FORENSIC MENTAL HEALTH Association of California

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Ethical Considerations in Psychiatric Diagnoses in Forensic and Correctional Settings

Karen Franklin, PhD

SUGGESTED READINGS*

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Karen Franklin, Ph.D. is an independent practitioner in the San Francisco Bay Area specializing in psychological evaluations in criminal cases. She also teaches forensic psychology at Alliant International University and serves on the Ethics Committee and the Forensic Psychology Executive Committee of the California Psychological Association. Her peer-reviewed publications have appeared in *the American Behavioral Scientist, Behavioral Sciences & the Law, the Journal of Interpersonal Violence, Sexuality Research & Social Policy,* and *the Journal of Forensic Psychology Practice*. A former legal affairs journalist and criminal investigator, she is a frequent media commentator on forensic psychology topics, and hosts a forensic news blog at http://forensicpsychologist.blogspot.com. More information and contact information is available at her website, www.karenfranklin.com.

Ethical Considerations in Psychiatric Diagnoses in Forensic and Correctional Settings

Karen Franklin, Ph.D.

Forensic Mental Health Association
Annual Conference
March 25, 2010

DSM Backdrop: Psychiatry Under Attack

(1970s)

- Rosenhan: "On Being Sane in Insane Places"
- Antipsychiatry movement

External Pressures

- Insurance companies
- Federal government
- Researchers
- Other mental health professionals (psychologists, social workers)

DSM-III: Focus on Reliability

- Consistency (vs. validity)
- Atheoretical checklists
- Subjectivity
- Diagnosis as technical issue
- Domain of statisticians
- Beyond the expertise of public or clinicians

(Christopher Lane, 2007)

Lowering the Bar

- Normal traits pathologized
- Slight changes in wording, duration, number of criterion
- Prevalence rates can "rise and fall as erratically as the stock market."

-- Kutchins & Kirk, Making Us Crazy

DSM-III-R & DSM-IV

(1987 & 1994)

- Major changes
- Few field trials
- Big Pharma influence
- Experts hand-selected
- New disorders
- Poor empirical data

Creating a New Disorder

- Conduct study
- Discover problem
- Label
- Diagnosis
- Promote
- Marginalize critics

DSM-V Diagnostic Expansion

(2013)

- Psychosis Risk Syndrome
- Mixed Anxiety Depressive Disorder
- Minor Neurocognitive Disorder
- Temper Dysfunctional Disorder with Dysphoria
- Binge Eating Disorder
- Behavioral Addictions (e.g., gambling)

Forensic Use: DSM Caveats

(Handout)

- Imperfect fit
- Inexact science
- "Significant risks"
- Misunderstanding
- Misuse

Forensic Deployment

- Criminal sentencing
- Insanity
- Execution
- Monetary awards
- Civil incapacitation

Adversarial Arena

- **Push for certainty**
- **Pull to affiliate**

- Overzealousness
- Allegiance effects
- Confirmation bias
  - Pretextuality
    - Reification

Psychopathy Checklist (PCL-R) In Court

(DeMatteo & Edens 2006)

- 87 reported cases, 1991-2004
- 3 main uses:
  - Civil commitment (SVP)
  - Capital sentencing
  - Mental state at time of offense

PCL-R In Court
(DeMatteo & Edens 2006)

- Scores misinterpreted
- Research mischaracterized
- Inappropriate inferences, including malingering

Partisan Allegiance
(Murrie et al 2007)

- Average scores: 26 versus 18
- 18/23 cases were more than 1 SEM apart
- Large differences, in expected directions
- Reliability questionable in adversarial settings

Conclusions

- Unreliable scoring and interpretation
- Group data misapplied
- Partisan allegiance
- Psychopathy as strategic weapon
- Mask of science
- "Wildly pejorative"

Antisocial Personality Disorder
(DSM-III - 1980)

- Sociologist Lee Robins
- Delinquent children (N = 524)
- St. Louis child guidance clinic
- 1924-1929
- 30-year follow-up

Critiques

- Weakness of personality theory
- Innumeracy
- Temporal instability
- Overinclusivity
- Diagnostic overlap
- Race and class bias

Anthropological Research
(Gail Stevens)

- 66% of eligible Black prisoners
- 34% of eligible White prisoners
- "Another label for black criminal?"

