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# Civil Commitment Without Psychosis: *The Law's Reliance on the Weakest Links in Psychodiagnosis*

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## ABSTRACT

Civil commitment of mentally disordered persons in the United States was generally limited to persons who were clinically and judicially determined to have psychotic disorders, until 2 U.S. Supreme Court decisions in 1997 and 2002 sanctioned the commitment of nonpsychotic sex offenders who had completed their prison sentences. Such commitments are based on diagnoses of paraphilias and personality disorders – often using the miscellaneous "not otherwise specified" designations for these diagnostic categories. These diagnoses have poor conceptual validity and low interrater reliability. Accordingly, civil commitments that are based on diagnoses of such nonpsychotic disorders have a weak foundation.

## I. Mental Disorders that Qualify for Civil Commitment

### *History and Legal Justification for Civil Commitment*

*Civil commitment* is the legal process by which a court orders the involuntary confinement or restriction of a person alleged to be mentally disordered, in order to treat the person or to protect the person or the public. This confinement or restriction may consist of involuntary psychiatric hospitalization, confinement in a "secure treatment facility" or a locked unit of a nursing home, or a requirement that the individual submit to outpatient psychiatric or psychological treatment.

The authority of the state to civilly commit a person due to his or her mental disorder is premised on two traditional powers of government: the police power and the *parens patriae* power. The authorization that the police power confers on a state (or the federal government) to civilly commit a individual is derived from the government's plenary power to enact and enforce laws for the protection of the public health, safety, welfare, and morals ("Developments – Civil Commitment," 1974). The state's *parens patriae* authority is derived from English law, which, at the time of the settling of the American colonies, gave the King, as sovereign, the responsibility for the care and custody of "all persons who had lost their intellects and become ... incompetent

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to take care of themselves" ("Developments – Civil Commitment," 1974, pp. 1207-1208). These two doctrines have been utilized by states to authorize the civil commitment of persons alleged to be mentally ill, mentally retarded, chemically dependent, or sexually deviant. The most common use of civil commitment has been with persons alleged to be mentally ill. The use of civil commitment with two of these groups – the mentally ill and the sexually deviant – has engendered the most public debate about the defensibility of civil commitment, and is the primary focus of this article.

## *Mental Disorders as Constitutionally Acceptable Criteria for Civil Commitment*

**Civil Commitment of Persons with Psychoses: Constitutional Law: 1972 – 1992**

Civil commitment of the mentally ill came under intense scrutiny by the courts and the mental health professions in the United States during the 1970s, when a series of state and federal court decisions limited its scope. Beginning with the landmark federal district court decision in *Lessard v. Schmidt* (1972), numerous courts held that, based on the Due Process requirements of the Fourteenth Amendment to the U.S. Constitution, civil commitment could not be solely justified based on the *parens patrie* authority, and that the police power authority would be minimally required to limit civil commitment to mentally ill persons who were dangerous to themselves or others.

The penultimate pronouncement of this limitation on the states' authority to civilly commit the mentally ill came in the case of *O'Connor v. Donaldson* (1975, p. 575), in which the U.S. Supreme Court considered the appellant, Donaldson, to be a "harmless mentally ill person" and held that there is "no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom." The Court reiterated this holding four years later in *Addington v. Texas (1979)*, holding that the Fourteenth Amendment's Due Process Clause requires that civil commitment be justified by clear and convincing evidence of mental illness and dangerousness to self or others. Seven years after *Addington*, the U.S. Supreme Court upheld the civil commitment of a sex offender under Illinois's Sexually Dangerous Persons Act, holding that, because the statute was civil and was designed, at least in part, to provide treatment for the "mentally ill" person, the constitutional privilege against self-incrimination did not apply (*Allen v. Illinois*). In the wake of these court decisions, there was considerable public and legislative debate about what behavior would be sufficient to meet the constitutional standard of "dangerousness to self or others." But there was surprisingly little discussion in the judicial or legislative arenas or in the professional literature about what psychodiagnostic categories constituted "mental illness" sufficient to justify civil commitment.

All of the major court decisions that addressed the scope of the state's power to civilly commit individuals involved persons who were alleged to have what are considered *psychotic disorders* in the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM*) (American Psychiatric Association (APA), 2000b). The psychotic disorders include schizophrenia and bipolar or depressive disorders with psychotic features. The *DSM*, currently in its text-revised fourth edition (APA, 2000b), is the official "bible" of psychodiagnostic nosology, used by psychiatrists, psychologists, clinical social workers, and other mental health professionals to diagnose mental disorders. Psychotic symptoms typically include delusions and/or hallucinations, and may also include disorganized speech and/or grossly disorganized or inappropriate behavior (APA, 2000b, p. 927).

For example, Alberta Lessard, the Milwaukee-area schoolteacher whose case resulted in the groundbreaking decision that first promulgated the dangerousness standard for civil commitment, had been alleged to be mentally ill based on a diagnosis of schizophrenia – a psychotic disorder (*Lessard v. Schmidt*, 1972, p. 1081). Kenneth Donaldson, the appellant in the U.S. Supreme Court's adoption of the dangerousness standard for civil commitment, had also been found to be mentally ill based on a diagnosis of paranoid schizophrenia (*O'Connor v. Donaldson*, 1975, p. 565). The appellant in the U.S. Supreme Court's reiteration of the dangerousness prerequisite in *Addington v. Texas* (1979, pp. 420-421) had also been found to be mentally ill based on a diagnosed psychotic disorder: "psychotic schizophrenia" with "serious delusions" and "paranoid tendencies." The appellant in the U.S. Supreme Court's decision in *Allen v. Illinois* had been found by court-appointed psychiatrists to be "psychotic" "out of touch with reality" "and suffering from schizophrenia" (Allen v. Illinois, 1985). All of these cases brought disputes about the constitutional requirements for civil commitment to the courts with persons who had been diagnosed as having psychotic disorders.

The fact that civil commitment of the mentally ill has generally involved persons alleged to have psychotic disorders may be attributable to the fact that some civil commitment statutes require a seriousness of mental illness that implies psychosis. For example, Wisconsin's civil commitment statute defines mental illness for purposes of civil commitment as "a substantial disorder of thought, mood, perception, orientation, or memory, which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life…" (Wisconsin State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act, 2003-2004, §51.01(13)(b)). Many other states used identical or very similar wording to define "mental illness" for purposes of civil commitment. This definition tracked the definition of the term "psychotic" that was set forth in the second edition of the *DSM*, which was current at the time that the statutory definition was enacted:

> Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious distortion in their capacity to recognize reality. Hallucinations and delusions, for example, may distort their perceptions. Alterations of mood may be so profound that the patient's capacity to respond appropriately is grossly impaired. Deficits in perception, language and memory may be so severe that the patient's capacity for mental grasp of his situation is effectively lost. (APA, 1968, p. 29)

Similarly, the APA's *American Psychiatric Glossary* (1994) defines the term *psychosis* as "a severe mental disorder characterized by gross impairment in reality testing, typically shown by delusions, hallucinations, disorganized speech, or disorganized or catatonic behavior " The APA also recommends that civil commitment be limited to persons who have "a severe mental disorder" and who "lack capacity to make a reasoned treatment decision" (Stromberg & Stone, 1983). "Severe mental disorder" in this context is "generally of a psychotic magnitude" (Zonona, Bonnie, & Hoge, 2003).

However, the U.S. Supreme Court did not have occasion to consider whether a mental disorder that was *not* a psychotic disorder was constitutionally sufficient to justify civil commitment until the case of *Foucha v. Louisiana* (1992). In *Foucha*, the Court held that continued commitment of an insanity acquittee was improper absent a determination in a civil commitment proceeding of current mental illness and dangerousness. In that case, the appellant had been found not guilty by reason of insanity due to a drug-induced psychotic disorder. When he subsequently challenged his commitment, his psychotic disorder was in remission, but he was

diagnosed as having antisocial personality disorder – a non-psychotic disorder, which the Court would not consider to be mental illness. Writing for a plurality of the Court, Justice White declared:

> The State, however, seeks to perpetuate Foucha's confinement ... on the basis of his antisocial personality, which, as evidenced by his conduct at the facility, the court found rendered him a danger to himself or others... [E]ven if his continued confinement were constitutionally permissible, keeping Foucha against his will in a mental institution is improper absent a determination in civil commitment proceedings of current mental illness and dangerousness. [T]he State asserts that because Foucha once committed a criminal act and now has an antisocial personality that sometimes leads to aggressive conduct, a disorder for which there is no effective treatment, he may be held indefinitely. This rationale would permit the State to hold indefinitely any other insanity acquittee not mentally ill who could be shown to have a personality disorder that may lead to criminal conduct. The same would be true of any convicted criminal, even though he has completed his prison term. It would also be only a step away from substituting confinements for dangerousness for our present system, which, with only narrow exceptions and aside from permissible confinements for mental illness, incarcerates only those who are proved beyond reasonable doubt to have violated a criminal law. (p. 78, pp. 82-83)

Thus, the *Foucha* decision appeared to stand for the legal principle that, although mental illness coupled with dangerousness to self or others could constitutionally justify civil commitment, antisocial personality disorder – a nonpsychotic disorder -- could not. The Court's primary rationale for rejecting antisocial personality disorder as a constitutionally permissible basis for civil commitment appeared to be based on the premise that "a personality disorder that may lead to criminal conduct" is not the type of mental illness that the Court had previously said justified civil commitment. Second, the Court seemed to find significance in its assertion that antisocial personality disorder is "a disorder for which there is no effective treatment" (p. 82). Justice O'Connor's concurring opinion in the case, adds, "I think it clear that acquittees could not be confined as mental patients absent some medical justification for doing so; in such a case the necessary connection between the nature and purposes of confinement would be absent" (p. 88). Apparently, Justice O'Connor did not consider a diagnosis of antisocial personality disorder to be sufficient "medical justification" for civil commitment.

Mental health law commentator Bruce Winick (1995) heralded the *Foucha* decision as a landmark in mental health law, declaring, "Through *Foucha's* window, mental health law looks quite different" (p. 534). He went on to speculate that the decision established "new constitutional limits on the power of the states to impose civil commitment and involuntary mental health treatment" (p. 608), adding:

> Although the Court did not explain why antisocial personality disorder could not justify involuntary hospitalization, I have suggested that this condition should be distinguished from the major mental illnesses because, unlike those illnesses, it is psychosocial rather than organic in nature, it does not respond to organic treatment techniques that have become the hallmark of the modern psychiatric hospital, and it does not produce the cognitive and volitional incapacities that serve to justify involuntary hospitalization. (p. 608)

In other words, Winick (1995) suggested that the logic of *Foucha* would lead to civil commitment being limited to persons with psychotic disorders that are typically treated with psychotropic medications. However, as will be explained, the prediction that *Foucha* would constitutionally limit civil commitment to persons who were psychotic and dangerous was Pollyannaish.

