



Diagnostic Controversies in Forensic Psychology Practice

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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. 

References

- American Psychiatric Association (2002). *Diagnostic and statistic manual of mental disorders* (4th Ed., text revision). Washington, DC: Author.
- Andreasen, N.C. (2007). DSM and the death of phenomenology in America: An example of unintended consequences. *Schizophrenia Bulletin*, 33, 108-112.
- Blanchard, R., Lykins, A.D., Wherrett, D., Kuban, M.E., Cantor, J.M., Blak, T., Dickey, R., & Klassen, P.E. (in press). Pedophilia, hebephilia, and the DSM-V. *Archives of Sexual Behavior*.
- Franklin, K. (in press). The public policy implications of “Hebephilia”: A response to Blanchard et al. *Archives of Sexual Behavior*.
- Greenberg, S., Shuman, D., & Meyer, R. (2004). Unmasking forensic diagnosis. *International Journal of Law & Psychiatry*, 27, 1-15.
- Lane, C. (2007). *Shyness: How normal behavior became a sickness*. New Haven, CT: Yale University Press.
- Prosono, M. (1994). History of forensic psychiatry. In R. Rosner (Ed.), *Principles and Practice of Forensic Psychiatry*. New York: Chapman & Hall.
- Rhodes, L. (2000). Taxonomic anxieties: Axis I and Axis II in prison. *Medical Anthropology Quarterly*, 14, 346-373.
- Stevens, G.F. (1993). Applying the diagnosis antisocial personality to imprisoned offenders: Looking for hay in a haystack. *Journal of Offender Rehabilitation*, 19, 1-26.
- Toch, H. (1998). Psychopathy or antisocial personality in forensic settings. In *Psychopathy: Antisocial, criminal, and violent behavior* (Editors: Milton, T., Simonsen, E., Birket-Smith, M., Davis, R.) New York: Guilford Press, pp. 144-158.

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