Anthropological Research
(Gail Stevens)

- Coded message
- Moral culpability
- Denial of services

The only diagnosis of "a nonpathological condition deemed to enhance culpability."

Anthropological Research
(Lorna Rhodes)

- Strategic use
- Axis I versus Axis II
- Territorial disputes
- Diagnostic game

"Mad" versus "Bad"

Alternate, Overlapping Explanations

- Trauma
- Substance abuse
- Environmental pressures
- Prison survival strategies

Appeal of Born Criminal Theories

- Scientific aura
- Naturalize / legitimize incapacitation
- Explain institutional failures
- Professional domain expansion
- Emphasize danger and risk

Pretextuality*

Pretext:

- something serving to conceal plans
- a fictitious reason concocted to conceal the real reason
  - *"A pretextual traffic stop"*

- Diagnosis to meet legal criteria
- Moral values disguised as science
- Hidden biases

** Michael Perlin*

Kansas v. Hendricks
(1997)

Mental abnormality:

"A congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such person a menace to the health and safety of others."

Diagnostic Triad

- Antisocial PD
- Pedophilia
- "Paraphilia NOS"
  - Rapists: **"Paraphilia NOS-Nonconsent"**
  - Sexual offenders against adolescents: **"Paraphilia NOS-Hebephilia**

Pedophilia

- Most common diagnosis
- 37% to 70% of cases

Reliability - Pedophilia

- Poor reliability*
- Imprecise wording
- Child molesters heterogeneous

** Levenson 2004*

Paraphilias

(Wilhelm Stekel, 1930)

"Sexual activities which run counter to accepted social behavior and which are antibiological, either *per se* or because they are socially prohibited."

- *Homosexuality*
- *Masturbation*

DSM-IV-TR Paraphilia

(Criterion A)

"Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving

1) nonhuman objects,

2) the suffering or humiliation of oneself or one's partner, or

3) children or other nonconsenting persons

that occur over a period of at least 6 months."

Listed Paraphilias

1. Exhibitionism
2. Fetishism
3. Frotteurism
4. Pedophilia
5. Masochism
6. Sadism
7. Transvestic fetishism
8. Voyeurism

Critiques

- Arbitrary
- No empirical basis
- Imprecise
- Outdated
- Poor reliability and validity

Paraphilia as an SVP Diagnosis

- Common
- 35% to 70% of cases
- Rapists
- Offenders against adolescents
- Extremely poor reliability*

** Levenson 2004*

"Paraphilia NOS - Nonconsent"

- Poor validity
- Rapists heterogeneous
- Not preferentially aroused
- Rape excluded as DSM diagnosis
- V Code: "Sexual Abuse of an Adult"

Wording Inadvertent

"Unfortunately, the DSM-IV wording of paraphilia was not thought out carefully, which has led to much interpretation…. **The term nonconsenting persons was meant to apply only to exhibitionism, voyeurism, and sadism, … not … rapism**."

- Allen Frances, 2008

Wording "not thought out"

"Paraphilia NOS, nonconsenting partners, is an inherently weak construct…. There is a **danger of misusing DSM-IV TR mental disorders** … so as to justify an SVP commitment. Paraphilia NOS has the potential to be **a catch-all diagnosis for persons accused of sexual offenses**…."

-- Allen Frances, 2008

Hebephilia Critiques

- Imprecise & ad hoc categories
- Poor interrater reliability
- Validity not established
- Relatively common among male population
- Confusing illegal/immoral with deviant

http://bit.ly/hebephilia

U.S. v. Shields
(2008)

- Hebephilia may exist
- But no proof it is a serious mental disorder

APA Ethics Code

2.04 Bases for Scientific and Professional Judgments
Psychologists' work is based upon established scientific and professional knowledge of the discipline.

APA Ethics Code

9.01 Bases for Assessments
Psychologists base the opinions contained in their recommendations, reports, and diagnostic or evaluative statements, including forensic testimony, on information and techniques sufficient to substantiate their findings.

Forensic Specialty Guidelines

- **4.05 Knowledge of the Scientific Foundation for Opinions and Testimony**
- When providing opinions and testimony that are based on novel or emerging principles and methods forensic practitioners, when possible, **make known the limitations** of these principles and methods.

