Antisocial Personality Disorder Is Not Enough: A Reply to Sreenivasan, Weinberger, and Garrick

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This commentary seeks to extend the recent article by Sreenivasan *et al.*, which supports the contention that case law history allows for the commitment of a sexually violent predator/sexually dangerous person (SVP/SDP) based on a diagnosis of antisocial personality disorder and absent a paraphilic condition. We argue that a clear sexual disorder must be present before a person can be found to be an SVP/SDP. A diagnosis of antisocial personality disorder is not enough.

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> The psychiatric diagnosis, and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sex 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.—*Kansas v. Crane*, 534 U.S. 407, 413 (2002)

Sreenivasan and her colleagues[1] are to be commended for their clarifying discussion of the several problems confronting forensic psychiatrists and psychologists in the assessment of persons under investigation as possible sexually violent predator/sexually dangerous persons (SVP/SDPs). We want to expand that discussion with regard to the question of the treatability of SVP/SDPs and especially with regard to the clinical appropriateness of designating a person as an SVP/SDP on the basis of a diagnosis of antisocial personality disorder alone.

First, it is our opinion that the treatability of a person to be designated as an SVP/SDP is not a matter for the forensic expert to decide. Second, we believe that even when state SVP/SDP laws allow for broad interpretation of mental disorders, it is not clinically appropriate to make a finding of SVP/SDP without a diagnosis of paraphilia.

Sreenivasan *et al.*[1] argue that past laws allowed for the commitment of sex offenders on the premise that offenders were amenable to treatment. Since amenability to treatment is no longer a criterion of SVP/SDP laws, an antisocial person with poor prognosis for sex offender treatment may now qualify for civil commitment. Sreenivasan *et al.* suggest that mental health professionals may find it ethically difficult to argue for the involuntary civil commitment of a person with only a diagnosis of antisocial personality disorder, in that "This disorder does not readily fit into assumptions of the medical model of involuntary civil commitment—that is, the necessity to protect individuals when they are unable to recognize their need for treatment because of a serious mental illness" (Ref. 1, p 477). They further argue that given the difficulty in treating persons diagnosed with antisocial personality disorder, the civil commitment of such persons may only serve to protect society and not the needs of the SVP/SDP. Sreenivasan *et al.* see this as a dilemma confronting the testifying mental health expert, but they do not offer a resolution. We believe that this is not a real dilemma and is not the problem that may confound the forensic expert.

The U.S. Supreme Court has repeatedly upheld the constitutionality of state civil commitment statutes, regardless of whether the persons so committed are in fact treatable.[2,3] Therefore, treatability is now a matter for only those mental health workers who provide treatment to SVP/SDPs. Therefore, the treatability dilemma, as posed by Sreenivasan *et al.*, is not the most salient problem posed by the antisocial personality disorder diagnosis in the SVP/SDP context.

The real problem posed by the use of antisocial personality disorder as a diagnosed mental disorder

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for SVP/SDPs is whether this diagnosis can ever be considered sufficient to identify the person who qualifies for an SVP/SDP designation. Sreenivasan *et al.* are helpful in spelling out the case law history in this regard. They point out that, in some states, a diagnosis of antisocial personality disorder is a sufficient diagnosis in and of itself to lead to an SVP/SDP finding, whereas in other states, case law has held that a diagnosis of antisocial personality disorder qualifies only if it is found in combination with some other diagnosis. In our opinion, an antisocial personality disorder diagnosis alone is not a sufficient diagnostic condition for an SVP/SDP civil commitment without an attendant diagnosis of paraphilia that indicates an established deviant sexual preference.

To be considered for an SVP/SDP designation, a person must have committed sexual crimes, and such crimes are defined differently in various states. In California, sexually violent offenses against two victims are required, while other states require only one victim of such an offense. However, once a potential SVP/SDP is identified, it is the task of the forensic expert to distinguish between "the typical recidivist convicted in an ordinary criminal case" from the SVP/SDP defined in California SVP statutes[4] as one of "a small but extremely dangerous group of sexually violent predators that can be identified while they are incarcerated."

The forensic expert is asked to identify only those SVP/SDP candidates whose diagnosed mental disorder drives them to reoffend in a sexual manner. Clearly, the *Kansas v. Henricks* decision held that a finding of "mental abnormality or personality disorder" satisfied substantive due process (Ref. 2, pp 356–60). *Kansas v. Crane*[3] advanced a further qualification that "there must be proof of serious difficulty in controlling behavior." An antisocial personality disorder diagnosis indicates the presence of general criminality associated with a pattern of the violation of the rights of others, repeated arrests, and traits typical of the criminally predisposed, such as impulsivity, aggression, deceitfulness, recklessness, irresponsibility, and lack of remorse. However, the definition of an antisocial personality disorder does not demand the presence of sexual abnormalities, although it is possible for any criminally or noncriminally oriented person to commit sexual misbehavior and violate the law. In our experience, most individuals with antisocial personality disorder do not commit sexual crimes. It is our contention that individuals who have serious difficulty controlling their emotions and volition in such a manner that they repeatedly commit criminal sexual acts must undoubtedly have a paraphilia.