**The Rise and Fall of Sexual Psychopathy Laws**

An exception to the general rule that civil commitment was limited to persons with psychoses took place in the late 1930s and 1940s, when many states enacted laws to authorize the civil commitment of sex offenders. "These laws were viewed as alternatives to criminal processing and imprisonment for this group of offenders" (Brakel, 1985, p. 740). These laws were intended to "benefit sex offenders by curing them in perhaps a shorter time than they would serve as convicted criminals ... [and to] protect society against premature release of dangerous offenders who had not been cured within the maximum period of incarceration available under a predicate criminal statute" (American Bar Association, 1989). By 1960, over half the states had civil commitment laws for what were termed "sexual psychopaths" or "sex deviates." Typical of these laws was Minnesota's Psychopathic Personality Law, which was enacted in 1939. That law authorized the civil commitment for an indeterminate period of time of anyone with a psychopathic personality, defined as:

> [T]he existence in any person of such conditions of emotional instability or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of his acts, or a combination of such conditions as to render such a person irresponsible for his conduct with respect to sexual matters and thereby dangerous to other persons. (Minnesota Statutes, §26.10, 1941)

The U.S. Supreme Court upheld the constitutionality of this statute in *Minnesota ex rel. Pearson v. Probate Court* (1940), favorably citing a limitation of the statute's scope by the Minnesota Supreme Court to "those persons who, by an habitual course of misconduct in sexual matters, have evinced an utter lack of power to control their sexual impulses and ... are likely to attack or otherwise inflict injury, loss, pain or other evil on the objects of their uncontrolled and uncontrollable desire" (p. 272). Despite this limitation, men were civilly committed under this statute for nonviolent offenses, including masturbation (*In re Dietrich*, 1943). Comparable laws in other states resulted in civil commitments of "sexual psychopaths" for such activities as "peeping in a house" (*State ex rel. Haskett v. Marion County Criminal Court*, 1968) and sodomy (Motz, 1954).

However, in the 1970s many states began repealing their sexual psychopathy laws because of skepticism about treatment effectiveness, psychiatric inability to predict dangerousness or diagnose sexual psychopathologies according to accepted medical standards, and public opinion that increasingly favored punishment for sex offenders over treatment (Veneziano and Veneziano, 1987). In calling for repeal of sexual psychopathy laws, the Group for the Advancement of Psychiatry (1977) declared:

> First and foremost, sex psychopath and sex offender statutes can best be described as approaches that have failed. The discrepancy between the promises in sex statutes and performance have rarely been resolved ... The notion is naive and confusing that a hybrid amalgam of law and psychiatry can validly label a person a "sex psychopath" or "sex offender" and then treat him in a manner consistent with a guarantee of community safety. The mere assumption that such a heterogeneous legal classification could define treatability and make people amenable to treatment is not only fallacious, it is startling. (p. 935)

Most of the sexual psychopathy laws were repealed following influential reports from the Group for Advancement of Psychiatry and the American Bar Association's Criminal Justice Mental Health Standards Committee – both of which maintained that these so-called "sexual psychopathy" laws lacked scientific validity, were based upon inaccurate prediction methods, and relied on ineffective treatment (American Bar Association, 1989; Group for the Advancement of Psychiatry, 1977). Some state legislatures, such as Wisconsin's, were motivated to repeal their

sexual psychopathy laws by public outrage about sex offenders who had been committed under these laws as an alternative to criminal sentencing, and who were then released from a sex offender treatment facility sooner than they would have been had they been sentenced to prison (Ransley, 1980).

**The Revival of Civil Commitment for Nonpsychotic Sex Offenders**

However, in the 1990s, concerns about the release of sex offenders who had completed their prison sentences led to a new wave of state civil commitment laws aimed at so-called "sexual predators." These laws differed from the previous sexual psychopathy laws in that they were primarily aimed at sex offenders who had been either convicted and sentenced or found not guilty by reason of insanity and committed, *and were about to be released from imprisonment or insanity commitment*. The new commitment laws were variously called "sexual predator" laws, "sexually violent person" laws, "sexually dangerous person" laws, or other similar terms – and will hereinafter be referred to as "SVP laws" or "SVP commitment laws." As of 2005, there were 17 states with SVP commitment laws: Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, New Jersey, North Dakota, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin.[2]

One of the first such laws was enacted by Kansas. In 1996, LeRoy Hendricks, who had been convicted and sentenced for sexually molesting children, successfully challenged his civil commitment under Kansas's newly-enacted Sexually Violent Predator Act (KSVPA) (1994). That law provided for the civil commitment of convicted sex offenders who had completed their prison sentences and who were about to be released. The law required that the inmate have "a mental abnormality or personality disorder which makes the person likely to engage in repeat acts of sexual violence" (KSVPA, Kansas Statutes Ann. § 59-29a02 (a), 1994). The statute defined "mental abnormality" as "a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such person a menace to the health and safety of others" (KSVPA, Kansas Statutes Ann. § 59-29a02 (b), 1994). The Kansas Supreme Court held that the KSVPA was a violation of the Due Process Clause of the Fourteenth Amendment because it failed to require evidence of mental illness, as required by *Foucha (In the Matter of the Care and Treatment of LeRoy Hendricks,* 1996). The Kansas Court noted that the civil commitment law under which Hendricks had been committed specifically distinguished between the type of mental illness required for ordinary civil commitments, versus the "mental abnormality" or "personality disorder" allowed for civil commitment under the KSVPA. That distinction was set forth in the law as follows:

> The legislature finds that a small but extremely dangerous group of sexually violent predators exist who do not have a mental disease or defect that renders them appropriate for involuntary treatment pursuant to the treatment act for mentally ill persons defined in ... [Kansas's general civil commitment law], which is intended to provide short-term treatment to individuals with serious mental disorders and then return them to the community. In contrast to persons appropriate for civil commitment under [Kansas's general civil commitment law], sexually violent predators generally have antisocial personality features which are unamenable to existing mental illness

[2] The District of Columbia still has its sexual psychopathy law, which was enacted in 1948 (District of Columbia Code Annotated §§ 22-3803 - 22-3811 (2005). However, like most of the now-repealed sexual psychopathy laws, the D.C. law was designed as an alternative to imprisonment, not, like the current SVP commitment laws, as post-imprisonment confinement. The D.C. law is seldom used anymore (Fitch & Hammen, 2003, p. 28). Accordingly, it will not be considered in the following discussion of SVP commitment laws.

> treatment modalities and those features render them likely to engage in sexually violent behavior. (pp. 131-132)

Thus, the Kansas Supreme Court recognized that, whereas civil commitment under Kansas's *general* civil commitment law for the mentally ill comported with the U.S. Supreme Court's reasoning in *Foucha* by requiring evidence of "mental illness," the KSVPA departed from *Foucha* by allowing civil commitment based not on mental illness but rather on "antisocial personality features which are unamenable to existing mental illness treatment modalities" (pp. 131-132). In striking down the KSVPA, the Kansas Supreme Court criticized the Washington Supreme Court's upholding of an almost identical law. The Washington Supreme Court had held that the terms "mental illness," "mental abnormality," "mental disorder," and "personality disorder" are largely synonymous. The Kansas Supreme Court disagreed with the Washington Supreme Court analysis, agreeing, instead, with dissenting Washington Supreme Court justices who had condemned that analysis as "psychiatric incantations" (pp. 135-136).

But the U.S. Supreme Court overruled the Kansas Supreme Court's invalidation of the KSVPA, holding, instead, that the KSVPA was consistent with the Due Process Clause and with previous U.S. Supreme Court decisions that had permitted the civil commitment of sex offenders (*Kansas v. Hendricks*, 1997):

> A finding of dangerousness, standing alone, is ordinarily not a sufficient ground upon which to justify indefinite involuntary commitment. We have sustained civil commitment statutes when they have coupled proof of dangerousness with the proof of some additional factor, such as a "mental illness" or "mental abnormality." .... These added statutory requirements serve to limit involuntary civil confinement to those who suffer from a volitional impairment rendering them dangerous beyond their control. The Kansas Act is plainly of a kind with these other civil commitment statutes: It requires a finding of future dangerousness, and 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. Kan. Stat. Ann. § 59-29a02(b) (1994). The precommitment requirement of a "mental abnormality" or "personality disorder" is consistent with the requirements of these other statutes that we have upheld in that it narrows the class of persons eligible for confinement to those who are unable to control their dangerousness. (p. 358)

Rejecting the reliance on *Foucha* by both appellant Hendricks and the Kansas Supreme Court, the Court went on to state:

> Hendricks nonetheless argues that our earlier cases dictate a finding of "mental illness" as a prerequisite for civil commitment, citing *Foucha,* and *Addington*. He then asserts that a "mental abnormality" is *not* equivalent to a "mental illness" because it is a term coined by the Kansas Legislature, rather than by the psychiatric community. Contrary to Hendricks' assertion, the term "mental illness" is devoid of any talismanic significance. Not only do "psychiatrists disagree widely and frequently on what constitutes mental illness," .... but the Court itself has used a variety of expressions to describe the mental condition of those properly subject to civil confinement. (pp. 358-359)

Thus, without specifically explaining why a trial court finding of diagnosed antisocial personality disorder was a constitutionally insufficient basis for civil commitment in *Foucha,* but a finding of "mental abnormality" was sufficient in the *Hendricks* case, the U.S. Supreme Court authorized civil commitment of non-psychotic individuals. Essential to the Court's holding in *Hendricks* was the requirement that civil commitment be limited "to those who suffer from a volitional impairment rendering them dangerous beyond their control" (p. 358). The Court noted that this was precisely the type of problem allegedly exhibited by Hendricks, who had a history of multiple convictions for sexual molestation of children, and who described himself as having

uncontrollable urges to molest children when he was stressed. Implied in the Court's reasoning was a possible distinction between mental disorders that affect volitional control, such as the pedophilia diagnosed in LeRoy Hendricks, and mental disorders that do not have volitional impairment as a required diagnostic criterion, such as the antisocial personality disorder diagnosed in Terry Foucha. Following *Hendricks*, there was much debate and litigation about the extent to which a person had to be "volitionally impaired" in order to qualify for civil commitment.

