Psychiatric Association, which is the organization that creates and publishes the DSM.

Q Doctor, have you ever written any articles that have been peer reviewed?

A Yes. I've written a number of articles on the areas of diagnosis and assessments, and have been peer reviewed over the past ten years.

MR. THOMPSON: Jennifer, I have had marked the CV. That is I get one. I'm going to hand that to Dr. First.

Q Doctor, is that a current copy of your vitae?

A Yes, it is.

Q You have numbered a number of or authored a number of articles.

It would appear that there's over 50 said articles that you've been involved in writing or co-authored; is that correct?

A That's correct.

Q And was there any particular flavor or subject that you concentrated on in the writing of those?

A Most of the articles have something to do with the issue of diagnosis, assessment of the DSM.

So there's no flavor per se, but my entire area of research and my entire career has been associated with the issue of diagnostic

assessment.

Q Doctor, do you see -- this DSM, what was it created for? What was its use to be?

A It's primary use is to help clinicians in making psychiatric diagnoses. It's probably three main audiences of the DSM.

The main audience is clinicians. Probably the second audience is researchers, and the third audience educators and students to try to be able to teach people about psychiatric diagnosis, and that's the main function of the DSM.

Q Is the DSM to be utilized in forensic arenas?

A It has been utilized in forensic arenas. It was not developed for that purpose at all.

In fact, the purpose of the DSM has several cautionary statements to make the point. I mean, when the DSM-IV was being developed, we understood that it was being used in forensic settings.

When we put it together, we were not designing it for that use, but because we were aware that it was used in those settings, a number of cautionary statements -- was a general cautionary statement put in the front of the book, and there's also a specific section in the introduction to the DSM-IV that talks about its use in forensic settings.

And basically these are cautions that make it clear that the needs of the forensic community are not -- not equivalent to the needs of the clinical community, but the DSM was put together specifically with the needs of the clinical community and the understanding that it was going to be used by clinicians as its primary point of construction.

So the cautions basically point out that if it's used in a forensic setting, it's important for people in the forensic setting to understand that basic concepts such as mental disorder and criminal responsibility, those things do not necessarily map directly on to the

DSM. So it was a clear warning against using it without taking that in account.

Q Have you become aware of any misuses of the DSM in the forensic arena?

A Yes. In particular I've become aware that it is -- has been incorporated into sexual violent predator legislation. It's been incorporated in interpretation of those laws.

My understanding is that forensic experts have cited certain disorders in the DSM as meeting statutory requirements, when in fact the disorders in and of themselves do not.

Q Doctor, I -- in order for you to get ready for this deposition, we sent you some documentation.

One of the documents that we sent you was an article that I have now marked as Exhibit 4.

And this is an article that was authored by Thomas Zander. I'm going to show you Exhibit 4. Do you recognize that, sir?

A Yes. That was one of the articles

that you sent me. That is correct.

Q I also sent you what has been marked as Exhibit 5, which is the Sexually Violent Predators in the Courtroom: Science on Trial, one of the authors being Prentky. I'll hand you that as well.

A Yes.

Q Did that help crystallize -- first off, did you read those?

A Yes. I read both of those.

Q So when we talked earlier about the usage of the DSM in the forensic arena and mentioned the sexually violent predator arena, these are the articles that have generated your interest?

A Correct. Right.

Q And yesterday you had the opportunity to meet with Dr. Halon and myself for about three hours, I think it was, to discuss how this process in the sexually violent predator arena works in regards to a particular issue being paraphilias, the other the idea of a personality

disorder not otherwise specified; is that correct?

A That is correct.

Q All right. For the record, I believe it's important for you to articulate how this -- currently utilized in the DSM-IV-TR in America.

That wasn't the original obviously. Could you kind of give us a brief history in regards to how the process has been moved forward from the original DSM?

A The original DSM came out -- was called DSM-I, and then its successor was DSM-II in 1968. The third one was DSM-III in 1980.

What distinguished the DSM-III from its two predecessors was it was the first version of the DSM which introduced operationalized diagnostic criteria to enhance diagnostic reliability and facilitate communications among clinicians and researchers.

Q I want to stop you there, because I'm kind of a layperson when it comes to these things.

Operationalized diagnosis. Could you explain that?

A Sure. The DSM -- the easiest way to explain it is to contrast it with the way the disorders were defined in the DSM-I and DSM-II.

In the DSM-I and DSM-II, for every disorder there would be a paragraph or so description of what the disorder was, and they were written in relatively vague terms.

And users of DSM-I and DSM-II would read these paragraphs and have to infer from those paragraphs what was really meant, when they applied them in clinical settings.

In DSM-III every disorder had specific criteria, which were essentially rules for defining the different disorders.

And the criteria were typically lettered -- they'd have letters, and under each letter there could be lists which were numbered.

So for example, the diagnosis of major depressive disorder, which is one of the more common diagnoses used in clinical settings,

it's defined by a number of lettered criteria, A through F.

And the A criterion had a number of symptoms listed 1 through 9. So for example, the A criterion for major depressive disorder says something like in order to meet the A criterion for major depressive disorder, you had to have depressed mood or loss of interest most of the day for nearly every day lasting for at least two weeks.

And then under that A criterion is a list of nine symptoms that specify that you need five out of this list of nine, and that list of nine includes things like having difficulty sleeping or sleeping too much, losing your appetite or eating too much, having suicidal ideas or making a suicide attempt.

So those are very, very specific symptoms that are listed, and in order to make a diagnosis, you have to basically meet those criteria.

So for major depression, for example,

you need five out of the nine for a least two weeks.

And then the rest of the criterion specify other aspects of the disorder, most typically rules for what it's not.

So for instance, in order to meet the criteria for major depression, you have to also be able to say this is not due to a medical condition or a substance.

So that's the typical outline of the criteria, and they're very, very specific and they provide much more specific guidelines for clinicians when they're making the diagnosis.

However, the DSM, despite having these very specific rules, does have some provisos in the beginning of the book indicating that it's a clinical guide, that clinicians need to exercise their clinical judgement before making these diagnoses.

This is not something that somebody -- it's not to be used as a cookbook for a layperson to just open up the DSM, look at

the list and basically apply them in making a diagnosis.

Q So that was -- going back to the III --

A III in 1980. And since the III there's been a major revision in 1987, which is the DSM-III-R, and then another major revision in -- that came out in 1994, which was the DSM-IV.

The DSM-IV-TR, which was a text revision, which came out in the year 2000, was almost exclusively an update of the text.

What I mean by that is every disorder, in addition to having the diagnostic criteria that we just talked about, has several pages of descriptive text that talks about -- more about the specific criteria.

There's a section called associated features, which would indicate for every disorder, other common features that are often seen in a disorder, but are not part of the definition.

So for major depression, for instance, it might say in effect that irritable mood is often seen -- very commonly seen in depression, but is not one of the required features.

Then there's a section about the course, how depression occurs over time. There's a section about familial factors. There's a section for differential diagnosis.

So this text explains and provides additional information about the disorder to enhance the diagnostic criteria.

So since that text, and the criteria themselves are based upon what's currently known in the literature, it was felt that after 1994, that by the year 2000, the text that was in the DSM-IV was not sufficiently out of date to justify a major revision in the text.

The decision was made, however, not to have a change in the criteria, except in a few extreme circumstances.

And the reason I mention that is the

paraphilia section of DSM-IV-TR was one of the few sections in which there was a change in the criteria, because it was -- an error was identified that was made in the DSM-IV that we felt needed to be corrected, so there was a change in the criteria for that, like -- the only other disorder I believe that there was a change was a tic disorder, because there was an error there.

In fact, the error in the tic disorders was similar to the errors in the paraphilia section, because it had to do with the application of a criterion which we call the clinical significance criterion, which was a requirement that was -- a criterion that was added to about 70 percent of the disorders of the DSM, making it clear in order to make a diagnosis of the disorder, the individual disturbance has to cause either clinically significant distress or impairment.

That criterion was added across the board and came to our attention after the DSM-IV

came out, because its application to tic disorders and paraphilias was erroneous and required a change.

Q Okay. The area of paraphilia, you said there was one change that occurred in the TR.

Is there universal agreement in regards to paraphilia being a mental disorder?

A You're -- in what sense?

Q It's in the -- obviously it's been listed.

Was there any argument about its inclusion in the DSM?

A Well, the reason -- the reason paraphilias are in the DSM -- the DSM-I and the DSM-II include the paraphilias, and so did DSM-III all the way through.

They're there partly because historically psychiatrists have treated paraphilias and have considered paraphilias evidence of psychopathology.

When -- so DSM-III was simply -- that

corresponding section of DSM-III was essentially an attempt to provide some operational criteria for that, and it's been carried through from DSM-III to DSM-IV.

There was a rule in the DSM-IV that unless there's evidence -- empirical evidence justifying the change, things are left pretty much the way they are.

So for the DSM-IV paraphilias, they were there because they were in III-R, and they were in III-R because they were in III and all the way back through the line.

So they're there because the -- sort of -- they're traditionally considered psychopathology.

Individuals over time have questioned the conceptual validity of the paraphilias, but the American Psychiatric Association has decided -- has chosen to keep them in.

Q Another term you just used is conceptual validity. Can you define that?

A Yes. Conceptual validity has to

do -- it's an abstract term, because the concept itself is abstract.

Validity is a term that talks about whether something is real or not. So when I say is a disorder valid, the real question there is a real concept that people would consider to be evidence of a mental disorder.

Now, we don't have any gold standard for what is or is not a disorder. So the standard we use instead are things like whether or not labelling something of a disorder provides some useful function with respect to predicting the future regarding treatment. So when I stay validity, we're really talking about it in those terms.

With respect to the concept of paraphilia, paraphilia is an interesting concept, and it's an example of the issue of conceptual validity.

In DSM-II homosexuality was considered to be a paraphilia, because it was considered to be an abnormal sexual preference,

to be attracted to members of the same sex, and the same way it was considered to be abnormal to be aroused by sadistic fantasies, for instance.

It became questioned in the '70s about whether or not homosexuality was in fact an abnormal psychopathology, and it was decided in 1975 to remove homosexuality from the list of the paraphilias, and so in that point, in DSM-II, homosexuality was removed.

There's been similar -- some questions raised about the other paraphilias with respect to is it pathological, is it evidence of psychopathology to have an abnormal sexual arousal pattern, and that articles have been written about that.

But the -- it's been felt that the evidence is not strict enough to suggest that they should be removed, so they continue in the DSM, and they're considered to be useful, because people do come for treatment for this concern, and it -- it does -- it has been considered in the past and continues to be

considered to meet the construct of what -- something that's a mental disorder.

Q Now, you have -- your answer dealt with the clinical arena.

A Correct.

Q My question then switches to this. Conceptual validity in the forensic arena, does it mean the same thing you just articulated, or do you think there's something else?

A The rules for what a mental disorder in the forensic communities may overlap with what's considered a mental disorder in the medical sense, but they're not equivalent and the rules are different.

There are legislative rules. The legislatures decide for the purpose of defining -- creating legislation what they consider to be mental disorder.

That may or may not be equivalent to what's in the DSM. I -- what I could say for sure is they're absolutely not equivalent. Sometimes they're the same. Oftentimes they're

not.

Q Okay. Let's get back to paraphilias. There are criterion to establish a diagnosis of paraphilia. I think there's a Criterion A and Criterion B.

Can you take a little bit of time to describe the Criterion A and B in the current text revision?

A What was -- like most of the disorders in the DSM, the concept of paraphilia doesn't have criterion per say.

What's in the DSM are -- I'm consulting the DSM-IV-TR, so I make sure that everything that I say from memory is in fact --

MR. THOMPSON: Jennifer?

MS. KAROL: Can you hear me?

MR. THOMPSON: Yes, we can.

MS. KAROL: There we are.

A So let me --

MS. KAROL: I cannot hear you.

I can't hear anything at all.

MR. THOMPSON: Anything at all

right now?

MS. KAROL: A little bit of you right there.

MR. THOMPSON: Let's go off the record for a second.

(Discussion off the record.)

(The requested portion was read back)

A So actually as I'm looking at the DSM, there actually is in the text for paraphilia -- if I remember correctly, we -- when we were writing this section we were considering actually coming up with general criterion and putting them in a box that would apply to all the paraphilias, and actually each paraphilia would be a subset.

But as I'm looking at the actual DSM itself, it looks like we did it halfway. The text reflects some general criteria, but they don't actually appear in the box.

So let me focus on the criteria that do seem to apply across the paraphilias, and

there are, in fact, as Mr. Thompson mentioned, two criterion, Criterion A and Criterion B.

Criterion A gets into the general construct of what a paraphilia is, and it's basically recurrent, intense, sexually-arousing fantasies, urges or behaviors generally involving, and then we give three clauses, non-human objects, the suffering or humiliation of oneself or one's partner, or -- so one is non-human objects, two is suffering or humiliation of oneself or one's partner, or three, children or other non-consenting persons that occur over a period of at least six months, and that's what we're calling Criterion A.

Now, what that corresponds to is each of the actual paraphilias and the actual criteria include a Criterion A.

We attempted to do when we created that compound sentence, which was to cover the actual Criterion A as they apply to each of these individual disorders.

So what I mean by that, if we

actually look at the specific paraphilias that are actually included in the DSM-IV-TR, we have exhibitionism, and its A criterion says over a period of six months recurrent, intense, sexually-arousing fantasies, urges or behaviors involving the exposures of one's genitals to an unsuspecting stranger.

And then we go on to fetishism, and that has a similar phrase. Six months, recurrent, intense, sexually-arousing fantasies, urges or behaviors involving use of non-living objects and so on.

So what this compound criterion was was our attempt to summarize the content of the eight criteria as they cut across the different disorders.

So what are the disorders? Again, there's exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism and voyeurism. Those are the specific ones.

So our three categories were an

attempt to summarize those those different A criteria.

