CROSS-EXAMINATION IN SEXUALLY VIOLENT PREDATOR CASES

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Cross-examination of Sexually Violent Predator (SVP) evaluators can be a difficult task partly because it places the defense attorney on unfamiliar grounds. The SVP law involves complex mental health issues for which there is limited scientific basis. Concepts such as volition, capacity, predisposition, sexual deviance, and, to some degree, prediction of future behavior are things that lie outside the realm of science or are, at best, poorly understood. These are, however, central features in SVP laws.

In this paper, mental health issues relative to the SVP law will be explored, and directions for cross-examination will be indicated. Because laws may differ across judicial districts and are in various stages of higher court clarification, this paper will not present detailed, specific questions. The following must be viewed as an exploration of the mental health science issues in the SVP law that are the focus of cross-examination and not as specific instructions regarding cross-examination of the experts.

The sexually violent predator laws have three major elements. These are: 1) the inmate has been convicted of prior sexually violent predatory offenses; 2) the inmate has a mental condition (described with various nomenclature) which impairs their volition and predisposes them to sexual violence; and 3) because of the mental condition, the inmate is "likely" to commit sexually violent predatory offenses in the future.

The issues under the first element depend on statutory definitions of "sexual violence" and "predatory." Neither of these are a matter of psychological expert opinion. Sexual violence is defined in statutory terms; although in California there have been some modifications to the code by changing the meaning of the words, rather than changing the wording of the code. For example, the minimum form of sexual behavior which meets the statutory requirement for "substantial sexual conduct" (to meet the definition of sexual violence) is masturbation. Early in the SVP cases in California, there was considerable controversy among SVP evaluators and the courts as to what kinds of behavior actually constituted masturbation. A higher court resolved this issue by defining any kind of touching in the genital areas, however slight, as masturbation.

The first element also includes a definition of predatory in terms of the degree of the relationship between the sex offender and the victim and the sex offender's intent at the time they committed the offense. However, there is no psychological expertise regarding when relationships are casual or when they are more or less than casual. There is, moreover, no scientific basis in psychology for addressing the issue of whether or not the offender "established and promoted the relationship for purposes of victimization" (i.e., intent).

The two elements of the Sexually Violent Predator law that are a matter of psychological expertise relate to the mental condition and prediction of future dangerousness. The primary focus of this paper is on the mental condition; however, before getting into these issues, I will make a few comments regarding prediction of future dangerousness.

The research community has been involved in predicting general, violent, and sex offense recidivism for many years. For the most part, the reasons for this activity have not been to identify individuals for incarceration, which, of course, would be pointless, since an individual cannot be incarcerated only on the basis of predictions of future criminal activity.

The individual must do something criminal. The primary focus in the research community has been to identify risk factors in order to develop theoretical models regarding recidivism and sex offense behavior. There has also been an interest in identifying risk factors for treatment planning and supervision; that is, there is hope to be able to develop specific treatment objectives and supervision techniques for offenders based on their level of risk.

The SVP law has propelled prediction of sex offense recidivism to front and center stage. This was unnecessary, misleading, and counterproductive. Prediction is probably not essential to SVP. The central issue has always been whether the individual has a mental condition as defined under the statute. If an individual suffers the requisite mental condition (is predisposed to sexual violence and is unable to control their dangerous behavior), then one could reach the conclusion that they are likely to reoffend with some degree of confidence and without recourse to actuarial prediction.

The remainder of this paper will primarily explore issues for cross-examination regarding the second element stated above, i.e., a mental condition. Cross-examination issues and questions regarding prediction will not be dealt with in this paper. Issues regarding prediction are, although complicated, more straight forward and perhaps even more familiar than the issues relative to

the mental condition. The latter is, moreover, an area, which defense attorneys have shown a certain reluctance to explore and understand.

SVP MENTAL CONDITION

Most forms of sexually violent predator law define a mental condition along the lines of the Washington State definition, which is: "...a congenital or acquired condition affecting the emotional or volitional capacity that predisposes the person to the commission of criminal sexual acts in the degree constituting the person a danger to the health and safety of others."

The mental condition is variously named "mental defect," "mental abnormality," or "mental disorder." Whatever the nomenclature, the rest of the mental condition definition follows fairly consistently. Throughout the rest of this paper, the term "mental condition" will be used as a generic term for any specific nomenclature defining the mental condition.

SVP evaluators are taking three approaches to addressing the mental condition, depending somewhat on their interpretation of the law and higher-court decisions. In one approach, evaluators address the mental condition only by defining a DSM-IV diagnosis, generally a paraphilia and/or personality disorder, and assume (or hope) that meets the statutory definition of mental condition. A second approach addresses the statutory language of volitional or emotional capacity and predisposition to sexual violence. Finally, a third approach, and one that should become increasingly relevant, is to address the general requirements for civil commitments as indicated by the U. S. Supreme Court decision (Kansas vs. Hendricks) and the historical approach to civil commitments, which requires that the individual is unable to control their dangerous behavior. Each of these will be explored in the following.

There are two other issues central to the notion of SVP mental condition that will be briefly discussed at the end of this paper. These have to do with sexual deviance and psychopathy. The uphill battle that you face in court is that almost everybody believes that a sex offender is "sick" and that they do suffer from a mental condition. Evaluators, either because they believe the same as "everybody," or because it is expedient, will undoubtedly play on the term "sexual deviancy." Evaluators often use the term "sexual deviance" to describe nothing other than the sex offense behavior, but in doing so imply that the behavior is "sick," which tends to establish in the jury's mind that a mental condition is present.

