Use of DSM Paraphilia Diagnoses in Sexually Violent Predator Commitment Cases

Michael B. First, M.D., Columbia University, Department of Psychiatry and New York State Psychiatric Institute

Robert L. Halon, Ph.D., Private Practice

Address correspondence to Dr. First, New York State Psychiatric Institute,
1051 Riverside Drive, Unit 60, New York, NY 10032,
phone: 212-543-5531, fax: 212-543-5525, e-mail: mbf2@columbia.edu

Running Head: Use of DSM Paraphilia Diagnoses in SVP Commitment Cases

Corresponding author: Dr. First, New York State Psychiatric Institute,
1051 Riverside Drive – Unit 60, New York, NY 10032.
telephone: 212-543-5531, fax: 212-543-5525, e-mail: mbf2@columbia.edu

Abstract

There is legitimate concern in the psychiatric community that the constitutionality of sexually violent predator (SVP) commitment statutes, depending as it does on the requirement that a sexual offender has a mental abnormality that *makes* him commit violent predatory sex offenses, reflects almost exclusively a concern for public safety with little regard for notions of clinical sensibility or diagnostic accuracy. However, given that mental health experts' diagnostic opinions are, and will continue to be, important to the triers-of-fact in regard to the application of the SVP statutes, we describe valid means of making a DSM-IV-TR paraphilic diagnosis and provide a three-step approach for the judicious application of the diagnosis in the context of SVP commitment evaluations that emphasizes the importance of ***not*** making a paraphilia diagnosis based solely on the sexual offenses themselves. Finally, we discuss the appropriate use of a Paraphilia *NOS* diagnosis in SVP cases.

Introduction

In 1990, Washington State passed the first sexually violent predator (SVP) involuntary commitment statute which was designed to allow for the civil commitment of sex offenders to mental hospitals after they completed mandatory prison sentences. According to the Washington State SVP statute, the offender must be found to be "a person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence"; i.e., a "sexually violent predator." (1) Under the SVP laws of most states, "mental abnormality" is statutorily-defined as "a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts"; "personality disorder" is not defined in these laws. Nineteen states have since enacted similar laws, many modeled after the Washington State statute. (2)

Despite a number of challenges to the constitutionality of SVP statutes, the U.S. Supreme Court in two separate rulings (Kansas v. Hendricks (3) and Kansas v. Crane (4)) upheld the constitutionality of the Kansas State Sexually Violent Predator laws; essentially making similar laws with analogous proof requirements constitutional in all states. Crucial to the finding of constitutionality was The Court's ruling that a risk of dangerousness by itself is not sufficient grounds for civil commitment under the statute—otherwise any criminal who is considered to be at high risk for re-offense of a violent crime could be held indefinitely after the offender has completed his prison sentence (i.e., many if not most career criminals). As noted by the Supreme Court, "the precommitment requirement of 'mental abnormality' or 'personality disorder' is

consistent with the requirements of these other statutes that we have upheld in that it narrows the class of persons eligible for confinement to those who are unable to control their dangerousness." (p. 358, (3))

In considering the role of psychiatrists, psychologists, and the DSM-IV-TR in assisting triers of fact in making such a determination, it is crucial to understand that there is a disjunction between the legal criteria for civil commitment, which are implied in such statutorily-defined constructs as "mental illness," "mental abnormality" or "personality disorder" and the diagnostic categories found in the DSM-IV-TR. This lack of equivalence is explicitly noted in both the U.S. Supreme Court in the Hendricks decision (i.e., "legal definitions...which must 'take into account such issues as individual responsibility... and competency,' need not mirror those advanced by the medical profession." (p. 359)) as well as in caveats contained in the introductory sections of DSM-IV-TR which state that "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.'" (p. xxxiii). (5).

The goal of sexually violent predator statutes is to identify individuals who seem to be at higher risk for committing sexual offenses by virtue of having a mental abnormality that makes them commit such crimes and to confine them indefinitely; whether such identification comports to any clinical psychiatric diagnosis seems irrelevant to the states' plan. Nonetheless, the Supreme Court in Kansas vs. Crane did explicitly acknowledge the potential relevance of psychiatric diagnoses in the determination of whether the statutorily-defined mental health criteria (i.e., the legal requirement in SVP laws) are satisfied:

> "Hendricks underscored the constitutional importance of distinguishing a dangerous sexual offender subject to civil commitment 'from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings.' 521 U.S., at 360. That distinction is necessary lest 'civil commitment' become a 'mechanism for retribution or general deterrence' – functions properly those of criminal law, not civil commitment. *Id.*, at 372—373 (Kennedy, J., concurring)...The presence of what the 'psychiatric profession itself classifie[d] ... as a serious mental disorder' helped to make that distinction in *Hendricks*." (p. 412)

Given the lack of equality between clinical and statutorily-defined dysfunction, and the Supreme Court's requirement that the offender's dangerousness be causally linked to such dysfunction (i.e., a "mental abnormality" or "personality disorder"), we contend that the role of the mental health professionals who act as "expert witnesses" in SVP commitment trials is not to *determine* whether an individual actually suffers the kind of "mental abnormality" defined in these laws but *only* to assist triers-of-fact in making that determination.

Of all the disorders contained in the DSM-IV-TR, some of the Paraphilias come closest to addressing the type of sexual psychopathology defined in the SVP laws, even though none directly address the requisite predisposition to act on the paraphilic fantasies and urges or involve volitional impairment in reference to doing so. According to the American Psychiatric Association's 1999 Task Force Report on dangerous sex offenders, "only the paraphilic diagnoses focus directly on psychopathological features of deviant sexual behavior, but these conditions appear to be absent in most offenders. In contrast, a

significant number of sex offenders may have substance abuse or personality disorder diagnoses, but these conditions usually have little explanatory connection to the offender's sexual behavior."(p. 9) (6) Consequently, the DSM-IV-TR clinically-defined paraphilias have been the diagnoses most often used to address the statutes' version of the "mental abnormality."