In 2000, the Kansas Supreme Court again considered the application of the KSVPA in *In re Crane* (2000). The Court vacated the commitment of Crane, a sex offender who had been diagnosed with antisocial personality disorder and whose behavior state psychologists described as "a combination of willful and uncontrollable behavior" (p. 290). The Kansas Supreme Court ruled that the commitment violated the *Hendricks* requirement of volitional impairment, because Crane had some control over his behavior. Two years later, the U.S. Supreme Court vacated the Kansas Supreme Court's decision, holding, in *Kansas v. Crane* (2002):

> In recognizing [in *Hendricks*] that [lack of control is required], we did not give to the phrase "lack of control" a particularly narrow or technical meaning. And we recognize that in 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. (p. 413)

In so holding, the Court raised a host of new questions. If the volitional impairment required by substantive due process for civil commitment of a sex offender must be "serious" but not necessarily complete, how might "the nature of the psychiatric diagnosis" impact the committability of the offender? How "serious" does the offender's "mental illness, abnormality, or disorder" have to be to qualify as "serious" under the Court's holding?

The Court recognized that it had set forth an imprecise constitutional standard, but maintained that constitutional protections of liberty in mental disability law "are not always best enforced through precise bright-line rules" (p. 413). The Court defended this position by first asserting that states have considerable discretion to define the mental abnormalities and personality disorders that are prerequisites for civil commitment. Second, the Court noted that psychiatry is "ever-advancing," and its "distinctions do not seek precisely to mirror those of the law" (p. 413). Thus, the Court chose a conservative path "by proceeding deliberately and contextually, elaborating generally stated constitutional standards and objectives as specific circumstances require" (p. 414). Finally, the Court left open the question of whether civil commitment could be constitutionally justified based on a purely "emotional" impairment that did not impair the person's volition. The Court noted, "Nor, when considering civil commitment, have we ordinarily distinguished for constitutional purposes among volitional, emotional, and cognitive impairments" (p. 415). The Court then ducked the issue, saying, "The Court in *Hendricks* had no occasion to consider whether confinement based solely on "emotional" abnormality would be constitutional, and we likewise have no occasion to do so in the present case" (p. 415).

# II. Psychodiagnostic Validity and Reliability Issues Raised by *Hendricks and Crane*

## *How Do Legal Standards of "Mental Abnormality/Disorder" and "Personality Disorder" Mesh with DSM-Based Psychodiagnosis?*

**"Mental Disorder," "Mental Abnormality," and "Personality Disorder" as Criteria for Civil Commitment: What Do These Terms Mean?**

In holding that civil commitment based on legislatively defined standards of "mental abnormality" or "personality disorder" was constitutionally allowable, the U.S. Supreme Court highlighted the disconnect between legal standards and psychodiagnostic standards relied on by the mental health professions. In so doing, the Court engaged in very little analysis of the issues related to the substantive challenge made to these terms by the parties challenging the constitutionality of the Kansas SVP law. Rather, the Court took a classically conservative stance in deferring to the reasoning of state legislatures. Whether such deference was merited by the integrity of the legislative determination about the meaning and validity of the terms "mental abnormality" and "personality disorder" is another question.

Legal scholars and some state and federal judges have been less deferential to legislative determinations about the validity of commitment criteria such as "mental abnormality" or "mental disorder." For example, Wisconsin Supreme Court Justice Shirley Abrahamson wrote a scathing dissent from that Court's decision in *Wisconsin v. Post* (1995, pp. 142-144) upholding the constitutionality of Wisconsin's SVP law (referred to as chapter 980), declaring as follows:

> But a recognition that mental illness or the neologism "mental condition component" may be defined in more than one way hardly suggests that mental illness can be defined howsoever the state pleases. If the constitutionally prescribed threshold of mental illness has no core meaning and can mean everything, then it means nothing... Finally "mental disorder" is defined in chapter 980 not in terms of mental illness, mental disease or mental defect but in terms of a predisposition to sexual crimes. Under chapter 980 "mental disorder" is "a congenital or acquired condition affecting the emotional or volitional capacity that predisposes a person to engage in acts of sexual violence." *Wis. Stat. § 980.01(2)*. Since every condition is necessarily either congenital or acquired, and since "emotional or volitional capacity" simply describes the decision-making processes affecting how people act, mental disorder under chapter 980 means no more than a predisposition to engage in acts of sexual violence. Thus chapter 980 attempts to create a mental disorder authorizing lifetime commitment based not on mental illness but on past crimes for which the prospective committee has already served the prescribed sentence. This definition is entirely circular: a prospective committee's "mental disorder" is derived from past sexual offenses which, in turn, are used to establish a predisposition to commit future sexual offenses.

Justice Abrahamson's reasoning would apply to the SVP commitment statutes of all 17 states that have such statutes, because no state requires that the person facing commitment be "mentally ill" – the term traditionally used in civil commitment statutes. Rather SVP commitment statutes use the terms "mental abnormality," (Florida, Iowa, Kansas, Massachusetts, Missouri, New Jersey, Pennsylvania, South Carolina, Virginia, Washington), "mental disorder" (Arizona, California, Illinois, Minnesota, North Dakota, Wisconsin), or "behavioral abnormality (Texas) (Miller, Amenta, & Conroy, 2005, pp. 32-35). Nearly all states link these terms to phrases such as "that predispose the person to the commission of sexual acts" (Massachusetts) or similar language (Miller, Amenta, & Conroy, 2005, pp. 32-35). As Justice Abrahamson observed, there is

circularity to these criteria for civil commitment because the criteria themselves define the outcome. Analogizing to the criminal law, it is as if the elements of a crime were defined by the crime itself, such as defining the crime of burglary as the act of one who burglarizes.

The term *personality disorder* has a meaning defined by *DSM-IV-TR* as a diagnostic category (APA, 2000b, pp. 685-689). This category, and its use in SVP commitment cases and, potentially, in other civil commitment cases, will be discussed later in this article. However, the terms "mental abnormality" and "mental disorder" do not correspond to specific diagnostic categories in *DSM-IV-TR*. The term "mental abnormality" is totally foreign to the *DSM*, while the term "mental disorder" embraces almost *all* diagnostic categories in the *DSM.* The legislative history of SVP commitment laws in all states makes it clear that the one category of mental disorders not intended for coverage by these laws was the category of psychotic disorders traditionally covered by civil commitment laws. In fact, as noted in *Kansas v. Hendricks* (1997, p. 351), the Kansas Legislature created that state's SVP law specifically because "a small but extremely dangerous group of sexually violent predators exist who do not have a mental disease or defect that renders them appropriate for involuntary treatment pursuant to the [general involuntary civil commitment statute]." Florida, specifically *excludes* from the coverage of its SVP statute persons who would be considered mentally ill under the state's civil commitment law for the mentally ill (Florida Administrative Code, § 65E-25.003, 2005).

As Justice Abrahamson noted, the language in Wisconsin's statute that defines "mental disorder" as "a congenital or acquired condition" does not add specificity to the definition, because "every condition is necessarily either congenital or acquired" (*Wisconsin v. Post*, 1995, p. 143). This same or almost identical language in found in the SVP statutes of California, Illinois, Iowa, Kansas, Massachusetts, Missouri, North Dakota, Pennsylvania, Texas, Virginia, and Washington (Miller, Amenta, & Conroy, 2005, pp. 32-35). The fact that 11 of the 17 states with SVP laws have defined "mental disorder" or "mental abnormality" as a "congenital or acquired condition" is noteworthy, particularly since this definition raises problematic questions of statutory construction.

If, "the stipulation that the mental abnormality condition be either congenital or acquired certainly 'covers all the bases'" (Brakel & Cavanaugh, 2000, p. 78), it means that the words "congenital or acquired" would be redundant. However, under canons of statutory construction, every word of a statute is to be given meaning if at all possible (*Potter v. United States*). The only way to avoid interpreting these words as being redundant, would be to find a third type of condition that would make the specification of "congenital or acquired" meaningful. Presumably, an "acquired" mental condition is one that is developed through learning, experience, or other environmental factors. According to *Webster's Third New International Dictionary of the English Language,* "congenital" can mean "existing at or dating from birth" (Gove, 2002, p. 478). But a second definition of "congenital" in that same dictionary is, "acquired during development in the uterus *and not through heredity*" (Gove, 2002, p. 478) [italics added]. Similarly, *Elsevier's Encyclopaedic Dictionary of Medicine* defines "congenital" as, "Relating to an alteration or disease which has been produced or developed in the course of uterine life" (Dorian, 1987, p. 184).

The only way to give the words "congenital or acquired" meaning and avoid redundancy is to apply these latter two definitions to the statute, and thereby exclude mental disorders that are arguably genetic in origin, such as personality disorders (First, Bell, Cuthbert, Krystal, Malison, Offord, Reiss, Shea, Widiger, & Wisner, 2002). As will be discussed, antisocial personality disorder is one of the most common diagnoses applied to respondents in SVP

commitment cases. There is substantial evidence that this personality disorder has genetic origins (McGuffin & Thapar, 1998). The inclusion of the words "congenital or acquired" in the definitions of "mental disorder" and "mental abnormality" in SVP commitment statutes is probably more a reflection of sloppy draftsmanship than it is a legislative intent to exclude persons who have genetic mental disorders. Given the choice between giving a narrow interpretation of these statutes that would exclude many candidates for commitment versus giving a broad interpretation that arguably makes statutory language redundant, most courts are likely to do the latter.

**Are Legal Standards for "Mental Disorder/Abnormality" and "Personality Disorder" Separable from Psychodiagnosis?**

In theory, legal criteria for civil commitment that state or imply a psychodiagnostic construct, such as "mental illness," "mental disorder," or "personality disorder" are distinguishable from the diagnostic categories found in *DSM-IV-TR*. In fact, *DSM-IV-TR* itself makes this distinction by offering the following caveat:

> When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. 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. (pp. xxxii-xxxiii)

The courts have also recognized this distinction between a legally-specified mental condition and psychodiagnosis. For example, in the *Crane* decision, the U.S. Supreme Court approvingly cited the aforementioned caveat from *DSM-IV-TR*, and added:

> The Constitution's liberty safeguards in the area of mental illness are not always best enforced through precise bright-line rules. States retain considerable leeway in defining the mental abnormalities and personality disorders that make an individual eligible for commitment; and psychiatry, which informs but does not control ultimate legal determinations, is an ever-advancing science, whose distinctions do not seek precisely to mirror those of the law. (p. 413).

