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Affidavit of Frederick Winsmann, PH.D., ABPP, for Brad Steven's Commitment Appeal Panel

Forensic psychologist and Harvard professor, Fredrerick Winsmann, Ph.D., ABPP, disagrees with MSOP evaluators and finds a clean bill of mental health for one man at the MSOP, yet the man remains confined.

Daniel A. Wilson and Russell J. Hatton

2/7/2021

PETITIONER'S EXHIBIT 101

STATE OF MINNESOTA

COUNTY OF GOODHUE

In the Matter of the Civil Commitment of
Brad Ronald Stevens (Respondent)

JUDICIAL APPEAL PANEL
Judicial Appeal Panel File No. AP19-9157
Goodhue County Court File No. 25-P9-04-001747

AFFIDAVIT OF FREDERICK WINSMANN, PH.D., ABPP

Commonwealth of Massachusetts)
)ss.
County of Norfolk)

Dr. Frederick Winsmann, hereby states and affirms the following:

1. I am licensed as a psychologist in the Commonwealth of Massachusetts and the State of New York. I am Board-Certified as a forensic psychologist by the American Board of Professional Psychology (ABPP). I am a Diplomate of the American Board of Forensic Psychology, and I am a Fellow of the American Academy of Forensic Psychology. My business address is 222 Forbes Road, Suite 204, Braintree, Massachusetts 02184. My curriculum vitae is attached as Exhibit One.

2. I am retained by Attorney Kevin Wetherille in the above matter, who requested this affidavit concerning diagnosis.

3. My opinion therefore is outlined in this affidavit regarding whether the category of Other Specified Paraphilic Disorder (OSPD), without a specifier, is accepted within the profession of psychology as a valid diagnosis of a mental disorder.

4. The creation of established mental disorders is based in conceptual validity. The phrase conceptual validity discriminates between what is a disorder and what is not a disorder.[1]

5. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the most widely used manual of diagnosis in psychology in the United States. As reference in order to follow the history behind the DSM, I note that the DSM-I was published in 1952, the DSM-II in 1968, the DSM-III in 1980, the DSM-III-Revised in 1987, the DSM-IV in 1994, the DSM-IV-Text Revision in 2000, and the DSM-5 in 2013. I note that beginning with DSM-5, Roman numerals to denote the edition were replaced with Arabic numerals. I also note that "Not Otherwise Specified" (NOS) is the phrase used in the DSM-IV-TR before the "other specified" and "unspecified" categories took the place of the NOS category in DSM-5.

6. The miscellaneous category of Other Specified Paraphilic Disorder (OSPD) is utilized in the fields of clinical and forensic psychology by virtue of the fact that it is a category listed in DSM-5.

7. OSPD, standing alone, does not represent a mental disorder. OSPD represents uncertainty, including whether the individual actually should be assigned to such a category. A scientific construct must have sufficient conceptual validity and reliability in order to become a mental disorder. That is, constructs may rise to the level of a mental disorder if, and only if, sufficient conceptual validity and reliability has been scientifically established.

8. I have completed approximately 210 sexually violent predator (SVP) evaluations, which is, collectively, the phrase given to SVP-type evaluations when referring to all 21 jurisdictions that have a law regarding the civil management of sexual offenders. I have done so in seven different United States jurisdictions. I have two publications in peer-reviewed journals concerning SVP evaluations.

9. OSPD, which is coded as 302.89 in DSM-5, is defined as follows:

> This category applies to presentations in which symptoms characteristic of a paraphilic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the paraphilic disorders diagnostic class. The other specified paraphilic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific paraphilic disorder. This is done by recording "other specified paraphilic disorder" followed by the specific reason (e.g., "zoophilia"). Examples of presentations that can be specified using the "other specified" designation include, but are not limited to, recurrent and intense sexual arousal involving *telephone scatologia* (obscene phone calls), *necrophilia* (corpses), *zoophilia* (animals), *coprophilia* (feces), *klismaphilia* (enemas), or *urophilia* (urine) that has been present for at least 6 months and causes marked distress or impairment in social, occupational, or other important areas of functioning. Other specified paraphilic disorder can be specified as in remission and/or as occurring in a controlled environment (p. 705).

10. OSPD, without a specifier, which is, simply, a truncated version of OSPD with a specifier, is not generally accepted in the psychological community as it is not a category in DSM-5. Moreover, OSPD, without a specifier, defies discernable logic: the DSM-5 category is for an other, specified paraphilic disorder, whereas the specifier in this case is missing. The DSM-5 explicitly states, in regard to OSPD and using this category, "This is done by recording 'other specified paraphilic disorder' <u>followed by the specific reason</u>" (emphasis added, p. 705).