The notion of psychopathy, especially a high score on the Hare Psychopathy Checklist-Revised (PCL-R) (1990), leads to a favorite ploy on the part of SVP evaluators, which is to indicate that the offender is a particularly "bad" person. While this may be true, psychopathy does not indicate a mental condition and, moreover, appears to be highly contrary to the notion of volitional impairment or inability to control behavior.

DSM-IV Diagnosis:

The experience in California indicates that evaluators like to establish a DSM-IV diagnosis for the sex offender and assume that meets the statutory requirements for a mental condition. This is, however, obviously not appropriate. Nowhere in DSM-IV does one find any reference to a disorder that affects emotional or volitional capacity. Those words are not even used in the DSM-IV. Additionally, the legal definition appears to require some degree of impairment, which will be discussed in more detail below, but there are no diagnosed mental disorders in DSM-IV that require or specify any level of impairment.

Perhaps most important is the fact that no DSM diagnosis predisposes an individual to any particular behavior, and the DSM specifically excludes requirements for causal connections between predisposing factors and behavior categories used for diagnosis. DSM-IV (page xxiii) states: "...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 does not require that there be knowledge about its etiology."

Also note, regarding the issue of being in control of behavior, DSM-IV (page xxiii) states: "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." And later: "...does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder."

The above arguments indicate that a DSM-IV diagnosis does not, in and of itself, address the SVP legal definition. Obviously, the legal definition means something different from the disorders defined in the DSM-IV. However, in spite of these cautions, mental

health professionals who evaluate sexually violent predators are highly interested in establishing a DSM-IV diagnosis of paraphilia. It is much easier to address a DSM-IV diagnosis than it is to address the murky issues of volitional or emotional impairment or inability to control behavior.

However, it also seems clear that part of the confusion results from the way that various clinicians use the term "paraphilia" and the criteria deemed necessary to meet the diagnosis. DSM-IV is not clear on this issue. Paraphilias have two major diagnostic criteria. The first (Criterion A) is that "recurrent, intense sexually arousing fantasies, sexual urges or behaviors" occurred over a period of six months or more. There is, however, no instruction on what frequency of fantasies, urges, or behaviors is necessary to meet the criterion of recurrent. Alas, "intensity " is equally undefined.

The result is that many mental health professionals consider Criterion A satisfied if there were two or more sex offenses over a period of six months or more. The second criterion (Criterion B) in DSM-IV states: "The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning." Then, on page 525 of DSM-IV, in addressing the requirement for clinically significant distress or impairment, it states: "...(e.g., are obligatory, result in sexual dysfunction, require participation of non-consenting individuals, lead to legal complications (emphasis added), interfere with social relationships)." That comment seems to indicate that incarceration is sufficient to meet the Criterion B requirement for impairment.

However, in the definition of mental disorder, on page xxi, DSM-IV states that, for a condition to be a mental disorder, it must be due to a dysfunction within the individual. Most significantly, the definition of a mental disorder goes on to state: "Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual as described above." This definition indicates that incarceration, in the absence of "dysfunction within the individual," would not qualify for meeting Criterion B under the paraphilias, i.e., incarceration without dysfunction is not sufficient to indicate impairment.

As seen in the above, there is much confusion regarding what is necessary to meet the diagnostic Criteria for a paraphilia. By selectively attending to only some aspects of the discussion in DSM-IV, one can diagnose a paraphilia based on the fact that the behaviors occurred at least twice over six months or more and resulted in incarceration. That is certainly a curious position for professionals to espouse, because, if it is made on that basis, the diagnosis does not require professional expertise. In spite of that, it is often argued in court that this approach is sufficient to meet the diagnosis of paraphilia. It is then argued that the diagnosis of paraphilia more-or-less, automatically meets the requirements for an SVP mental condition. This debate tends to totally confuse the jury and allows SVP evaluators to avoid dealing with the issue of inability to control behavior.

But SVP evaluators cannot avoid dealing with a determination of inability to control behavior by resorting to DSM-IV. Not only does DSM-IV not address the law, as discussed above, but the diagnosis of a paraphilia absent considerations for psychopathology is not generally accepted. The American Psychiatric Association in their Task Force report (1999) makes it very clear that a diagnosis of paraphilia should not be made if there is not also psychopathology, usually in the form of a compulsion. It was for this reason that the Task Force report concluded that most sex offenders do not suffer from a paraphilia.

The situation is further clarified by Abel (1989), who, in discussing the paraphilias, notes that: "A hallmark of the paraphilias is that the unusual or bizarre imagery or acts are insistently and involuntarily repetitive" (emphasis added). As noted by Dr. Abel, what distinguishes a paraphilia from a criminal sex offense is that, in the case of paraphilia, the individual is driven to the behavior, cannot control it, and engages in it on an involuntary basis. Sexual behavior (criminal or otherwise) that an individual chooses to engage in is not paraphilic.

The requirements for psychopathology or compelled behavior is seen clearly in the description of a paraphilic disorder described by Abel (1989). "There is a subcategory of rapists who, like other paraphiliacs (emphasis added), attempt to control their urges to rape, but, at times, the urge to commit rape exceeds their ability to control, and they offend. They feel guilt afterwards and, hence, the urges decline rapidly, only to recur at a late date to repeat the cycle."