Given the complications and subtleties involved in integrating clinical diagnostic information with the kinds of dysfunction required by the statutes (i.e., that a mental abnormality is present which specifically drives sexually violent predatory behavior), the potential for misapplication of the DSM-IV paraphilia diagnosis in SVP cases is much more than simply of hypothetical concern. We contend that, during the process of adjudication of SVP commitment trials, profound and avoidable errors are made by some mental health professionals who invalidly diagnose paraphilia, assert that there is volitional impairment based solely on the fact that the offender has a paraphilia diagnosis, and thus wrongly claim that the statutorily-defined SVP commitment criteria are adequately addressed by the clinical diagnoses. In such case, mental health experts have made a DSM-IV-TR diagnosis of paraphilia without providing valid evidence to justify the diagnosis. Instead, they infer from the criminally sexual behavior the existence in the offender of the requisite "deviant sexual arousal pattern" (i.e., recurrent, intense sexually arousing fantasies and urges) that is the defining feature of a Paraphilia. For example, in the SVP evaluation report of a sexual offender in Washington State (7), the evaluator, in the absence of evidence of a deviant pattern of arousal to rape (i.e., urges and fantasies focused on rape), concluded that the respondent "appears to suffer from a mental abnormality, Paraphilia NOS: Rape, which predisposes him to engage in sexual

acts with nonconsenting persons. Central to [the respondent's] disorder is a pattern of sexual assault extending over a period from 1979 through 1992, during which he was convicted of three sexually violent crimes and was implicated in three additional sexual assaults." Many of those experts compound their error by not discussing the possibility that the sex crimes had some cause other than a "mental abnormality", and by definitively stating that the respondent suffers the statutorily-defined mental abnormality.

Although current SVP commitment statutes are motivated almost exclusively by concerns for public safety and show little concern for diagnostic accuracy, our goal is to insert greater clinical sensibility into the process. Thus, the aim of this paper is to provide guidance as to what constitutes an accurate diagnosis of paraphilia and to describe the *appropriate* use of those diagnoses in SVP commitment hearings. We propose the following three-step process to assist in those diagnostic efforts. First, establish whether paraphilia is present, i.e., provide reasonable evidence of the existence in the offender of the recurrent, intense sexually arousing fantasies (i.e., mental imagery that the individual considers to be erotic) and urges (i.e., to act on the fantasies) that are *sine qua non* to the paraphilic diagnosis. Second, if a paraphilia is present, establish whether or not the offender's sexually violent crimes occurred as a direct consequence of that paraphilia. Third, rather than assuming that a diagnosis of paraphilia implies volitional impairment, present positive evidence suggesting whether the offender is, or is not, volitionally impaired with regard to committing sex crimes. We acknowledge that this third step in the process may be difficult, if not impossible, to accomplish; i.e., differentiating those offenders who legitimately lose control from those who simply choose to violate social rules (8-10). It is a conclusion to which, we believe, no expert

witness can testify with any degree of certainty and that fact must be plainly stated to triers-of-fact. We therefore advocate providing triers with as much *objective* information about the tri-able mental health issues as exists without testifying as to whether the cited data *actually fit the legal criteria*. Whether the expert information fits the legal criteria is a decision for triers-of-fact to make just as they make the ultimate decisions about whether the psychiatric evidence presented to them is adequate for establishing that the defendant was "legally insane" at the time of the commission of the crime or "incompetent" in reference to be able to present a defense.

STEP 1: Establishing the Presence of a Paraphilia

The core diagnostic construct that forms the basis of the Paraphilia category is that the person becomes sexually aroused in response to fantasies and urges to stimuli considered to be abnormal. Early editions of the DSM defined the category using words such as "deviant" (DSM-I and DSM-II), "unusual and bizarre" (DSM-III), and "not part of normative arousal-activity patterns" (DSM-III-R), raising the obvious questions about the range of sexual stimuli that are to be considered normal, usual, or typical. DSM-IV sidestepped this thorny issue by completely avoiding the normal/abnormal dichotomy and instead adopted a definition constructed to cover the specific Paraphilias included in DSM-IV:

> "recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors generally involving (1) nonhuman objects [to cover the paraphilias fetishism and transvestic fetishism]; (2) the suffering or humiliation of oneself or one's partner [to cover the paraphilias sexual sadism and sexual masochism], or (3) children or other nonconsenting persons [to cover the

paraphilias pedophilia, frotteurism, exhibitionism, and voyeurism]." (p. 566) (5)

The range of stimuli that can be a focus of sexual arousal in individuals is potentially limitless. John Money (11) identified and named over 100 different types of sexual interests that he considered "deviations" (which he called "lovemaps," i.e., "what you need to get turned on"). DSM-IV-TR includes criteria sets for eight specific paraphilias (exhibitionism, fetishism, frotteurism, pedophilia, sexual sadism, sexual masochism, transvestic fetishism, and voyeurism) selected because they are the ones that most commonly come to clinical attention. Individuals with other types of paraphilia (e.g., zoophilia) are diagnosed using the residual category "Paraphilia Not Otherwise Specified."

To be classified as a paraphilia in DSM-IV-TR, three elements must be present: 1) there must be a clearly specifiable deviant mode of sexual gratification; 2) there must be evidence of a pattern of arousal (i.e., sexual urges and sexually arousing fantasies) in response to this deviant mode of gratification that is recurrent and intense and occurs over a period of at least 6 months; and 3) the person has acted on his paraphilic urges or else the urges or fantasies cause marked distress or interpersonal difficulty.[1] All three are essential to the diagnosis, regardless of how uncommon or unusual the paraphilia is. (12) The first two elements correspond to criterion A in the definition of each of the paraphilias, and the third element corresponds to criterion B.

Diagnostically, one error that can result in a false positive diagnosis (i.e., opining that a paraphilia is present in the respondent when it is not) is to base the diagnosis solely

[1] For paraphilias that do not involve non-consenting victims (e.g., fetishism), the diagnosis is made if the paraphilic fantasies, urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

on the presence of the criminal sexual behavior without evidence causally connecting that behavior to the paraphilic arousal pattern. Sexually violent behavior such as molesting a child or rape is not in and of itself indicative that a paraphilic arousal pattern is the cause of the behavior; i.e., not every sex offender's sexually deviant behavior is driven by a paraphilic sexual arousal pattern. For example, in an analysis of the psychiatric diagnoses of a sample of 113 male sex offenders, Dunsieth and colleagues (13) found that only 58% had a paraphilia.

