Defining Mental Disorder When It Really Counts: DSM-IV-TR and SVP/SDP Statutes

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Civil commitment under the sexually violent predator (SVP) statutes requires the presence of a statutorily defined diagnosed mental disorder linked to sexual offending. As a consequence of broad statutory definitions and ambiguously written court decisions, a bright line separating an SVP mental disorder from ordinary criminal behavior is difficult to draw. Some forensic evaluators reject whole categories of DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders: Text Revision) diagnoses as qualifying disorders (e.g., personality and substance abuse disorders), while others debate whether recurrent rape constitutes a paraphilic disorder. We argue that the ramifications of the SVP process, in representing both the balancing of public safety and the protection of an individual's right to liberty, demand that decisions about what is a legally defined mental disorder not be made in an arbitrary and idiosyncratic manner. Greater clarity and standardization must come from both sides: the legalists who interpret the law and the clinicians who apply and work under it.

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Perhaps one of the most controversial areas in forensic mental health is the civil commitment of sex offenders upon completion of their prison sentences. Several states have enacted either Sexually Violent Predator (SVP) or Sexually Dangerous Person (SDP) provisions.[1,2] The SVP/SDP laws are meant to protect society from the relatively small group of sex offenders who have both a mental disorder and a high risk of recidivism. The criteria necessary for categorizing an individual as an SVP/SDP include findings that the person was convicted of offenses determined by the state to constitute a sexually violent crime; the person has a diagnosed mental disorder; and as a result of that disorder, the person is likely to engage in sexually violent offenses. Individuals identified as an SVP/SDP are civilly committed for treatment in designated mental health facilities after serving their prison terms. The period for an SVP/SDP commitment is indefinite.

SVP/SDP statutes exist because of legislatures' concern about the release of known dangerous sex offenders from prison into the community. Notorious sex crimes committed by released offenders serve to reinforce society's acceptance of laws designed to identify extremely dangerous incarcerated sexual offenders who represent a threat to public safety. However, these laws have not been without controversy.

As civil commitment can only be initiated if the individual is determined to harbor a mental disorder, some in the psychiatric community view the SVP/SDP laws as an inappropriate use of psychiatry to promote preventive detention.[3] Those who oppose the laws worry that in pursuing the worthwhile effort to reduce sexual crime, these laws violate individual civil rights and could provide a slippery slope toward

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psychiatric commitment for whatever behaviors society deems deviant at any given time.

On the other hand, the U.S. Supreme Court has considered these concerns and has held the SVP process to be constitutional, fulfilling the intent of civil commitment. Those who support the statutes view them as a necessary way of protecting potential victims from a small group of highly dangerous predators.

The conceptual debate between these camps is likely to continue as long as SVP/SDP laws exist, and cannot be settled easily. Even among those who do not oppose the SVP/SDP civil commitment statutes, there is much debate about what is meant by a diagnosed mental disorder and what disorders should qualify.[1,4–6]

The rationale for SVP/SDP commitment is the presence of a statutorily defined "diagnosed mental disorder," which is linked to sexual offending. But what is meant by that term? The ramifications of the SVP/SDP process, in representing both the balancing of public safety and the protection of an individual's right to liberty, demand that decisions about what is a legally defined mental disorder should not be made in an arbitrary and idiosyncratic manner. The purposes of this article are to discuss the statutory and case law definitions of diagnosed mental disorder and what guidelines are offered as to who qualifies for an SVP/SDP civil commitment; to examine what the Diagnostic and Statistical Manual of Mental Disorders: Text Revision (DSM-IV TR)[7] can and cannot offer to the process and what disorders may qualify; and to propose a conceptual template toward developing expert consensus in rendering SVP/SDP diagnoses.

Definition of SVP/SDP Mental Disorder by State Statutes

The current SVP/SDP statutory laws must not be confused with the earlier sexual psychopath laws (enacted in the 1930s and repealed by the 1980s). A brief historical overview serves to place the implementation of the current SVP/SDP statutes in context.