A properly made diagnosis of paraphilia, meaning one based on the requirement that the behaviors were involuntary, would meet the statutory requirement under SVP that the offender was unable to control their dangerous behavior. However, note that a paraphilic diagnosis only meets the SVP requirements when the behaviors are involuntary. The individual may suffer from involuntary urges and fantasies, but unless those are translated into behavior, it does not constitute a mental condition under SVP. It may be important in some cases to keep in mind that involuntary urges or fantasies do not necessarily indicate involuntary behavior.

While this clarification is helpful, much difficulty remains in addressing the mental condition. The greatest dilemma is that there is essentially no scientific basis for determining when a person lacks the ability to control their behavior. There are some extreme situations in which reaching that conclusion seems inescapable (for example, individuals who are psychotic or otherwise mentally greatly impaired. However, almost all sex offenders are considered rational and not severely impaired, so that finding that they were unable to control a specific behavior at a specific instant is, for the most part, beyond the scope of mental health science.

The issue is: How does one discriminate between a person who lacks the ability to control their behavior from one who chooses (willfully) not to control their behavior? Melton, et al., (1997) presents a brief discussion of the notion of freewill versus determinism in science, and state (page 8):

> In the present context, the significance of these differing, underlying assumptions about motivation and freedom is that there is no basis in any of the prevailing models of abnormal behavior to differentiate "caused" or "overborne" behavior from behavior that is the product of free and rational choice.

To further complicate the picture, neither the courts nor the legislature have defined what is required for inability to control behavior (or volitional impairment); that is, they have not defined the rules in use by which one determines when an individual meets the statutory requirements for inability to control behavior. The legal and scientific issues involved in the concept of "inability to control behavior" is discussed in much detail by Janus (1997, 1998) and Janus and Nudell (1999).

Determining that an individual is unable to control any specific behavior requires that one can identify measures or indicators which discriminate between an individual who is unable to control their behavior from one who is unwilling to control their behavior. A most difficult task. To even approach the problem, one must have a model which identifies variables that differentiate between unable and unwilling.

The general model of a paraphilia (as discussed by Gene Abel (1989) above) is at least a good starting place. In that model, the individual is compelled to behaviors for which they have inhibitions. They only engage in the behavior when the compulsion overcomes their inhibitions. Following the behavior, they feel guilt. As the guilt subsides, the compulsion builds and the behavior repeats itself. This model strongly suggests, if not requires, that the individual does not want (at least at some level) to engage in the behavior. In psychological terms, we can speech of this behavior as being ego dystonic; that is, it is against the values or ego structures of the individual. In support of that notion, one would then attempt to identify the values of the sex offender and make a determination of whether or not the offence behavior was consistent or inconsistent with their personal values.

The above model also indicates that the behaviors would be repeated; however, it must be cautioned that repeated behavior by itself is not sufficient to indicate that the individual is unable to control it. Many criminal behaviors are repeated. In the SVP law, it is only behaviors repeated because the individual lacks the ability to control the behavior that is important; repeatedly choosing to engage in the behavior does not count.

Addressing the issue of "unable to control " dangerous behavior is the essential element under the legal requirements for an SVP mental condition. However, as seen from the above discussion, this is not an easy task. The first step that any evaluator must take in addressing this issue is to describe the approach or model which identifies factors that they will use to determine that the person was unable to control their behavior.

This will only be partially successful and, under the best of circumstances, it is difficult to find convincing data supporting an opinion that the individual was unable to control their dangerous behavior. This ought to be in favor of the sex offended, since it makes it difficult for the state to prove their case. Unfortunately, in court, this seems to frequently get turned around to where the respondent must produce evidence that they where able to control their behavior. It seems somewhat akin to having to prove that one is innocent.

APPROACHES TO CROSS-EXAMINATION

The discussion up to this point suggest three approaches to cross-examination of the SVP evaluator. Each of these will be addressed in the following, although, as will be noted, they are not entirely independent, and questions noted in one section may be appropriate in other sections as well. The general approach is to avoid as much as possible discussion about DSM-IV and volitional impairment and to move as directly as possible to addressing unable to control dangerous behavior.

- Now comes DSM-IV-TR and, although it claims that no substantive changes were made in the criterion sets, Criterion B for pedophilia (and some others) now states: "The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty." DSM-IV-TR represents a marked deviation in that a diagnosis of pedophilia (or any victim-involved paraphilia) does not require that the individual is distressed by the behavior or that there are any necessary impairments. This is further clarified on page 571:

  Because of the ego-syntonic nature of pedophilia, many individuals with pedophilic fantasies, urges, or behaviors do not experience significant distress. It is important to understand that experiencing distress about having the fantasies, urges, or behaviors is not necessary for a diagnosis of pedophilia. Individuals who have a pedophilic arousal pattern and act on these fantasies or urges with a child qualify for the diagnosis of pedophilia.

  If one stops at this point and considers that illegal child molest behavior automatically qualifies (so long as the fantasies, urges, or behaviors existed for six months or more) as pedophilia, it means that the diagnosis of pedophilia does not address the mental condition under SVP (or more generally, U. S. Supreme Court Kansas vs. Hendricks); that is, there is no indication that the individual was unable to control their dangerous behavior. In fact, noting that pedophilia is ego-syntonic indicates that it is behavior that the individual wants to engage in. They do not have inhibitions or values that make the behavior objectionable to them. Unable to control behavior seems to require ego-dystonic behavior (i.e., against their values). If the individual does not have inhibitions against the behavior, then there is nothing to stop the individual from willfully engaging in the behavior.