While a diagnosis of a mental disorder is distinguishable from a legal criterion involving a specified mental condition, a diagnosis appears to be indispensable to the determination of whether or not that criterion is satisfied. Again, *DSM-IV-TR* and the courts appear to be in general accord on this point. In *DSM-IV-TR*, following the foregoing caveat, it states:

> When used appropriately, diagnoses and diagnostic information can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g. involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. (p. xxxiii)

Similarly, the U.S. Supreme Court, in *Crane*, recognized the essential contribution of psychodiagnosis to the legal determination in a sex offender civil commitment case:

> *Hendricks* underscored the constitutional importance of distinguishing a dangerous sexual offender subject to civil commitment "from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings." [....] *The presence of what the "psychiatric profession itself classified . . . as a serious mental disorder" helped to make that distinction* in *Hendricks.* And a critical distinguishing feature of that "serious ... disorder" there consisted of a special and serious lack of

> ability to control behavior. In recognizing that fact, we did not give to the phrase "lack of control" a particularly narrow or technical meaning. And we recognize that in 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. [Italics supplied.] (pp. 412-413)

Indeed, the Supreme Court cited the *DSM* four times in *Crane.*

Thus, for the reasons recognized in *DSM-IV-TR* and by the U.S. Supreme Court, psychodiagnosis is a critical, and perhaps essential component of the legal determination in a civil commitment case. Although psychodiagnosis in this context may be problematic under any circumstances, as will be shown, allowing civil commitment based on a diagnosis of a mental disorder that is not a psychotic disorder invites special problems of diagnostic validity and reliability; moreover this practice may have legal and social implications not envisioned by the legislators and judges who have allowed civil commitment without evidence of psychosis.

## *Basing Civil Commitment on DSM Criteria for Psychotic Disorders versus Nonpsychotic Disorders: Problems of Psychodiagnostic Validity and Reliability*

### Debates About the Validity of Concepts of "Mental Disorder/Illness"

One of the most fundamental moral, political, and scientific issues in the mental health field concerns the definition of what constitutes a "mental disorder" for purposes of diagnosis and intervention. The uncertain boundaries between what is considered "normal" and "abnormal" in mental health account for a variety of phenomena that are unrivaled in physical health, including the ever-growing number of diagnosable conditions listed in the *DSM,*[3] and debates in professional circles and in the public arena about whether particular behaviors (*e.g.,* homosexuality, cigarette-smoking, binge-eating,[4] etc.) should be considered mental disorders.

Debates about the validity of the construct of "mental illness" and "mental disorder" have raged for the past half-century. One of the first commentators to raise the question of the validity of the concept of "mental illness" was psychiatrist Thomas Szasz who published an article in the journal, *American Psychologist* (1960), that became his groundbreaking book: *The Myth of Mental Illness* (1961). Szasz forcefully argued that the term "mental illness" is not an "illness" in the sense that it identified any abnormal physical pathology. Rather, he argued,

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[3] For example, *DSM-II* (APA, 1968) was a small, spiral-bound notebook, of only 134 pages that briefly described 182 mental disorders (Houts, 2002; Kirk & Kutchins, 1992). By contrast, *DSM-III* was 494 pages long and contained 265 mental disorders (Houts, 2002). *DSM-III-R* (APA, 1987) grew to 567 pages and 292 diagnoses (Houts, 2002). And *DSM-IV* swelled to 365 diagnoses in 888 pages (Houts, 2002). This dramatic expansion of the *DSM* was attributable to a doubling in the number of new diagnoses in 26 years, as well as the increase in descriptive language used to define the mental disorders.

[4] A proposed disorder called *binge-eating disorder* is listed in Appendix B of *DSM-IV-TR* (APA, 2000b) as a diagnosis for further study. This proposed disorder includes overeating and "a sense of lack of control over eating" as diagnostic criteria.

"mental illness" is a metaphor for psychological or social problems experienced by the person so labeled. He further argued that psychiatry enforces societal norms and justifies coercive interventions by claiming that the "patient's" "illness" deprives him/her of the ability to make competent choices. Szasz's writings document countless examples of psychiatry being used as an instrument of social control (Szasz, 1963). Sociologists and other scholars supported Szasz's contentions with sociological research and evidence from the practice of clinical psychology and psychiatry that questioned the validity of psychodiagnosis by demonstrating its arbitrary application (Scheff, 1966, 1975; Laing, 1967; Foucault, 1965). Kutchins and Kirk (1997) summarized the conclusions of these thinkers as follows: "Mental disorder ... is not a scientific or medical concept, but a lay concept and a value judgment" (p. 29).

Winick (1995) has argued that the questions raised by Szasz and others about the validity of the concept of "mental illness" has been shown to be "oversimplistic," because, "The evidence of the past 30 years has strongly suggested that the major mental illnesses may have an organic etiology and has shown that they respond to organic treatments" (pp. 556-557). This observation ignores that fact that, although research lends some support for the biological basis of behavior, in ordinary clinical practice, there are no diagnostic tests that can verify a diagnosis of mental illness. For example, after a review of possible physiological trait markers for schizophrenia, Szymanski, Kane, and Lieberman (1994, p. 486) concluded, "At present, there are no abnormal physical, radiologic, or laboratory findings that can be employed in establishing a diagnosis of schizophrenia." Acknowledging this point, a prominent psychiatrist has written

> Most psychiatric disorders are idiopathic conditions with no known causes. The literature is filled with debate about what constitutes a disorder or how one defines a case. Critics question the validity of current diagnostic classifications or nosologies, challenging their fundamental assumptions or theoretical underpinnings. Because there is no method for externally validating current diagnostic constructs (i.e., verifying their accuracy using external measures that do not depend on the constructs themselves), it is likely that the field will be rife with controversy until the causes that lead to the emergence of specific clinical conditions can be determined (Caine, 2003, p. 1).

However, the argument that the controversy about the validity of psychodiagnosis will abate once external tests for mental illness are clinically available begs the question about the validity of psychodiagnosis, because *all* behavior has "an organic etiology," *i.e.*, a biological substrate. Only three decades ago, homosexuality was a diagnosis set forth in *DSM-II* (APA, 1968). By a vote of the members of the American Psychiatric Association, that organization removed this diagnosis from the manual, based not on any neurophysiological discovery, but rather on the judgment that homosexuality is a natural variation in human sexuality (Bayer, 1981). The fact that homosexuality may be identifiable neurologically (Savic, Berglund, & Lindström, 2005; LeVay, 1993) would not justify reinserting the diagnosis of homosexuality in the *DSM.* Thus, the decision of whether or not to label *any* behavior (and its biological substrate) "abnormal" or "mental illness" remains as much a social and political judgment as it ever was. Therein lies the debate about the validity of all psychodiagnosis.

**Definitions of "Diagnostic Validity" and "Psychodiagnostic Reliability"**

The term *validity* in psychology generally refers to the extent to which a test measures what it purports to measure (Kazdin, 2003). Bentall (2003) defined *diagnostic validity* as follows:

> [T]he extent to which ... a diagnostic system fulfills the purpose for which it was designed... For example, the validity of a diagnostic concept might be assessed by seeing whether it corresponds to a naturally occurring cluster of symptoms, by seeing whether the diagnosis runs in families, or is associated with any particular type of pathology, or by seeing whether it usefully predicts what happens to the patient in the future or which types of treatment are likely to be effective. (p. 526)

In general, diagnostic validity includes an "examination of if and how well the *DSM-IV* assesses categories of psychopathological disorders" (Nelson-Gray, 1991, p. 310).

Wakefield (1992, p. 232) identified the subcategory of psychodiagnostic validity, which he termed *conceptual validity*, defining it as "discriminating disorder and nondisorder." Wakefield explained, "Criteria that identify all individuals with disorders, and only individuals with disorders, are referred to as conceptually valid criteria" (Wakefield, 2003, p. 30). Wakefield (2003) referred to conceptually invalid diagnoses as the "false-positives problem in *DSM*" that result in "overdiagnosis" (p. 23). Wakefield (1992, p. 232) further explained, "Conceptual validity is critical for ... diagnostic criteria, because all other types of validity, such as predictive or construct validity, are relevant to psychodiagnosis only if whatever is being validity measured or predicted is, indeed, a disorder." The discussion of diagnostic validity in this article is generally equivalent to Wakefield's idea of *conceptual validity* -- whether the diagnosis accurately discriminates between what is reasonably considered a mental disorder and what is not. In addition, the following discussion will consider the extent to which certain mental disorders have *face validity*, which refers to the extent to which a measurement, or, in this case, a diagnosis, appears to make common sense and is persuasive (Lacity & Jansen, 1994).

A critical component of diagnostic validity is *reliability*. *Diagnostic reliability* "concerns the consistency with which diagnoses are employed by different clinicians or on different occasions" (Bentall, 2003, p. 43). Bentall (2003) explained the relationship between the concepts of validity and reliability as follows:

> If two psychiatrists met the same patient, we would expect both to make the same diagnosis. Similarly, we would expect a patient to be assigned the same diagnosis on two different occasions (unless the patient recovered and later developed a separate illness altogether). Without this kind of diagnostic consistency, there would be no way of agreeing about who suffers from a particular disorder and who does not. [....] Of course, while reliability does not guarantee validity, it is obvious that *a diagnostic system cannot be valid without first being reliable.* Unless psychiatrists and psychologists can agree about which patients suffer from which disorders, there is no possibility that the process of diagnosis will fulfill any useful function. (p. 43, p. 68)

Since diagnostic reliability is an essential requirement for diagnostic validity, this article will examine the reliability of the diagnoses used in civil commitment – both in case types in which psychosis is a requirement for civil commitment and in post-*Hendricks* types in which it is not.