Determining which sexual offenses have occurred as a result of a paraphilia requires diagnostic evidence apart from the sexual offenses themselves. However, not infrequently, evaluators have asserted the presence of a paraphilia based solely on the history of the sexual offenses, which is the logical fallacy of "affirming the consequent". That is, assuming that the sex offenses were necessarily a consequence of a paraphilia (i.e., the antecedent). For example, the expert in a California SVP evaluation report (14) claimed that "[the respondent] clearly meets the diagnostic criteria for a paraphilia for nonconsenting sexual aggression because he has committed four rapes over a seven year period. [The respondent] began raping at age 17, and sexually reoffends almost immediately upon release from custody. He seems incapable of controlling his aggressive sexual impulses. [The respondent] is obviously aroused by aggression, since he achieves erections and ejaculates during the rapes."

Concluding that an individual's behavior is driven by paraphilic rapism based entirely on a history of committing repeated rapes within a circumscribed period of time is never justified. Recidivism among rapists, as is the case with other types of violent criminals, is not uncommon. Rapists may repeatedly rape for a variety of reasons such as

aggressive impulses and a complete disregard for others. The fact that the offender can function sexually while committing a rape provides no specific information about what is going on in his mind vis-a-vis the focus of his sexual arousal pattern during the act. Furthermore, given that the legal definition of rape entails penetration, the rapist is required to function adequately at least in that way while raping. Therefore, that fact cannot suffice as evidence that there is a mental abnormality driving the rape behavior.

A likely contributing factor for this type of error (i.e., making the diagnosis of paraphilia on the sole basis that the criminally sexual behavior occurred over a period of 6 months or more) is the accidental change in the wording of criterion A for the paraphilias introduced during the last stages of the DSM-IV production process. Criterion A in DSM-III-R required "recurrent intense sexual urges and fantasies" occurring over a period of 6 months, wording that was retained in the March 1993 draft criteria for DSM-IV. (p. O:6) (15) However, in the final version of DSM-IV that appeared in May 1994, the criterion A wording was slightly altered to require "recurrent, intense, sexually arousing fantasies, sexual urges, *or behaviors*" over a period of 6 months. The decision to add "behavior" to criterion A was actually a side effect of a more significant change to the DSM-IV criteria for paraphilias: the phrase "the person has acted on these urges or is markedly distressed by them" in DSM-III-R criterion B was replaced with the phrase "the fantasies, sexual urges or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."

This change was intended to incorporate the standard wording of what was termed the "clinical significance criterion that was added to most DSM-IV disorders in order to

help "establish the threshold for a diagnosis of a disorder in those situations in which that symptomatic presentation by itself (particularly in its milder forms) is not inherently pathological and may be encountered in individuals for whom a diagnosis of 'mental disorder' would be inappropriate"; i.e., "the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning." (p. 8) (5)

Because the behavioral element of criterion B (i.e., "acted on the urges") that appeared in DSM-III-R had been removed, the phrase "or behavior" was added to criterion A in DSM-IV to reflect the fact that it was typically the person's paraphilic behavior that brought him to clinical attention (A. Frances, personal communication, 2006). However, it is important to understand that at no time was there ever any intention by the APA that these semantic changes were to signify a change in "caseness" (i.e., it was assumed that both the DSM-III-R wording and the DSM-IV wording would identify exactly the same set of individuals as having a paraphilia). Reflecting this intent, the only change to the Paraphilia section reported in the "Annotated Listing of Changes in DSM-IV" appendix in DSM-IV (16), was the addition of the gender dysphoria specifier to the diagnosis of Transvestic Fetishism.

Shortly after the publication of DSM-IV, it soon became evident that this minor change in wording had been misinterpreted as indicating something much more significant (17). In particular, conservative religious groups mistakenly worried that the removal of "acted on these urges" was a signal that the American Psychiatric Association was moving towards eliminating Pedophilia from the DSM by requiring that the individual experience distress or impairment (18-20). To eliminate this confusion in

DSM-IV-TR, the original DSM-III-R wording of criterion B (i.e., "the person has acted on these urges or is markedly distressed by them").was reinstated for those paraphilias involving non-consenting victims (i.e., Pedophilia, Voyeurism, Exhibitionism, Frotteurism, and Sexual Sadism) (21). The criterion A wording, however, was not restored to what it was in DSM-III-R; it had never been anticipated that any clinician would interpret the addition of "or behaviors" in Criterion A as indicating that the deviant behavior, in the absence of evidence of the presence of fantasies and urges causing the behavior, would justify a diagnosis of a paraphilia.

The fact that some experts would use a literal interpretation of criterion A to justify making the paraphilia diagnosis based entirely on criminally sexual behavior goes against both the spirit of the DSM-IV and the requirements of the SVP commitment statutes in which the prior sexually criminal behavior alone is insufficient for finding that the offender is a sexually violent predator. The introduction to DSM-IV-TR states clearly that "the specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion.' (p. xxxii) (5) The core construct of a paraphilia, which involves a deviant focus for sexual arousal, is the historical *sine qua non* of the diagnosis, and is so well-established as to be irrefutable. The fact that a valid diagnosis of paraphilia cannot be made on the sole basis of the sexually criminal behavior is clearly stated in the "Diagnostic Features" section for the paraphilias: "For Pedophilia, Voyeurism, Exhibitionism, and Frotteurism, the diagnosis is made if the person has acted *on these urges* or the *urges or sexual fantasies* cause marked distress or interpersonal difficulty" (emphasis added) (p. 566). Were the sexually criminal behavior itself sufficient for making the diagnosis of

paraphilia there would be no need for input from mental health professionals in making the diagnosis.