So the non-human objects was meant to cover fetishism and transvestic fetishism, both of which require arousal either due to cross-dressing, which was clothes, or fetishism, which is the other non-living object.

The second clause, which is the suffering or humiliation of oneself or one's partner, that clause was meant to cover sexual masochism and sexual sadism.

And the third clause, which is children or other non-consenting persons, was there to cover exhibitionism, pedophilia and voyeurism.

So that's the -- so those three examples, which is -- that's why it says generally involving, were the summary statement that covers the actual specific paraphilias that are listed in the DSM.

So like for instance, one in particular which I know has caused some

confusion, the children or other non-consenting persons, obviously the phrase children was there to cover pedophilia.

And voyeurism, if you look at the actual criteria, the act of observing an unsuspecting person who is naked or in the process of disrobing or being changed, inducing sexual activities, and we look at exhibitionism, it uses the phrase unsuspecting stranger again.

So the non-consenting person phrase was specifically trying to capture the objects of exhibitionism and voyeurism, and was not meant to mean anything else.

I understand from reading the articles that the -- the use of the word non-consenting there has been imagined to have a more elaborate meaning than was originally intended when we wrote that sentence.

Q Let me ask you this. Was it ever the draftors of the DSM-TR's point to include a rape victim as coming under the heading non-consenting person?

A Not -- no. When we use the phrase non -- well, I'll get into the issue of paraphilic rape, but certainly it is true that the Clause Number 3 in the general definition of paraphilia was constructed specifically to cover the specific paraphilias that are already included in the DSM-IV-TR, was not an attempt -- in fact, if you look at those three examples, they don't cover the hundreds of hundreds of paraphilias which are covered under paraphilia NOS.

There's literally -- people have been shown to be aroused by -- like for instance, an area that I happen to have some direct research experience, is a paraphilia called apotemnophilia.

That's a paraphilia that -- in which an individual derives sexual arousal about the idea of them being an amputee. I've actually done some research on that whole area.

That -- being an amputee isn't covered under any of these three categories.

It's not a non-human object. It not the suffering and humiliation of oneself or one's partner, and it's not a children or other non-consenting person. It's -- yet it's a valid paraphilia.

So this use of non-consenting was specifically there to cover exhibitionism and voyeurism and not anything else.

Now, 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 paraphilic.

Q So it would be improper to utilize the term non-consenting, meaning a rape victim, for the purposes of fulfilling Criterion B?

A No. A. 3.

Q I'm sorry.

A It would be inappropriate to assume that the use of the word non-consenting in Clause 3 of the first sentence on Page 566 of

the DSM was in any way intended as a -- connected to the issue of paraphilic rape.

Q That's not to say you can't under the NOS category have paraphilic rape?

A Correct. But it's incorrect to say that we were intending by the use of the word non-consenting to give some nod to the concept of paraphilic rape.

Q In regard to paraphilic rape, are you familiar with the criterion or what one would actually look for to find out whether there's a paraphilic rapist?

A Well, I'm not -- I know that from reading the material, the two articles, that there was some discussion that -- I believe Doren -- is that his -- in the article -- somewhere in the Zander article there was something that he talked about that might help.

But as far as the DSM goes, the only context we have is the category -- I mean, basically the way the DSM works is we've identified the -- how many paraphilias.

There's one, two, three, four, five, six, seven, eight. So you've identified eight specific paraphilias of the hundreds of hundreds that might exist.

Those eight were basically historical. They're carry-overs from DSM-I and DSM-II.

The only exception to that was the addition of frotteurism, which I believe was added to DSM-III-R, if I remember correctly, and there are many, many other ones that are possibles.

And for any other one that may be presumed to exist -- you have to remember that this book is meant for clinicians.

And the idea is that when a clinician uses the DSM, they open it up. They try to find what diagnosis -- specific diagnosis applies to the individual who is being evaluated.

If none of the individual specific disorders apply, they are told to use one of the NOS categories.

NOS stands for not otherwise specified. The term not otherwise specified is very, very important, because there's the concept that the DSM includes two types of disorders, specific disorders that have criteria, and then not otherwise specified disorders, which is everything else.

And the idea is that if any patient one sees in clinical practice, one needs to come up with a diagnostic label that applies.

You can either use one of the specified categories to indicate what that is, or there's these waste-basket categories called NOS.

The NOS that applies -- you have a choice of depressive NOS, anxiety NOS. There's a number of different NOS's to indicate that it's in the ballpark of that section of the book, but it doesn't meet any of the criteria within that section.

So paraphilia NOS applies if you believe there's -- as a clinician that the

individual you're seeing meets the general principal of paraphilia, yet is not one of the eight that's specifically listed.

So any paraphilia, whether it's apotemnophilia, the one that I've been familiar with, or paraphilia great (phonetic) would -- therefore the bucket that would apply to cover that is paraphilia NOS.

Now, if you actually look at the actual definition of paraphilia NOS in the DSM-IV, it specifically says this category is included -- it basically -- not -- gives in writing sort of what I just said.

It says this category is included for coding paraphilias that do not meet the criteria for any of the specific categories.

So if you have a paraphilia that's not one of those eight, this is the -- this is the one you would use.

And it gives examples. It says examples include but are not limited to telephone scatalogia, obscene phone calls,

necrophilia, partialism, zoophilia, copophilia and uriphilia.

The ones that are there I believe are there because I think that in DSM-II some of them were -- they're there for a hodgepodge of reasons.

It was never intended to be in any way, shape or form an exhaustive list. There's nothing particularly special or -- it may be infamous.

I mean, zoophilia is -- probably more has been written about it in the literature than is justified in nature. I mean, that's a very, very rare one, and it's there because people are interested.

Again, the other ones, there's no real implication that these are common or not common or more common than the ones that are -- the other 200 that aren't listed there.

So -- so paraphilic rape, by the rule written here, if one clinician believed that that exists, they're evaluating a client who

they believe has that, this is the Code 302.9 that would apply.

And what I've sort of implied over and over again, it's up to the user of the category to substantiate the validity to it.

The fact that it's given the code 302.9 is simply a declaration that that person believes it's a legitimate paraphilia, but it may or may not be. It depends upon -- it's up to the clinician to justify their use of that.

And this is true with insurance companies. I would submit this to insurance. The insurance company may say, "Doctor, before we cover your section, you need to provide us with your justification for using it." So it's, again, up to the user of the category to sort of justify its validity.

Q Well, when you talk about the term substantial justification, are we talking simply what the clinician thinks, or are you talking about more in regards to documented studies that can establish a particular point?

A Well, that is the context in which it's being used. Obviously if I'm submitting this to an insurance company, I don't need to give any studies for them to decide to cover it.

They're going to cover it based upon whether they believe -- they'll believe it's a valid category.

The NOS categories -- I mean, in the front of the DSM there's a statement. Maybe I can find it. I think in the cautionary statement.

It's a statement to the effect that -- not every disorder of interest is covered in the DSM. Here it is. Okay. Good.

Under the cautionary statement, the second paragraph says, "These diagnostic criterion, the DSM-IV classification of mental disorders, reflect a consensus of the current formulation of evaluating knowledge in our field.

"They do not encompass, however, all the conditions for which people may be treated

or that may be appropriate topic for research efforts."

That clause was put in there because we recognize the DSM, while it includes a number of disorders, over 300, there are other disorders that people are studying that are of interest, and may be legitimate, but for a number of reasons, usually issues of insufficient empirical basis, they're not in the DSM.

The two ways things are in the DSM -- up until DSM-III, things were put in there because of historical interest. You know, things were there because they were there before.

Somewhere around between DSM-III-R and DSM-IV a conscious decision was made by the American Psychiatric Association to only include disorders for which there was a reasonably large body of empirical evidence.

So any disorder added from DSM-IV on has a barge across that really didn't apply to

disorders that were put in the book prior to that.

So it's kind of a two-class system in the DSM. There's those disorders that have been grandfathered in, and then -- and then new disorders are added that are harder to get in.

And people have pointed out the inconsistency that results from that, that there are disorders that are currently in the DSM for which there's absolutely not a shred of empirical evidence.

An example might be a disorder called associate view, which is in the associate sort of section.

I'm not sure there's been any studies in existence, it's a disorder that people have written case reports about, yet it's there because -- it's there for historical reasons.

It clearly would not -- if somebody today proposed to add associate view to the DSM it wouldn't get in, because we'd say well, that's a very interesting, peculiar condition

that you've written a case about, but at this time doesn't meet what we currently would consider the -- whatever the standard is.

Now, there's no published standard of what the standard for getting into the DSM is. There's nothing that the DSM task force decides on a case-by-case basis, but it's very, very clear that certainly a reasonable or substantial amount of research evidence would need to be presented to the task force to justify getting it in.

Q Well, one that is not in the book is paraphilic rape --

A Correct.

Q -- or non-consent, terms that are synonomous, I believe, with how state evaluators tend to use them.

Is that to suggest, given your last comment, that there isn't a vast empirical body of thought, that suggests that it should be in?

A Well, yes, but not exactly. The requirement for getting in is both that there is

a body of evidence, and that it was put through the process to get in.

Historically in the mid '80s, during the production of the DSM-III-R, the sexual disorders that were grouped at the time thought that there was some -- they thought there was some validity or interest in the concept.

At the time, in the 1980s, the -- to get into the DSM was easier. It's almost as if you could convince Robert Spitzer, who headed the DSM-III-R, that it was a worthwhile category, you were far along your way.

The sexual disorders work group I believe -- and I actually -- as I said, I worked with Dr. Spitzer, and in preparation for the deposition I did discuss -- asked him some questions about the history, so that I could get a first-hand account of his recollections, at least of how things got in with respect to or the issue around paraphilic rapism.

His recollection was that the sexual disorders work group -- some of the members of

the work group thought this was an -- an entity that had some validity based upon their initial observations, or the limited research that may or may not have been done at the time, and they had proposed that category along with some other categories.

They didn't -- but other categories were proposed around the same time. One, for instance, was called masochistic personality disorder, and another disorder that was proposed by yet another group of individuals was late luteal phase dysphoric disorder.

The reason I'm bringing those two in is these three disorders, when they were sort of rising up in the -- you know, sort of generating discussion and getting out comments, those three disorders became the target of a lot of criticism, specifically by women's groups, who felt that all three of those conditions, were they added to the DSM III-R at the time, might be harmful to women.

So for instance, the masochistic

personality disorder, the thought there was that -- that disorder describes a personality style where individuals get themselves -- find themselves in an abusive relationship because they're drawn to that for personality reasons. So there was a lot of concern that that disorder might end up blaming the victim.

As far as paraphilic rapism is concerned, the concern there was from the very beginning that rapists might use that to evade criminal responsibilities.

And because of that concern, and because of the sense that unlike those other two disorders -- like masochistic personality disorder has its roots in Freudian writings, so a large amount -- not a lot of science, but certainly a lot of history and analytic work behind that disorder.

The late luteal dysphoric disorder, which was relatively new at the time, even then there was -- you know, the idea there was PMS, which was a recognized condition, that a

subgroup of women with PMS have severe psychopathology and it's menstrual-cycle related.

And there were a number of researchers at the time already doing work in that and they were spearheading the effort to try to get this in.

This disorder, on the other hand, was created, according to Dr. Spitzer, more by -- a very limited number of people sort of thought it up based upon their observations.

So the three of them had the weakest empirical base, and it was felt, given the weakness of the empirical base and the potentially explosive nature of the disorder with respect to really causing problems potentially, it was decided that somewhere along the process to completely drop it.

The other two disorders, in contrast, were felt to have sufficient interest and validity, they ended up in the appendix. The appendix in the back of the DSM was created to

encourage further research.

This disorder they chose not to even put in the appendix because they felt it was so problematic. It didn't make sense to add it.

That was basically the evolution with respect to the DSM. When the DSM-IV process started in 1987, there were no serious proposals to add to the DSM-IV.

There were -- other than some changes in the wording that we thought were innocuous, which ended up not being so, there were no changes to the DSM-IV paraphilia, at least conceptually -- no intent to make any changes in the DSM-IV paraphilia section.

We made some changes, but they were there for -- we thought were stylistic reasons, not case reasons.

Q You used the term problematic. And what I gather from your answer was a certain amount of politics, where certain women's groups didn't want to get involved.

The idea is that somebody who

committed rape might use it as a mental disorder under some some kind of McNaughton standard, get off on, not reason -- by reason of insanity. That was a concern.

And I think you also said there's a lack of empirical evidence to support it.

A There are virtually no studies done. I'm not sure there are any studies that were done around that.

It was more some individuals in the sexual work group had worked -- I believe -- I suspect they worked in treating paraphilias and they were seeing this condition in their practice, and they felt that hey, you know, there are 150 paraphilias listed in these books. This is one of them, and we think it's common enough that it should get special mention.

Or to put it another way around, there was the thinking at the time that this is a shift in thinking that's changed over time.

Back in the days of III-R, it was felt that if a disorder had some interest to it,

you put it in the book and you would generate research, and eventually the validity would follow it.

Around -- after III-R came out, we said -- we twisted it around and we said the DSM should reflect what's out there, not be sort of a leading edge, so there was a philosophical change.

So I think when the paraphilic rapism was originally proposed for III-R, it was felt that hey, this sounds like a good idea. We should put it in.

That's what I think Dr. Spitzer's initial support of the category, because of his own personal sense of hey, this is just another paraphilia like the rest of them. Why not put it in.

Even though there's very little data, it seems right. We'll put it in there and data will follow it.

That's -- the entire possess has been flipped around. So we now require the data

before putting it in, not the -- by putting in there it will generate data.

So I think at the time it was considered for III-R, there was almost no data on it, and the understanding would be if they put it in the data would follow.

But because of the perception of the damage or the disadvantage of adding it outweighed the advantage of generating the research, it was felt that the wiser move was to leave it out.