- Also note that this interpretation of the DSM-IV-TR criteria for pedophilia does not identify elements of a mental condition that require treatment. The diagnosis as now stated in DSM-IV-TR only requires that the individual is engaging in illegal and socially objectionable behavior; that, in and of itself, does not indicate psychopathology requiring treatment. Given that a person has a diagnosis of pedophilia, what are the treatment issues? There appear to be none, or at least none that address "sickness."

  There are at least two things about the new DSM-IV-TR that should make it clear that a DSM diagnosis does not address any legal issue. The first is the continuing, and perhaps even increasing, confusion as to what a paraphilic diagnosis is. Secondly, the diagnostic criteria for some paraphilias have changed from DSM-IV to DSM-IV-TR, and they may change even further in DSM-V. However, the law does not change with respect to the stated requirements for type and degree of impairment. Obviously, the variable diagnostic criteria of DSM cannot be used to address fixed criteria of the law.

Affect on Emotional or Volitional capacity and Predisposing:

Legal definitions of mental health concepts are generally couched in legal terms that do not correspond with terms used in the mental health profession. It is, therefore, necessary for the mental health professionals addressing these legal issues to first make it very clear to the court exactly how the legal definition is being addressed.

Leaving out some of the qualifying terminology in the SVP definition of a mental disorder and expressing it in a more streamlined form, we could state: "a condition affecting the emotional or volitional capacity that predisposes a person to the commission of sexually violent crimes." However, addressing these essential elements of the legal definition is not an easy task. The definition from a psychological point of view is vague, imprecise, and convoluted. Let us first consider the notion of emotional or volitional capacity

The notion of capacity is a particularly difficult topic to address. Mental or emotional capacities are not observable. What is observed is the expression of those mental or emotional capacities, and it is, for the most part, impossible to determine whether the individual has the capacity for any particular expression or whether they choose to limit expression of capacity. In casual conversations, and in non-professional literature, one finds frequent reference to mental or emotional capacities when, in fact, what is actually being noted is mental or emotional performance. In science, one cannot disregard the difference between capacity and performance; however, it would appear that the frequent statutory use of the word "capacity" is more in line with the common usage rather than a strict scientific concept.
It is probably non-productive to labor the issue of capacity versus expression in the SVP law. What does appear to be important, however, is to note that an "affect on capacity" can best be interpreted as an impairment; there does not appear to be any relevance for an affect on capacity which improves the capacity. The only interest is on a condition which reduces (i.e., impairs) that capacity. Therefore, it seems that the most reasonable interpretation of the clause "an affect on emotional or volitional capacity" is emotional or volitional impairment. While this may clarify the situation somewhat, there are still substantial problems,

and it appears that the notions of emotional or volitional impairment may, in fact, be redundant and that only the notion of volitional impairment is actually relevant.

Emotional impairment is almost a meaningless concept. There is no consensus among psychologists and neuroscientists as to what exactly emotion is, let along emotional impairment. Rather than labor over the meaning of emotional impairment, especially for consideration of the SVP law, it seems adequate to restrict the discussion to volitional impairment, because any emotional state which causes one to be unable to control their behavior affects volition. Also, the Supreme Court in Kansas vs. Hendricks noted that civil commitments had to be based on volitional impairment; nothing is mentioned about any other impairment. The focus is now one of defining volitional impairment.

Volition is not a scientific concept and has not been investigated or even defined in mental health research. It is a topic of much philosophical debate and is a term sometimes used in the law. Its meaning, however, seems restricted to its common language use. Webster defines volition as: "1. An act of making a choice or decision; also a choice or decision made; 2. The power of choosing or determining; will." Since there is no scientific definition of volition in psychology, we are limited to the common-language definition. Volition refers to the willfulness of a decision or choice, and it does not directly or exclusively determine the quality of the decision in terms of outcome.

The quality of one's decision is affected by a number of mental abilities, including intelligence, judgment, memory, creativity, etc. and any number of individual characteristics, such as impulsivity, timidity, cautiousness, etc. One could make a lengthy list; that is, there are many cognitive processes and individual characteristics which determine or shape the quality of one's decisions. None of these things have anything to do with volition or the willfulness with which one makes the decision. A highly intelligent person would generally make a better decision than someone of low intelligence, but both can make their decisions with full volition. The same is true for judgment, etc.

Predisposition is another knotty issue which, in the final analysis, may not be important. Predisposition refers to a condition existing prior to the act which is causally related to the act. In mental health science, that can only refer to a psychopathological process which existed prior to the first sex offense, which was, at least in part, a causal factor in the offense. It would be impossible to talk about predisposing or causal processes without referring to a theory of psychopathology. However, there is no general consensus regarding such theory and, most significantly, determining the existence of such psychopathological processes in an individual is a lengthy, complicated, and uncertain business. Almost certainly, there would be little consensus among different interpretations of what the psychopathological process involved. Many SVP evaluators claim that the offender is predisposed to sex offense recidivism because they have a history of such behavior. However, they are actually talking about a disposition and not a predisposition. However, pursuing this topic does not seem to be a highly fruitful line of inquiry. If an offender has a history of sex offending, and they are unable to control that behavior, it seems that one would probably be willing to concede that there is some psychopathology present which is associated with the behavior, even though one may not be able to determine what that process is. However, an evaluator cannot conclude that an offender is predisposed simply based on a history of sex offense behavior. To do so necessarily implies that all sex offense behavior is due to psychopathology, a conclusion with which few, if any, in the sex offender research community would agree.