Sources of information that are potentially useful, although never definitive in the attempt to determine the presence of a paraphilia, include the diagnostic interview; self-report questionnaires; and history of specific sorts of sexual behavior. (22) The diagnostic interview should include questions about the individual's sexual thoughts, fantasies, urges, interests and behavior, both with regard to paraphilic and non-paraphilic targets. Self-report questionnaires (e.g., Clarke Sexual History Questionnaire—Revised (23)) can also be useful in providing a comprehensive assessment of sexuality, and some such instruments include normative data for male sex offenders. Although information gleaned from interviews and questionnaires is potentially very useful, one must always be skeptical about the veracity of methods that rely on self-report because of the legal and social sanctions offenders may face as a result of acknowledging their paraphilic interests and past illegal behaviors.

A history of past sexual offenses thematically related to a paraphilia (e.g., arrests for indecent exposure in someone with a possible exhibitionistic paraphilia or arrests for child molestation in someone with possible pedophilia) is certainly relevant as a potential indicator of an underlying paraphilic arousal pattern. However, as emphasized in this paper, the fact that the person has a history of past sexual offenses cannot by itself be considered sufficient evidence that the offenses were the product of paraphilic sexual fantasies and urges. The evaluator must delve deeper and examine the specific details of the sexual offenses in order to establish that the behaviors are being driven by paraphilic urges. For example, if the offender's rape behavior appears to be following a script as

evidenced by multiple rape victims describing the rapist as engaging in the exact same sequence of physical behaviors and verbalizations, it might be reasonable to infer that the rapes are motivated by a paraphilia. Furthermore, any behavior can have other possible causal explanations; hence, alternative explanations for the sexually criminal behavior must also be considered (see step 2, below).

Possession of paraphilic-themed pornography may also be an indicator of an underlying paraphilia, given the face-valid link between use of a particular type of pornography for the purposes of sexual arousal and the person's underlying sexual preferences. For example, Seto, Cantor and Blanchard (24) found that possession of child pornography was positively related to self-reported sexual interest in children and to phallometrically-measured sexual arousal to children and that possession of child pornography was a stronger indicator of the presence of a pedophilic arousal pattern than was having a history of sexually offending against child victims. Of course, the fact that an individual is in possession of child pornography does not by itself indicate that the person is a pedophile, it must also be established that the images are being used by the person for the purposes of sexual arousal.

Physiological measures such as polygraphy, unobtrusively-measured viewing time for sexual stimuli, and penile plethysmography testing (PPG) have been purported to provide useful information regarding which types of sexual stimuli an individual finds sexually arousing. While a discussion of the relative advantages and disadvantages of these methods is beyond the scope of this paper, suffice it to say that none of these methods provide a fool-proof indicator of the presence of an underlying paraphilia due to their vulnerability to manipulation and because of questions about the predictive validity

and reliability of these measures. Research suggests that combining data from all sources (self-report, offense history, physiological methods) might provide the most robust results. For example, Laws and colleagues (25) in a study in which offense history was considered a dependent variable, compared three assessment modalities (PPG using erotic slides, PPG using audio stimuli, and a self-report card-sort measure of sexual interest) on their ability to differentiate boy-object and girl-object child molesters. Combining all three modalities provided classification accuracy (91.7%) greater than any single measure.

STEP 2: Establish that the sexual offenses occurred as a direct consequence of the paraphilia diagnosed in Step 1 and rule out other possible non-paraphilic explanations for the sexual offenses.

This step entails establishing whether there is evidence that a causal connection exists between the paraphilia and the sexual offenses. One element of making such a connection is to establish that the sexual offenses are of a kind that is in harmony with the specific paraphilia that has been diagnosed; i.e., child molestations by an individual diagnosed with pedophilia. Said another way, child molestation by a voyeur or exhibitionist who has not experienced fantasies or urges for sex with children does not establish that the voyeurism or exhibitionism was causal in the commission of the child molestation. When the pattern of repeated sex crimes is found to be in harmony with a validly diagnosed paraphilia, a reasonable argument can then be made that the sexual offenses are causally related to the diagnosed paraphilia.

A second element in establishing causality between the sexual offenses and a paraphilia is to rule out other possible explanations for the behavior. Not all sex offenders have a paraphilia. For example, the prevalence of pedophilic sexual interests among adult sex offenders with child victims appears to be approximately 40-50% (26-28). Therefore, when confronted with the task of determining whether a sexual offense is a manifestation of an underlying paraphilia, the mental health expert must consider the full range of non-disordered conditions and mental disorders which might account for the behavior, i.e., determine its differential diagnosis.

Perhaps the most important disorder that should be considered in the differential diagnosis for a sexual offense is *antisocial personality disorder* because this personality type is so often found in the profiles of sexual offenders. For example, 56% of Dunsieth's sample of 113 convicted sex offenders (13), and 40% of Becker's (29) sample were diagnosed with antisocial personality disorder. DSM-IV-TR diagnostic criteria for antisocial personality disorder items that are relevant to repeatedly committing sexual offenses include: "failure to conform to social norms with respect to lawful behavior as indicated by repeatedly performing acts that are grounds for arrest," "impulsivity or failure to plan ahead," "irritability and aggressiveness," "reckless disregard for the safety of self or others" and "lack of remorse." (p. 706) However, the presence of any one or any combination of those signs is not evidence that the individual is predisposed to committing sexually violent predatory offenses or, even if he is, that he is also volitionally impaired in reference to actually committing the crimes.

It is therefore crucial to not only look for positive evidence of the existence in the offender of the requisite paraphilic fantasies and urges, but to consider whether the sexual

offenses may be *better understood* as being part of the "pervasive pattern of disregard for and violation of the rights of others" that is the core defining feature of Antisocial Personality Disorder, rather than being indicative of a paraphilia. What differentiates paraphilic from antisocial motivation is that for the sexual offenses to be considered part of a paraphilia, there must be evidence of the offenses being a behavioral expression of the underlying paraphilic urges and fantasies.

Not uncommonly, in an attempt to demonstrate that the antisocial personality disorder contributes to the individual's dangerousness, and hence qualifies the offender as having the statutorily-defined "mental abnormality," evaluators diagnose sexual offenders with both paraphilia and antisocial personality. For example, in Kansas vs. Crane, Michael Crane, the defendant, was convicted of lewd and lascivious behavior and pled guilty to aggravated sexual battery for two incidents that involved exposing himself to two adults (a tanning salon attendant and a video store clerk). He was diagnosed as having both Exhibitionism and Antisocial Personality Disorder. The experts in that case, however, opined that the Exhibitionism by itself was not enough to qualify as a diagnosed mental abnormality for the purposes of SVP commitment, but that the combined diagnoses of Exhibitionism and Antisocial Personality Disorder would qualify.