And if anybody wanted to use it, people are free to do what they want, but the book wasn't going to take the lead in putting it in.

Q Are you familiar with any follow-up research that is, in fact, identified as paraphilic rapism?

A I personally am not. I mean, I'm not -- I'm not a researcher in -- specifically in the field of paraphilia, but I'm not aware from my reading so far that there's been any

significant -- I mean -- actually in reading the Zander and other articles, I guess there's some citations there.

So most of the work that's been done I guess has been cited in that article, but what I understood from the article, the amount of work that's been done has been quite limited.

Q You had mentioned that there were some -- I mean, there were no substantive changes particularly between the III-R and the IV and then the IV-TR.

A Not intentionally.

Q But you have become aware that there, in fact, was a substantial change that perhaps has impacted people caught up in this SVP arena; is that fair?

A That is correct. Let me explain. In fact, one of the changes I have to admit I wasn't aware of even until today, when I was -- and actually reviewed as far as I could tell the history of the changes.

What this has -- basically -- first

of all, let me talk about what the changes were, and one of them was actually corrected in the TR, and other one is -- remains uncorrected.

The original construct of paraphilia -- let me actually give you even more of a history, because it's an opportunity to talk about the evolution of the DSM and the construct of paraphilia.

In the DSM-II, the paraphilias were listed in the text from the DSM. It mentioned the idea of preferential, that this is a preferential state, that people with paraphilias preferred this pattern of sexual attraction to others.

When the DSM-III criteria were created, presumably trying to operationalize the construct at the time, it was actually phrasing in the DSM-III for the paraphilias that actually -- actually could you hand me the DSM-III so I can get it exactly right, so I don't misquote it?

Q I'll give you the whole thing. I

don't know which one you need.

A So the wording for all -- for most of the paraphilias in the DSM-III included phrases like the following.

This would be -- this is an example for pedophilia. It said -- it defined pedophilia as the act or fantasy of engaging in sexual activity with prepubertive children. It's repeatedly preferred or the exclusive method of achieving sexual excitement.

So when DSM-III actually introduced -- it's interesting. If you actually read through all the paraphilias, they use that word for some of them and not the others, and I think it was sloppy writing as far as I could understand.

But that one, pedophilia, had that phrasing. And I think there was at least one other one that mentioned it was preferred. Maybe that's the only one. Let's see.

Here's another one. Pedophilia. Yes. Zoophilia is another one, which got

dropped, but at the time it was the act or fantasy of engaging in sexual activity with animals as a repeatedly preferred and exclusive method of achieving sexual excitement.

So this preferred thing was written in with some of them and -- another difficult -- what we ended up doing -- this was the very first time criteria was created for hundreds of disorders.

So it was sort of understood when the DSM-III came out that there were probably some errors involved and some inconsistencies.

And one of the motivations for doing the DSM-III-R so soon after the DSM-III was to kind of correct a lot of those errors.

So one of the interesting problems with the paraphilias in the DSM-III is the wording for every one of the paraphilias was different, you know. They vary from one to another.

When DSM-III-R was put into effect, the unified wording -- because they felt the

concept of paraphilia was a general construct, and the only thing that differed one paraphilia from another was the focus of the sexual deviation and the nature of the sexual deviation and nothing else.

So coincident with the time of the DSM-III-R, it was also discovered that research had either come out or was unfortunately ignored by accident, that the requirement that it be preferred or exclusive was an error, that it was found an individual with paraphilias could be attracted to multiple abnormal things, or they could have normal attractions in concert with this abnormal attraction.

So the construct of requiring it to be preferred was discerned an error, and that was completely dropped.

So if we look at the DSM-III-R definition of paraphilias, there was essentially uniform wording that applied across the line.

And it basically would be a phrase -- every one of them started out the same way. It

said over a period of at least six months there's recurrent, intense sexual urges and sexually-arousing fantasies involving blank, and then blank would be whatever the nature of it was.

So exhibitionism was the exposure of one's genitals to an unexpecting stranger. Fetishism was the use of inanimate objects, et cetera.

They all have the same wording, and including pedophilia, since that is obviously a category that's relevant to the SVP issue.

And it was over a period of at least six months, recurrent, intense sexual urges and sexually-arousing fantasies involving sexual activity with a prepubescent child or children, generally age 13 or younger. That was the A criterion.

They all had the same B criterion, which was the person has either acted on these urges or is markedly distressed by them.

And that was -- so basically in order

to get a paraphilias diagnosis in the DSM-III-R it was -- you had the intense urges and fantasies, and you either acted on them or you were distressed by them, and that was the general wording that applied across all of them.

When we did the DSM-IV, we -- the work groups basically did not recommend any changes.

And to give you an example of that, probably the easiest way to kind of trace the history of how the DSM evolved is to look at the options book.

The options book was the document that was published by the American Psychiatric Association on September the 1st, 1991.

This book was a reflection -- basically presented to the public at large, this is what we're thinking.

And it was opportunity for people to write in and scream bloody murder, they want something or make some suggestions.

For many of the disorders that say --

you know, we're thinking of several options for doing things.

Let me read you the summary of what -- this gives you an idea of what the thinking was for paraphilias at the time.

It says there are only two proposals for changes in the section of paraphilias. This is the entire working deliberations of what needed to be done.

One was the addition of a specifier for transvestic fetishism, and that specifier in particular was you were allowed to indicate whether or not there was gender dysphoria.

Let me put that in lay language. Transvestic fetishism means that somebody is sexually aroused by dressing -- men are sexually aroused by dressing like a woman.

So that's cross-dressers. A lot of people who cross-dress are actually turned on by doing that.

It turns out a certain group of those people, in addition to being sexually aroused,

feel uncomfortable with being a man.

So there's a essentially -- those people actually have issues about their own gender identity, so they co-occur.

So it was felt that it would be a helpful addition to the DSM concept of transvestic fetishism to have a specifier indicating a subgroup of individuals who had gender issues.

The only other proposal was the telephone scatalogia, which is people who are sexually aroused by making obscene phone calls, is included in the appendix.

So even when we started work with DSM-IV, it was clear there was not a lot of data for telephone scatalogia, but the thought was maybe we put it in the appendix and encourage it being studied, and criteria for telephone scatalogia in fact was listed.

In fact, it's very interesting. It says here under -- each one of these things has a little description that describes its -- the

rationale.

It says this category was listed in the DSM-III-R as an example under paraphilia NOS.

It is being proposed for inclusion in the appendix, because literature review suggests it may be one of the more common paraphilias.

It's kind of interesting. They actually identified a paraphilia in the NOS category, and there was a proposal to move it up to appendix status.

And it's interesting, because the paraphilic rape is not mentioned here as something.

When you look at the criteria for all the other paraphilias though, the proposal at the time was there would be no changes from the DSM III-R, for all the other paraphilias.

So the intention of the work groups as of the options book -- and the options book generally was considered to be -- you know, the most radical changes were in this book, so for

all the other paraphilias, no changes were recommended.

The next sort of hint at history is the -- do you have the draft criteria? Did I bring it back to the other room?

I think I may have brought it in the other room. Let me take ten seconds to walk in the other room.

(Recess taken)

CONTINUED DIRECT EXAMINATION BY MR. THOMPSON:

A So what -- the next document that was published prior to the DSM-IV coming out was a book called the DSM-IV draft criteria. It was published on March 1st, 1993.

And the purpose of this book was to go from the options to this is the actual criteria that were used for planning to put into the DSM-IV.

So if you actually look at what's here, it basically confirms what the options book said.

It is for each of these categories,

like pedophilia, for instance, is a reprinting of the DSM III-R criteria.

So for instance, it says over a period of at least six months, there's recurrent, intense sexual urges and sexually-arousing fantasies involving sexual activity with a prepubescent child. So it's urges and fantasies.

And then there was a B criterion, the person acting on those urges is markedly distressed.

So this is as of March 1st, 1993, roughly a year before the actual publication of the DSM-IV.

But we actually sent the text and galleys, et cetera into the publisher by that fall, so it's basically six months before it actually went to press.

Interestingly, when you actually look at the DSM-IV itself, we discovered that there's -- the criteria are not the ones that were in the draft. They're actually somewhat

different.

Now, I was involved as the editor of the text and criterion, worked very closely -- I worked with Dr. Allen Frances on actually putting the book together and writing the text.

And during that six-month period, we made a decision that actually is relevant to the entire book.

I think I mentioned this earlier in the deposition, that we decided to include this criterion called the clinical significant criterion and added across the book, so the whole book would be consistent, and that criterion would replace the B criterion.

The B criterion was an attempt to sort of say okay, you have these fantasies and urges, but what's the threshold for which calling it a disorder.

And the B criterion in the DSM-III-R was either on the urges or being distressed by them. That was the threshold.

So we said okay. Well, we're going

to use the threshold -- the standard threshold statement applies throughout the whole book. We'll just apply it to the paraphilias.

And that threshold statement was -- which is called -- it was also the B criterion, it says the fantasies, urges and behaviors causing clearly significant distress or impairment in social, occupational or other important areas of functioning.

And it was put in there without a lot of thinking about what the implications of that actually might be. The assumption was we were just standardizing the language.

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.

When someone acts on their urges, that's a behavior. So we wanted to emphasize the behavioral aspects of this.

So we rewrote the A criterion, so that 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.

So we changed the wording from a requirement of urges and fantasies to this statement that now says urges, fantasies or behaviors, thinking that that was equivalent.

And it now comes to my attention that what's happening is that the word -- well, actually before I go there, let me talk about the other change.

It was pointed out to us after the DSM-IV came out that this was not -- this was not -- that we may have made a mistake, and people actually said, well, what's this B criterion that says that the urges, behaviors and fantasies cause either distress or impairment.

People interpreted that as us meaning

that we were changing the threshold to make it harder to get a paraphilia, that we were requiring that the person was bothered by the urges.

In fact, most people with paraphilias are not bothered by it, insofar as they feel fine having them.

They feel that the problem is it gets them into trouble, but they feel it's okay to have them, or that it causes impairment in social, occupational and other areas of functioning.

We meant that to be equivalent to the idea of acting on the urges, but it was after the fact that people pointed out to us that it's not so obvious to anyone else that that's what we meant, and people thought that actually -- so it created a whole host of problems and confusion.

And we cleary meant that certainly for disorders like pedophilia and sadism and masochism and exhibitionism and voyeurism that

involved non-consenting individuals, that acting on it was supposed to be part of it.

So what we ended up doing, we ended up restoring the wording from DSM-IV -- the DSM-III-R wording for the DSM-IV B criterion for those few disorders, for the pedophilia, voyeurism, sexual sadism, sexual masochism and exhibitionism.

The reason we didn't restore completely is that we still felt that for fetishism and transvestic fetishism, so if you want to wear rubber while you're having sex, we felt that acting on that is not sufficient to call it a paraphilia.

So actually there was a little change here, and the idea -- we actually felt that the clinical significance criteria does apply to that one, but not the other one, so we have this sort of hybrid B criterion.

The other problem was I didn't realize until today actually that we had rewritten the A criterion in a way that also

caused another problem.

And the A criterion we're now discovering, it's being used by individuals to -- to mean that all you need to do is to focus on the behaviors in order to meet the criteria for paraphilia, without keeping into regard the issue of urges and fantasies.

It's very, very clear that the requirement in DSM-III-R and the requirement for the concept of paraphilia in any book ever written about paraphilias is that the construct is that it's a deviant pattern of sexual arousal.

Now, arousal is manifested in a number of different ways, fantasy, the sense of urges and behavior. These are different manifestations.

The problem is the way that sentence is written with an "or," people have mistakenly -- whether it was done in good faith or not, but mistakenly interpreted that all you need is behavior, and you don't have to worry

about the other two halves of it, which is urges and fantasies.

And the problem with focusing on behavior is behavior has to be viewed in context.

If somebody has a certain behavior, they punch the wall. There are many, many different reasons why someone might punch the wall. They're angry. Maybe they heard a voice telling them to punch the wall.

Any -- any behavior that any human being does, in order for it -- to understand it and interpret it correctly in terms of psychopathology, you need to consider the context.

Paraphilia is a good example. If somebody -- it's -- you have a picture of somebody wearing rubber while they're having sex, and you say, oh, this is evidence of a paraphilia because they did it.

That's not sufficient, because you have to know what was the circumstance. Maybe

they did it because it was a Halloween party and that's why they wore it.

And the same thing for all of the paraphilias. Exhibitionism, which is exposing oneself, if you're drunk and you go outside and somebody tears your clothes off, you know, walking around exposing yourself, you get arrested for that condition, that's not evidence of a paraphilia, because the behavior may have been that the person exposed themselves, but it wasn't in the context of a paraphilia, which means the context of being an abnormal sexual arousal pattern.

So when it comes to pedophilia, for example -- now certain behaviors have a different range of context that you need to consider.

So if you see somebody who molests a child or who rapes an individual, and you're trying to determine if it's evidence of a paraphilia, you need to consider what are the other possible reasons why that person may have

done that behavior.

And only now you can call it paraphilia if it fits in the construct of paraphilia, which is an abnormal arousal pattern.

Q Just so I'm clear on this, the words that changed when -- and used to be an "and" in regards to the behaviors --

A No, no. It's confusing. The problem was the "and" -- the reason the error was made is we could not have -- it would have been illegitimate to say urges and fantasies and behaviors.

If we put the "and" in to those three words, it would have been incorrect, because it would be equal to have paraphilias who never act on it, who were upset by -- there might be someone who is attracted to children, who collects child pornography, who comes into treatment and says, "I know this is wrong, yet I have these urges and fantasies. I need help."

That person has pedophilia. They

might go to clinical -- they wouldn't get -- they wouldn't -- likely not get into the forensic system, except that they got in trouble for the child pornography.

Let's forget the child pornography. Let's just say he's coming in saying, "This is horrible. I feel horribly guilty. I want to change."