**Diagnostic Validity as a Legal Requirement of Substantive Due Process**

The U.S. Supreme Court justices deciding *Hendricks* and *Crane* also recognized a substantive due process form of conceptual validity for psychodiagnosis. In *Kansas v. Crane* (2002), the Court limited the scope of SVP commitments as follows:

> [T]here 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. (p. 413)

In other words, the justices suggested that, in order for a civil commitment statute to be consistent with the constitutional limits on State power imposed by the Fourteenth Amendment's Due Process Clause, the statute's criterion for committability that specified a mental condition, i.e., "mental disorder" or "mental abnormality," would have to distinguish persons who have that condition from those who do not. The recognition that diagnostic validity might raise substantive due process implications was also evident in the following colloquy between Justice Souter and the Kansas Attorney General in the oral argument in *Hendricks* (1996, Oral Argument, pp. 20-22), in which the Kansas Attorney General was defending Kansas's use of a civil commitment criterion that allowed commitment of a person alleged to have a "mental abnormality or personality disorder":

> SOUTER: When you speak of a--I think you spoke of a medically--you didn't use the word medically recognized category. What was the term you used?
>
> GENERAL STOVALL: Medically justified.
>
> SOUTER: Medically justified. Do you mean by that a category which is recognized in some standard medical literature like the DSM manual?
>
> GENERAL STOVALL: I don't think we are limited, Justice Souter, just to the DSM, but I think certainly the psychiatric community has to believe that this is a condition that they can identify and diagnose, but it would not--
>
> SOUTER: You don't take the position that the--or maybe you do, that the legislature of any State could say, we recognize a category of mental abnormality or mental illness. It hasn't been recognized in any medical or psychiatric literature, but we're recognizing it now, and that satisfies the rule that requires some mental illness element. You wouldn't say that a State could do that.
>
> GENERAL STOVALL: That would not be the argument the State would make. We're very comfortable with the fact that what we're describing is medically justified.
>
> SOUTER: What is the function of this medical recognition as you understand it under Foucha? Why do we have this element? Why do we--why would you say--why do you say that in order to satisfy the mental illness element under Foucha there has got to be a medically recognized category within which the particular individual falls?
>
> GENERAL STOVALL: I think so that the Court doesn't worry that we confine merely for dangerousness or merely for a class of people that we don't want to be around. We need to--to be able to civilly commit and provide treatment for them it has to be a medically recognized condition, I--
>
> SOUTER: It's less likely to be abused if there's a categorical approach rather than a purely individual approach.
>
> GENERAL STOVALL: That would be correct.

In this colloquy, the Kansas Attorney General and Justice Souter are referring to Justice O'Connor's concurring opinion in *Foucha v. Louisiana* (1992, p. 83), in which she stated that civil commitment could not be justified "absent some medical justification for doing so; in such a case the necessary connection between the nature and purposes of confinement would be absent."

In Justice White's plurality opinion in *Foucha* (1992, p. 76, nt. 3), he refers to the need for psychiatric opinion to be "reliable enough to permit the courts to base civil commitments on clear

and convincing medical evidence that a person is mentally ill and dangerous." In the above-quoted colloquy, the Kansas Attorney General, while initially contending that a state would not need a *DSM*-recognized mental disorder to justify civil commitment, upon being pressed by Justice Souter, agrees with him that a "medically recognized" "categorical" approach is "less likely to be abused." Thus, diagnostic validity is not simply an issue for psychodiagnosis; it is also relevant to issues of constitutional law and sound public policy.

In this regard, it is noteworthy that, in *Kansas v. Hendricks* (1997) – the decision that marked the turning point between civil commitment being primarily used for persons with psychotic disorders to it being used for persons with non-psychotic disorders – Justice Kennedy warned, in his concurring opinion, *"[I]f it were shown that mental abnormality is too imprecise a category to offer a solid basis for concluding that civil detention is justified, our precedents would not suffice to validate it"* (p. 373) [italics supplied]. If Justice Kennedy had not joined the four other justices who made up the majority in *Hendricks*, the case would have probably resulted in the Kansas commitment law being struck down as unconstitutional. Thus, the conceptual validity of psychodiagnosis becomes pivotal in considering the viability of law and social policy that allow civil commitment without psychosis.

**Validity and Reliability of the Diagnosis of Psychosis**

Prior to the 1990s, civil commitment proceedings in the United States were limited primarily to persons with psychotic disorders. Numerous studies of involuntary hospitalization and civil commitment of persons alleged to be mentally ill have shown that nearly all such persons are diagnosed with psychotic disorders, and that the presence of psychotic symptoms is critical to the decision to recommend commitment (Segal, Watson, Goldfinger, & Averbuck, 1988; Thompson & Ager, 1988; Bagby, Thompson, Dickens, & Nohara, 1991). Given that the diagnosis of a psychotic disorder was generally essential to civil commitment prior to *Hendricks* and *Crane*, consideration of the diagnostic validity and reliability of such diagnosis is relevant to the justifiability of this use of the state's civil commitment authority.

Psychotic disorders comprise the diagnoses that psychiatry and clinical psychology consider to be the "major" mental illnesses, including: schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder with psychotic features (APA, 2000b, pp. 750-751). Of all of the diagnoses in *DSM-IV-TR,* the diagnoses of psychotic disorders probably have the most conceptual validity and face validity. Hollingshead and Redlich (1958) coined the term *lay appraisal* to identify the social judgments that family members and acquaintances of a mentally ill person make of that person's behavior to assess the extent to which the behavior constitutes mental illness. Such public conceptions of what constitutes mental illness are a good indication of the extent to which the psychodiagnostic categorization of particular behavior as mental illness or mental disorder has face validity.

Link, Phelan et al. (1999) used nationwide survey data to assess public attitudes about what constituted mental illness. They presented the survey sample with five vignettes, four of which described symptoms that corresponded to *DSM* diagnoses, and one that described a person who was troubled, but who arguably did not qualify for a *DSM* diagnosis. Of the five diagnostic depictions, the only one that the survey respondents overwhelming (88%) identified as "mentally ill" was the one that described paranoid schizophrenia with psychotic symptoms of delusions and auditory hallucinations. A vignette depicting symptoms of major depressive disorder – a diagnosis that may include psychotic symptoms -- was identified by 69% of the

survey sample as mental illness. Depictions of alcohol dependence and cocaine dependence were considered mental illnesses by less than half of the surveyed sample.

Cross-cultural studies have yielded similar data, suggesting that the perception of mental disorder as being limited to psychotic disorders is not limited to Western cultures. For example, in Nigerian and Malaysian villages, the labels *madman* or *crazy* are applied only to people who display psychotic symptoms (Warner, 1994). Indeed, there is considerable evidence that the psychotic symptoms of hallucinations and delusions that correspond with Western diagnostic categories of schizophrenia are largely consistent with cross-cultural perceptions of mental illness worldwide (Jablensky, Sartorius et al., 1992).

Although there has been considerable public debate about the extent to which civil commitment is an effective or appropriate intervention with psychotic patients who refuse psychiatric treatment, there is little disagreement within the mental health professions or the general public about whether people who display psychotic symptoms are "crazy" or "obviously ill" (Treffert, 1985). As is admitted in *DSM-IV-TR* (APA, 2000b, p. xxx), "[N]o definition adequately specifies 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." Yet, even among the strongest critics of the medical-model approach to the classification of mental disorders, as reflected in the *DSM,* there is agreement as to the validity of the diagnosis of psychotic behavior as mental disorder (Bentall, 1993).

Although there is relatively broad consensus in the mental health professions and within the general public that psychotic behavior equates with the concept of "mental disorder," the research as to reliability (rate of agreement) of diagnoses of psychotic disorders shows variable outcomes. A milestone in the history of the *DSM* was the 1980 revision that was embodied in *DSM-III* (APA, 1980), in which "[g]reat emphasis was given to attempts to improve reliability" (Kutchins & Kirk, 1997, p. 252). "Since discretion was viewed as the breeding ground for diagnostic unreliability, the developers of *DSM* sought to control discretion by using checklists, structured interview schedules, and formal decision rules" (Kutchins & Kirk, 1997, p. 252).

Interrater diagnostic reliability -- the extent to which one clinician's diagnosis of a patient will agree with that of another clinician -- is usually measured by a statistic called the kappa coefficient, which, as the drafters of *DSM-III* explained, "indexes chance-corrected agreement. A high kappa (generally 0.7 and above) indicates good agreement as to whether or not the patient has a disorder within that diagnostic class" (Spitzer, Forman, & Nee, 1979). Schizophrenia, one of the major psychotic disorders, received coefficients that were generally near or above the 0.7 standard in the field trials for *DSM-III,* especially when broader diagnostic categories were used, such as schizophrenia instead of paranoid schizophrenia (Kirk & Kutchins, 1992, pp. 143-151). However, many interrater diagnostic reliability studies completed subsequent to the *DSM-III* field trials were less encouraging, achieving kappa coefficients well below the 0.7 standard for the psychotic disorders (Kirk & Kutchins, 1992, pp. 151-156).

However, when psychotic *symptoms* are assessed that would allow a diagnostician to determine simply whether the person has a psychotic disorder or not, the reliability coefficients appear to be consistently above the 0.7 standard (Muller & Wetzel, 1998; Carter, Mackinnon, Howard, Zeegers, & Copolov, 1995; Haddock, McCarron & Tarrier, 1999). This fact is relevant to the civil commitment context where, in determining whether a statutory commitment standard requiring a psychotic disorder is met, a determination of the *specific* psychotic disorder diagnosis may be unnecessary, as well as being impractical given short timeframes in which such

commitment proceedings are typically held. Thus, in a commitment proceeding in which the judge or jury is required to determine whether or not the person facing commitment is "mentally ill," and this concept is understood to mean "a psychotic disorder," examining psychiatrists and psychologists are very likely to have a high rate of agreement as to whether or not the person meets that commitment standard, though they might have a lower rate of agreement as to the diagnosis of the specific psychotic disorder.

**General Diagnostic Validity Issues with the "Paraphilias" Category**

Although there is general public and professional consensus that persons who are psychotic are validly conceptualized as being mentally ill, there is much less consensus that persons whose sexual behavior deviates from social norms are so conceptualized. Because *Hendricks* and *Crane* gave states the constitutional license to civilly commit sex offenders, renewed attention has been focused on the extent to which persons with what *DSM-IV-TR* refers to as *paraphilias* possess the "mental disorder" or "mental abnormality" that makes them qualify under a civil commitment law for so-called "sexual predators," "sexually dangerous persons," or "sexually violent persons" (SVPs).

The paraphilias, as listed in *DSM-IV-TR*, include the following diagnoses: exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and paraphilia-not-otherwise-specified (paraphilia-NOS) (APA, 2000b, pp. 566-576). Criterion A of the general diagnostic category of paraphilias in *DSM-IV-TR* requires that the person demonstrate "recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving 1) nonhuman objects; 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months" (APA, 2000b, p. 566). Criterion B requires that the person be distressed or have impaired functioning, except for the diagnoses of pedophilia, voyeurism, and sexual sadism, which can be made based solely on the person having acted on his or her paraphilic urges.