The fact that some individuals with antisocial personality disorder commit sexual offenses as part of their pattern of violating the rights of others has been sometimes used to make a case for the idea that antisocial personality disorder in the absence of a comorbid paraphilia qualifies as the requisite statutorily-defined "mental abnormality or personality disorder" in SVP commitment proceedings (30). However, sex crimes committed by a person with Antisocial Personality Disorder are often an expression of

lack of concern for consequences for oneself and, especially, for others. Given that the original sexual psychopath laws were intended to provide treatment and offer a possible cure for future sexual offender, those with antisocial personality disorder, who were thought to be unamenable to such treatment efforts, were excluded from commitment. Since amenability to treatment is not a criterion for SVP commitment, Sreenivasan and colleagues (30) argue that an antisocial person with poor prognosis may now qualify for civil commitment.

There are, however, valid reasons to question whether a diagnosis of antisocial personality, even at disordered levels, would pass constitutional muster as the sole basis for civil commitment. (31) In considering which mental disorders might qualify for the appropriate application of civil commitment statutes, the US Supreme Court in Kansas vs. Crane required that "the severity of the mental abnormality itself must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, and or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case." (4) Given that evidence suggests that up to 80% of the adult male prison population may meet criteria for antisocial personality disorder (32), it is unclear whether an SVP commitment based solely on a diagnosis of antisocial personality disorder would be held constitutional by the US Supreme Court; although it appears that such commitments have been upheld by some state courts. (See Zander (33), pp. 52-62 for discussion of this issue.)

Other mental disorders that can be associated with sexual offenses, and must therefore be ruled out as a cause, include substance abuse or dependence (e.g., sexual assault related to heightened sexual interest accompanied by disinhibition during

intoxication), bipolar disorder (e.g., sexual assault during manic phase consistent with the criterion "excessive involvement in pleasurable activities that have a high potential for painful consequences"), a psychotic disorder (e.g., sexual assault that is the result of a delusion or command hallucination), or a cognitive disorder (e.g., a consequence of personality change due to a medical condition, disinhibited type). Given the high rates of Axis I disorders thought to exist among sex offenders, it is crucial to conduct a comprehensive diagnostic evaluation looking for the presence of comorbid disorders and, if a comorbid disorder is present, rule it out as a *cause* of the sexual offense (e.g., in Dunsieth's sample (13), 85% had a substance use disorder and 35% had bipolar disorder).

STEP 3: Do not assume that a diagnosis of a paraphilia implies volitional impairment. One needs to provide positive evidence that the offender has difficulty controlling his sexually assaultive behavior as a result of the paraphilia or of a comorbid condition.

Once a diagnosis of paraphilia has been established (step 1) and other explanations for the sexual offense have been considered and ruled out (step 2), the next step is to determine whether, as a result of a mental disorder, the paraphilic offender has difficulty controlling his behavior vis-a-vis committing future sex offenses. It is important to understand that having a diagnosis of a paraphilia does **not** imply that the person also has difficulty controlling his behavior. Diagnostic heterogeneity is the rule with all psychiatric disorders:

> "It is precisely because impairments, abilities, and disabilities vary widely with each diagnostic category that assignment of a particular diagnosis

does not imply a specific level of impairment or disability." (DSM-IV-TR, p. xxxiii) (5)

The diagnostic features that are characteristic of all individuals with a paraphilia are the presence of a deviant sexual arousal pattern (i.e., recurrent and intense sexually arousing fantasies and urges) and the fact that the person has either acted on the urges or else the urges or fantasies cause marked distress or interpersonal difficulty. While it is probably true that some individuals with a paraphilia do have difficulty controlling behavior associated with their paraphilia, many do not. Like most mental disorders, the severity of a paraphilia and its associated features can vary widely between individuals. For some, the paraphilic urges are ego-dystonic and result in extreme shame and guilt when they arise during sexual fantasies. Others may collect pornographic material thematically related to their paraphilic urges when they then use as sexual stimuli during masturbation. Still others may cross the line from fantasy to behavior, acting out their fantasies and urges with others, but only in situations where they have easy access to potential victims (e.g., a person whose molestation of children is confined to family members). On the most severe end would be an individual who has devoted his life to luring intended victims and makes no efforts to control his behavior. All of these individuals would qualify for a DSM-IV diagnosis of paraphilia but only a subset *might* be considered to have difficulty controlling their behavior due to the paraphilia.

Given this huge variability in the levels and types of behavioral control individuals with paraphilic urges are thought to experience, it is crucial in SVP commitment trials to present evidence to show whether the particular individual being evaluated has a serious

difficulty controlling his behavior and that the difficulty arises from a mental disorder. However, there are no established validated scientific methods for measuring an individual's impairment in his ability to control his behavior.(9). Indeed, on this basis, the American Bar Association has argued, successfully in some jurisdictions, for the elimination of volitional impairment as a basis for the insanity defense. (34) Similarly, in expressing its concerns about the difficulties in operationalizing volition, the American Psychiatric Association (35), in its statement on the insanity defense, noted "the line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk." (p. 685).

Caselaw provides some indications of what kinds of evidence might be relevant to an inability to control standard, e.g., the offender verbally acknowledging that he cannot control his sexual desires when "stressed out" (in Kansas v. Hendricks (3)) and evidence of repeated sexual misconduct despite negative consequences like re-arrest (36). However, there is no clear articulation even in these examples of what qualifies as inability to control. In lieu of a direct assessment of volitional capacity, many SVP evaluations have instead focused on the presence of risk factors that predict future sexual violence, on the assumption that those who are scored as being at high risk of sexually re-offending do so because of difficulty controlling their behavior. The validity of this approach has been justifiably criticized. (8) Generic risk assessment measures such as the Sexual Violence Risk (SVR)-20 (37) and actuarial measures such as the Static-99 (38) and the Rapid Risk Assessment of Sex Offense Recidivism (39) should therefore be used with caution in SVP evaluations. These generic measures were designed to predict general violence or non-specific sexual violence rather than the types of predatory sexual

violence that is the target of most SVP statutes, and the actuarial measures were and are designed for purposes of supervising sex offenders in the community (8). Furthermore, having a high risk of reoffending according to one of these instruments does not also imply that there is a mental abnormality causing this high risk or that, even if caused by a mental abnormality, there also exists in the offender the requisite volitional impairment in reference to committing the offenses.