There's no behavior involved, because the person hasn't done anything. They're just fantasizing, yet that meets the criteria for pedophilia, because that person is bothered by it.

That is what we wanted to capture. So we couldn't have put an "and" there for fantasies urges and behaviors.

The "or" is there because in fact you don't need -- what we probably should have done is to -- what the DSM-III-R did is it required fantasies and urges.

So it should be fantasies and urges are required, plus behavior, you know, plus

minus behavior, so that's what should have been there.

The algorithm got messed up because we put the -- by putting the procedure in the Criterion A with an "or," logically it looks like it could be any of the three.

But it was absolutely -- that's disregarding the concept of what a paraphilia is.

The book is a guide. It's a way of operationalizing constructs, constructs of psychopathology.

Paraphilia is an abnormal pattern of arousal. That is the core concept. There are many that manifest it.

In all cases, someone who has a true paraphilia, has some fantasy life reflecting the arousal pattern, so you may or may not have the behaviors.

Q Let me stop you there. I just want to make it clear.

When I asked you this question with

regards to a reasonable degree of medical certainty, and your testimony, if I understand it correctly, is in order to properly diagnose a paraphilia, there has to be these -- this fantasy and urges?

A Correct.

Q Is that correct? And if you don't have evidence of that, you can't make the diagnosis of paraphilia. Is that fair?

A That's correct. The behavior by itself, out of context of whether or not there are fantasies or urges, is not sufficient to make the diagnosis.

Q And that is your opinion to a reasonable degree of psychiatric certainty?

A Psychiatric and medical certainty.

Q Thank you. I also gave you some additional information the other day, one of which happened to be Dr. Robert Wheeler's initial evaluation of a gentleman by the name of William Davenport; is that correct?

A That's correct.

Q Now, you had an opportunity to review that one particular document; is that correct?

A That is correct.

Q Okay. Within that document, did you find any evidence -- let me stop you there. The term differential diagnosis comes up.

Could you explain what a differential diagnosis is or why it's important?

A A differential diagnosis is -- the concept of a differential diagnosis is people present with a symptom or problem in real life, whether it's hearing voices, whether it's acting a certain way, punching a wall or raping someone, for instance.

The process of differential diagnosis for any isolated symptom, there are always a range of explanations that are possible.

Differential diagnosis is a process by which one eliminates the range of explanations and arrives at a single explanation.

That is a crucial aspect of

differential diagnosis. There is no symptom in the DSM in psychiatry where that symptom equals the diagnosis.

You always have to think about alternative possibilities and rule them out in order to be able to make a diagnosis.

That's the concpet of differential diagnosis. In medicine there's an occasional -- there's the phrase pathomonic, which means that you have the symptom that inevitably looms as a particular diagnosis. That is rare in medicine and non-existent in psychiatry.

So differential diagnosis is absolutely crucial to doing a valid psychiatric evaluation.

Q I'm going to go ahead and hand you what's been marked as Exhibit 2, I believe.

And is that Dr. Wheeler's initial report that I shared with you yesterday?

A Yes, it is.

Q Within that report did you find any discussion of differential diagnosis?

A No.

Q Is it fair to characterize what you have there as a listing of behaviors that transpired between Mr. Davenport and others?

A Yes.

Q Is it also fair to characterize Dr. Wheeler making a diagnosis based on the behaviors?

A Yes. Dr. Wheeler, I believe, had absolutely no evidence cited in his report that indicated anything apart from behaviors.

Q To a reasonable degree of professional and medical certainty, do you believe that coming to the conclusions -- making the diagnosis of paraphilia NOS, non-consent or rape, was appropriate in this situation?

A No, I do not.

Q Why is that?

A Because he made his -- that diagnosis was basically based exclusively on inference that the behavior pattern seen here in this necessarily involved this arousal pattern, and

there's no evidence to substantiate that.

He simply looked at the fact there were multiple behaviors, and simply assumed that there must be -- must be arising out of the paraphilia.

But that's circular reasoning. You need to establish that there's an arousal pattern consistent with that paraphilia before making that diagnosis.

Q How does one -- you know, candidly a lot of times individuals don't always tell the truth to a clinician when they're getting a report.

A That is correct.

Q How is it that one can, you know, try to make a diagnosis with that kind of limitation placed on it?

A Well, when one -- obviously an individual -- individual report, it's only one source of information. There's other informants.

In this particular case, for

instance, there were a number of sexual partners, including spouses and ex-spouses, that this individual was involved with.

If he had an abnormal arousal pattern, an obvious source of inquiry would have been to ask the spouse, independent of the individual, to describe what their sex life was like.

For instance, for someone -- it's very common for someone who has a sexual deviation pattern to ask the partner or try to get the partner to participate in that fantasy in order to enhance their sexual enjoyment.

For instance, if someone has sexual masochism as a paraphilia, they will typically ask a partner to do an act of bondage in order to be able to enjoy that.

So there should be some element of that, I would expect, in -- in Mr. Davenport's life, and in fact there is no attempt even to inquire about that.

We don't know one way or another in

this case whether there was, but there was no attempt to even find that out.

So there's one avenue, is to look -- ask other individuals who -- independently, without, you know, be an informant to be able to comment on the person's sexual fantasy life.

Another method which is used and sometimes successful is a test called piapatino plethosonography (phonetic), which is a test of physiological arousal, when you expose someone to visual stimuli that are of different -- that would be consistent with the paraphilic focus.

So for instance, for this particular individual, to determine whether or not he had a paraphilia, you could show slides or pornography of children, rape, animals, every single one, see what arousal patterns.

Even if he denies that he is sexually aroused by rape fantasies -- it's not even clear how that -- that question was actually asked in the evaluation, but let's assume that you asked that question and he denied it. That would be

one way to determine whether or not that is truthful.

And you could also give other kinds of -- there are other tests, self-reports and interviews that have been used to help uncover that.

But again, tests -- direct one-on-one tests could be -- you know, could be, you know lied.

But I mean, this guy has a -- you know, a long history, and there should be through informants and other methods some ability to be able to consider -- I mean, another issue here -- so there's the issue of -- two issues.

One is whether or not an attempt was made to establish the arousal pattern. The other is -- one aspect of the report that comes out over and over and over again is the fact that I believe every one of the assaults occurred in the context of substance use.

And the role of substance use -- and

this is rape, too. Since -- this is an interesting combination.

This is not -- you know, people commit rape for a number of reasons. 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 of paraphilic rape or paraphilia NOS non-consent.

Rape is more often than not committed because it's an opportunity for someone to achieve sexual gratification from individuals who are convenient.

And his -- you know, if someone does that under substance, that may make him more sexually aroused or horny when he's on a substance, or maybe his desire goes up, and whoever the convenient target is at the time he chooses. So that's another possible explanation.

Again, I can't tell from reviewing the records what the alternate explanations may or may not be, but I can say from reviewing the report is that there doesn't appear to be any attempt to consider alternative explanations and rule them out.

Q So if I understand it correctly, the fact that one has been involved in forced sex on other individuals a number of times doesn't ipso facto lead to a diagnosis of paraphilia?

A Absolutely true. Certainly people who actually have a paraphilia would have done that, but the opposite is not true. People who do that do not necessarily have the paraphilia.

Q Let's switch a little bit to volition, if we could.

The fact that one has a paraphilia or personality disorder, does that in any way make the determination that one lacks the ability to control one's behavior?

A The diagnosis in and of itself does not. It's important to understand that.

There's another one of the things that the cautionary statement in the front of DSM is, that there's a tremendous amount of heterogeneity.

If you fit a diagnostic label -- lots and lots of patients who are very different from one another will fill in a diagnostic label.

It is certainly true that some individuals with paraphilia, some individuals with personality disorders, lack volitional impairment -- have volitional impairment. I mean, have -- are impaired in their ability to control their decision-making.

But it is not true that having any of the diagnoses in the DSM necessarily indicates a lack -- of the presence of volitional impairment, including even disorders that are even more -- you know, schizophrenia, bipolar disorder, a pure psychosis, where it's well-known.

In fact, people have used insanity defenses under the grounds of volitional

impairment, but no one has ever said that having schizophrenia means that you have a volitional impairment.

It has to be evaluated on a case-by-case basis to see whether that individual with that mental disorder happens to also have volitional impairment.

It is true that volitional impairment in some individuals occurs in schizophrenia. Volitional impairment in some individuals occurs in paraphilias, but not true for all individuals.

Q Doctor, in order to help understand an individual who may have impairment, you need to perhaps look inside that particular individual, what's going on in his mind that drives these behaviors. Is that fair?

A That's true.

Q Do you believe that certain psychological testing could be of significant value in trying to figure out what's going on in an individual, for example the MMPI or

Rorschach?

A Certainly an MMPI. I'm not that familiar with the Rorschach, and probably not the hugest fan of Rorschach from my understanding, but I certainly can say the MMPI would be. The utility of Rorschach is unknown.

I wouldn't comment positively or negatively. I think I would comment that the MMPI would be helpful.

Q And you --

A Certainly psychological testing principle would be helpful.

Q And you -- in essence this was a book, the DMS, that was written for clinicians?

A Correct, and researchers.

Q In the forensic arena, given the difficulty that clinicians can be lied to or misled, that sort of problem, do you think that perhaps psychological testing adds -- has value in the forensic arena?

A Absolutely. Absolutely. It is -- many psychological tests have validity checks

built into the test.

So there's tests -- as you know, the user sometimes uses it simply to get a sense of that individual's willingness to be honest, overreport, underreport.

So tests are, if for no other reason, are informative along -- to help draw conclusions about the individual's general sense of validity in the way of the report.

MR. THOMPSON: Okay. We've been going about two hours now. The court reporter, I think, needs a break. Jennifer, are you still with us?

MS. KAROL: I am here.

MR. THOMPSON: You want to take a half-hour break? Would that work for you?

MS. KAROL: Bob, can you hear me?

MR. THOMPSON: You didn't say anything, I don't think. Would a

half-hour break work for you?

MS. KAROL: That's absolutely fine. So I will give you a call back at 11:30 my time, which would be what?

MR. THOMPSON: 2:30 here.

(Recess taken)

CONTINUED DIRECT EXAMINATION BY MR. THOMPSON:

Q Doctor, we talked about diagnostic validity, but how about psychodiagnostic reliability? Are you familiar with that term?

A Yes.

Q Could you explain that so we hopefully have an understanding of what that is?

A Yes. Actually I call it diagnostic reliability. Psychodiagnostic work. Diagnostic reliability is the ability of two individuals making diagnoses to agree on the same diagnosis when they see the same person. So for instance, if you have --

MS. KAROL: Sorry to interrupt. Can we have the doctor speak up a

little bit?

MR. THOMPSON: We'll have him come up a little closer.

A So diagnostic reliability is the ability of two -- for two evaluators to agree on the same diagnosis when they see the same individual.

Q Are there studies that have been done to take a look at that diagnostic reliability within the DSM itself, like perhaps major categories?

A When the DSM-III came out -- before it came out they did a field trial, and as part of the field trial they tried to assess reliability, and the way they did that is they enlisted a number of clinicians in practice, and they had people as pairs evaluate the same patient, and they filled out forms and they saw how well they agreed. So there was a general reliability trial across the whole book.

And that's the last time there's ever been a general reliability trial for DSM.

Individual reliability of individual disorders has been looked at, but that was the last time there was a full reliability trial.

Q Going back to the one that was done, I guess, across the board, how reliable --

A Actually I want to look at the book and see -- in the back of the DSM-III there's actually a table.

The -- okay. They actually -- according to this table they had -- it says it was -- the reliability was 1.0, with a prevalence of .6 percent.

And it's my recollection that you need a certain number of cases in order to be able to have meaningful statistics, and I believe that number is too low to be able to draw any conclusions.

So I suspect -- they only had a handful of cases. And the 1.0 would suggest that of the handful of cases they had they were able to at least agree that a paraphilia was present.

So that's the data from the field trial, but I believe the number of all cases was just -- was very, very, very low.

Q Are you familiar with any research since that came out in regards to the field of paraphilias?

A No, but I'm not -- that's not my main area of focus, so it's possible there might be something out there I'm not aware of, but I'm certainly not aware of any reliability data about paraphilias.

Q Did the APA, when it was drafting the DSM, give consideration to the idea of these -- you know, conducted some field testing in the III. Did you give any thought to the reliability and validity of the paraphilic diagnosis?

A Not in particular. I think when DSM-III was being put together, they were looking to establish -- you know, make a general statement that the reliability of the DSM-III was better than DSM-II.

Because paraphilias are so rare in clinical practice, unless you specifically were trying to examine the reliability of paraphilias, it would be -- I wouldn't expect the field trial to give much data with regard to reliability.

Q So again, understanding the DSM is a clinical book for clinicians to, you know, basically alleve [sic] pain or suffering or counsel somebody, perhaps the reliability or validity is perhaps not as important as the forensic arena. Would you agree with that comment?

A Well, it's desire -- I -- again, it's probably more important in the forensic arena, but, you know, decisions with respect to individual's liberty and -- and other issues like that are involved, so there's a requirement of systematic nature of evaluations.

So in clinical work, you know, we try to help the clinicians make a diagnosis. So I think the importance of -- of certainly

reliability clinically is a little less important probably. Certainly -- also very, very important for research.

Validity of course is important as well, but, you know, it's hard to say what arena is the most important arena.

Validity is an important process. It's probably -- certainly very important in the forensic arena.

Q I have heard that you're not -- in the clinical setting, you're not saddled with a particular diagnosis.

As you treat somebody you can change your diagnosis and change your treatment, giving that as a kind of a broad-based statement, whereas in the forensic arena, once a decision has been made by a trier of fact, you're saddled with that decision.

A Yes. I guess if you put it that way, certainly the impact of the wrong diagnosis in a forensic setting will be much larger than the impact of a wrong diagnosis in a clinical

setting, when a clinician can modify their diagnosis based upon how things turn out.