The intent of the sexual psychopath laws was to identify convicted sex offenders amenable to treatment who would then be placed in a psychiatric hospital in lieu of prison. These sexual psychopath laws were formulated during a period of optimism that mental health interventions could cure offenders[3] and that hospitals were both more humane and more effective than prisons. The laws fell into disfavor in the 1980s in reaction to well-publicized cases of sex offenders who committed heinous acts after purportedly successful completion of their hospital treatment.

Another important contextual factor occurred at approximately the same time. There was a trend away from indeterminate prison sentences that gave judges and parole boards considerable discretion. Instead, courts applied fixed sentencing for similar crimes. Determinate sentencing reflected, in part, a shift in the criminal justice system from rehabilitation to incapacitation. The purpose of determinate sentences was to increase fairness and reduce possible bias. An unintended consequence was that some high-risk sex offenders served shorter sentences than they would have under an indeterminate scheme.

Despite the move to repeal sexual psychopath laws, civil commitment statutes emerged in the 1990s for a subpopulation of dangerous sex offenders. Earl K. Shriner was such an individual.[3] Mr. Shriner served a 10-year term for the kidnap and assault of two teenaged girls. Two years after his release from custody, he sodomized a seven-year-old boy and cut off his penis. This case and the public outcry that ensued led the state of Washington to be the first to enact an SVP law. The purpose was to identify sex offenders who should be civilly committed because of their mental disorder, which predisposes them to dangerous sexual behavior.

Currently, most states with SVP/SDP laws define the qualifying mental disorders in very similar terms. The common definition of a diagnosed mental disorder is, "a congenital or acquired condition affecting the emotional or volitional capacity that predisposes the person to the commission of criminal sexual acts in a degree constituting the person a menace to the health and safety of others" (Ref. 1, p 473).

This legal definition is remarkably vague and difficult to apply in specific cases. For example, it is not clear why both congenital and acquired conditions are specified, as these together cover the territory of all conditions. The terms "emotional and volitional capacity" seem to form an important part of the definition but are not defined further. Nor do these terms have clear definitions within psychology or psychiatry. The term predisposes is never defined precisely, so it is not clear what degree is required before the statutory definition is met.

Perhaps absent most in the definition is any indication of which mental disorders might warrant an SVP/SDP civil commitment. Case law emerging in the various states has also been ambiguous on this question.[1] Moreover, the legal reasoning provided in the states' case decisions is not usually clear, specific, or clinically helpful. In summary, the statutory definitions across the states are so broad that they defy precise guidance as to what warrants a designation of an SVP/SDP mental disorder.

Definition of Mental Disorder: U.S. Supreme Court

The U.S. Supreme Court twice reviewed SVP matters, in *Kansas v. Hendricks*[8] and *Kansas v. Crane*.[9] On each occasion, the Court found the process to be constitutional. In both cases, the requirement of a mental abnormality coupled with dangerousness was cited as a predicate for civil commitment. Moreover, the Court recognized the historical view that restraining dangerous mentally ill persons for treatment via civil commitment has not been considered punishment (as articulated in *Jones v. U.S.*[10]).

In *Kansas v. Hendricks*, Mr. Hendricks had a long history of sexual molestation of children. He admitted to having sexual desires for children, urges that he could not control when he was under stress. Mr. Hendricks was given the diagnosis of pedophilia, a disorder that the Kansas trial court qualified as a mental abnormality under the Kansas SVP Act. However, the Kansas State Supreme Court invalidated the SVP Act on the grounds that mental abnormality did not satisfy due process, in that involuntary civil commitment must be predicated on a mental illness. The U.S. Supreme Court reversed the State Supreme Court's ruling, noting that states were left to define terms that were of a medical nature that have legal significance. The Court ruled that mental abnormality, as defined by the Kansas SVP statute, satisfied substantive due process requirements for civil commitment: "it couples proof of dangerousness with proof of some additional factor, such as 'mental illness' or 'mental abnormality' " (Ref. 8, p 346).