Forensic Specialty Guidelines

Forensic practitioners seek to provide opinions and testimony that are sufficiently **based upon adequate scientific foundation**,and **reliable and valid** principles and methods that have been applied appropriately to the facts of the case.

Ethical Duties

- Know the relevant literature and controversies
- Acknowledge scientific limitations
- Understand the potential harms

Educative Role

- The scientific reliability and validity of psychiatry's diagnostic system is contested.
- Some diagnoses are weaker than others.

Educative Role

- Diagnoses appropriate for clinical treatment or research may not be reliable or valid enough for forensic use.

CAVEAT: Use of DSM-IV in Forensic Settings*

When the *DSM-IV* categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a *DSM-IV* mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the *DSM-IV* diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.

Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or its associated impairments. Inclusion of a disorder in the Classification (as in medicine generally) does not require that there be knowledge about its etiology. Moreover, the fact that an individual's presentation meets the criteria for a *DSM-IV* diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.

It must be noted that *DSM-IV* reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication. New knowledge generated by research or clinical experience will undoubtedly lead to an increased understanding of the disorders included in *DSM-IV*, to the identification of new disorders, and to the removal of some disorders in future classifications. The text and criteria sets included in *DSM-IV* will require reconsideration in light of evolving new information.

The use of *DSM-IV* in forensic settings should be informed by an awareness of the risks and limitations discussed above. When used appropriately, diagnoses and diagnostic information can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, *DSM-IV* may facilitate the legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information regarding longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

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* From the Introduction to DSM-IV-TR (2000), p. xxxiii

Diagnostic Reification in Court

Karen Franklin, PhD

Good psychologists think in shades of gray. But the inside of a courtroom is painted black and white. One side wins, the other loses. Here, I discuss an ethical dilemma posed by this disjuncture between scientific uncertainty and the law's pull for absolutes. This dilemma concerns diagnostic labeling in court.

Three separate trends are pushing this issue to the forefront. The first is the reification of the DSM as scientific truth. Increasingly, mental health experts feel compelled to invoke the Diagnostic and Statistical Manual of Mental Disorders in forensic reports and testimony in order to legitimize their opinions on everything from civil commitment and criminal responsibility to civil damages and parental termination. The legal implications of diagnostic labeling are profound. "Paraphilia NOS" can mean lifelong hospitalization; "schizophrenia" can separate a parent from her child; "Antisocial Personality Disorder" can demonize a person in the minds of jurors, and "posttraumatic stress disorder" can either excuse criminal conduct or, conversely, win monetary awards.

Parallel to this reification is a second and more alarming trend, the use of diagnoses in an arbitrary and pretextual manner in order to obtain specific legal outcomes. Recent statutes and case law – especially in the area of sexually violent predators – pull strongly for such practices, by requiring a diagnostic label as a predicate for civil commitment of dangerous individuals.

In contradistinction to these two trends is a third trend of growing awareness among both mental health professionals and the public of serious flaws in the DSM diagnostic system. An emergent body of critical scholarship exposes the manual's underlying biases, and the poor validity of many diagnoses. DSM labels, we are learning, have been created, modified, and deleted with little empirical rationale, often due to partisan influence and the privileging of biologically based theories. Indeed, given the state of uncertainty regarding the scientific reliability and validity of many conditions catalogued in the manual, DSM diagnoses are more properly regarded as scientific hypotheses awaiting empirical verification rather than established facts.

The convergence of these trends in the black-and-white arena of the courtroom presents an ethical quagmire. Even as they become disillusioned with the scientific underpinnings of the DSM, psychologists are increasingly pressured to establish their professional legitimacy through referencing "the bible" in reports and testimony.

The APA Ethics Code and the *Specialty Guidelines for Forensic Psychologists* both contain language pertinent to this ethical dilemma. The Ethics Code's aspirational principles highlight our duty to act with integrity and honesty. We are cautioned to avoid misrepresentation and subterfuge and be vigilant against "factors that might lead to misuse of [our] influence." "Psychologists take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices," asserts Principle D.

The enforceable standards of the Ethics Code provide additional guidance, requiring a sufficient scientific and factual basis for professional judgments (Section 2.04) and diagnoses (Section 9.01). These duties are echoed by the Forensic Specialty Guidelines, which instruct psychologists to "make known the limitations" of "novel or emerging principles and methods" in forensic opinions and testimony (Section 4.05).