Q Could you speak to the issue -you testified on it briefly earlier today- the NOS categories?

In regards to when a clinician comes up with an NOS category, whatever it is, it is up to that individual clinician to be able to supply the proof that this actually exists and it is treatable or -- could you speak to that issue? Does that make sense?

A I mean, let me put it this way. Diagnostic categories are specific. The validity of an existing category is generated based upon the body of knowledge that is behind it.

The specific categories, by virtue of the fact that they have been out there and published by researchers and clinicians using them for years, will build up a certain amount of validity, and they get changed based upon data.

The NOS categories by definition aren't really categories. They're basically holding places to allow clinicians to have a code for their work.

So if you see an individual and say the diagnosis is NOS, all you said is that they don't -- their diagnosis doesn't meet the criteria for any specific categories. You're not really saying much about what that person actually has.

So you can't -- the validity of that -- of the use of that category completely depends upon the body of knowledge behind what they're proposing.

But there's no inherent -- and certainly the reliability -- if you look at any study, the NOS categories have much lower reliability than the specific category, as you might expect, because they're certainly undefined. It could get in there for any reason.

Q If I understand that, the fact that a

particular clinician uses the NOS category, you might candidly expect that the validity of that, the interrated reliability I guess is another way of describing it, is going to potentially suffer because it's so diverse.

A There's no criteria. Exactly. The reason that DSM diagnosis has greater reliability, the DSM-II diagnosis has specific criteria.

The NOS categories have no criteria. They're just vague descriptions of the kinds of things that might fit in.

And in fact the definition of an NOS category is in the negative. It's here's something that doesn't meet criteria for anything else, so it's inevitable that it won't have good reliability.

Take the concept of paraphilic rapism. There are no accepted diagnostic criteria as far as I'm aware that have been published that propose certain categories.

So without a standardized definition,

it can't possibly achieve the kind of reliability that the disorders that are in the DSM have.

Forget validity for a second. The lack of a definition. Just from reading -- my own reading there seems to be different understandings of what the phrase non-consent actually means.

That's the kind of thing that creates unreliability. When individual clinicians have their own idiosyncratic interpretations of what something means, that's an invitation for unreliability.

The reason why the DSM has any reliability is it contrains people in how they understand the disorders. It provides the definitions.

So you create reliability by sort of constraining the individual's ability to ideosyncratically apply their own way of looking at things.

The NOS categories inherently,

without any specific definitions, are -- are inevitably not going to be reliable.

And the only NOS categories -- you know, let me give you an example of an NOS that could be helpful.

In the DSM -- in the back of the DSM is an appendix, and there are 23 categories in the appendix there are not official.

If you, the clinician, want to use one of the categories in the appendix, because they're not official, you use the NOS category for the right -- like for instance, there's a category called minor depressive disorders.

If you -- and that's not an official category in the DSM, not officially recognized, but you see a patient, and you want to claim that they have that, and write down minor depressive disorder, you would actually use the code for depressive disorder NOS.

Now, in that circumstance there's at least a chance of achieving reliability, because there's a definition in the book for minor

depressive disorder.

If you have an NOS category and it's an undefined condition, that's by convention or agreement or whatever, without clear-cut criteria, so everybody is clear what you're talking about, it's inevitable that the reliability is going to be poor.

Q In your -- at this time, your basis of knowledge, you don't believe that reliability -- you haven't seen any studies that would verify this laundry list of things that clinicians can hang their hat on when they're making a diagnosis of paraphilia NOS rape or non-concept; is that correct?

A I mean, I'm also not aware there's any published definition of what that is. So assuming that's true, and I think that appears to be true, then it can't possibly -- if you were to do a reliability study, you have to inevitably do it with some kind of a definition.

You can't possibly get reliability on a concept that's undefined. It's up to the

individual's own, you know, ideosyncratic understanding of what that actually means.

Q How is it then that without that criteria that somebody could -- I'll use the word brazen, make a diagnosis of a paraphilia NOS without being able to support that diagnosis somehow?

A How can they do it? I don't know. It's like -- I think it's very -- they're working on tenuous grounds with respect to -- and especially in an area where the implication of using the diagnosis has such a great effect.

It gives me great concern that, you know, using diagnoses with unproven validity and reliability, as if that there a well-established category, is a real -- a real potential problem.

Q Would it be enough in your mind to have a group of individuals who practice in a particular area, they do perhaps evaluations of sexual predators, banned together and say "We're going to start diagnosing people who commit rape based on behavior, that we're going to create a

paraphilia NOS non-consent slash rape, to justify what we do"?

Is that the kind of validity studies you're talking about?

A If that group of individuals had said, you know, "We're going to come up with a definition of paraphilia, and here's the diagnostic criteria. I know it's not in the DSM. We're going to come up with our own criteria set and publish it, and then do studies to show that individuals within that group can use it reliably," that might be -- you know, that might be a way to establish reliability.

Just for a group of people to simply dictate that because we do it, therefore it's reliable, I mean, you need evidence to prove that.

Reliability is something that you need to be achieved and proven. You can't simply claim it's reliable.

Without data and without a definition that everybody is definitely using, I can't

imagine how you could possibly achieve reliability.

Q Well, perhaps they can't, but you have had an opportunity to review some work that we have -- I've given you on Mr. Davenport, and although it doesn't get into -- actually I don't think Wheeler's report talks about anything about the differential diagnosis or why he has paraphilia NOS.

Other than regurgitating his criminal behavior, there was nothing that's cited to any research or literature that justified the creation of this category; is that correct?

A That's correct.

Q And as we're sitting here today, you're not familiar with any group that's approached the APA to create this brand-new category in the last, say, two or three years?

A Absolutely that's correct. Nobody approached us with that at all.

Q All right. Now, you had mentioned the idea of field testing.

Were all -- and I also want to make sure I'm clear on this.

All the diagnostic fields were field-tested in the originial, in III; is that correct?

A Yes.

Q Okay. Can you tell me -- you know, when -- I read the introduction to the DSM.

The APA spent a lot of time in the introduction cautioning individuals about its useage in the forensic arena.

You have touched briefly -- maybe not briefly, but you touched on that particular issue a little earlier.

Why did the APA issue those kinds of warnings in --

A Because --

Q -- the introduction?

A -- we're aware that the DSM which -- when the DSM was created, it was created as a clinical document, period, and that the design of it, the construction in every way, shape or

form, that was the constituency for which it was being used.

We became aware over time that because the DSM -- well, let me put it this way. The DSM -- 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 of some kind of standard or weight or something, used in settings outside the DSM.

So we felt that it was crucial to explicitly indicate the limitations of the DSM and use and settings outside of the clinical setting, and the providing explicit warnings as to in what ways it's likely to be inappropriately used.

So it was -- it was in recognition of -- I think a general recognition that it was being abused and used inappropriately, because there was an assumption that a book developed for one set of audiences would be applicable without change to another.

Q So let's assume -- I'm going to talk about this non-consent for a second.

This is one of the potential issues that the authors of the DSM had, that -- the fact that a paraphilia NOS category could conceivably be used as a bible to say that there's a mental abnormality or personality disorder or mental -- a mental disease or defect, when in fact unless there is the validity that -- studies that go behind it, it's a total misuse of the book. Is that fair? In the forensic arena.

A Well, the problem is to -- from what I've seen, I was -- there seems to be a bit of a slight of hand, where by using the diagnostic term and codes for paraphilia NOS, and because that term and code happens to appear in the DSM for clinical reasons, that there's this implication that there's a certain amount of reliability and validity -- that because the book is a scientific document, because the proposed or purported category that's being used

in the forensic setting can be named or used and coded in the book, therefore the validity and reliability that is generally present for most of the disorders in the book necessarily would apply to that category.

It's a slight of hand, because absolutely there's no connection with the use of the phrase paraphilia NOS and any kind of reliability -- validity reliability that applies to other elements of the book. It's absolutely no connection.

Q So again, you've addressed this, that it is incumbent upon the people that are proffering this to show that validity --

A Absolutely.

Q -- and reliability?

A Absolutely.

Q All right. Has the APA ever done any studies on -this is kind of an amorphous term- volitional control or the inability to control based on --

A Well, the APA doesn't do studies, but

most of the work that goes into the DSM is done by researchers, and we review that research when putting together the DSM. So the answer's certainly no.

Q Have -- phrasing it correctly then, the researchers that the APA has reviewed -- strike that for a second, because I'm losing my train of thought here.

Volitional control. Are you familiar with research on volitional control?

Let me ask you this. Let's define the term.

What do you -- when I use the word volition, what does that mean to you as a psychiatrist?

A Volition is the ability to make decisions and act according to the decisions that you make.

Q Do paraphilias have the ability to override volitional control of an individual?

A Ever? In any individual ever?

Q Yes.

A It could.

Q Okay. How about a personality disorder?

A Certain aspects of certain personality disorders are -- well, I'm not -- I think -- yes. Some individuals with some personality disorders might have an aspect of impairment in volitional control.

Q Some. Is that --

A Well, for instance, the two categories that have -- one category that's umpulsivity is one of the criteria for borderline personality disorder.

Impulsivity -- in fact there's a criterion about impulsivity in at least two different areas, reckless driving.

Now, that in and of itself, that criterion doesn't necessarily mean -- I mean, impulsivity is not equivalent to loss of volitional control.

So there's -- I mean, the issue of volitional control is not in any of the

criteria. That's for sure.

It's possible that certain individuals with certain personality disorders could be impulsive and act, but I'm not sure it's the personality disorder itself that's doing it.

That's -- I'm not sure it's a -- it's the nature of a personality disorder to have an issue with volitional control.

Q You know, they talk about in the DSM personality disorders are long-lasting, pervasive, don't go away. Is there research that supports that?

The reason why I'm asking the question, understanding how the DSM-TR-IVs come to be, a lot of the language has stayed the same for a period of time.

A Actually, the answer is the research suggests that that may not be completely true.

Q Can you elaborate a little bit on that?

MS. KAROL: I got to jump in

here. Can you guys speak up just a little bit louder? I think you're trailing off a bit.

MR. THOMPSON: Sure. We'll give that a shot.

MS. KAROL: Thank you very much.

MR. THOMPSON: Thank you for letting us know.

A So the question is about how the concept of personality disorders is changing over time.

I think it used to be standard thinking that once you have a personality disorder you have it for life.

That is becoming clear that's not the case. There's a very -- there's a study going on right now called the CLIPS study, which is a longitudinal study of personality disorder over time.

And one of the surprising results of that study is the personality disorder is not

anywhere near as stable as people thought.

People actually have times when their personality gets better, and they go from disorder to non-disorder over time. So it's much more fluid than what was originally understood.

So I actually -- I would say that the criteria as stated in the DSM-IV-TR probably overly pathological -- I'm not sure that truly captures the nature of personality. Personality is much more changeable than was originally thought.

Q So an individual would be wrong, because science has advanced in this field, to believe wrongfully that a personality disorder, once you got them stay forever, you can't change them?

A That's correct. Personality stays forever. Personality disorder -- the distinction is not just one of semantics.

Everyone has a personality, and the basics of your personality are always there, but

the extent to which your personality interferes with your life, and its rigidity does change over time, so that you can have a tendency to be paranoid, and that may always be there, but the intensity of that could abate over time.

So you could go from somebody with paranoid personality disorder, where one's paranoia interfered with your ability to interact with people, to being paranoid, but at least that is no longer considered to be a disorder.

Q Does the research seem to indicate that as you age your personality disorder is perhaps mitigated?

A Yes. By and large, most -- many personality disorders, certainly borderline and antisocial are two, the evidence suggests that they mitigate with age.

Q So that would not surprise those of us who understand testosterone levels as they fall in regards to libido issues.

And I guess -- I'm drawing some

linkages here that maybe I shouldn't draw, but as I look at age, you know, there's a maturity factor, and then there's a line of thought that talks about the adolescent brain isn't fully developed.

And we had a Supreme Court case that talked about whether you should put juveniles to death because they didn't have the ability to fully understand what they were doing when they did it, and they should not be held culpable as a result.

And with that being said, does this seem to tie into that as well, that as one becomes more mature, perhaps physiologically as well as emotionally, any perceived personality disorders that you may have had may mitigate or subside over time?

A Absolutely.

Q The study that you have referred to, I want you to say it again, and where is it being held at. Who's doing the study?

A CLIPS. It's an acronym, C-L-I-P-S.

And it stands for -- I forget the -- Collaborative Longitudinal something for Person -- I forget the acronym, but the lead author is actually a Dr. Andrew Skodol, who's actually at this institution, but it's a multi-center study that's been going on now for a number of years.

And the point of the study was they enrolled people with personality disorder a certain number of years ago, and following them over time and doing periodic assessments, and that's allowing people to have a really good window into how -- you know, what happens longitudinally.

And so -- when you say personality disorder doesn't change, it's based on a concept that, you know, people have never looked at it carefully enough to really test whether -- the truth or falsity of that hypothesis.

This is a unique -- it is an NIMH-sponsored study. They spent a tremendous amount of money to do it, and providing unique data to be able to see something no one has ever

seen before.

Q NIMH --

A National Institute of Mental Health. That's the main government-funding body in the United States for mental health research.

Q So if I understand it, the research is ongoing?

A Yes.

Q Is there a time frame when one might get a final, published paper?

A They have been publishing papers all along. So they're in the major psychiatric journals.

There was a paper in the American Journal of Psychiatry. There's a paper in the Archives of General Psychiatry.

So it's -- there's a number of papers, and at least ten have been published already on different aspects of the study.

Q Are you familiar with anybody who has tried to counter those results, saying whatever the basic research that you've done, it's in

error or wrong?

A I haven't heard of people countering it. I think it's surprised a lot of people who have seen it, because it goes against some conventional wisdom.

But I think the study is really raising major questions in everybody's mind in what people understood.