What was this mental abnormality according to the U.S. Supreme Court? The Court, in the majority opinion, stated that involuntary commitment statutes have been upheld consistently to detain people who are "unable to control their behavior and thereby pose a danger to the public health and safety" (Ref. 8, p 346), provided that proper procedures and evidentiary standards were followed. The Court underscored that state legislatures were not required to use the term "mental illness," and that the states were free to use any similar term. In reviewing the Kansas statute, the Court noted that there must be "a finding of future dangerousness" that then "links that finding to the existence of a 'mental abnormality' or 'personality disorder' that makes it difficult, if not impossible, for the person to control his dangerous behavior" (Ref. 8, p 358).

How would this U.S. Supreme Court ruling fit with contemporary DSM-IV-TR[7] nomenclature? In the *Hendricks* case, the DSM-IV[11] diagnosis at issue was pedophilia, and was one found to correspond with the legally defined mental disorder. But would other disorders qualify or comport within the broad meaning offered by the Court?

In *Kansas v. Crane*,[9] the Court had an opportunity to rule on this issue. Mr. Crane, a previously convicted sex offender, was diagnosed as having exhibitionism and antisocial personality disorder. While the experts believed that exhibitionism alone would not support a classification as an SVP, they opined that the combination of the disorders would meet SVP criteria. Mr. Crane was declared an SVP, and the case was appealed.

The Kansas State Supreme Court reversed the lower court's finding and interpreted the *Hendricks* case as requiring, " 'a finding that the defendant cannot control his dangerous behavior'—even if (as provided by Kansas law) problems of 'emotional capacity' and not 'volitional capacity' prove the 'source of bad behavior' warranting commitment" (Ref. 9, p 411). The case was then appealed to the U.S. Supreme Court. Kansas argued that the State Supreme Court wrongly interpreted *Hendricks* as requiring that it must always be proved that a dangerous individual is "completely unable to control his behavior" (Ref. 9, p 411).

The U.S Supreme Court held that there was no requirement for a total or complete lack of control. The Court wrote that lack of control was not absolute, and if such an approach were used it would, "risk barring the civil commitment of highly dangerous persons with severe mental abnormalities" (Ref. 9, p 407).

The Court recognized the important distinction between the civil commitment of dangerous sex of-

fenders from other dangerous persons, for whom criminal proceedings would be more proper. The Court reasoned that such a distinction was necessary; otherwise, civil commitment would become a "mechanism for retribution or general deterrence" (Ref. 9, p 407). However, the Court never specified how to make this differentiation. Nor did the Court define its own conception of a qualifying "mental disorder."

In *Crane*, the Court acknowledged that no precise meaning was given to the phrase, "lack of control." The Court wrote:

> [I]n cases where lack of control is at issue, "inability to control behavior" will not be demonstrable with mathematical precision. It is enough to say that there must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis, and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case [Ref. 9, p 413].

In both *Hendricks*[8] and *Crane*,[9] the Court avoided offering specific guidance as to what mental condition would support "proof of serious difficulty in controlling behavior." Rather, the Court acknowledged that states should have "considerable leeway in defining the mental abnormalities and personality disorders that make an individual eligible for commitment" (Ref. 9, p 413). While such allowance has been granted to the states, as mentioned, the states have remained equally nonspecific on this point.

In *Crane*, the Court considered whether an SVP mental abnormality could be justified solely on the basis of emotional as opposed to volitional impairment. Mr. Crane carried the dual diagnoses of exhibitionism and antisocial personality disorder (with the Court citing the DSM-IV[11] for reference); the experts believed that these diagnoses impacted his emotional capacity. The Court acknowledged that in *Hendricks,* the discussion was limited to volitional disabilities, such as pedophilia (referencing the DSM-IV criterion), which involved what the layperson might describe as a lack of control. The Court wrote that they had not drawn a clear distinction between a purely emotional versus volitional sexually related mental abnormality. They further noted that there might be considerable overlap between defective understanding and appreciation, and the inability to control behavior. The Court stated that they had no occasion to consider in either *Hendricks* or *Crane* whether civil commitment on the basis of emotional abnormality would be constitutional.