What does this guidance mean, in practice? At minimum, psychologists should be aware of the raging controversies over certain DSM diagnoses and should be transparent in informing the court of the limitations of scientific certainty. More controversially, perhaps, psychologists may want to reconsider the automatic assignment of DSM labels. For example, an insanity report can discuss an individual's state of mind and psychiatric symptoms at the time of an offense without ever referencing the DSM. Even more controversial is the question of whether we have an ethical obligation to take action when we see other psychologists engaging in pretextual or biased use of DSM labeling in court.

Like the moon's powerful pull on ocean tides, the legal arena exerts a force that is hard to resist. Psychologists are pulled to affiliate and be of service, especially if we are convinced of the moral or scientific correctness of our opinion. We are pulled to abandon nuances and opine with a level of certainty beyond what the science supports. This is a pull that we are ethically obligated to resist.

***Karen Franklin, PhD**, is a forensic psychologist, an adjunct professor at Alliant International University, and a member of the CPA's Ethics Committee and the Executive Committee of the Forensic Psychology Section. Comments may be sent to mail@karenfranklin.com. More information on this topic is available at Karen Franklin's forensic psychology blog, forensicpsychologist.blogspot.com.*

Diagnostic Controversies in Forensic Psychology Practice

Karen Franklin, PhD

As far back as the Middle Ages, physicians were testifying in court as experts on mental disorder. But rather than invoking psychiatric diagnoses, they adhered to the theological orthodoxy of their day. For example, pioneering expert Sir Thomas Browne testified in 1664 that two women on trial for witchcraft suffered from demonic possession (Prosono, 1994).

Over the ensuing centuries, as physicians shifted from theological to medical theories of insanity, psychiatry's role in legal proceedings steadily increased. Today, mental health experts in the United States invoke the formal diagnostic nomenclature of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. Judges and lawyers, in turn, keep copies of the DSM at hand, and appraise experts' credibility based on their adherence to its diagnostic criteria (Greenberg, Shuman, & Meyer, 2004, p. 6).

The DSM's Rise to Ascendancy

How did the DSM rise to this naturalized position as the *sine qua non* of forensic psychiatric practice? The first edition, published in 1952, was designed primarily for doctors working in mental hospitals, and was not widely accepted as a basis for expert witness testimony. A modest tract of just 132 pages, it utilized the psychoanalytic tradition to explain most of its several dozen disorders as "reactions" to external stressors.

Things changed radically with the 1980 publication of the third edition. This was the work of a small group of biomedical psychiatrists attempting to wrest ideological supremacy from the psychoanalysts (Andreasen, 2007; Lane, 2007). Rather than being theoretically neutral as its authors maintained, the DSM-III marginalized environmentally based theories of mental disorder, boosting the biological model favored by the nascent pharmaceutical industry. By approaching disorders as discreet taxons, rather than continuous phenomena, it also encouraged a more formulaic, reductionist view of mental illness.

As it turned out, these changes made the new DSM better suited for legal application. The legal system wants unambiguous answers: Is this person sane or insane? Competent or incompetent? Damaged or undamaged? Unlike the DSM-I, the DSM-III spoke this categorical, all-or-nothing language.

Not surprisingly, then, as forensic psychiatry expanded as a field, practitioners relied more and more on DSM diagnoses to support their psycholegal opinions. In some ways, they had little choice. A formal diagnosis is an essential element in some types of legal cases, such as the insanity defense, incompetency to stand trial, and civil commitment. Even when a diagnosis is not explicitly required, courts typically expect and even demand one.

Psychologists are relative newcomers to the forensic arena, and entered from a position of inferiority that made it unlikely they would challenge this diagnostic orthodoxy. A few forensic psychologists did try to warn against overreliance or reification of DSM diagnoses (e.g., Greenberg, Shuman & Meyer, 2004). However, their faint warnings fell on deaf ears as a growing army of their brethren marched into courtrooms around the country to testify on everything from criminal responsibility and parental termination to tort damages and civil commitment.