Q The reason why I raised the issue is we had a chance to talk yesterday about substantive due process in regards to you got to have some standards by which a reviewing court can make a determination whether this is legitimate or not.

And there was a case called -- I think it was the Hendricks, Kansas case. Mental abnormality is a term that we can't utilize because it's too broad-based and doesn't really mean anything.

We had a chance to have a discussion yesterday, and today you had a chance to review that.

Do you have any concerns that we may be stepping over that line in regard to this vague notion of mental abnormality and utilizing a DSM diagnosis that may not have validity or interrated reliability to it, to take liberty away from individuals?

A Well, I mean, I think the -- the problem as far as I understand it is that most of the statutes require the presence of an abnormal personality disorder of some sort that impairs the volition of that person, and therefore results in being dangerous.

And the problem with using -- the DSM was never meant to inform that judgement, that the DSM says nothing about the nature of volitional impairment as it applies to particular disorders.

So an error that I understand is being done is people are making assumptions that because somebody has Disorder X or Disorder Y, therefore by definition that in and of itself is enough evidence to say that volitional --

there's volitional impairment, simply by the presence of the disorder, and that's probably -- there are no disorders that necessarily imply volitional impairment.

The second problem is that, you know, one of the most important questions here is there are many reasons why someone could be dangerous.

Many criminals, once they're released from jail, remain to be dangerous because they're bad people, who feel no problem with committing more crimes for their own gain.

That is not the same as having a mental -- establishing the presence of some kind of mental disorder that is the cause of the dangerousness.

And the problem is that none of the DSM categories are inherently connected with dangerousness, not inherently connected with volitional impairment.

And, you know, when you purport -- come up with a personality disorder that is not

in the DSM or one that's in the DSM, there's a big problem in making the stretch that it's necessarily connected to the issue of volitional impairment. In the world of DSM that creation, I think, is a problem.

Q You said -- you used the word stretch.

When you say that, does that mean there hasn't been sufficient research done to justify those types of conclusions?

A Well, it's a combination of -- I mean, it's not a conceptual issue. There's no question that there's no diagnosis in the DSM that by necessity has volitional impairment.

So anyone who makes a claim like that -- it's not even a research question. It's a misuse of the way the diagnostic labels were intended.

There's a heterogeneity to a label. That means that there's a wide range of behaviors and capacities and dangers associated with that label.

In order to know about volitional capacity, you have to particularly evaluate that one issue and that one individual.

The diagnosis is irrelevant. All you really need to know is a volitional problem that's due to some -- is a volitional problem, is it sort of based in the brain in some way. That would be sufficient.

But coming up with the logic in the opposite way, of finding a DSM label and then saying because they have that label, therefore they have volitional impairment, without actually seeing whether that particular individual has actual evidence of volitional impairment, is a mistake.

And it's not even -- there's no -- I mean, the data is out there. The data is there's no disorder for which volitional impairment is built in. You don't need to do a study.

Q So if I'm understanding what you just said -I'm going to paraphrase it- the fact that

you have committed criminal acts in and of itself cannot lead to a diagnosis -- mental health diagnosis, by itself, just the behavior. You can't just make that leap.

And you also can't make the leap that because you have a mental health diagnosis, a disorder, like a paraphilia NOS, whatever, you can't make the leap that it is going to cause future behavior?

A Correct. Absolutely.

Q How does the APA look at developmental disability-type folk?

A Mental retardation?

Q Yes. I mean, are they in the DSM?

A The DSM includes -- the DSM is a book for mental health professionals. It is intended to include clinical conditions that mental health professionals are called on to treat or intervene.

Individuals with developmental disabilities are commonly seen by mental health professionals, so intellectual disability is in

the DSM.

There are a number of disorders that are in the DSM that have no -- that no -- no one would claim to be mental disorders.

Stuttering is an example. Reading disorders. They're there because they're disorders.

And I mean -- I guess learning disorders or speech disorders, whatever, but they're covered in the DSM simply as a matter of utility to users of the DSM. There's no statement by inclusion in the DSM that the disorder is a mental disorder.

Q Okay. Something like fetal alcohol syndrome, would that be a mental disorder, or is that just a congenital defect?

A Well, fetal alcohol disorder is an interesting case, but there's actually been a move to include fetal alcohol syndrome in the DSM by some serious researchers.

And the reason it's not in the DSM is because -- first of all, fetal alcohohol

syndrome refers to the -- when a fetus in utero is exposed to a mother who drinks, the toxic effect of the alcohol having a negative impact on the fetus.

Once that fetus is born, there's this idea that there's a range of negative aspects to that person, both physical and psychological, which were presumed to be caused by the alcohol.

The problem with the idea of a fetal alcohol -- the syndrome just refers to that concept.

The attempt to label a collection of symptoms in an individual as being due to the effect of alcohol, there's never been a strong scientific basis to be able to clarify what that is.

It's well-understood that individuals who have been exposed to alcohol in utero have a higher risk of conduct disorder, attention deficit disorder, a host of problems.

But there's no syndrome of symptoms that hang together as a specific sequellae of

having been exposed to alcohol.

So the fetal alcohol syndrome is a concept, and as a group of symptoms which doesn't hold together.

So it's not in the DSM now, and it probably won't be in the future because of that, unless such a syndrome is actually elucidated.

Q There obviously have been several renditions as we have gone through the DSM.

Should we be expecting another one sometime soon in the future?

A The next DSM is projected for the year 2012. Work is just beginning to get underway.

There's been no changes, no idea of changes, no proposals, no anything at this point in time.

Part of what I'm saying about fetal alcohol is really a guess. I'm confident that there will be a proposal to have some fetal alcohol something in the DSM-V.

I'm not confident, based upon my

reading of the literature, that that will be successful.

Q Okay. Is it your intent to be working on that this time around?

A My role isn't clear. Right now I have -- I've been involved in the preparation, but my precise role in the DSN remains unclear.

Q Let's talk about the term mental disorder.

What does the APA mean by a mental disorder?

A Well, the APA has had trouble with the word mental disorder many, many years, and has attempted to dodge -- there is no definition of the word mental disorder. I'll say that. That's probably the best thing.

The DSM, even as a diagnostic manual -- mental disorder is in the title. It's historical. There really is no -- that's why any attempt to define mental disorder will not work out, because we don't have a definition of mental disorder.

Q Okay.

A And certainly what we do have is the DSM is related to the international classification of diseases, which is the actual classification used in the United States.

There's a section of international classification of diseases called mental behavioral disorders.

It's a very wide section, and even though they don't figure out the different mental disorders.

There's no clear -- it's a term of convenience. When we use the term, it means that chapter in the ICD.

Q When the APA uses the term clinical significance, utilized in the DSM, there are those of us that read that.

I don't know what that means. That means a little significant -- could you assist me get a better understanding of what clinical significance means?

A That's a problematic term that we

recognize. The reason why the phrase clinical significance is added is to make it clear -- most disorders occur on a continuum.

There's a little bit of depression and a lot of depression in different individuals.

The issue of when you decide an individual has -- is a case is determined -- you know, the idea that you need to make a distinction that if you look at the individual's level of symptoms, there's a point where if it's too low you wouldn't call it a disorder, and if it reaches some threshold, you would then call it a disorder.

The problem is that there's no good way to define that. We're basically leaving it up to the clinicians.

So we specifically chose the phrase clinical significance to imply that it's a clinical judgement, the actual threshold for whether something is a disorder.

So the term -- so clinically

significant distress or impairment means that it's the amount of distress or impairment that seems enough to justify clinical care.

But we do not define what that is, and the reason we don't define what that is is there's no good empirical way as of yet to be able to make a definition.

So it's -- basically the APA has admittedly dodged a very important problem because we don't have an answer, but it's sort of a way of telescoping or indicating the importance of clinical judgement in making these things.

Q We had touched a little earlier on there had been a movement or some talk about trying to remove paraphilias from the DSM. There was a group of individuals --

A There are individuals who claim that in the same way that homosexuality is a normal variant, that paraphilias are a normal variant as well.

Q If I understand it correctly, the

idea that what you're really doing is a reflection of societal norms.

A That's the -- the problem is that there's a question about the norms and whether it's simply a societal norm issue.

And homosexuality -- I mean, the reason homosexuality used to be in there is society used to consider it abnormal, and at a certain point societal norms shifted, and it became normalized and it was dropped from the book.

I don't believe that the APA or people who do work with paraphilias believe that inherently all the paraphilias are dictated by societal norm.

There is a sense, depending how one looks at it, that there is set -- sexual desire exists for the purpose of procreation.

So certain -- you could say that something has gone wrong and when is primarily attracted to having sex with animals.

Few people -- I mean, I don't think

someone would argue that having zoophilia is simply a societal norm.

The -- where it gets -- obviously where it gets a little hazier, certain of the paraphilias which are more accepted, like fetishes is an example of one that's probably more in that gray area of, you know, why is it abnormal to, you know -- you know, want to use plastic or whatever it is in a fetish -- it's harder to call.

But I think what's happened, there's been a sense that clearly the concept of paraphilia has validity.

When it comes down to each of the particular paraphilias, you know, ones have perhaps more problems than others, but I think there's a sense of let's leave the entire thing alone because of its utility.

Q And again, directing utility, it's used for clinicians to address a need in a particular patient.

A Well, it's used for clinicians

because people come in for treatment, asking for treatment for these things. That's correct.

Q Having said that, the idea of pedophilia -- I think we had a chance to discuss this briefly, from a cross-cultural standpoint, perhaps in Africa or ancient Greece, where that was kind of an accepted norm of behavior, nobody disagrees that having sex with a consenting child or even -- let's call them can't consent, is wrong.

But as of the mental disorder, as listed in the book, that -- that's part of the concern with paraphilia. Am I making that --

A You could argue that -- I mean, this gets into the core of the concept here, that sexual arousal is a trait that people have, and the capacity to be aroused by, you know, an appropriate choice, meaning if someone who you're going to be able to procreate with, will be considered to be somebody which is normal.

Therefore, being -- you know, wanting to have sex with a three-year old, besides the

fact that it's harmful to the three-year old, I think it's fairly -- at least in my -- being easier to make a case that something is wrong with that individual's -- something has gone wrong with that person's arousal mechanism, so that their repertoire of what turns them on is restricted to a three-year old child.

So I don't think I have any problem with saying that that's an unsocietal norm. There are certain disorders, like the adolescent one -- I forget --

Q Ephebophilia?

A Ephebophilia is obviously more controversial, because people point out, you know, age of consent has changed over time.

When you look at that one, that's obviously a lot less clear in claiming that that's valid as a paraphilia, because that's, if anything, a poster child for the societal values problem in paraphilia.

So that I think most of the rest of them I think are on much stronger ground, and I

think are sort of much more impervious to the issue of societal values.

Pedophilia, you know, is -- again, I suspect in those African cultures where they have sex with children, they don't have sex with three-year olds, so even there there's a cut-off.

The question is there's something wrong and inappropriate about having sex with at least some children, and exactly where you draw that line may be societal -- you know, societal-dependent, and that's where you get into the paraphilia thing.

Q You've used the term normal sexual behavior.

Normal, as I understand, is to procreate, to have sex --

A Let me make it clear here. What we're talking about now is closer, in my opinion, based upon my -- I think APA has never made a -- I think if you look at the DSM as a policy document of the APA, the fact that those

disorders are in there as defined, the APA's is these are not -- these are psychopathology.

You started the question about what the controversy is, so I'm reflecting on the controversy, because I think the APA's position is unambiguous. These are psychopathology.

Q And they haven't defined normalcy. Have they ever defined sexual deviancy?

A Well, I think the paraphilia -- I mean, there is -- there is no definition of normal sex, per se.

They've sort of cherry-picked out certain things that are easy to say are abnormal, like when you have sex with animals.

I think it's easier sometimes to point to an abnormality, certainly in extreme cases.

Where you get into the gray area is a -- much harder to be able to pick out what's -- what's normal versus abnormal.

Q It seems, having had an opportunity to listen to you, that the idea of paraphilias

has changed over time in regards to -- we talked a little earlier about homosexuality, it used to be in, now it's out.

Change probably was society grew up or politics changed, something along those lines.

Have any other fields in psychology changed as much as paraphilias?

A Over time?

Q Yes. Any other diagnosis.

A Under normal, abnormal lines, you mean? I mean, moving things out, things that once were abnormal are now considered normal, in that direction?

Q Yes.

A Not aware of any, any other one. I mean, I guess the other -- the other side of the sexual chapter, which is sexual dysfunction, may be one also, whereas those have changed over time.

Like for instance, the definition of anorgasmia, not being able to have an orgasm,

now that we understand it -- I'm not sure it's a societal issue. Maybe it's not.

We now understand there's a lot of variable capacity -- normal -- there's a lot of variability in one's capacity to reach orgasm, and therefore you don't necessarily label people who have a certain amount of trouble as being disordered, because we now understand that's part of normal variation.

Let me give you another example of where there's a mis -- in the sexual realm, and maybe that people have such very rigid ideas about sex, and once you learn more about them there's a little bit of a shift in understanding.

Now, this doesn't apply as well to other disorders, but no reason to think it couldn't, like insomnia.

I guess you could imagine that people need less sleep or more sleep, that might shift some sense about it.

Every section of the DSM is

potentially -- you know, could be affected by new knowledge and new ways of thinking, and certainly in adding things as well as taking things out.

Q I guess the one thing that -- trying -- I think I've learned is that this field of psychology is ever expanding.

A Evolving, yes.

Q And what was true yesterday may turn out not to be true tomorrow?

A That's certainly true.

Q And for us to make a blanket statement this is how it is and always shall be would be simply false in this particular field, because of the dynamic nature of the field. Is that fair?

A That's fair.

Q Are you familiar with the term egosyntonic?

A Yes.

Q What does that term mean?

A Egosyntonic refers to the

individual's sense of whether some -- some problem may -- some trait they have is a symptom or whether it feels like it's part of themselves and normal.