The most common paraphilic diagnosis leading to the consideration of an offender as a possible SVP/SDP is pedophilia, defined as the presence, over a period of six months, of recurrent, intense, sexually arousing fantasies, sexual urges, or behavior involving sexual activity with a prepubescent child or children. Offenders with pedophilia are significantly less likely to have an antisocial personality disorder than are those who rape. A single act of pedophilic behavior may qualify for designation as an SVP/SDP. However, in the absence of an established sexually deviant preference exhibiting both a pattern and duration of offending against children, it would be difficult to argue that the offender would be likely to reoffend. Again, an offender with a long-standing pattern of sexual offenses against children would clearly qualify for a diagnosis of pedophilia.

The offender who poses more of a diagnostic challenge for forensic experts is the antisocial person who takes what he wants when he pleases, not an uncommon scenario for those who rape. An example is the burglar with a history of raping women he encountered while in the pursuit of loot. However, such a person would still be only "a typical recidivist," and never an SVP/SDP, unless he took special pleasure in the aggressive taking of sex. In the latter scenario, an additional diagnosis of paraphilia is indicated.

Repeated coercive sex most often indicates a specific arousal to forced sexual assault, over and above simply a search for sexual gratification. People presumably steal because it is either easy or is the only way to obtain a desired object. However, the taking of sex is rarely easy and is always risky. Masturbation, prostitution, and casual encounters are much safer and easier avenues to gratification.

Of course, women may also be sexually assaulted by men who in a general way enjoy being aggressive. Consider the case in which an enraged husband with a history of domestic violence forces his wife into sexual activity during an argument. However, when sexual assaults are committed as part of a general aggressiveness, we are again only dealing with the "typical recidivist." Such a person's recidivism would be driven by general criminological variables, and he would be more likely to fall afoul of the law by way of nonsexual reoffending. However, if an offender sexually assaults women as an expression of a pattern of hostility and desire to control women and this is

coupled with a distinct sexual arousal to forced sex, then the offender has a paraphilia.

Sreenivasan *et al.* propose to sharpen the dilemma facing the forensic expert by offering two examples. Two individuals, each with a diagnosis of antisocial personality disorder, had long, nonsexual criminal histories, as well as a record of some sexual assaults. One was a burglar, who in the course of entering homes to steal property also happened upon women, whom he raped. These impulsive opportunistic acts may well be expressions of the antisocial person's entitlement to take what he wants when he wants it. It would be difficult to argue that such an offender is likely to reoffend sexually without evidence specifically indicating that he had sought sex in addition to loot. The other offender "stalked the neighborhood looking for women who lived alone"[1] and then broke into multiple homes, committing several sexual assaults all within a week. This example suggests a diagnostic quandary, since the offender who was obviously aroused by forced sex was caught before he had demonstrated the six months of paraphilic sexual behavior required for a firm diagnosis of paraphilia according to the DSM-IV-TR.[5] However, the DSM-IV-TR allows the diagnostician some latitude by stating: "The exercise of clinical judgment may justify giving a certain diagnosis for an individual even though the clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe" (Ref. 5, p xxxii). Given such a case, it would no doubt be more informative to the court to discuss how this second individual clearly demonstrates deviant sexual arousal to forced sex, rather than rigidly keeping to the six-month criterion in the DSM-IV-TR for the diagnosis of paraphilia. The court would be diagnostically misinformed if the expert proposes that the second offender simply suffers from an antisocial personality disorder and ignores his clear sexual deviance.

Given a longer history of repeated rapes, usually present in SVP/SDP cases, the forensic expert must diagnose paraphilia, in addition to a possible antisocial personality disorder or other diagnostic condition. In the case where several acts of rape have occurred over only a limited span of time and/or have occurred in concert with other offenses such as burglary, those acts of rape must exhibit a clear and special lust for the aggressive taking of sex to indicate an ongoing desire for such activity. Again, an ongoing clear and special lust for the aggressive taking of sex, or a sexualized hostility toward women, leads to a diagnosis of paraphilia.

A final consideration is whether antisocial personality disorder makes a person likely or, as is required in some states, very likely to commit sexual offenses. In California, the diagnosed mental disorder must consider the individual likely to commit sexually violent predatory criminal acts, defined as a "substantial danger—that is a serious and well-founded risk."[6] Unquestionably, an individual with antisocial personality disorder may commit sexually violent offenses. However, this disorder afflicts 50 to 70 percent[7–9] of the ordinary prison population and is far more likely to result in nonsexual criminal behavior. Again, the diagnosis of Antisocial personality disorder alone, without an attending diagnosis of paraphilia, would almost never lead to a finding that an offender would be likely, or very likely, to reoffend with another sexually violent act.

Sreenivasan *et al.* are correct that statutory and case law do not exclude antisocial personality disorder from being a qualifying condition for SVP/SDP. Indeed, statutory and case laws do not preclude diagnoses such as caffeine-related disorders from being considered in an SVP/SDP assessment. However, reliance on such diagnoses alone is not clinically appropriate. Paraphilias are the diagnostic conditions that cause a person to experience serious emotional or volitional difficulty predisposing the commission of criminal sexual acts.

In summary, careful consideration of the activities with which the forensic mental health expert is concerned indicates that a diagnosis of antisocial personality disorder alone is not enough to call for an SVP/SDP designation.

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