These diagnostic criteria cast a wide net for a variety of sexual behaviors that are commonly found in American culture, raising questions about the conceptual validity of the paraphilias as a diagnostic category. For example, does a woman whose sexual urges involve the use of a "nonhuman object" called a vibrator, and whose husband divorces her because she prefers sexual gratification with the vibrator to having sex with him, have a paraphilia? Some diagnosticians might consider the breakup of a marriage to constitute the "impairment in social functioning" needed to apply the diagnosis. Does a man qualify for a paraphilia diagnosis if he engages in consensual sexual activity that involves the humiliation of his sexual partner, if he is fired from his job when his boss discovers the couple's sexual-role-play dungeon during a visit to their home? Again, loss of a job could be considered "impairment of occupational functioning" so as to qualify for a paraphilia diagnosis. The general criteria for this diagnostic category are broad enough to encompass these and many other common sexual behaviors involving consenting adults. As will be explained, this fact has serious diagnostic and legal implications when these general diagnostic criteria are used to justify a diagnosis of paraphilia-NOS.

Considering paraphilias to be a mental abnormality for purposes of civil commitment raises further issues of psychodiagnostic conceptual validity. The first issue of validity is raised by the fact that many of the states that enacted SVP commitment laws in the 1990s also enacted and subsequently repealed so-called sexual psychopathy laws in the 1930s through the 1980s. As explained previously, the major rationales for this repeal was the recognition by the mental health professions that, "The notion is naive and confusing that a hybrid amalgam of law and

psychiatry can validly label a person a 'sex psychopath' or 'sex offender' and then treat him in a manner consistent with a guarantee of community safety" (Group for Advancement of Psychiatry, 1977, p. 935). The State of Washington, which was the first state to enact an SVP law, did so only 6 years after repealing its sexual psychopathy law (Morris, 2000). Morris (2000, p. 1200) noted that the repeal of sexual psychopathy laws nationally had been based on the inability of mental health professionals "to identify a specific mental disorder experienced by individuals who should be included within the targeted group and the lack of successful treatment methodologies to improve their condition."

How could psychodiagnosis of sex offenders for civil commitment be conceptually invalid in the 1980's, and then suddenly regain validity a few years later? It would be difficult to imagine a physical condition being considered a disease, then being debunked as a disease, only to be relabeled a disease a few years later. Furthermore, the second rationale for repealing the sexual psychopathy laws – lack of successful treatment methodologies – appears to have equal applicability to current SVP commitment laws, because the research regarding the treatment of sex offenders continues to show that treatment has little or no effect on sexual recidivism rates (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005; Lösel & Schmucker, 2005). For example, Hanson, Broom, and Stephenson (2004) compared the recidivism rates of 403 treated sex offenders to those of 321 untreated sex offenders over a 12-year period and found no significant differences between the two groups as to sexual recidivism, violent recidivism, or general recidivism.

Thus, we cannot justify conceptualizing the paraphilias as mental disorder by asserting that illegal paraphilic behavior is more amenable to treatment than other criminal behavior unrelated to mental disorder. Given that amenability to treatment does not clearly distinguish paraphilic sex offenders from other criminals, SVP commitment proponents may have a difficult time proving that "the severity of the mental abnormality itself ...[is] sufficient to distinguish the dangerous sexual offender ... from the dangerous but typical recidivist convicted in an ordinary criminal case," (p. 413) – a form of diagnostic validity required as a matter of substantive due process by *Kansas v. Crane* (2002).

Polaschek (2003) has questioned the conceptual validity of the diagnostic category of paraphilias in the *DSM*, noting, "[A]n immediate source of heterogeneity is the various combinations of features that are possible" (p. 156) for the diagnosis, as set forth in Criterion A and B of the diagnostic criteria. He added:

> There are a variety of bases on which a diagnostic category can be of value to the health professionals and researchers who work with the conditions concerned. It can enhance our understanding of etiology, prognosis (or with offensive behavior, risk assessment), and treatment planning, for example. If it doesn't achieve any of these pragmatic aims, then at least it can provide a descriptive basis for grouping like cases together. Really for sexual offending, the *DSM-IV* fails on all grounds. There is no evidence that those who meet the criteria for paraphilia are more or less treatable than those who do not, or that they require a similar or a different approach to treatment. There is no evidence that those with the paraphilia are more or less likely to reoffend than those without. What evidence does exist suggests that there are no obvious differences in prognosis or treatment between those offenders who meet criteria and those who do not. (p. 157).

The position of the APA on the issue of the psychodiagnostic validity of the paraphilias is paradoxical. On the one hand, it has included the paraphilias as a diagnostic category in *DSM-IV-TR* (APA, 2000b, pp. 566-576). On the other hand, it argued against the civil commitment of persons based on paraphilias in both *Hendricks* and *Crane* by filing *amicus curiae* briefs with the

U.S. Supreme Court urging that the Kansas SVP law be held unconstitutional or at least be constitutionally limited (APA, 1995, 2000a). It explained that the *DSM* is not designed "to identify those subject to various legal standards, such as those for involuntary confinement" (APA, 1995, p. 11). Thus, the organization appeared to be maintaining that a category such as the paraphilias is valid for purposes of diagnosis and treatment, but not as a basis for civil commitment.

Nevertheless, the paraphilias are commonly the diagnostic basis for the "mental abnormality" or "mental disorder" that is alleged as part of SVP commitment proceedings. Of these paraphilia diagnoses set forth in *DSM-IV-TR*, the ones most commonly used in SVP commitment cases are: pedophilia and paraphilia-NOS (Becker, Stinson, Tromp, & Messer, 2003; Levenson, 2004a). Therefore the discussion of diagnostic validity and reliability in the following sections of this article will focus on these two paraphilias.

However, in considering the broader issue of the social policy implications of allowing civil commitment without psychosis, it should be kept in mind that, potentially, even a seemingly harmless paraphilic diagnosis, such as fetishism, could form the basis for an SVP commitment, if, for example, a man with fetishism was sexually aroused by women's underwear, and committed a burglary to steal women's underwear and thereby satisfy this sexual arousal. Such a case could occur in Wisconsin, which has a typical SVP commitment law, and which permits the civil commitment of "sexually violent persons" whose only offense is burglary, if the crime is found to have been "sexually motivated" (Wisconsin Sexually Violent Person Commitments Law, Wisconsin Statutes, §§ 980.01(6)(b), 2003-2004). Although the likelihood of such a commitment is probably low, the fact that the law would even allow it speaks volumes about the social control potential inherent in the underlying diagnosis.

**The Prevalence of the Diagnosis of Pedophilia in SVP Commitment Cases**

LeRoy Hendricks, the Kansas sex offender whose case led to the U.S. Supreme Court's landmark decision in *Kansas v. Hendricks* (1997, p. 355), admitted that when he "gets stressed out," he "can't control the urge" to have sexual contact with children. Pedophilia was the diagnosis that led to the *Hendricks* decision, and it is one of the most frequently made diagnoses in SVP cases. For example, in a review of 120 cases of men committed as SVP's in Arizona, Becker, Stinson, Tromp, and Messer (2003) found that 63% had been diagnosed with pedophilia. In a study of 450 male sex offenders who were considered for SVP commitment in Florida, the diagnosis that had the third highest correlation with a decision to commit was pedophilia (Levenson, 2004a). Fitch (2003) reviewed diagnostic data for men committed as SVPs in 14 states, and found that in 12 of those states, at least 70% of sex offenders committed had a paraphilia diagnosis, and, of that percentage, 45-88% had a diagnosis of pedophilia.

The files of 193 sex offenders who had been evaluated by Wisconsin Department of Corrections psychologists for SVP commitment between 1995 and 2005 were reviewed for this article to determine prevalence of diagnosis. Of that number, 71 (37%) had a diagnosis of pedophilia as at least one of their diagnoses. Of 242 men committed to Wisconsin's SVP facility on June 10, 2005, 143 (59%) had a firm or provisional diagnosis of pedophilia (L.G. Sinclair, personal communication, June 10, 2005). Clearly, the diagnosis of pedophilia is a major basis for SVP commitments.

**The Debate About the Validity of the Diagnosis of Pedophilia**

*DSM-IV-TR* (APA, 2000b, p. 572) defines the criteria for a diagnosis of pedophilia (Code 302.2) as follows:

> A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).
>
> B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
>
> C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.
>
> *Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12 or 13-year old.*

There has been considerable debate within the fields of psychiatry and clinical psychology about the conceptual validity of the diagnosis of pedophilia. There is no credible dispute about the fact that society legitimately criminalizes sexual behavior between adults and prepubescent children. But the fact that behavior is legitimately deemed a crime does not, by itself, justify its being labeled a mental disorder. If it did, the *DSM* could incorporate the criminal codes of every state. Thus, for example, though Moser and Kleinplatz (n.d., p. 11) make it clear that they do not condone sexual activity between adults and children, they forcefully argue for the removal of the entire paraphilia category from the *DSM,* and they note that, if the paraphilias were removed from the *DSM*, this diagnostic category would not be relied on by adults who have sex with children to avoid criminal responsibility by asserting an insanity defense.

In questioning the conceptual validity of the diagnosis of pedophilia, Green (2002) cited numerous anthropological studies that have documented the acceptance of adult-child sexual activity in other cultures (Ford & Beach, 1951; Diamond, 1990; Bauserman, 1997; Bullough, 1990). Among the Siwans or North Africa and Aranda aborigines of Central Australia, pederasty (sexual relationships between men and boys) was an accepted cultural practice found by Ford and Beach (1951). Diamond (1990) described heterosexual relationships between men and prepubescent girls in Hawaii and Polynesia as commonly accepted, and viewed as beneficial to the girls. Bauserman (1997) documented pederasty between men and boys ages 10 or 11 in New Guinea. Green (2002) also pointed to the fact that, until the end of the 19th century, the legal age of sexual consent in England was 10. "This was not in some loin cloth clad tribe living on the side of a volcano, but the nation that for six centuries was already graduating students from Oxford" (Green, 2002, p. 468). Child prostitution was rampant in England during the late nineteenth century (Bullough, 1990). Green (2002, p. 468) asked, "Were all customers pedophiles? Were they all mentally ill?"