Ultimately, the Court's commentary on the terms volitional and emotional impairment is not particularly useful to those who conduct SVP/SDP evaluations. Nonetheless, even in *Kansas v. Hendricks*, an egregiously clear case of sexual deviance, in which a man asserted that the only barrier that could keep him from sexually assaulting children was death, the U.S. Supreme Court filed a narrowly ruled decision. In the five-to-four decision, the swing voter, Justice Kennedy, wrote a separate opinion cautioning against overly broad interpretations of the boundaries of suitable mental disorders.

The U.S. Supreme Court holdings are largely silent and unhelpful in defining clearly what constitutes an SVP/SDP mental disorder. There is the instruction to consider the features of the case to determine the mental abnormality. Can a personality disorder qualify as an SVP/SDP mental disorder alone, or must it be coupled with a sexual deviancy disorder? Moreover, what mental abnormality is sufficient to distinguish between the cases of a dangerous sex offender and an ordinary criminal?

Definition of Diagnosed Mental Disorder: DSM-IV-TR

Given the vagueness of the Supreme Court's decisions coupled with the states' broad and ambiguous definitions encompassed in the SVP/SDP statutes, one might hope that the DSM-IV-TR[7] would provide clearer guidelines on what constitutes a mental disorder. Unfortunately, the introduction of the DSM-IV-TR openly states that it is unable to provide a precise definition of a mental disorder:

> Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies the precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions [Ref. 7, pp xxx-xxxi].

Although the concept of mental disorder is crucial to both psychiatry and to the SVP/SDP laws, it is impossible to define well in the abstract. In practice, forensic clinicians use the DSM-IV-TR to describe mental disorders present in an individual. The courts, however, have not provided clear indications about which of these are applicable to the SVP/SDP statutes.

In the introduction, the DSM-IV-TR addresses its use in forensic settings:

> In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability [Ref. 7, p xxxiii].

This caution in the introduction emphasizes the need for a case-by-case analysis of the elements present in the individual and its correspondence to the legal definition of an SVP/SDP diagnosed mental disorder. Moreover, the cautionary statement does not imply that the DSM-IV-TR cannot be used to justify SVP/SDP civil commitment, as may be concluded erroneously if no further review of the caution were undertaken. The DSM-IV-TR offers a widely accepted method of defining and diagnosing mental disorders and provides the means of conveying to the trier of fact the best information available on psychiatric disorders. In both *Hendricks*[8] and *Crane*,[9] the U.S. Supreme Court recognized the DSM-IV[11] classification system when referring to the diagnoses rendered.

Another potential misinterpretation of the DSM-IV-TR is that the mere presence of a specific disorder in an individual is equivalent to that person's having met the legally defined mental disorder. The introduction states explicitly:

> Moreover, the fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time [Ref. 7, p. xxxiii].

Bearing this caution in mind, a clinician conducting an SVP/SDP evaluation should not rely on the diagnosis alone to conclude that all persons with such a diagnosis are predisposed to reoffend sexually.

DSM-IV TR Mental Disorders: Which Qualify for an SVP/SDP Mental Disorder?

As indicated earlier, the statutes and the U.S. Supreme Court have not delineated what specific mental disorders do or do not qualify for an SVP/SDP commitment. Therefore, it may follow that any DSM-IV-TR diagnosis could render a person eligible for commitment as long as it can be demonstrated that such a condition predisposes the person to committing dangerous sexual acts. But which ones should count for an SVP/SDP commitment?

Pedophilia

This disorder is probably the most easily identified and supported mental disorder in SVP/SDP cases. Pedophilia is widely recognized as sexual deviance, and the DSM-IV-TR criterion sets for this disorder are well defined. Those who meet the diagnosis of pedophilia engage in deviant urges, fantasies, and behaviors over an extended period. Such individuals are distinguished from those who engage in sexual activity with children that may be short-term and situational (e.g., incestual context during divorce or other stress, influenced by intoxication).