Ultimately, expert witnesses testifying in SVP commitment trials must clearly inform triers that there is no professional consensus in the field of mental health concerning what constitutes volitional impairment nor even what constitutes adequate psychiatric or psychological evidence of it. Therefore, mental health professionals testifying as "experts" in SVP commitment trials must caution triers-of-fact that although evidence they present *might* address the legal question of whether a respondent suffers such impairment, it cannot definitively do so. At the same time the expert should also inform triers that even information yielded by scientifically-generated actuarial risk assessment instruments cannot address the issue of volitional impairment.

Use of Paraphilia NOS in SVP Commitment

After pedophilia, the next most commonly diagnosed paraphilia in men convicted of sexual offenses has been "Paraphilia Not Otherwise Specified (NOS)" (e.g., 56% in Becker's series (29) and 44% in Dunsieth's series (13)). Furthermore, in a study of 450 sex offenders being considered for civil commitment in Florida, a diagnosis of Paraphilia NOS was more highly correlated than any other psychiatric disorder with the recommendation by forensic evaluators to commit. (40)

In its description of Paraphilia NOS, DSM-IV-TR notes "this category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, *but are not limited to*: telephone scatalogia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of the body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine)." (Emphasis added.) (p. 576) (5) As noted in the DSM-IV-TR description, this list of paraphilias is not exhaustive. Any of John Money's one-hundred-plus sexual deviations (11) (with the exception of the eight already included as specific categories in the DSM-IV-TR) could be diagnosed in the DSM-IV-TR as Paraphilia NOS.

The version of Paraphilia NOS that has been most widely applied in SVP commitment cases to offenders who have been convicted of raping adults is often called "Paraphilia-NOS-nonconsent." Doren (41) suggested that a diagnosis of paraphilia-NOS-nonconsent is appropriate if "the offender has repetitively and knowingly enacted sexual contact with nonconsenting persons over a period of at least 6 months (specifically for sexual arousal to the nonconsensual interaction) and the behavior has caused him significant impairment in social, occupational, or other areas of functioning." (p. 67) It should be noted, however, that Doren's formulation does not conform to the DSM-IV-TR diagnostic construct of a paraphilia because it focuses on the offender's "repetitively and knowingly enacted sexual contact with nonconsenting persons" and only obliquely refers to the core paraphilic focus specifically for sexual arousal to non-consenting interaction.

The idea that rape might be the focal point of a person's sexual urges and fantasies is not novel. In *Lovemaps*, John Money's 1986 book cataloguing various paraphilic foci (42), he defined "bioastophilia" (Greek) as a "syndrome in which the stark

terror, screaming, yelling, and struggling" of the victim is integral to the offender's sexual arousal. (p. 54). A similar diagnostic construct, paraphilic rapism (also known as "paraphilic coercive disorder") was considered by the DSM-III-R advisory committee for possible inclusion into DSM-III-R as a new type of paraphilia. According to the draft for DSM-III-R diagnostic criteria from 10/05/85 *paraphilic coercive disorder* was described as being characterized by "a persistent association, lasting a total of at least six 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." (p. 110) (43) It was considered by the advisory committee to be "relatively uncommon among men who commit rape" (p. 171) (43), and it was to be distinguished from sexual sadism (which also may involve fantasies of rape) by virtue of the fact that in sexual sadism, the focus of sexual arousal is the humiliation and suffering of the victim. In paraphilic coercive disorder, in contrast to sexual sadism, it is specifically the coercive nature of the sex act which is the source of sexual arousal.[2] The committee ultimately decided to recommend against including this diagnosis in DSM-III-R because of concerns raised that this category might be used by rapists in an attempt to reduce criminal responsibility; hence, the proposed category did not even appear in the 08/01/86 second draft of the DSM-III-R diagnostic criteria.

Conceptually, given the wide variety of stimuli known to be the focus of paraphilias, there is no reason to doubt the existence of a paraphilia in which the aberrant

[2] In the case of paraphilic coercive disorder included in the DSM-III-R Casebook (44. Spitzer R, Gibbon M, Skodol A, Williams J, First M. Perfect Relationship. In: Spitzer R, Gibbon M, Skodol A, Williams J, First M, editors. DSM-III-R Casebook. Washington, D.C.: American Psychiatric Press, Inc.; 1989.) the individual with the paraphilia fantasized about rape but was turned off if he felt that the woman was in any way suffering.

focus of sexual arousal is *precisely the nonconsensual aspect* of the interaction. The problem, of course, is that most rapists are not known to be driven by paraphilic fantasies or urges and there are inherent difficulties in differentiating those rapists who are driven to rape by such a paraphilia from the vast majority of rapists who commit rapes for other reasons. For example, the Crime Classification Manual, developed by the FBI's National Center for the Analysis of Violent Crime, includes several classifications of rape. One classification, which is based on the interaction of sexual and aggressive motivations for the rape, includes four subcategories only two of which are associated with sexual fantasies: the *power-reassurance* rapist for whom the assault is primarily an expression of his rape fantasies; and the sadistic rapist, whose sexual behavior is an expression of sadistic fantasies. The other two categories, the *exploitative rapist* whose sexual behavior is expressed as an impulsive-predatory act and the anger rapist whose sexual behavior is an expression of anger and rage, are not associated with sexual fantasies and are thus clearly non-paraphilic.