11. The DSM-5 also explicitly states, "The other specified paraphilic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific paraphilic disorder" (p. 705). Clearly, the diagnosticians in this case, in dropping the specifier, are not communicating the specific reason that the respondent does not meet any specific paraphilic disorder. However, that which is being described appears to be arousal to coerced sex. This is a description of paraphilic coercive disorder (PCD), which is also referred to as paraphilic rapism. Zinik and Padilla (2016) stated,

> "There has never been a diagnostic category in any edition of the Diagnostic and statistical manual of mental disorders (APA, 1952, 1968, 1980, 1987, 1994, 2000, 2013) that describes an individual who is persistently aroused by coercive sex and repeatedly commits acts of rape" (p. 1).[2]

No DSM has never included a diagnosis whose criteria included non-sadistic rape.[3] PCD has been rejected from the DSM on four separate occasions.[4, 5]

12. Diagnosticians need to guard against the medicalization of criminality. Frances and First, in 2011, wrote,

> Rape is always a crime and is never, by itself, sufficient evidence of a mental disorder. There was little interest (and very limited research) in the psychiatric status of rape until it became a convenient way to subject rapists to involuntary psychiatric commitment after their prison sentences has been served. Inappropriately redefining rape as a mental disorder helped to close the legal loophole created when fixed sentencing drastically reduced the prison terms of the worst sexual offenders. The recent widespread misuse of the diagnosis paraphilia NOS in SVP hearings has resulted from a misinterpretation of the intent of DSM-IV-TR. Its overuse represents an inappropriate medicalization of criminal behavior to serve a practical public safety purpose (p. 560).[6]

13. In 1976, a disorder titled "Sexual Assault Disorder" was recommended for inclusion into DSM-III. The criteria for Sexual Assault Disorder were:

A. The fantasy of sexual assault is erotically exciting.

> B. There is significant motivation to translate the exciting fantasy into action. The individual has committed an act of sexual assault, or inevitably will in the near future. If the act has been committed in the past, there is significant motivation to repeat it.

A DSM-III Task Force, convened in June 1976, reviewed and ultimately rejected the proposal to include Sexual Assault Disorder.[7]

14. A committee of the American Psychiatric Association (APA), called the Work Group to Revise DSM-III, was formed in 1983 to revise that which was at the time the third edition of the DSM. Paraphilic rapism was a proposed mental disorder, and it was defined as, "A persistent association, lasting a total of at least 6 months, between intense sexual arousal or desire, and acts, fantasies, or other stimuli involving coercing or forcing a nonconsenting person to engage in oral, vaginal, or anal intercourse." The proposed mental disorder for a rape-based paraphilia was renamed PCD. The criteria for PCD were as follows:

> A. Over a period of at least six months, preoccupation with recurrent and intense sexual urges and sexually arousing fantasies involving the act of forcing sexual contact (for example, oral, vaginal, or anal penetration; grabbing a woman's breast) on a nonconsenting person.
> B. It is the coercive nature of the sexual act that is sexually exciting, and not signs of psychological or physical suffering of the victim (as in Sexual Sadism).
> C. The individual repeatedly acts on these urges or is markedly distressed by them (pp. 45 – 46).[8]

The APA Board of Trustees rejected PCD in 1986 based on validity concerns.[9]

15. The concept of paraphilic rape was rejected a third time by means of a 1999 APA Task Force Report.[10]

16. The APA again considered a proposal to add PCD to DSM-5 before its publication in May 2013. The scientific validity of this proposal was again questioned. The proposal was rejected.[11]

17. Research provides little empirical justification in support of the diagnosis of PCD.[12,13] PCD has not withstood the validation process such that it became a disorder in any DSM.

18. PCD is not a mental disorder. Frances and First, in 2011, wrote,

> The problem is that paraphilia NOS has been widely misapplied in SVP hearings to criminals who have no mental disorder by evaluators who have misinterpreted DSM-IV. Psychiatric diagnoses from the DSM-IV-TR are generally considered admissible in court because they are accepted by the field at large as widely recognized, clinically valid categories that can be reliably assessed. By virtue of their residual and idiosyncratic nature, cases given the label of NOS are by definition outside of what is generally accepted by the field as a reliable and valid psychiatric disorder (p. 557).[14]

19. Beginning with the publication of DSM-III in 1980, construct validity has been a particular concern. The DSM-I, along with DSM-II, lacked the current level of construct validity that DSM-III began to demand. The DSM-III began the more stringent practice of behaviorally anchoring disorders, which refers to the actual list of observable behaviors that have been vetted as determining a particular mental disorder. This practice of behavioral anchoring appears to have been prompted, at least in part, by reports of improper civil commitments where disorders assigned were not based in such observable behaviors, but, rather, in theoretical constructs. Unlike other fields, where, for example, diagnosis is based in actual, recordable malignancy at the cellular level such as cancer, or as another example, actual recordable blood levels such as hemophilia, psychology relies on observing specific, tested behaviors to assign mental disorders. And, due to the uncertain etiology of psychological disorders, such disorders are not assigned the

term "disease," which is reserved for known etiologies. Diagnosing is a scientific practice requiring scientific evidence.