One area of debate is whether diagnosed pedophilia can ever be in remission. Some evaluators believe that a prior remote pattern of pedophilic behavior does not mean that the disorder is current. Such evaluators may argue that the remoteness of the acts and the individual's lack of endorsement of current pedophilic urges and fantasies justify an in-remission categorization. However, DSM-IV-TR describes pedophilia as tending to be chronic and lifelong, with the expression of sexual deviancy waxing and waning in response to opportunity, stressors, or interaction with comorbid disorders. In addition, those who are in custody do not have the opportunity to engage in deviant sexual behavior with children, nor are they very likely to endorse pedophilic urges and sexual fantasies in an adversarial context. Thus, a conclusion that the disorder is in remission would be weak in such circumstances. Careful consideration of the case facts and other data (e.g., treatment variables, physical debilitation) is necessary before a conclusion that the pedophilia is in remission can be justified for

those who have been in custody with the lack of opportunity to reoffend.

Paraphilia NOS

The disorder, paraphilia not otherwise specified (NOS), nonconsenting person, has been used most frequently to diagnose the presence of sexual deviancy in the form of coercive sexual contact, primarily for the crime of rape. This diagnosis is given to distinguish the criminally inclined individual who rapes as a part of a broad repertoire of illegal activities from the rapist driven by deviant sexual urges—namely, arousal to coercion.

This is probably the most controversial concept in SVP/SDP evaluations and one that has a long and much misunderstood history. During construction of the DSM-III-R[12] in 1985, the suggestion was made to add paraphilic coercive disorder as a separate category in the paraphilia section. Researchers in the area supported this suggestion; however, there had been little systematic research on the usefulness, reliability, validity, or definition of the proposed disorder. Moreover, significant debate ensued in a 1985 DSM conference about categorizing rape behavior as a mental disorder. There was considerable concern that such a disorder could be used in forensic settings to exculpate rapists. Consequently, the disorder was not included in the DSM-III-R. In the DSM-IV,[11] new disorders for inclusion had to demonstrate a high degree of empirical support. There was no suggestion for including a category for coercive sexual disorder in the DSM-IV, nor in the Text Revision.[7] Paraphilic coercive disorder is not mentioned in the examples of paraphilia NOS, and it is not included in an appendix of suggested diagnoses for further study. The basis for the exclusion of a separate coercive sexual disorder in the DSM-IV was that there were insufficient data to support this disorder.

Unfortunately, the DSM IV wording of paraphilia was not thought out carefully, which has led to much misinterpretation, nor was it corrected in the Text Revision. In DSM-III-R, Criterion B included distress or acts. In DSM-IV, the acts element was referred to as behaviors under Criterion A and remained so in DSM-IV-TR. The DSM-IV-TR describes the essential features of a paraphilia as, "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors . . ." (Ref. 7, p 566). The use of "or behaviors" was an inadvertent placement and in no way meant to signify that a paraphilia could be diagnosed based on acts alone. Rather, the behaviors were meant to signify the culmination of urges and fantasies. This distinction is necessary to separate paraphilia from opportunistic criminality. The other misleading aspect was the narrative in the introduction of the paraphilias that one type was nonconsent. The term nonconsenting persons was meant to apply only to exhibitionism, voyeurism, and sadism. It was not meant to signify rapism specifically; rape was not included as a coded diagnosis nor as an example of NOS. While there may be cases where the diagnosis is justified purely on the basis of rape behavior, it was never intended to convey that the acts alone would be paraphilic. Some rapes may be triggered by opportunity, others may occur in the context of intoxication-related disinhibition, and some may reflect character disorder or other nonparaphilic pathology.

The discussion regarding paraphilic coercive disorder was not widely promulgated to the general clinical community, and the confusion regarding paraphilia NOS is understandable. However, now that this information is disclosed in a public forum, SVP/SDP evaluators should take notice of the current clarification and of the meaning of "or behaviors" in the narrative descriptor of this set of disorders. The use of paraphilia NOS to describe repetitive rape cannot be justified on the basis of the term "or behaviors" alone.

This distinction does not mean that paraphilia NOS cannot or should not be used to describe some individuals who commit coercive sexual acts. However, such diagnosis would require considerable evidence documenting that the rapes reflected paraphilic urges and fantasies linking the coercion to arousal. One acceptable standard for using it may be to demonstrate clear substantiation of urges and fantasies, either as inferred by the acts perpetrated on the victim or by the interview information, so as to distinguish it from criminal behavior that is not rooted in sexual psychopathology.