Unable to Control Dangerous Behavior:

In the above, the notion of "an affect on emotional or volitional capacity" was reduced to volitional impairment. However, that analysis ignored the term "affect." A fundamental consideration has to do with the degree of affect intended in the original statement, or what is the degree of volitional impairment necessary to meet the statutory requirements. In the California SVP statute, there is a subsequent paragraph which includes the language "...has a diagnosed mental disorder which makes (emphasis added) the person a danger...." The key notion in that statement is that it is the mental disorder (mental condition), which controls the person's behavior, implying very strongly that the degree of the affect is such that it renders the individual unable to control their behavior. Thus, one can conclude that the statutory language of the SVP law is, in reality, equivalent to the U. S. Supreme Court's decision that the volitional impairment must be to the degree that the individual is unable to control their behavior.

Civil commitments in general require that the committed person lack the ability to control their dangerous behavior. The U.S. Supreme Court in Kansas vs. Hendricks noted that civil commitment requires that the person is volitionally impaired to the degree that they lack the ability to control their behavior. This has been supported in the California Supreme Court and appellate court decisions and in a Kansas Supreme Court decision. It seems firmly established that the SVP civil commitment requires that the individual is volitionally impaired to the degree that they lack the ability to control their sex offense behavior.

DSM-IV DIAGNOSIS:

The above section on the use DSM-IV diagnoses to meet SVP requirements was lengthy and fairly detailed. Many of the questions for cross-examination will be obvious from considering that material. The primary focus of the cross-examination is to show that DSM-IV diagnosis does not address the statutory language, and secondly, there is disagreement among mental health professionals as to what is required for a diagnosis of paraphilia The main strategy of the cross-examination is to spend as little time as possible cross-examining on DSM-IV. Evaluators are very comfortable talking about DSM-IV, and it will give them a chance to demonstrate their expertise to the jury, even though that expertise is irrelevant.

You may want to start your cross-examination in this regard by asking the evaluator if they think that it is necessary for a person to be unable to control their behavior (or that the behaviors are involuntary) for a diagnosis of paraphilia. If they say that it is, then address those issues and not the diagnosis. If they say that it is not necessary, than point out that the diagnosis is therefore, irrelevant to SVP.

If the above ploy does not work, then you must continue to address issues of DSM-IV. The next most productive approach is to establish that there are two (at least) major approaches to diagnosis of paraphilia, and that one of them requires that the behaviors are involuntary. Ask the evaluators if they know who Gene Abel is. Certainly they will, since he is one of the biggest names in the field. Then ask them if they are aware that Dr. Abel has indicated that a paraphilia requires involuntary behavior. Do they agree with that? If they do agree, then you have established that involuntary behavior is required, and that is equivalent to unable to control behavior. If they argue that Dr. Abel's opinion is only one of several, then ask them: If there are different opinions regarding how paraphilia is diagnosed, then how can it be used to address the legal definition? The legal definition is fixed and cannot change depending on how various mental health experts diagnose a paraphilia.

In the worst case, you may have to go through a lengthy cross-examination involving questions on the DSM-IV "Definition of Mental Disorder" (page xxi) and "Use of DSM-IV in Forensic Settings" (page xxiii). In that regard, ask the evaluator to read the definition of a mental disorder, paying particular attention to the part which specifies dysfunction within the individual. Ask the evaluator if they feel that being incarcerated is due to dysfunction within the individual or due to a conflict between the individual and society.

Point out to the evaluator that, under the paragraph "Use of DSM-IV in Forensic Settings," a diagnosis does not indicate any degree of impairment or ability to control behavior. Ask the evaluator if that is so, then how can they use a DSM-IV diagnosis to address issues of impairment in the SVP definition of a mental disorder? At the most basic level, you may have to ask the evaluators if the words "volition," "emotion," and "capacity" are even used in DSM-IV, and since they are not, how can DSM-IV address the statutory language of SVP law.

Emotional or Volitional Capacity:

Evaluators will often want to stick to the statutory language of the SVP law, which states "an affect on emotional or volitional capacity...."

The first task in cross-examination is to focus on the degree of effect (impairment) that the evaluator thinks is necessary to address the statutory criteria. The point of this ploy is to try to force the direction of the cross-examination back to the issue of inability to control behavior; it is an attempt to avoid discussing volitional and emotional capacity.

Ask the evaluator what degree of affect is necessary to establish the mental condition. It is impossible to even imagine what sort of response you will get from the evaluator. However, unless they volunteer that the affect is such that the person cannot control their behavior, then ask the evaluator if the affect is such that it renders the individual unable to control their sexually dangerous behavior. If they say it does, then you can question them regarding the basis for that conclusion. If the evaluator indicates that the degree of affect is not such that the offender was unable to control their behavior, you may have an appeals issue, in that the evaluator did not address the essential element of the requirement for a mental condition under the SVP law. How this plays out will depend on the status of higher-court clarifications of the SVP mental condition.