Indeed, it has been well documented that pederasty was an accepted cultural practice in ancient Greece (Bloch, 2001). In China, until the mid-20th century, boys were married to adult women, and sexual activity between them was an accepted cultural practice (Lou, 1970). Today, in Ethiopia, child brides as young as 7 are married to adult men (Salopek, 2004a). In the U.S., it was not long ago that child brides as young as 10 years old were permitted to be married in some states; indeed, in Texas, sixty 14-year-old girls were married in 2002 (Salopek, 2004b). In the wake of volumes of evidence from history and from anthropological research that sexual activity between adults and prepubescent children has been accepted in many cultures -- including subcultures in the U.S. -- the rhetorical questions posed by Green (2004, p. 468) are, "[A]re we to

conclude that all the adults engaged in these practices were mentally ill? If arguably they were not pedophiles, but following cultural or religious tradition, why is frequent sex with a child not a mental illness under those circumstances?"

Green (2002) cited further evidence to question the conceptual validity of the diagnosis of pedophilia. First, several studies have found that a significant percentage of members of the general public report sexual attraction to prepubescent children. Briere & Runtz (1989) surveyed 200 university males and found that 21% reported some sexual attraction to small children, 9% experienced sexual fantasies involving children, 5% had masturbated to fantasies of children, and 7% said that they might have sex with a child if not caught. In another sample with 100 male and 180 female undergraduate students, 22% of males and 3% of females reported feelings of sexual attraction to a child (Smiljanich & Briere, 1996).

Second, Green (2002) pointed to five studies that measured penile arousal in men who were recruited from community samples. These studies found that 17-58% of the men had measured arousal when shown images of prepubescent girls. For example, Hall, Hirschman, & Oliver (1995) found that, in a community sample of 80 men with no history of pedophilic behavior, 26.25% showed penile arousal when shown slides of prepubescent girls. These researchers reported that their findings replicated the findings of four other studies reported within the previous 6 years.

O'Donohue, Regev, and Hagstrom (2000) pointed to the vagueness of the diagnosis of pedophilia, in questioning the validity of this *DSM* diagnostic category. They argued that Criterion A of the diagnosis "seems too vague and thus precludes the clinician from assessment without making inferences" (p. 99). Criterion A requires that the person diagnosed with pedophilia have, "[o]ver a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children" (APA, 2000b. p. 572). O'Donohue et al. point out that, because such terms as "recurrent" "intense," and "behaviors involving sexual activity with a prepubescent child" are undefined, "This imprecision can result in both false positive and false negative diagnoses, because of the level of inference required" (p. 99). As an example, they asked:

> If a person chooses to work as a school bus driver because it fulfills a sexual desire to be around children, is that choice considered a behavior that is sufficient to fulfill the criterion? Suppose that the driver has not actually touched a child in an inappropriate manner, but is clearly behaving because of his or her sexual attraction. Does that constitute a behavior that is sufficient to meet this criterion? Another noncontact behavior, for example, might be purchasing child pornography. Would that constitute a behavior that is sufficient to meet the criterion? Should clinicians be assessing micro-responses, such as staring at children, in order to assess for pedophilia? Could this constitute relevant behavior for the diagnosis? Again, because the criterion is unclear, it becomes difficult for clinicians to reliably diagnose this disorder. (p. 100).

Of course, numerous clinicians have defended the conceptual validity of the diagnosis of pedophilia. Berlin (2002), though acknowledging that some societies might not view adult-child sexual behavior as necessarily disordered, defends the diagnosis in our society because (a) pedophiles may have volitional impairments to indulge their "unacceptable cravings" that are involuntary; (b) pedophilia should be considered a disorder because it leads to psychological burdens and impairments; and (c) labeling pedophilic behavior a disorder leads to treatment for the pedophile and research about pedophilia. Berlin's defense could apply equally well to homosexuality, which, three decades ago, was a *DSM* paraphilia diagnosis, because it was

considered an "unacceptable craving" that caused psychological burdens and impairments, albeit because of societal intolerance (Bayer, 1981)

Spitzer[5] and Wakefield (2002) have also defended the conceptual validity of the diagnosis of pedophilia. They argued that pedophilia is a valid diagnostic category, because it is a "harmful dysfunction" that causes pedophiles to be "less likely to reproduce and pass on their genes to their progeny than individuals whose sexual attraction function is working properly" (p. 500). Anticipating an obvious counterargument, they asserted that their rationale does not justify consideration of homosexuality as a mental disorder, because "homosexuality does not necessarily involve harm to self or others and thus cannot be classified as a disorder" (p. 500). This attempted distinction ignores the reality that social judgments about whether a sexual orientation is harmful to self and others vary depending on changing cultural values – again, as evidenced by the fact that homosexuality only 30 years ago was considered a mental illness (Bayer, 1981) – and, to a minority of clinicians, it is still so considered.[6]

Unquestionably, adult-child sexual behavior can cause serious psychological harm to the child. However, contrary to the assertions of Spitzer and Wakefield, adult-child sexual behavior does not *always* result in harm to the child (Briere & Elliott, 1994; Kendall-Tackett, Williams, & Finkelhor, 1993). In a comprehensive meta-analysis, Rind, Tromovitch, and Bauserman (1998) documented that many children who had child-adult sexual experiences did not suffer adverse psychological consequences. Berlin (2002, p. 480) cited this study to observe that, while adult-child sexual behavior may be considered morally and/or legally *wrong*, it is not necessarily psychologically *harmful*, adding, "How many youngsters have been inadvertently hurt, treated as if they must inevitably have become 'damaged goods,' because of a failure to distinguish between having been wronged versus having been harmed?"

In the Rind, Tromovitch, and Bauserman (1998) study referred to by Berlin, the researchers statistically examined the correlations between child-adult sexual experience, family environment, and psychological adjustment in a large group of studies based on college samples. They found that although child sexual experience with adults was associated with adjustment problems for the child, this effect was heavily confounded with poor family environment. In fact, the factor of family environment predicted adjustment variance better than child-adult sexual experience by a factor of 10. When they examined studies that controlled for family environment, statistically significant correlations between child-adult sexual experience and childhood adjustment problems usually disappeared. These results call into question the common assumption that child-adult sexual experience inevitably causes psychological problems for the child.

Sbraga and O'Donohue (2003) presented a strong argument to question the expertise of many expert witnesses in child sexual abuse court testimony. They argued that by employing *post hoc* (backward) reasoning from current symptomatology to past child sexual experience with

[5] A major article in *The New Yorker* magazine referred to Spitzer, as the "one man [who] revolutionalized psychiatry" by leading the APA's effort to make the *DSM* the "instrument of enormous power" that it is, as a determinant for health insurance reimbursement, and the ultimate authority for what constitutes mental disorder for the mental health professions, the courts, government, schools, etc. (Spiegel, 2005, pp. 56-57).

[6] Interestingly, Spitzer and Wakefield appear to be allied with this minority. Spitzer (2003) is the author of a major study purporting to show the benefit of homosexual "reparative therapy" to convert homosexuals into heterosexuals – a practice that Wakefield (2003, p. 459) has called "ethically defensible" because it can lead to "more satisfying lives," but that the APA has condemned as unscientific and unethical (APA, 2000c).

adults, expert opinion is scientifically invalid and should not be offered or allowed. Observing that these experts usually base their *post hoc* reasoning on one of several models of assumed consequences of child sexual experiences with adults, these researchers demonstrated the lack of scientific validity of these models. Rind (2003) elaborated on the reasoning of Sbraga and O'Donohue, offering case studies in which adults, who had child sexual experiences with adults, reported them as positive contributions to their psychosexual development. Rind (2003) concluded his treatise by cautioning:

> This is not to argue that CSA [child sexual abuse] does not cause psychological harm in particular cases. Rather the point is that the assertion that CSA invariably or even typically causes psychological harm is highly suspect on empirical, statistical, and methodological grounds. Thus, it is inadvisable for researchers or clinicians automatically to assume that CSA explains current psychological problems, especially when there is evidence for confounding factors.... Societal ignorance or forgetfulness of the logical fallacy *posthoc ergo propter hoc* (after this therefore because of this) is pervasive on this issue, perhaps in part because people do not want to appear to be unsympathetic to victims. But the role of scientific psychology should be to get beyond such motivations and examine nature as it is, applying rigorously rational and empirical approaches. (p. 353, p. 356)

In summary, the debate about the conceptual validity of the diagnosis of pedophilia centers around how adult-child sexual activity can be deemed pathological when it is, and has been, so prevalent cross-culturally and historically, and when the core feature of it – arousal to images of naked children – is so commonly found in the general public. Again, while there is unanimity of opinion in the serious clinical world about the legitimacy of laws prohibiting adult-child sexual behavior, the diagnostic codification of such behavior as a mental disorder remains the focal point of considerable debate within the mental health professions. In contrast, as explained previously, there is virtually no serious debate within psychiatry and clinical psychology that psychotic disorders – the traditional basis for civil commitment -- are appropriately conceptualized as mental disorder.

**Reliability of the Diagnosis of Pedophilia**

The published research regarding the interrater reliability of the diagnosis of pedophilia is very sparse. Although the field trials for *DSM-IV* studied interrater reliability for many of the major diagnostic categories, no field trials were conducted for any of the paraphilia diagnoses (O'Donohue, Regev, & Hagstrom, 2000). The paucity of research to verify the interrater reliability of the pedophilia diagnosis is remarkable given the serious implications it can have on an individual so labeled, particularly in the wake of the SVP commitment laws sanctioned in *Hendricks* and *Crane.*

Interestingly, the only published research regarding the diagnosis of pedophilia is in the context of SVP commitment cases. Levenson (2004b) looked at the cases of 295 sex offenders who were evaluated by two independent psychologists or psychiatrists hired by an independent agency to assess whether the men should be referred for SVP commitment. In evaluating interrater reliability between examiners, Levenson used the kappa coefficient standard recommended for critical decisions by Bloom, Fischer, and Orme (1999), in which a co-efficient below 0.60 is considered poor, 0.60 to 0.74 is considered fair, and 0.75 to 1.0 is considered good. Other researchers have advocated even higher standards for evaluating inter-diagnostician agreement in forensic settings (Marshall, Kennedy, Yates, & Serran, 2002). In Levenson's study, the diagnosis of pedophilia had only a 0.65 kappa coefficient, thus falling into the "fair" category

recommended by Bloom et al. (1999), and even falling below the lower level of acceptability (0.70) for clinical (not forensic) diagnosis recommended by Spitzer, Forman, and Nee (1979).