The term rape does appear within the DSM-IV-TR[7] in the context of sexual sadism. It is possible that the repetitive expression of sadistic behaviors (e.g., domination, strangulation, beatings) in a particular case of a serial rapist may well warrant the diagnosis of paraphilia NOS, with sadistic traits, when there is insufficient evidence to support the criteria for sexual sadism. The DSM-IV-TR Casebook[13] provides an illustration of paraphilia NOS, for a serial rapist (Jim) without antisocial traits. The narrative in the

Casebook states, "During the development of DSM-III-R, the term *Paraphilic Coercive Disorder* was suggested for this particular kind of Paraphilia, but the category has never been officially recognized. Therefore, Jim's disorder would be coded as Paraphilia Not Otherwise Specified (DSM-IV-TR, p.579)" (Ref. 13, p 173). However, reliance on the Casebook to buttress an argument for using paraphilia NOS to signify paraphilic coercive disorder may be a weak avenue; particularly, in a forensic context. The Casebook, unlike the DSM-IV, does not reflect the work or endorsement of the DSM-IV Task Force; therefore, it is not authoritative.

The sexual disorder section does include an NOS category. Throughout the DSM-IV, the NOS diagnosis reflected the Task Force's intent to include generic residual categories for patients with clinical problems that did not fit into one of the more specific definitions of disorders. As with the specific criteria sets, the intent for NOS was to allow clinicians to use their judgment for each individual as to whether the symptom cluster caused enough distress and/or impairment to be a mental disorder. There were no guidelines as to how such judgments should be made and no hard and fast rules; it was left to the clinician to make the determination on a case-by-case basis. This vagueness in guidelines was intentional so as to permit the clinician flexibility in using the Manual.

Nonetheless, paraphilia NOS, nonconsenting partners, is an inherently weak construct, given the lack of a set of defined criteria. There is a danger of misusing DSM-IV TR[7] mental disorders by applying an idiosyncratic interpretation of case facts to shoehorn individuals, so as to justify an SVP/SDP commitment. Paraphilia, NOS has the potential to be a catch-all diagnosis for persons accused of sexual offenses and for whom the clinician cannot identify criteria for a specific clinical diagnostic category.

Attempts to describe rape-related paraphilia is a difficult diagnostic endeavor.[6,14,15] Identifying the behavior as paraphilic as opposed to criminal is complicated by the often comorbid disorder of antisocial personality disorder. The line between personality disorder and sexual disorder may not be drawn easily in certain instances, nor may one disorder exclude the other. In some instances, the behaviors demonstrated can be articulated to reflect paraphilic urges and fantasies; in other instances, it may be more accurate diagnostically to render only the antisocial personality disorder.

Antisocial Personality Disorder

The position that antisocial personality disorder (ASPD) is a qualifying mental disorder has generated much debate in recent articles.[1,4–6] It has been argued that ASPD should be excluded on the grounds that SVP/SDP commitment should require the presence of a sexual deviancy disorder. ASPD has been viewed as triggering rape or other deviant sexual behaviors because of criminal rather than sexual motives. Further, it is argued, that most prisoners in custody would qualify for ASPD, and no one is suggesting that they be transferred from a prison to a psychiatric hospital. In this view, the use of ASPD to trigger SVP/SDP commitment is not justified and would represent preventive detention.

The other view argues that there has been no proscription on the use of ASPD in the SVP/SDP statutes or the U.S. Supreme Court rulings.[8,9] This position maintains that the application of ASPD or any other diagnosis as a qualifying mental disorder should be formulated on a case-by-case basis, rather than excluding *pro forma* entire categories of diagnoses. The core distinction between these views is that those who oppose the use of ASPD base their position on group analysis. Those who support the use of ASPD base their position on conducting an analysis of a specific individual's predisposition to engage specifically in repetitive sexual criminal behavior.