Furthermore, the 1999 APA Task Force report on Dangerous Sexual Offenders cautions that:

> "whether or not any rapist has a paraphilia represents a controversial issue in the research literature. DSM-IV has not classified paraphilic rapism as a mental disorder. Some researchers believe that a small group of rapists have diagnostic features similar to those with other paraphilias. The ability to make the diagnosis with a sufficient degree of validity and reliability remains problematic. In addition, other research has shown that many rapes are not

the product of primary sexual interests but rather represent an exercise in power and control." (pp. 169-170) (6)

The appropriateness of using the Paraphilia NOS category as any basis for SVP commitment is hotly debated. Some have argued that it should be used rather liberally for any case in which an individual has repeatedly engaged in sexual behavior with nonconsenting persons even in the absence of reliable data about a person's sexual fantasies and urges. (45) On the opposite end are those who argue there are no circumstances where it would be appropriate to use this diagnosis because it is "contrary to the intent of the drafters of DSM... and the consensus of scholarly opinion regarding [its] appropriate use..." (33) (p. 47)

Our inclination is to come down somewhere in the middle on the appropriateness of using the Paraphilia NOS category as the basis for the claim that the individual's sexual offenses are driven by a mental disorder. There are certainly some dangerous sexual offenders out there whose sexual offenses are clearly driven by a paraphilic sexual arousal pattern involving fantasies and urges to commit rape and it may be appropriate to apply a diagnosis of Paraphilia NOS to such individuals. On the other hand, given the implications of a false positive diagnosis (i.e., indefinite, potentially lifelong civil commitment) and given all of the complexities involved in determining whether rape behavior is motivated by a paraphilia as opposed to other causes (as discussed above), we recommend that a diagnosis of Paraphilia NOS be used only with extreme caution for sexual offenders incarcerated for raping adults, stringently following the three steps that

we have presented above. In such cases it is especially important to go beyond the fact of the sexual offenses themselves before asserting the presence of a paraphilia.

Accordingly, evidence must be presented to establish the presence of a deviant sexual arousal pattern in which the offender is aroused specifically by the non-consensual nature of the sexual act. Examples of such evidence include an admission by the offender that he has had fantasies and urges involving non-consensual sex and that it was the non-consenting aspect of the encounter that he found sexually gratifying; possession of a collection of pornography in which rape or other forms of coercion are the central sexually satisfying theme; evidence from consensual partners that the rapist repeatedly requested role-playing of rape scenarios with them, and a *pattern* of lack of sexual responsiveness when the partner is consenting. Given that it is common for offenders to not be forthcoming with such information, a careful analysis of the pattern of rape behavior may also provide the basis for inferring the presence of a rape paraphilia. For example, the rapist being described by his victims as having demanded that they act in an overtly submissive way or otherwise having acted in ways that suggest he is following a *rape* script during the assaults would suggest that the rape was committed not merely to secure sexual gratification from the act itself but through the non-consensual nature of the assault.

Conclusion

When attempting to establish the presence of the statutorily-defined "mental abnormality", a validly-made DSM-IV-TR diagnosis of Paraphilia can be very useful as long as one understands that DSM-IV-TR diagnoses can only be *one element* of the database. It is important to appreciate that only a subset of individuals who have

committed a sexual offense also have a paraphilia that is responsible for the sexual offense and that only a portion of that subset have difficulty controlling their dangerous behavior as a consequence of having the paraphilia (see Figure 1). The task of the mental health expert is to assist triers to identify that inner subset of individuals as it is those individuals who could more reasonably be found to meet the statutorily-defined criteria that constitute the "mental abnormality" in SVP commitment statutes.

References

1. Wash Rev Code Ann 71.09.030 (suppl. 1990-1991). In; 1991.

2. Davey M, Goodnough A. Doubts Rise as States Hold Sex Offenders After Prison,. New York Times 2007 March 4, 2007;Sect. 1.

3. Kansas vs. Hendricks, 521 U.S. 346. In; 1997.

4. Kansas vs. Crane 534 US 407. In; 2002.

5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition, Text Revision. Washington, D.C.: American Psychiatric Association; 2000.

6. American Psychiatric Association. Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association,. Washington, DC: American Psychiatric Association; 1999.

7. In Re: State of Washington v. W. Davenport, County of Franklin. Case # 96-2-01119-0, report of J. R. Wheeler, Ph.D. dated 2/10/96. In; 1996.

8. Rogers R, Jackson R. Sexually violent predators: the risky enterprise of risk assessment. Journal of American Academy of Psychiatry and the Law 2005;33(4):523-528.

9. Mercado CG, Bornstein BH, Schopp RF. Decision-making about volitional impairment in sexually violent predators. Law and Human Behavior 2006;30:587-602.

10. Grinage BD. Volitional impairment and the sexually violent predator. Journal of Forensic Science 2003;48(4):861-868.

11. Money J. The Lovemap Guidebook: A Definitive Statement. New York: Continuum; 1999.

12. Prentky R, Janus E, Barbaree H, Schwartz B, Kafka M. Sexually Violent Predators in the Courtroom: Science on Trial. Psychology, Public Policy, and Law, 2006;12(4):357-393.

13. Dunsieth N, Nelson E, Brusman-Lovins, LA, Holcomb J, Beckman D, Welge J, et al. Psychiatric and legal features of 113 men convicted of sexual offenses. J Clin Psychiatry 2004;65(3):293-300.

14. In re: Peo. V. G. Thomas, San Joaquin County, California, Case #12607C. SVP Evaluation report of G. Zinik, Ph.D., dated 11/24/1997, admitted as Exhibit A at SVP commitment trial. In; 1997.

15. Task Force on DSM-IV. DSM-IV Draft Criteria 3/1/93. Washington, D.C.: American Psychiatric Association; 1993.

16. American Psychiatric Association. Appendix D: Annotated Listing of Changes in DSM-IV. In: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, D.C.: American Psychiatric Association; 1994. p. 773-791.

17. First M, Frances A. Issues for DSM-V; Unintended consequences of small changes: the case of paraphilias Am J Psychiatriy in press.

18. Medinger A. American Psychiatric Association Decides Pedophilia Is No Longer a Disorder. In: Exodus Global Alliance; 1994.

19. Medinger A. DSM-IV and Pedophilia: What Did the APA Do? In: Exodus International; 1995.

20. Bowles L. Pedophilia: good news, bad news. In: WorldNetDaily; 1999.

21. First M, Pincus H. The DSM-IV Text Revision: Rationale and Potential Impact on Clinical Practice. Psychiatr Serv 2002;53:288-292.