So a good example is a panic attack, is a good example of someone who is egodystonic. So -- I mean, it's easier to understand egosyntonic by looking at what egodystonic is.

When somebody comes in for treatment, almost by definition, if they're coming in for treatment it's egodystonic, because it's something you want to get rid of.

They feel that something has gone wrong. It doesn't fit in their sense of self. My sense of self is not something that leads to panic attacks or depression.

Egosyntonic is when you have a problem or trait or something that you don't appreciate as being the symptom.

Many of the personality disorders are egosyntonic, because it feels like this is the way I am and the way I'm supposed to be.

Many of the paraphilias are egosyntonic in that the individual feels that this is my -- part of my repertoire of sexual arousal, and that's -- I'm fine with it, because that feels like -- they don't see it as something that is a problem for them, other than the fact that society doesn't like it, but internally feels like it fits into their, you know, sort of sense of self. That's the nature of it.

Q Do those terms play into being able to diagnose paraphilia at all?

A No. The only relevance to paraphilia is it could conceivably have an impact on dangerousness, only in that I think egodystonic is probably a good factor for dangerousness, because if you experience it as something you don't want, you may be more likely to exert control over it.

It doesn't necessarily mean because you're egosyntonic you couldn't, but I think the opposite, that egodystonic, which is probably a

good prognostic factor, but it's certainly not that all paraphilias are egosyntonic.

I think you could probably bend the rule. Most clinicians -- ironically most -- people using the DSM, when they see paraphilia, they're much more likely to seeing a dystonic one, because the fact the person is coming in for treatment means it's egodystonic.

A clinician can see an egosyntonic one when it's the spouse that says, "I can't stand the fact my spouse, you know, is attracted to X."

And there you sometimes have the conflict where it's the spouse is demanding the treatment, where the person who is actually getting the treatment doesn't appreciate it as an actual problem. But it's certainly not inevitable that all paraphilias are egosyntonic.

Q Anti-social personality disorders appear as a diagnostic entry in the DSM, correct?

A Correct.

Q Does that mean the APA considers the anti-personality disorder a major mental disorder?

A Well, the phrase major mental disorder generally refers to disorders like schizophrenia, bipolar disorders. It's another term that's mushy, major.

And like -- and it's -- so the answer is no. I think generally personality disorders are not major mental disorders in the -- the typical use of the word major mental disorder.

Anti-social personality is a personality disorder. It is not -- would not be considered a major mental disorder by the APA, using that definition of major mental disorder.

Q How about just a mental disorder?

A Yes, insofar that if we consider -- depends how you define mental disorder. Personality disorders are mental disorders in the DSM.

There's not a distinction -- when you use the phrase personality disorder, it's like a

mood disorder.

It's a type of mental disorder. It happens to affect the personality. Mood disorder is the domain of various moods.

Certainly one of -- so personality disorder is the same level of abstraction as the other disorders in the DSM.

The idea that personality disorders are somehow fundamentally different than the other disorders of the DSM is a mistake.

In fact, there's been a lot written to counter that. In fact, I believe a number of statements within the DSM that make the statement there's no evidence or no cautioning against believing that somehow personality disorders are different than the other disorders in the DSM.

Q So there was -- again I'm going to refer back to the Zander article, where it has personality disorders not otherwise specified, and he uses the example that this is just a convenient ruse to get outside of having to have

some kind of conduct disorder under the age of 15.

I'd just like to hear your thoughts on what his comment was and how you feel about that.

A This is the same discussion that applies to -- paraphilia NOS somewhat applies here.

The category personality disorder not otherwise specified exists to reflect the fact that patients commonly do not fit into any one specific category.

Ironically in clinical settings, it's commonly said that the most common personality disorder is personality disorder not otherwise specified.

And the reason for that is because there's been a lot written -- critiqued about the actual structure of the personality disorders in the DSM.

They're very specific of symptoms, and it's been argued that patients who we see in

real life don't meet that cluster. They meet a range of symptoms from all over the place.

So for that reason, and was one of -- it's one of the only categories in the DSM that has its own set of criteria that apply to the class, because of -- almost in recognition of how common it is for people to use the personality disorder NSO category.

So it's very important that you try to clarify that it's a -- what you're seeing when you're doing the treatment is a personality disorder, and the NOS simply means it doesn't meet the criteria for the ten in there.

So like with the paraphilia NOS, if you use an -- if you are seeing a patient with a personality disorder in the -- and they have personality disorder NOS, it becomes a mish-mash of what it really means.

And it's hard to draw conclusions about -- certainly the validity of whatever mish-mash you're seeing is only valid insofar as you're labeling it a personality disorder and

nothing else.

So the idea, as what was talked about in the Zander article, was one of the requirements of any anti-social personality disorder is that this individual meets criteria for conduct disorder.

And the reason for that is there's a huge body of evidence -- in fact, the creation of the concept of anti-social personality disorder, it was proposed by a group at Washington University of St. Louis, spearheaded by Lee Robbins.

Their work was on conduct disorders. The disorder got created by virtue of the fact this is the outcome of children with conduct disorders.

So the very validity of anti-social personality disorders grew out of the fact that it was the adult outcome of conduct disorders.

Now -- so -- but any anti-social personality disorder is also the criteria for a cluster of symptoms.

So if you have that cluster, and you don't have conduct disorder as a child, you don't have anti-social personality disorder as listed in the DSM, but you could claim that the person has a personality disorder that has the list of symptoms that are held in the -- on the anti-social personality disorders list.

The error would be to therefore conclude that other research -- anti-social personality disorder is one of the few disorders in the -- of all the personality disorders has probably the most research, attracts a lot of research, that and borderline.

The error would be that if you have the personality disorder NOS, anti-social feature, what they're calling that, to therefore then go to the literature for anti-social personality disorder, and draw conclusions because they share the same name or something like that would be absurd.

This is -- god knows what is true for individuals with anti-social personality

disorder NOS with anti-social type, whatever they call it, because it's not anti-social personality disorder.

So I think the error is, I believe, that they often use that with -- as a way of -- and that's where they try to get it -- actually they get around the kind of -- sort of requirement is -- the logic is well, they have this personality disorder, anti-social type, and then they start making statements about it that apply to anti-social personality disorder from the literature, and they try to slip it in that way. In fact it's a different entity.

And the same way you, the clinician, are licensed to label anything you want as personality disorder NOS, as long as you could back it up, you know, this is the way to do it that way.

The problem is you certainly can't draw any conclusions. You have to be very careful about any conclusions you draw from using the PD NOS anti-social type. And it looks

like they've gone above and beyond that.

Q So with a reasonable degree of psychological certainty, medical and psychiatric certainty, you would think that it would be improper to merely make the NOS diagnosis and then utilize the research on anti --

A Anti-social personality disorder. Absolutely true.

Q You can't draw those conclusions with this person that you have labeled with the NOS --

A Yes.

Q -- and utilize the vast research over here and say that's this guy?

A Because the research that was done over there was done on individuals that started out as conduct disorder and grew up into adult anti-social personality disorder.

Those are different -- you don't have a childhood conduct disorder pattern. And when you have an adult it's a different entity.

It certainly raises question that it

may really be -- you know, 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, that would raise major questions that all you're actually seeing is adult anti-social behavior and mislabelling it.

That's another way they may be getting around it, saying well, you know, they have a mental disorder because they conform to the current criteria for anti-social personality disorder, but I would argue that it's up to -- the burden of proof should be to prove that it's not just adult anti-social behavior, when the evidence is actually a mental disorder.

MR. THOMPSON: We're going to take about a five-minute recess so the court reporter can gather his fingers back.

MS. KAROL: Absolutely fine.

Let me ask you -- we can go off the record.

(Discussion off the record.)

(Recess taken)

CONTINUED DIRECT EXAMINATION BY MR. THOMPSON:

Q Doctor, does the APA differentiate between a mental illness and a psychotic disorder?

A Again, those are terms of imprecise definition. Psychotic disorder is fairly well-defined. It's a disorder characterized by the presence of psychotic symptoms.

Mental illness is an amorphous term. And the answer is yes. They're not equivalent I guess is a long answer to say yes. They do distinguish between those two. They're not equivalent.

Certainly all psychotic disorders are evidence of mental illness, but many people with mental ilness don't have a psychotic disorder.

Q So in using those general terms, and again, dealing with some of these -- can you put

some actual terminology in regards to describing them, like schizophrenia --

A Yes. Disorders that are typically psychotic. Some of the most famous one is schizophrenia.

And the word psychotic usually refers to symptoms like hearing voices, having dilusions of, you know, communicating with god. So those are psychotic symptoms.

Certain disorders are characterized as psychotic disorders, because they almost invariably entail psychotic symptoms, so schizophrenias and another disorder called dilusional disorder, certain forms of manic depression and major depression can be psychotic, so they're all examples of psychotic disorders.

Mental illness refers specifically to the idea that I guess -- you know, you have an illness that's due to some problem with your brain, so that -- that's a much more general, amorphous term.

Psychotic disorder is closer to a technical term. Mental illness is a general term.

Q The APA uses a term call enduring when it describes these personality disorders.

A Right.

Q Is it -- do you have an opinion that that may be changing or -- let's start this way.

What do you believe the APA meant when they used the term enduring, and following up on that --

A I remember it in the context -- let me find it. It's under the definition of personality disorder.

Q That's correct. They say it's an enduring characteristic.

A Let me see it. Okay. Right. So criteria for personality disorder, they all start out by saying enduring pattern.

I think -- even though it's -- as I said earlier, it's true that personality disorders change over time. By definition, they

-- it's still enduring in the sense that something that needs to last a relatively long period of time to be able to label as a personality disorder.

So I think the use of the adjective enduring in front of the word pattern in that criterion set is to distinguish it from the more typical use of the word pattern, which refers to the pattern symptoms that apply to a diagnosic set.

So it was trying to emphasize that all personality disorders, if there's any validity to them, it's a certain, you know, chronicity to them.

It's not to say they never get better, but certainly if somebody had a personality -- symptoms of a personality disorder that lasted a year and went away, I don't think it would be valid to conclude it was personality disorder, but something else.

Q They also use the term pervasive and inflexible.

A Correct. Both of those terms -- again, that whole criterion set is very helpful in the assessment of personality disorders.

And certainly if you're going to use the personality disorder NOS construct, and were basically telling you you need to use this criteria set, it's basically saying that in order to make a diagnosis of a personality disorder NOS, the symptoms that you're calling evidence of personality disorder need to be pervasive and inflexible.

So what that means is -- pervasive means it's not occurring only in one situation. So for instance, if you see someone who gets into fights with their boss, and yet doesn't get into conflicts with other people, it would be a mistake to consider the fighting with the boss as evidence of personality disorder, if you don't see that across more than one situation.

So pervasiveness is an intent to avoid a false positive of jumping -- taking something which is specific and calling that

personality disorder, because the essence of personality disorder, it's the way you view the world, that it colors -- it's the ultimate egosyntonic experience, because it's the way you experience the world through your personality.

So you carry your personality into every situation, so if you see -- 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 a sort you don't roll with the punches.

It's the non-adaptiveness of the trait. It's inflexible. No matter what the situation is, you act the same way.

The classic example would be paranoid personality. No matter how nice the person is you're talking to, the paranoid person still assumes that that person is out to get you,

because they inflexibly apply that belief regardless of the situation.

So inflexibility really gets at the crux of what makes a trait a disorder. It's a lack of flexibility. It doesn't change with the environment. It's not evidence -- it's not adaptable.

Q So if somebody had the capacity to basically pedophilia change his behavior and how he approached the situation, and he could vary it -- like I wanted something from you. I could be nice to you, versus I don't care about you on the other hand, you can't tell me.

Are you saying I could make a distinction of whether I had a personality disorder on the basis --

A No, no, no. I think that's interesting -- I mean, the camellia-like could be an inflexible trait.

It's a little counter-intuitive, but you need to take a step back. The -- the symptom is the lack of either one being so

manipulative or one changes one's presentation, whatever the situation is.

That would be sort of that trait in any -- I'm not sure there's actually criterion in the criteria section for anti-social personality disorder, but that quality is often associated with anti-social personality disorders.

There's another similar criterion. It's part of criteria set of borderline personality disorder, where the person also changes how they are, depending upon the situation, but that's more due to a lack of a sense of knowing who they really are inside, so they sort of conform to whatever circumstances. I think the anti-social version is a way of being manipulative.

So the trait is -- the reason why you would call -- now you say, how could that be inflexible.

What's inflexible about it is that person would be like that even with their close

friends, because they inflexibly do that in every situation.

That's what I mean by inflexible. It's the fact that they can't turn it off. That's just the way they are.

Q Now, we've talked a little bit about personality disorders.

Are you familiar with not guilty by reason of insanity?

A Correct.

Q That term, again a legal term, not a psychological term, but have you ever seen anybody attempt to use a personality disorder in a not guilty by reason of insanity case?

A Not successfully.

Q And I'd like you to expand on that. Why can't you do that? Why do you think it fails?

A Part of it is the standard for NGRI, especially when you get into -- it depends upon -- you know, they've evolved over time.

You know, many places have as their

only standard simply a cognitive appreciation of the criminality of the act, where that personality disorder -- I don't believe any personality disorder is felt to have a characteristic of the disorder, that quality. It would be more psychosis.

In those jurisdictions where volitional impairment, inability to control oneself, I believe there have been attempts to claim that personality disorder creates enough volitional impairment as to -- as to not be able to control one's actions.

I am -- right now we're at the point where my knowledge of why that -- I'm not a forensic psychiatrist, so my understanding -- my limited understanding is that those have been ruled out as acceptable grounds for, but I don't know why.

So I -- actually I don't know why. Maybe you could tell me how it is and I can comment on it and --

Q Could it simply be the fact that it

doesn't -- a personality disorder doesn't have the ability to override your decision-making ability?