The U.S. Supreme Court has not drawn the bright line of what is a diagnosed mental disorder; instead, the Court has noted that there should be a distinction between the repetitive criminal and those whose behaviors are driven by a mental disorder.[9] The Court discussed the need to consider the features of the case to determine if the individual has a mental abnormality, and if so, whether that condition renders the person distinguishable from an individual who is an ordinary criminal offender. The case characteristics of a particular offender should be the guideposts for the clinician. For example, the clinician's rationale should articulate how the failure to conform to social norms with respect to lawful behaviors relates to this person's proclivity toward dangerous sexual behavior toward others.

Clinicians who categorically exclude ASPD as a qualifying diagnosis may be criticized for ignoring the statutory language and Supreme Court guidance. Unless there is legal instruction to the contrary, either through statutory or case law, ASPD should be a

viable SVP/SDP mental disorder if it can be demonstrated that it leads specifically to a pattern of sexual offenses.

Other Disorders: Psychosis, Mood, Substance Abuse, and Cognitive Conditions

Generally, the SVP/SDP process has been based predominantly on a showing that the individual has a sexual deviancy disorder. There is no premise in the law to include only sexual deviancy disorders. Therefore, examiners should not be reluctant to use diagnoses other than the paraphilias as a qualifying SVP/SDP mental disorder if it can be demonstrated that such disorders are causally linked to the individual engaging in sexual crimes.

There may be cases of persons who have schizophrenia, in which an aspect of their disorder is recurrent sexual impulsiveness and aggression. While the general population of those who have schizophrenia may not be predisposed to committing criminal sexual offenses, a particular individual's psychosis may manifest repeatedly in a sexually aggressive manner. For example, a person's delusion may be that he is a deity who must impregnate all available females to save the world and produce perfect beings. Consequently, he rapes adult women. His psychosis predisposes him to engage repeatedly in sexual behavior with nonconsenting partners to fulfill the requirements of the delusion.

In addition, there may be cases of individuals with intellectual disabilities who commit sexual offenses. On a case-by-case basis, the clinician can examine how that specific person's limited cognitive capacity (e.g., impaired judgment, limited coping resources, poor frustration tolerance) impairs the person's ability to understand what is appropriate sexual behavior and what is not. Such impairment may, in some persons, result in repetitive pedophilic or rape behavior.

Mania and attendant hypersexuality may be a driving element in repetitive sexually assaultive behavior. An individual in a manic state may consistently become sexually disinhibited and force others into sexual activity or choose children as sexual targets. In such instances, bipolar disorder could be argued as representing a qualifying mental disorder for an SVP/SDP commitment.

Substance abuse and intoxication represent another class of disorders that may warrant a designation as an SVP/SDP mental disorder diagnosis. For example, an individual who rapes repetitively under the influence of stimulants may warrant an SVP/SDP civil commitment. Intoxication may be uncovering an underlying sexual deviancy disorder or may represent an aberrant reaction to the stimulant. As with ASPD, it is important to emphasize that while substance abuse as an SVP/SDP designated mental disorder may represent an unusual case, the presence of a clear pattern connecting substance abuse to sexual offending in that individual should be the basis of determining whether it is a qualifying mental disorder.

Comorbid Conditions

Comorbid conditions are both common and important for evaluators to consider in their interviews. Coexisting disorders may be associated with a worse outcome than if the individual presents with only one disorder. The cumulative impact of comorbid mental conditions such as sexual deviancy, personality disorder, and substance abuse may be the underlying mechanism for driving the individual to have a predisposition to commit deviant sexual acts. Therefore, we strongly encourage examiners to explore disorders present in the individual, in addition to paraphilias, that may drive repetitive sexual deviant behavior.

Developing an Expert Consensus

Forensic applications of DSM diagnoses are left largely to the individual clinician. As the SVP/SDP process demonstrates, there is no good fit between criteria sets in the DSM-IV-TR and the legal standards of mental disorder. However, clinicians have to apply these psychiatric and legal concepts to the individual being examined and then explain them to the trier of fact. If experts disagree as to what constitutes a diagnosed mental disorder, how will the lay trier of fact make this legal determination? Therefore, it would be of value if clinical examiners in the SVP/SDP field attempted to establish a consensus in several different areas of their work. Such a consensus would increase the reliability and credibility of the evaluations and facilitate communication across the psychiatric/legal interface. We suggest the following areas that need review and consideration.