22. Seto M. Pedophilia and sexual offenses against children. Annual Review of Sex Research 2004;15:321-361.

23. Langevin R, Paitich D. Clarke Sex History Questionnaire for Males--Revised (SHQ-R). Toronto: Multi-Health Systems; 2001.

24. Seto M, Cantor J, Blanchard R. Child pornography offenses are a valid diagnostic indicator of pedophilia. Journal of Abnormal Psychology 2006;115(3):610-615.

25. Laws D, Hansen R, Osborn C, Greenbaum P. Classification of child molesters by plethysmographic assessment of sexual arousal and a self-report Journal Of Interpersonal Violence 2000;15:1297-1312.

26. Blanchard R, Klassen P, Dickey R, Kuban M, Blak T. Sensitivity and specificity of the phallometric test for pedophilia in nonadmitting sex offenders. Psychological Assessment 2001;13:118-126.

27. Malesky B, Steinhauser C. 25-year followup of cognitive/hehavioral therapy with 7,275 sexual offenders. Behavior Modification 2002;26:123-147.

28. Seto M, Lalumiere M. A brief screening scale to identify pedophilic interests among child molesters. Sexual abuse: a journal of research and treatment 2001;13:15-25.

29. Becker J, Stinsin J, Tromp S, Messer G. Characteristics of individuals petitioned for civil commitment. Int Journal of Offender Therapy and Comparative Criminology 2003;47(2):185-195.

30. Sreenivasan S, Weinberger L, Garrick T. Expert testimony in sexually violent predator commitments: conceptualizing legal standards of "mental disorder" and "likely to reoffend". Journal of American Academy of Psychiatry and the Law 2003;31:471-485.

31. Vognsen J, Phenix A. Antisocial personality disorder is not enough: a reply to Sreenivasan, Weinberger, and Garrick. Journal of American Academy of Psychiatry and the Law 2004;32:440-442.

32. Widiger T, Corbitt E. Antisocial personality disorder. In: Livesley W, editor. The DSM-IV personality disorders. New York: Guilford; 1995. p. 103-134.

33. Zander T. Civil commitment without psychosis: the law's reliance on the weakest links in psychodiagnosis. Journal of Sexual Offender Civil Commitment: Science and the Law 2005;1:17-82.

34. American Bar Association. Criminal Justice and mental health standards. Washington, DC: American Bar Association; 1989.

35. American Psychiatric Association. American Psychiatric Association statement on the insanity defense. . Am J Psychiatriy 1983;140:681-688.

36. in re Crocker No C7-97-604 (Minn. Ct. App. August 19, 1997) *sum aff'd* (January 21, 1997) (unpublished). In; 1997.

37. Boer D, Hart S, Kropp P, Webster C. Manual for the Sexual Violence Risk-20. Burnaby, British Columbia, Canada: : The British Columbia Institute Against Family Violence, co-published with the Mental Health, Law, and Policy Institute at Simon Fraser University,; 1997.

38. Hanson R, Thornton D. Static-99: Improving actuarial risk assessments for sex offenders (User Report no. 02). Ottawa: Department of the Solicitor General of Canada.; 1999.

39. Hanson R. The development of a brief actuarial risk scale for sexual off ense recidivism. Ottawa, Ontario: Solicitor General of Canada.; 1997.

40. Levenson J. Sexual predator civil commitment: a comparison of selected and released offenders. Int Journal of Offender Therapy and Comparative Criminology 2004;48(6):638-648.

41. Doren D. Evaluating sex offenders: a manual for civil commitments and beyond. Thousand Oaks, CA: Sage; 2002.

42. Money J. Lovemaps. New York: Irvington; 1986.

43. Workgroup to revise DSM-III. Draft DSM-III-R in development - 10/5/85. Washington, D.C.: American Psychiatric Association; 1985.

44. Spitzer R, Gibbon M, Skodol A, Williams J, First M. Perfect Relationship. In: Spitzer R, Gibbon M, Skodol A, Williams J, First M, editors. DSM-III-R Casebook. Washington, D.C.: American Psychiatric Press, Inc.; 1989.

45. DeClue G. Paraphilia NOS (nonconsenting) and antisocial personality disorder. Journal of Psychiatry & Law 2006;34:495-513.

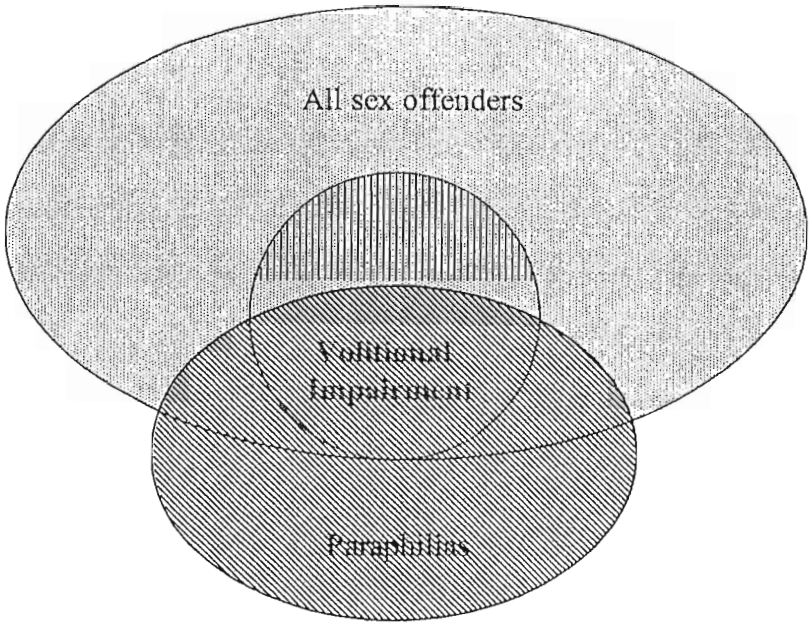

Figure 1 Relationship between sexual offenders (dotted circle), those with paraphilias (diagonal lines) and those with volitional impairment (vertical lines); intersection of all three represents those with very likely to be found to suffer the "mental abnormality" defined in the SVP laws.