If the above ploys fail, you may be forced to address the statutory language. Whatever terms are used by evaluators, the first question is to ask them to define their terms. You must establish that, in addressing an affect on capacity, you are actually talking about impairment. That should be fairly straightforward. Ask the evaluators if there are any affects on capacity of interest under

the law which do not degrade the capacity. Then, does not degradation of capacity indicate impairment in that function? Therefore, when we are talking about an affect on emotional or volitional capacity, are we not, in fact, talking about emotional or volitional impairment?

You may next want to establish that the primary consideration is volitional impairment and that emotional impairment does not in and of itself make any sense. Can they describe an emotional impairment that has an affect on sex offense behavior that does not have its affect by impairing the individual's ability to make a free choice; that is, it involved volitional impairment. Then ask the evaluator to define volition. There is no science or psychological research to fall back on, and one only has the common-language definition of volition, which is one's ability to make a free choice. After the evaluator has defined volition, ask the evaluator if there is any research regarding volition and what is involved in volitional impairment.

Evaluators will often claim that poor quality decisions by the offender indicate volitional impairment. Ask the evaluator what psychological constructs (concepts) or processes affect decision quality other than volition. Hopefully, the evaluator will be able to come up with a few things. If not, you may have to ask them questions: What about general intelligence? What about judgment? Then ask the evaluator how they determine the difference between poor judgment and impaired volition. Are there not several cognitive processes which affect decision quality that have nothing to do with volition? How does one determine when volition has impacted the decision quality?

Unable to Control Dangerous Behavior:

There are undoubtedly very few sex offenders who are unable to control their sexually dangerous behavior, and it is precisely that they are unable to do so that is the key. Nonetheless, that is the requirement of the law, and the fact that we do not like sex offenders is not sufficient for commitment. This is a very difficult sell to the courts. You are in the position of trying to convince the jury that the offender was able to control their behavior and offended essentially because they wanted to. While that may put you on good legal grounds, the argument has little jury appeal. It is, for this reason, that many defense attorneys find this approach frustrating and untenable. However, that is what the law requires. It is up to the defense attorney to somehow cajole, appeal, or threaten the jury into obeying the law.

The first line of inquiry with the expert is to ask them what they would look for in order to determine that a person is unable to control their behavior. How would they discriminate between a person who is unable to control their behavior from one who is unwilling to control their behavior? Another line of questioning is to ask the evaluators what evidence they found in the events of the sex offense which indicated that the offender was unable to control their behavior. Did they appear to want to be engaged in the behavior? Did they express guilt immediately afterwards? In this regard, note that guilt expressed after incarceration would most likely be viewed as self-serving and not an honest expression of guilt. Did the victims report anything consistent with the offender's being unable to control their behavior? Did the probation report indicate the presence of mitigating circumstances? Certainly, if an offender was so disturbed that they were unable to control their behavior, there should have been some mitigating circumstances. Finally, if the individual was so disturbed that they were unable to control their behavior, does the evaluator think that there should have been some mental defense issues raised in the trial? Was there any evidence for such issues at the trial?

Evaluators in California, when pressed for evidence to indicate that the offender was unable to control their behavior, have come up with a few arguments. Frequently they argue that the sex offender repeated the behavior at the risk of being incarcerated indicating that they could not control it. Another argument is that the behavior was impulsive, implying that it was not willful. Occasionally, one hears an argument that the behavior was ego dystonic, which is one of the better arguments, but one of the most difficult to prove. Frequently, evaluators argue that the offender has uncontrollable urges and fantasies, and that somehow this indicates that the behavior is also currently not under their control. Each of these is explored below.

1. **Repeated Behavior**

This is probably the most frequent explanation of why sex offenders behavior is not under their control; that is, they committed a crime, were arrested and incarcerated, got out and committed other offenses. The evaluators try to establish that this indicates that the offender was unable to control their behavior, because they committed a crime in spite of the fact that they knew that they would be incarcerated and that they were engaging in risky behavior.

The first question that you will probably want to ask the evaluator is if they feel that all repeat offenders are unable to control their criminal behavior. Bank robbers, drug dealers, kidnappers, what have you. How are these criminals any different than sex offenders?

Another line of questioning addresses the evaluator's conclusion that the risk taken by the offender when they reoffend after having been previously incarcerated indicates inability to control behavior. The major fallibility in that line of argument is that evaluators almost never determine what the offender's perceived risk was at the time when they committed the offense. Most offenders do not think that they are going to get caught, and some of them do not care. It is the perceived level of risk that is relevant to whether or not the offender was unable to control their behavior, not an objective assessment of the risk. You will want to ask the evaluators if they determined what the offender's perception was of the risk involved. Did the offender think that they were going to be caught?

There is also another line of questioning relative to the risk assessment and that has to do with the fact that many people are involved in risky behaviors on a repeated basis: sky divers, race car drivers, bungee jumpers, etc. Does the evaluator consider that all persons who engage in risky behaviors are unable to control their behavior? The point is that risky behavior does not indicate that one is unable to control it. It only indicates that one is ignorant of the risk or willing to accept the risk.

2. Impulsive Behavior

One of the more frequent arguments by evaluators that the offender was unable to control their behavior is to show that their behavior was impulsive and/or that the offender is generally impulsive. However, impulsivity is a general feature of antisocial personality disorder, and some 70% of prison inmates are diagnosed antisocial personality disorder. Does the evaluator think that 70% of the prison population is unable to control their dangerous behavior?