First, there should be a consensus regarding which diagnoses qualify for an SVP/SDP commitment, and under what circumstances. The two areas of controversy, paraphilia NOS and antisocial personality disorder, may be appropriate in some circumstances and

inappropriate in others. These should be clarified and detailed to avoid idiosyncratic determinations.

For Paraphilia NOS, one approach may be to demonstrate that there are sufficient case data regarding the individual's underlying deviant fantasies and urges upon which he has acted, so as to conclude that he is predisposed to commit dangerous sexual offenses. These may include identifying the presence of ritualistic behaviors (e.g., always uses duct tape to bind victims), statements, or behaviors that demean the victim (e.g., forces her to say she enjoys being raped), and behaviors that demonstrate arousal in controlling the victim (e.g., sustains an erection while victim is pleading for his or her life, crying, or making statements that he or she is being hurt).

For antisocial personality disorder, this would involve demonstrating how the disorder, based on the case facts, leads to repetitive sexual offenses as opposed to illegal acts of a general nature. This method of reporting the data and how they relate to the SVP/SDP criteria enhances the thoroughness and rigor of the reasoning, which ultimately makes the opinions easier to understand and defend in court.

Second, there should be agreement on the use of semistructured interviews for diagnostic evaluations in SVP/SDP cases. One of the more difficult, consequential, and scrutinized settings for psychiatric diagnosis is the SVP/SDP evaluation. The interviews afford no confidentiality. In addition, the findings pose risks for both the inmate and society, and will be challenged before a jury. Under these circumstances, it would be highly desirable to have the interviews be as standardized as possible on questions meant to tap the most common disorders likely to be present (viz., antisocial personality disorder, paraphilia, and substance abuse or dependence). Other possible but much less frequently encountered diagnoses (e.g., bipolar disorder, schizophrenia) would not routinely be the subject of semistructured interviewing, unless they seemed pertinent to the particular case. Semistructured interviewing will increase the reliability, transparency, and credibility of diagnosis with little or no increased interview time or effort.

Third, there should be consensus on the appropriate rationales that demonstrate convincingly that the diagnosed mental disorder qualifies for an SVP/SDP civil commitment. It is recommended that forensic clinicians attempt to achieve greater transparency by reporting the rationale they used to justify the presence of an SVP/SDP diagnosed mental disorder or the reasons why such a disorder is not present. It is not enough to base a conclusion that an individual does or does not have a qualifying SVP/SDP mental disorder solely on the presence or absence of a listed DSM-IV-TR disorder. By demanding the rationale for the clinician's opinion, there is less risk that the trier of fact will accept unknowingly idiosyncratic and/or ill-defined conclusions about whether a diagnosed mental disorder is or is not present. This assurance would provide additional quality control, reliability, and credibility to controversial diagnoses. The more detailed the documentation regarding an evaluator's opinion on whether a diagnosis does or does not represent an SVP/SDP mental disorder, the more clarity is provided for the trier of fact to consider fully the expert's opinion. Clear articulation of the reasoning on how a particular DSM-IV-TR disorder or set of disorders qualifies could serve to reduce an inclination toward overinclusiveness as well as underinclusiveness.

Conclusion

As a consequence of U.S. Supreme Court decisions that are written ambiguously and tentatively, the bright line separating an SVP/SDP mental disorder from ordinary criminal behavior is difficult to draw and tests a no-man's land between psychiatry and the law. One way to resolve this dilemma is to discuss the existing definitions of the legally qualifying mental disorder and call for more specificity. Legislative and/or judicial review may force the legal system to be more explicit as to the kind and degree of mental disorder that is constitutionally sufficient to deprive individuals of their right to freedom as well as support the need for public safety. As for forensic clinicians, their role demands a careful examination and articulation of the fit between DSM-IV-TR diagnoses and qualifying SVP/SDP mental disorders. Greater clarity and standardization must come from both sides: the legalists who interpret the law and the clinicians who apply and work under it.

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