20. If a clinician creates his own list of behavioral anchors, there is not any scientific way to study the infinite list of such *ad hoc* variations of behaviors anchoring the clinician's categorization. Hence, any such practice, on its face, lacks conceptual validation because the categorization is unique to the clinician making the assignment, and, therefore, the categorization cannot be reliably studied scientifically. It is virtually inconceivable that such an *ad hoc* category could be offered by any diagnostician to a reasonable degree of certainty because they are the idiosyncratic opinion of that individual diagnostician.[15]

21. Another important concept in diagnostics is that of reliability, which refers to the consistency with which diagnoses are applied by different clinicians or on different occasions. Bentall, in 2003, wrote, "A diagnostic system cannot be valid without first being reliable" (p. 68).[16] When *ad hoc* categories are applied, logic defies the ability to establish reliability as the criteria for such *ad hoc* categories are different for each clinician.[17]

22. There exists a higher standard in diagnosing disorders in forensic settings where liberty is at stake. Where such a higher standard exists, and a person may be deprived of liberty based, at least partly, on a diagnosis, dubbing *ad hoc* categories (which lack established conceptual validity and reliability) as diagnoses and assigning them to individuals is not generally accepted. Such *ad hoc* categories in this case, with which Mr. Stevens was previously assigned as a diagnosis, include Personality Disorder Not Otherwise Specified with Antisocial

and Narcissistic Traits, Personality Disorder Not Otherwise Specified with Narcissistic, Passive/Aggressive and Antisocial Traits, Other Specified Personality Disorder with Antisocial and Narcissistic Traits, and Paraphilia Not Otherwise Specified (without a specifier).

23. The diagnosis of OSPD (without a specifier) is not generally accepted within the fields of clinical and forensic psychology. OSPD with a specifier that connotes PCD is not generally accepted in the fields of clinical and forensic psychology as PCD is not generally accepted in the fields of clinical and forensic psychology. Furthermore, the other *ad hoc* diagnoses listed above in paragraph 22 are not reliable and valid diagnoses of mental disorders in forensic settings.

24. According to DSM-5, "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion, regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (p. 20).

25. In regard to the purpose of diagnosis, the original use of mental disorders was for the collection of statistical information; however, the purpose of diagnosing mental disorders has changed and now primarily assists mental health professionals in providing clinical care for patients.[18] First (2010) outlines four key areas that diagnosis is intended to address. These include (1) communication, (2) choosing effective interventions, (3) prediction of course, prognosis, and future needs, and (4) discerning disorder from non-disorder to determine those for whom treatment may provide benefit.[19] DSM-5, in further regard to the purpose of diagnosis,

states, "Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information such as morbidity and mortality rates" (p. 5).

26. There is a chapter in DSM-5 titled "Other Conditions That May Be a Focus of Clinical Attention." An introduction to the chapter reads, "These conditions are presented with their corresponding codes from ICD-9-CM [International Classification of Diseases, Ninth Revision, Clinical Modification] (usually V codes) and ICD-10-CM [International Classification of Diseases, Tenth Revision, Clinical Modification] (usually Z codes)" (p. 715). The chapter further states, "The conditions and problems listed in this chapter are not mental disorders" (emphasis added, p. 715).

27. The purpose of these conditions in DSM-5, labeled Z codes, is to draw attention to additional issues that are not recognized as mental disorders. In regard to discriminating between mental disorders and Z codes, DSM-5 states the following: "Socially deviant behavior (*e.g.*, political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above" (p. 20). Examples of Z codes in DSM-5 include Z63.4: High Expressed Emotional Level Within Family, Z59.0: Homelessness, Z59.6: Low Income, and Z64.0: Unwanted Pregnancy. Utilizing the example of Homelessness (Z59.0), which represents an easily-understood condition for the purpose of analogy, to consider such a condition to be a mental disorder is commonsensically absurd. Z codes are not mental disorders. Therefore, the Z

code of "Encounter for mental health services for perpetrator of nonspousal or nonpartner adult sexual abuse" (Z69.82) and the V code of Sexual Abuse by an Adult (V61.12), each of which has been assigned to Mr. Stevens, are not mental disorders or diagnoses.

Pursuant to Minn. Stat. §358.116, I declare under penalty of perjury that everything I have stated in this document is true and correct.

Dated: 5/28/2020

Frederick Winsmann, Ph.D., ABPP

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