As another line of inquiry, you might ask the evaluator to turn to DSM-IV, page 609, and read the description of impulse control disorder, which states: "The essential feature of impulse control disorders is a failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others. For most of the disorders in this section, the individual feels an increasing sense of tension or arousal before committing the act, and then experiences pleasure, gratification, or relief at the time of committing the act. Following the act, they may or may not be regret, self-reproach, or guilt."

Note the definition states that there "is the failure to resist." It does not state that the individual lacks the ability to resist. Michael Popkin, M.D., (1985) reviews the DSM-IV impulse control disorders and notes that, for any impulse control disorder: "The act is ego syntonic in that it is consonant with the immediate conscious wish of the individual."

Also, there is a study by Prentky, et al., (1995) in which the rapist recidivism was studied in terms of their degree of lifestyle impulsivity. "Impulsivity" was defined in terms of general impulsivity in many aspects of the offender's life, and classification into high or low impulsivity groups was based on judgments involving five variables: unstable employment; reckless behavior, with no regard for consequences; repeated instances of aggressive or destructive behavior; disruptiveness at school or work; and history of fighting. In that study, one views impulsivity as a general feature in the offender's life, and none of these people would be considered to be unable to control their behavior.

3. Uncontrollable Desires or Urges

This is one of the favorite topics of evaluators, especially if the offender has continued to engage in pornography, has expressed sort of deviant fantasies, or has "failed" a phalometric assessment. However, having uncontrollable urges is not a problem unless one is driven to act on those urges. Probably everyone has some degree of uncontrollable urges. In fact, many of our sexual urges are uncontrollable and are the result of a direct response to a stimulus. However, few of us are compelled to act on those urges, and few are unable to control behavior that might result from those urges. The key line of questioning for the expert in this area is to determine what evidence they have that the offender was unable to control their behavior and if the evaluator feels that the existence of urges necessarily implies behavior.

In this regard, note that, in the definition of some of the paraphilias (particularly pedophilia) in DSM-IV-TR, the presence or urges of behaviors over any period of time does not constitute a paraphilia unless the individual acts on those urges or is distressed by them. The DSM-IV makes a definite distinction between urges and behavior, and the existence of one does not require the other.

4. The Behavior was Ego Dystonic

If the evaluator could actually establish that the sex offense behaviors were ego dystonic, they would have a fairly solid argument; that is, if the sex offense behavior was against the offender's values or inhibitions, but they engaged in the behaviors

anyway, it implies that they were compelled to the behavior to the degree that it overcame their values or inhibitions against the behavior. When an offender engages in ego dystonic behavior, one would expect to find some evidence of guilt or sex self-condemnation following the behavior.

The first thing that you will want to question the evaluators about is what information they have about the offender's values or inhibitions; that is, how do they determine that the behaviors were ego dystonic. Determining a person's ego structure is not a simple task, and would require a lengthy period of interaction to even begin to guess what it is. You will want to ask the evaluators very specifically what the sex offender's values are which would inhibit sexual behavior.

SEXUAL DEVIANCE

Sexual deviance can be defined in a number of ways, including: deviance from a statistical norm, a social norm, or a mental health norm. The use of the term in one context does not establish meaning in any other context; that is, measures of statistical sexual deviance (i.e., phalometric) may predict sexual recidivism, but there is no necessary implication that statistical sexual deviance has anything to do with deviation from mental health (psychopathology).

A recent book Sexual Deviance (1997), edited by Laws and O'Donohue, explores the concept of sexual deviance. The authors point out in the introduction, on page 1:

This book is devoted to explicating what we know about those kinds of sexual deviance that are currently regarded by most mental health professionals as the major ones. The particulars surrounding these negative judgments made by mental health professionals about some sexual practices are, unfortunately, not so clear. For example, it is not clear on what grounds humans in general, or mental health professionals in particular, either do evaluate or should evaluate sexual practices. That is, should sexual practices be evaluated on the grounds of whether they harm others (If so, what kinds of harm, and how much harm, are necessary for the behavior to be regarded as a mental disorder?), or whether the sexual practices are unhealthy (utilizing this criterion is clearly problematic as it simply pushes the questions to how properly healthy practices can be distinguished from unhealthy ones), or whether the behaviors deviate from a statistical norm, or whether the behaviors seem to be maladaptive in some evolutionary sense? The lack of well-supported criteria upon which to distinguish permissible or healthy sexual behavior from unhealthy, deviant, and proscribed behavior probably is related to the inability of mental health professionals to provide clear demarcations of what distinguishes normal from abnormal behavior.

The problem is, first, one of identifying criteria or indicators of sexual deviancy and then developing methods for their measurement. As Laws and O'Donohue (1997) point out in their discussion beginning on page 5, under "Assessment Problems," constructs related to sexual deviance are among the most difficult to measure, but it is exactly this area of exploration which is most critical for advancement in our understanding of sexual deviancy.