Diagnostic Pitfalls

Most forensic practitioners are aware of flaws in the DSM. Diagnostic criteria change with each edition. Diagnoses suffer from

considerable overlap and innumeracy problems, and many are unreliable in clinical practice. Furthermore, the lowering of threshold cutoffs has caused some previously rare conditions to skyrocket (Lane, 2007).

This diagnostic imprecision can have alarming consequences in the courtroom. Discrepant diagnoses lend themselves to widely different legal outcomes. Mental retardation, for example, may spare a murder defendant from the death penalty. Schizophrenia may cost a parent her child. And posttraumatic stress disorder may support a large civil damages award. Faced with contradictory and sometimes highly technical diagnostic testimony, jurors sometimes throw up their hands and disregard the experts altogether, seeing them as nothing more than hired guns for one side or the other.

To their credit, the authors of the DSM recognized this potential peril. "In most situations," they cautioned, "the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder' " (American Psychiatric Association, 2000, p. xxxiii).

Despite this caution, as more psychologists enter forensic practice, we see a growing trend toward the use of the DSM in a mechanized, cookbook fashion. Diagnoses are presented to judges, jurors, and attorneys as concrete and tangible realities that will bolster a desired legal outcome.

New Diagnostic Applications

A timely example of this diagnostic reification is in the emergent sex offender civil commitment industry. Since 1990, 20 U.S. states and the federal government have enacted laws enabling the civil incapacitation of certain sex offenders. Despite the fact that most sex offenders do not have traditional mental disorders, the law requires that their offending be causally linked to a mental disorder or abnormality. This requirement has spawned a booming cottage industry with its own highly contested diagnostic nosology (Franklin, in press).

The lynchpin of this nosology is antisocial personality disorder. It is almost always diagnosed, and where the requisite conduct disorder is absent from the person's history a diagnosis of "personality disorder not otherwise specified with antisocial features" is often substituted. Whereas almost all chronic criminal offenders meet the minimum criteria for this disorder, in correctional settings the diagnosis is applied arbitrarily to a minority based on such factors as race and the desire to convey a negative message (Rhodes, 2000; Stevens, 1993; Toch, 1998). In sexually violent predator cases, this pejorative label reinforces the bias already held by judges and jurors due to the nature of the proceedings.

An antisocial diagnosis is especially important in rape cases, where typically no other DSM diagnoses apply. A diagnosis of "paraphilic coercive disorder" was considered for inclusion in the current edition (DSM-IV-TR), but was rejected because the APA task force did not find it to be reliable and valid. Because of this exclusion, evaluators often shoehorn rapists into a residual DSM category of "paraphilia not otherwise specified (NOS)," a condition originally intended for rare sexual conditions such as necrophilia or klismaphilia (sexual arousal to enemas).

But any "not otherwise specified" diagnosis is readily challenged by opposing experts and attorneys as an unreliable "wastebasket" category. To minimize this problem, some in the sex offender industry are pushing to add creative new diagnoses to the DSM-V, currently under development. For example, the previously obscure construct of "hebephilia," or the erotic attraction to adolescents, has been proposed for inclusion (Blanchard, Lykins, Wherrett, et al, in press).

If hebephilia makes a formal entrée in the DSM-V, its scientifically unreliable and even invalid nature will lend itself toward the same type of arbitrary application that occurs with the diagnosis of antisocial personality disorder. In other words, although the majority of normal heterosexual men are sexually attracted to teenage girls, the diagnosis will be used primarily as a label for men who do not meet the DSM diagnostic criteria for other disorders such as pedophilia.

Of course, invoking any such novel diagnosis could have a paradoxical effect. Controversy is mounting over both the secrecy of the current DSM revision process and, more broadly, over the influence of partisan interests on the process. With increasing public awareness, the use of any scientifically debatable new diagnosis could lead to even more vigorous challenges in court.

Psychologists who testify as expert witnesses must become familiar with these diagnostic controversies and their potential repercussions. Otherwise, they may be stepping into a minefield when they walk across the courtroom threshold.

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***Karen Franklin, PhD**, is a forensic psychologist and adjunct professor at Alliant International University. She and Craig Lareau, JD, PhD, ABPP will present a 6-hour forensic training institute on Diagnostic Controversies in Forensic Psychology Practice on April 16, 2009, at the California Psychological Association's annual convention in Oakland.*