A Certainly enough -- enough to hold you completely unresponsive I guess is an extent.

Certainly -- as we said earlier, I mean, a personality disorder can affect -- an aspect of personality could be like if you're a very impulsive person, you may not have as good control over your actions as someone who lacks that trait.

But I think 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.

Q There might be a distinction between this personality disorder and paraphilia, where this is a recurring drive, this urge that keeps coming up.

There's -- do you see a difference in degree in regards to the ability to control

oneself from a paraphilia, regardless of what it is, versus a personality disorder? Do you see distinction there?

A I think it's -- the issue of volitional impairment is probably different. The personality disorder -- if you were to try to claim volitional impairment in the context of a personality disorder, it would be based upon a general -- you know, general inability to control, because personality disorder talks about a trait that's true to the person.

It would be, again, pervasive and inflexible. So we talk about someone who pervasively by virtue of their personality has a volitional impairment.

In paraphilias and other disorders for which the issue of volitional impairment has ever been claimed, like pathological gambling, is a disorder where -- or substance addiction.

People would claim that their ability to choose -- resist the craving is impaired by virtue of having this disorder.

Volitional impairment is much more specific to one specific aspect of their behavior, rather than the general issue of volitional impairment.

So I think in the personality disorder it would be more likely used as a trait of volitional impairment, where in the paraphilia it's specifically -- I guess the way somebody would claim this, "I'm a pedophile. I see a kid in the playground. It's -- I can't -- the need to do something to him is so intense I can't control."

That's how they could -- might try to apply that volitional impairment. It's a situation-specific volitional impairment that is directly related to their arousal pattern.

Q We had talked a little earlier in regards to when you make a differential diagnosis you're trying to make sure you got the right diagnosis, and you need to rule other things out.

Let's talk about substance abuse and

personality disorders.

Is there a problem in diagnosing personality disorder when somebody has a substance abuse problem?

A Yes, because by definition, personality disorders stem from personality traits that are maladaptive, so it's a trait. It's part of who you are.

Subtance abuse -- I mean, there's two aspects how substance abuse can cloud the picture for personality disorder.

One is if you're under the influence of substances, how you behave under the influence of a substance is different than your normal trait behavior, so that's one error you could make.

The second error which arises specifically for anti-social personality is that because drugs are ilegal, someone who is addicted to drugs has to engage in illegal behavior in order to procure those drugs. That can look a lot like anti-social personality

disorder.

And where the mistake comes is -- the criteria stuff for anti-social personality disorder is so heavily behavior-based, and based on sort of bad behavior, if you couple that with the impulsivity aspect of anti-social, which could falsely -- somebody who is under the influence of drugs, they could look impulsive while they're on the drugs.

So if you couple that mistake of sort of seeing the impulsivity as a trait, when in fact it's due to drug use, and coupled with the behavior of seeking drugs, which is illegal, you could see how somebody could mistakenly label a drug user as an anti-social personality disorder, when in fact they are a drug user that does illegal things in order to procure their drug.

So certainly there are -- the reason it's complex is that people with anti-social personality disorder do like to take drugs, so a little bit of a chicken and egg problem.

Q How about alcohol? We're talking about drugs. Is alcohol the same?

A Alcohol much less so, because -- it can be. I mean, this is why context is important.

If somebody is an alcoholic, a really serious alcoholic, they could not -- if you look -- this is the -- this is a perfect example of why stupid application of the DSM could get you into trouble.

Like fails to fulfill financial responsibilities is a criterion in anti-social personality disorder.

To label that as part of anti-social personality disorder is sort of a lack of regard -- " don't care -- I don't need to do that."

Somebody who is an alcoholic may be so impaired that, in fact, they are unable to meet financial obligations because of their drug -- alcohol use, not because they have a personality disorder, where the essence of the

disorder is not caring to fulfill financial obligations.

So alcohol could -- less so than illegal drugs, because alcohol is cheaper. And -- so the illegality of it is less likely to apply.

But certainly if you have a real terrible disorder like alcohol dependence, you could be impulsive a lot because you're drunk and you could be non-functioning, and that can look like -- you know, you could see how somebody might mistake that for anti-social personality disorder.

So that's why it's important -- a good, careful, fair evaluation of an individual who has alcohol dependency and anti-social personality disorder would attempt to make that differential diagnosis.

And sort of -- in fact, the way I do it personally is faced with that differential diagnosis, I try to find periods of time in the person's life where they weren't so heavily

using alcohol, and if they really have anti-social personality disorder, 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.

You find a period of time when they're abstinent, where certainly their level of use is a lot lower, and you see what's left.

If their behavior goes away when they stop using, then you could see it would be an error to attribute their behavior to something other than the alcohol.

Q Did you see any type of discussion in Dr. Wheeler's report addressing what you have just said in regards to trying to make the differential diagnosis between the alcohol versus a personality disorder?

A No. None whatsoever.

Q Do you think it would be an error to simply diagnose somebody with a personality

disorder not otherwise specified without ruling out that alcohol might be the cause?

A Absolutely. In this particular case, the -- the -- Dr. Wheeler already concluded that he didn't have true anti-social personality disorder, because he didn't meet the conduct of the disorder, so he's already on potentially false positive grounds.

The substance on top of it further raises the question that what you're really -- the reason why he doesn't have conduct disorder as a child is because he doesn't really have any anti-social personality disorder as an adult, and the reason he doesn't have it as an adult is because what you're really seeing is a confound of alcohol, so that would further raise questions about the accuracy of the diagnosis.

Q All right. Do you think that -- a lot of times individuals to bad things and get incarcerated.

Does the fact of being incarcerated say anything about psychopathology?

A No. None.
Q Nothing at all?
A No.
Q I'm just playing with you. I don't think so either.
A I mean, that question says nothing about it. Well, the fact is our prisons are full of people with schizophrenia.
There's a connection between mental -- really bad mental disorder, and ending up in prison happens, but there's nothing about -- their being incarcerated in and of itself says nothing about their mental illness.
Q So the fact that one gets incarcerated in and of itself doesn't show anything about the inner workings of pathology in an individual?
A No. No.
Q Do you know whether or not, you know, this underlying psychological functioning of an individual can be changed by being incarcerated?
A Oh, yes.

Q How so?

A Actually I recently was involved in a case of a young man who was mistake -- inappropriately imprisoned at age 17 for rape.

There was a false confession by some colleagues of his. He spent 20 something years in prison, was finally exonerated, was suing the jurisdiction who incarcerated him, and I was actually involved in evaluating him to question what was the impact of the incarceration.

And it was my opinion that the incarceration actually allowed him to mature and go from someone who was probably headed down the toilet to someone who was able to be in much better control of his -- part of it is the passage of time.

We got him over the period of highest vulnerability, which is probably late teens, early 20s, and now he's in his 30s. He's much -- so the structure of the prison probably -- and sort of being kept safe during that period, it actually probably improved him.

Q So -- you know, I think traditionally one would look at the incarceration, all the negative things. You meet all these bad people and do bad things.

A Could happen. It could go both ways.

Q It could go both ways. In fact you may develop the skills that change how you kind of view the world and how you approach the world in prison.

A Absolutely. You're -- it's a force to -- encouraged to get rehabilitation, education, job opportunities, things that somebody may have never availed themselves of because their life was spinning wildly out of control, so prison actually did have a very positive benefit.

Q Let me ask this question. We talked about the paraphilias being driven behavior.

Do you think a prison setting alone would stop them from being able to observe the manifestations of somebody with a paraphilia?

A Absolutely. It would be very

difficult to observe the manifestations of a paraphilia, unless someone had free access to the Internet for pornography, but in the absence of that, I think it would be virtually impossible to observe that.

Q Okay. Frotteurism as an example.

A Well, again, I suspect that that wouldn't work in prison, because the essence of -- a lot of the essence of frotteurism is, A it's usually heterosexual, B, is an unsuspecting person.

I think the context of trying to rub oneself against another inmate would probably be not to, not to mention the fact it would be dangerous, I suspect it would propel the -- the arousal goal.

Q Okay. I'm going to switch to -- is there a distinction between the child molester and a pedophile?

A Yes.

Q And are there estimates out there, a ratio of people who are child molesters versus

pedophiles?

A I'm not familiar there are. And there's -- I mean, certainly a small minority of pedophiles are child molesters.

And the flip, which is how many child molesters are pedophiles, I don't know. Certainly not a hundred percent. It's well below that.

I don't know the actual percentage, of what percentage of child molesters do not -- are pedophiles, but certainly a decent number.

Q Is there any estimates that you're aware of in the literature on the number of pedophiles who never act out, never contact children?

A It's hard to say. I mean, the problem is that -- that these pedophiles who don't contact children don't ever come to clinical attention, so there's no way to do that study.

I think that may be a complete unknown number. I'm sure people have attempted

most -- the vast majority of studies on pedophiles are done in people who have offended the request of the population or have been threatened with incarcaration.

That does not cover the vast number of people in the community who are pedophiles. We're getting closer to it.

The legality of child pornography is finally creating an opportunity to have people be arrested for -- pedophiles be arrested who are, in fact, child molesters.

But even there it's not clear at all that those people who end up being arrested for child pornography are characteristic of the larger group of pedophiles in the community.

So the answer is it's unknown and virtually unknowable at this moment in time, but certainly a small percentage.

Q Okay. Are you familiar with any studies that deal with the reliability diagnosing pedophilia?

A Not personally, no.

Q For today's purposes -- let me ask you this question.

The APA put out a case book, the DSM case book, that dealt with something called a perfect relationship, and it dealt with paraphilic coercive disorder.

Now, that was never actually put in the DSM, but it's in the case book.

Could you help me get a better understanding of that?

A Yes. The case book was a private venture that was -- I was one of the co-authors on that.

That was the DSM-III-R case book. I'm not sure I was the co-author. Maybe not. But the lead author of that was Robert Spitzer, whose office we're sitting in.

This was a private book that -- in fact it was published by the American Psychiatric Press, which is the publishing arm, and books get to be published by the American Psychiatric Press by virtue of authors putting

together books and publishing it, so they -- they can consult them. They're not official documents.

Now, it got in there because Dr. Robert Spitzer, who had written the DSM-III, who was head of the DSM-III-R, of course had an interest in paraphilic coercive disorders, since he was running the process.

He was responsible for when the original proposal came in, and then when it got kicked out, so he thought it was interesting, and decided to throw it in there.

So I guess what you can say from that book is that that book substantiates or exists at least one case -- that's a real case, by the way. That's not made up.

I mean, the way the case book came to be is that we -- they asked individuals to contribute cases.

So somebody contributed that case, and that's a case that's been anonymized, so that's a real person.

The only thing you can conclude from that is that this is evidence that at least one case of this thing exists.

It's not the only one, but there's no other -- the fact that it was included in no way influences the validity of that or anything. It's just that --

Q Just so I understand it, this is a private venture by the American Psychiatric Press.

Is that affiliated with the American Psychological --

A It is -- the story is this. The American Psychiatric Press was created as a separate entity from the American Psychiatric Association Press.

In fact, certain -- the books that are policy books of the American Psychiatric Association are published with the picture of the APA logo on the cover. Those -- like the DSM, it's a book like that.

Q But the case book is not that type of

book?

A This book is not. It is an -- it has on the side American Psychiatric Press, and that -- it's 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.

Q Okay. So bottom line here, just so I got -- people that -- I see this in court occasionally, that this is an official document or policy statement tangentially issued by the APA.

A Is absolutely not true. The opposite is true. There's a disclaimer to say the opposite.

MR. THOMPSON: I think that's all the questions I have for today. Jennifer, are you still with us?

MS. KAROL: Indeed I am.

MR. THOMPSON: You took notes,

I hope.

MS. KAROL: Oh. Copious notes. Of course.

MR. THOMPSON: So I'm going to leave you at this point, and we will rejoin tomorrow 7 a.m. your time, 10 a.m. here.

MS. KAROL: Excellent. Both of you gentlemen have a great evening, as well as the court reporter.

(Time noted: 4:14 p.m.)

A C K N O W L E D G E M E N T O F D E P O N E N T

I, (MICHAEL B. FIRST), do hereby acknowledge I have read And examined the foregoing pages of testimony, and examined the same is a true, correct and complete Transcription of the testimony give by me, and any Changes or corrections, if any, appear in the attached Errata sheet signed by me.

_____ _____

Date MICHAEL B. FIRST

ROBERT J. THOMPSON, ESQ.
504 W. Margaret Street
Pasco, Washington 99301
PHONE 509.547.4011
E-MAIL rthompson@clearwire.net

IN RE: The Detention of: WILLIAM DAVENPORT

Dear Mr. Thompson ,

Enclosed please find your copy of the deposition Of MICHAEL B. FIRST, along with the original signature page. As agreed, you will be responsible for contacting the witness regarding signature.

Within 30 days of receipt, please forward errata sheet and original signed signature page to counsel For Defendant.

If you have any questions, please do not hesitate to call. Thank you.

Yours,

Reporter/Notary

Cc: JENNIFER KAROL, Esq.
JODY CRAWFORD, Esq.

Capital Reporting Company
1000 Connecticut Avenue, Northwest
Suite 505
Washington, D.C. 20006
(202) 857-3376

E R R A T A S H E E T

Case Name: In Re the Detention of:
WILLIAM DAVENPORT
Witness Name: MICHAEL B. FIRST
Deposition Date: December 11, 2006

Page No.	Line No.	Change

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Signature Date

C E R T I F I C A T E

STATE OF NEW YORK)
:ss
COUNTY OF)

I, RONALD A. MARX, a Notary Public within and for the State of New York, do hereby certify:

That MICHAEL B. FIRST, M.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that such deposition is a true record of the testimony given by such witness.

I further certify that I am not related to any of the parties to this action by blood or marriage; and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 16th day of December, 2006.

RONALD A. MARX