It is clear from the above that sexual deviance is not a well-defined concept, and determining when behavior is sexually deviant in the sense of psychopathology is so difficult as to be essentially impossible. In spite of this, evaluators frequently introduce the term "sexual deviance," referring to the fact the behaviors were illegal at the same time, implying very strongly that it establishes the presence of psychopathology. This fits in, unfortunately, very well with the juries' preconceived notions or prejudices regarding sex offenders. They find the behaviors sickening and conclude, therefore, that the sex offender is sick. In questioning the experts in this area, you will want to insist that they indicate the basis of their opinions regarding sexual deviance and cite specific references. Are their notions and definitions accepted in the field? The goal of this line of inquiry is to demonstrate to the jury that the very notion of sexual deviance is not well understood and, secondly, that the evaluator has not identified psychopathology. Although prediction is not addressed in this paper, I should point out that a frequent ploy on the part of evaluators is to identify sex offense behavior as sexual deviance and then to consider sexual deviance as an established factor in predicting future recidivism. It is, therefore, important that you establish exactly what the evaluator is talking about when they use the term "sexual deviance."

PSYCHOPATHY AND ANTISOCIAL PERSONALITY DISORDER

Antisocial personality disorder has never been a legitimate purpose for civil commitments (American Psychiatric Association 1999) and, in the legal arena, it has never been recognized as a mental defense or a factor which reduces culpability. Psychopathy, a term sometimes used synonymously for antisocial personality disorder, is a concept coming into vogue in SVP evaluations. As described, a psychopath is a very bad person, and this is frequently used as sufficient justification for

commitment under SVP. The PCL-R is currently used as part of the SVP evaluations in California, and the practice appears to be widely incorporated outside of California.

The notion of psychopathy has a relatively long history in psychiatry and psychology. An excellent overview and discussion is provided in Millon (1981), who also makes it clear that psychopathy and antisocial personality disorder are not equivalent. Hare (1996) has also addressed the differences in these disorders.

There is a central issue introduced by the very notion of psychopathy, and that has to do with its relationship to volitional impairment and inability to control behavior. At the onset, I would propose that, while psychopaths, as measured by a high PCL-R score, are an especially dangerous group and prone to a high rate of criminal recidivism, their criminal behaviors are not due to psychopathology, nor is there necessarily a lack of volitional control.

Hare (1985, etc.) developed the psychopathy checklist, originally consisting of twenty-two items based on Cleckley's conceptualization of psychopathy. Hare (1990) later revised the psychopathy checklist into a twenty-item test, currently referred to as the PCL-R. Analytic studies revealed that the PCL-R is composed of two correlated factors. The first factor, known as the personality dimension, measures interpersonal and affective traits, including superficiality, manipulativeness, pathological lying, lack of empathy, and a grandiose sense of self-worth. The second factor, known as the behavioral dimension, describes a chronically unstable, antisocial, and socially deviant lifestyle.

There are two major prevailing notions about the nature of psychopathy. One formulation views psychopathy as a continuum in which the manifestations of symptoms with varying degrees of intensity represent varying degrees of psychopathy. In this view, the psychopath is more or less created by background factors, most notably some form of deprivation. Another view, Harris, et. al., (1994) considers psychopathy to be a discreet classification; that is, one is either a psychopath or one is not a psychopath. In this view, the intensity of symptoms may represent the influence of developmental, cultural, and other factors.

The meaning of a score on the PCL-R is conceptualized differently in these two views. In the first view, the PCL-R represents a measure of the intensity of the psychopathic symptoms. In the second view, it represents the probability that one is a member of the psychopathic classification. Quinsey (1997, 1998) reported growing evidence not only of a discreet classification for psychopathy but also for a genetic basis.

Harris, et al., (1994) and Quinsey, et al., (1998) also addressed the issue of the interpretation one has to give to psychopathy if it is, in fact, genetically determined and represents a discreet class. This genetic pattern is not viewed as the result of recessive genes that could be considered "abnormal." It is instead seen as a genetically based adaptation pattern which has emerged in the course of evolution. If this view is correct, psychopathy cannot be viewed as a mental disorder, mental defect, or mental illness, but instead represents an adaptively successful way of surviving.

Hare (1998) has also commented on the different interpretations of psychopathy:

In most jurisdictions, psychopathy is considered to be an aggravating rather than a mitigating factor in determining criminal responsibility. This is the way it should be, in my view. However, I've been asked whether research evidence of the sort described above affective deficit, thought disorder, brain dysfunction might lead some to view psychopathy as a mitigating factor in a criminal case. As one psychiatrist put it, perhaps psychopathy will become "the kiss of life rather than the kiss of death" in first-degree murder cases. This would be disturbing, given that psychopaths are calculating predators whose behavior must be judged by the rules of the society in which they live. However, the issue is really one for the judicial system to settle. If psychopathy was to be used as a defense for a criminal act, though, the flip side of the coin would be that the disorder is currently untreatable, and civil commitment would probably be more or less permanent.

In summary, numerous conceptual formulature and theories regarding psychopathy have been suggested. Most notable, however, is a lack of reference to cognitive impairment (including volition) being part of the psychopathic make-up.

The primary line of questioning of the SVP evaluators if they use psychopathy or antisocial personality disorder to address the issue of mental condition focuses on some of the issues previously discussed. Most specifically, if the offender is unable to control their sexually dangerous behavior, which would indicate that, the behavior was something that they did not want to engage in. Ask the evaluators to describe the characteristics of psychopathy (or antisocial personality disorder). Is there anything in that description which would indicate that the person had inhibitions about engaging in any self-gratifying behavior? Are not

the primary psychopathic features of self-gratification, lack of concern for others' feelings, and lack of concern for consequences inconsistent with inability to control behavior?

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