**Prevalence of the Diagnosis of Paraphilia-NOS in SVP Commitment Cases**

Another common diagnosis in SVP commitment cases is paraphilia-not-otherwise-specified (NOS). In a study of 120 men who were civilly committed as SVPs in Arizona, Becker, Stinson, Tromp, and Messer (2003) found that 56% had been diagnosed with paraphilia-NOS. In a study of 450 male sex offenders who were considered for SVP commitment in Florida, the diagnosis that had the highest correlation with a decision to commit was paraphilia-NOS (Levenson, 2004a). Fitch (2003) reviewed diagnostic data for men committed as SVPs in 14 states, and found that in 12 of those states, at least 70% of sex offenders committed had a paraphilia diagnosis, and, of that percentage, 35-60% had a diagnosis of paraphilia-NOS in five states.

The files of 193 sex offenders who had been evaluated by Wisconsin Department of Corrections psychologists for SVP commitment between 1995 and 2005 were reviewed for this article to determine prevalence of diagnosis. Of that number, 86 (45%) had a diagnosis of paraphilia-NOS as at least one of their diagnoses. Of 242 men committed to Wisconsin's SVP facility on June 10, 2005, 98 (40.5%) had a firm or provisional diagnosis of paraphilia-NOS (L.G. Sinclair, personal communication, June 10, 2005). Clearly, consideration of this diagnosis is critical to an analysis of the diagnostic implications of *Hendricks*, *Crane*, and the body of law allowing civil commitment without psychosis.

**Doren's Argument in Favor of the Diagnosis of Paraphilia-NOS-Nonconsent**

*DSM-IV-TR* (APA, 2000b, p. 572) codes the diagnosis of paraphilia-NOS as 302.9, and defines it as follows:

> This category is included for coding paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

The most widely-recognized proponent of the applicability of the diagnosis of paraphilia-NOS to sex offenders is Dennis M. Doren, a Wisconsin psychologist who is the evaluation director of Wisconsin's SVP commitment program. In his widely-circulated book, *Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond* (2002), he devotes 22 of the 199 pages of text to his explanation and defense of the legitimacy of the diagnosis of paraphilia-NOS for certain sex offenders. Doren and his book have had a major influence on psychologists and psychiatrists who do evaluations of sex offenders for SVP commitment cases. Between 1994 and May, 2005, he conducted 74 training sessions regarding "sex offender civil commitment assessments" in 17 U.S. states, the District of Columbia, and three Canadian provinces (Doren, 2005). His book is on the suggested reading list for written and oral examinations of the American Board of Forensic Psychology (ABFP) for persons applying for Diplomate certification from that prestigious organization (ABFP, 2003, p. 3). Because the high prevalence of the diagnosis of paraphilia-NOS is consistent with Doren's argument favoring it – and may be a consequence of his widely-espoused position – a detailed analysis of his position follows.

Doren (2002, pp. 63-80) defended the use of this diagnosis for certain sex offenders with histories of sexual assaulting adults – a diagnosis he calls "paraphilia-NOS-nonconsent," acknowledging, "This category probably represents the most controversial among the commonly diagnosed conditions within the sex offender civil commitment realm." He argued that the

diagnosis is accepted among researchers and expert witnesses in sex offender cases, citing transcripts of testimony from SVP hearings and personal correspondence from such experts. However, he acknowledged that, in the *DSM,* there is "no separately listed paraphilia of this type" (p. 63), and offers speculation that the specific diagnostic category for a rape-related paraphilia may have been omitted because of unspecified "legal, political, and fiscal concerns" (p. 64).

Although *DSM-IV-TR* (APA, 2000b, p. 574) does not include a specific diagnostic category for a rape-related paraphilia, it does have a diagnostic category for sexual sadism, coded as 302.84 and set forth with the following criteria:

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The person has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

In the text description of this diagnosis in *DSM-IV-TR* (APA, 2000b, p. 573), examples of sexually sadistic behaviors are offered: "restraint, blindfolding, paddling, spanking, whipping, pinching, beating, burning, electrical shocks, *rape*, cutting, stabbing, strangulation, torture, mutilation, or killing" [italics supplied]. This text emphasizes that in sexually sadistic behavior, "it is the suffering of the victim that is sexually arousing" (APA, 2000b, p. 573).

Doren (2002) differentiated between rapists who are sadists and those who are not, explaining that, whereas a diagnosis of sexual sadism requires that the person find sexual excitement in the suffering of his victim, a diagnosis of paraphilia-NOS-nonconsent is appropriate "[i]f the offender has repetitively and knowingly enacted sexual contact with nonconsenting persons over a period of at least 6 months (*specifically for sexual arousal to the nonconsensual interaction*), and the behavior has caused him significant impairment in social, occupational, or other areas of functioning" (p. 67) [italics supplied]. In other words, whereas the core feature of sexual sadism is sexual excitement about the victim's suffering, the core feature of Doren's paraphilia-NOS-nonconsent diagnosis is sexual arousal to nonconsensual sexual interaction. Doren (2002) noted that approximately 2-4% of rapists find sexual excitement specifically in the suffering or humiliation of their victims (p. 67). This research finding of the low incidence of sexual sadism among rapists was explicitly stated in the description of the diagnosis of sexual sadism in *DSM-III-R* (APA, 1987), which put the figure at less than 10% (p. 288).

Doren (2002) suggested that a diagnosis of paraphilia-NOS-nonconsent is appropriate for cases in which the rapist's arousal to the nonconsensual aspect of the sexual assault is evidenced by such overt behavior as (a) ejaculation or other clear signs of sexual arousal during events that are clearly nonconsensual; (b) repetitive patterns of apparently scripted actions; (c) where virtually all of the person's criminal behavior is sexual; (d) raping when the victim had been willing to have consensual sex; (e) short time period after consequence before raping again; and (f) other factors that he identified as being indicative of the rapist being primarily aroused by the nonconsensual nature of the assault (pp. 68-77).

Of 242 men committed to the SVP facility in Doren's home state of Wisconsin on June 10, 2005, 98 (40.5%) had a firm or provisional diagnosis of paraphilia-NOS; of this number, the diagnoses of 50 men had the "nonconsent" specifier, while the remaining 48 had an "other" specifier. (L.G. Sinclair, personal communication, June 10, 2005). Given the apparent widespread

acceptance of Doren's diagnosis of paraphilia-NOS-nonconsent by forensic experts in the field (Becker, Stinson, Tromp, & Messer, 2003; Levenson, 2004a) and even by one psychologist who has been a strong critic of Doren (Campbell, 2004, p. 179), it is apparent that Doren's position as to the legitimacy of this diagnosis has been very influential. Nevertheless, as will be explained, the use of this diagnosis appears to be contrary to the intent of the drafters of *DSM-IV-TR* and the previous two editions of the *DSM,* as evidenced by (a) the wording of the *DSM-IV-TR* diagnosis of paraphilia-NOS; (b) the interpretation of that diagnostic category by experts in the study of the paraphilias; and (c) the well-documented history of the *DSM.*

**Does *DSM-IV-TR* Support the Diagnosis of Paraphilia-NOS-Nonconsent?**

On its face, the diagnosis of paraphilia-NOS, as set forth in *DSM-IV-TR,* appears to be intended for sexual behaviors that are not inherently violent: "telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine)" (APA, 2000b, p. 576). With the exception of telephone scatologia, the exemplified paraphilias are relatively rare. Although this enumeration in the definition of the diagnosis is not exclusive of other possible paraphilias, it seems counterintuitive that, had the drafters of *DSM-IV-TR* intended that this diagnosis include what Doren (2002) refers to as "a rape-related paraphilia" (p. 66), they would not have listed it, given that it is likely more common and certainly more socially problematic than such listed examples as klismaphilia and urophilia.

Price, Gutheil, and Commons (2001) described the category of paraphilia-NOS as one "reserved for sexual disorders that are either so uncommon or have been so inadequately described in the literature that a separate category is not warranted" (p. 226). In contrast, Doren (2002) admitted that what he calls rape-related paraphilia is a one of the "commonly diagnosed conditions" (p. 65) in SVP cases – a fact documented by Becker et al. (2003), who reported that 28% of their sample of sex offenders in SVP cases had been convicted of a rape-related offense. Furthermore, when the drafters of *DSM-IV-TR* intended that rape be identified as an example of a paraphilic behavior, they did so, by listing it among the examples of behaviors that could be the basis for the relatively rare diagnosis of sexual sadism, for which the rapist must be sexually excited by the suffering of the victim. (APA, 2000b, pp. 573-574). Thus, the absence of any mention of "rape" in the definition of the diagnosis of paraphilia-NOS in *DSM-IV-TR* suggests that the drafters of the manual did not consider it to be a behavior that would indicate the appropriate use of this diagnosis.

In fact, *DSM-IV-TR* (APA, 2000b) does include a diagnosis for the type of non-sadistic rape for which Doren (2002) applies the paraphilia-NOS diagnosis, but it is not found in the paraphilias category. Instead, it is categorized in the "V codes" of *DSM-IV-TR* (2000b), which are defined as follows:

> ...conditions or problems that may be a focus of clinical attention. These are related to the mental disorders ... in one of the following ways: 1) the problem is the focus of diagnosis or treatment and the individual has no mental disorder...; 2) the individual has a mental disorder but it is unrelated to the problem; 3) the individual has a mental disorder that is related to the problem, but the problem is sufficiently severe to warrant independent clinical attention. (p. 731)

In other words, a V-code diagnosis is made when the diagnosed person has a problem that is not, by itself, considered to be a mental disorder, but that may, nevertheless, be what *DSM-IV-TR* (2000b) refers to as "a focus of clinical attention" (p. 731). One such diagnosis is *sexual abuse of adult*, which is coded either as V61.12 if the focus of clinical attention is on a perpetrator who has

abused a partner, or V62.83 if the perpetrator has abused a non-partner. Examples in *DSM-IV-TR* (2000b) of the type of sexual abuse for which this diagnosis applies to a perpetrator are "sexual coercion" and "rape" -- the very conditions for which Doren (2002) advocates the diagnosis of paraphilia-NOS-nonconsent. The fact that *DSM-IV-TR* includes this rape-related diagnosis in the V-codes is further evidence that the drafters of *DSM-IV-TR* (2000b) meant to exclude non-sadistic rapists not only from the paraphilias category, but also from the entire class of mental disorders.

**Scholarly Opinion and the Diagnosis of Paraphilia-NOS-Nonconsent**

The argument that the diagnosis of paraphilia-NOS does not embrace the type of rape-related paraphilia that Doren asserts is also suggested by numerous scholarly discussions of this diagnosis by experts on the paraphilias. For example, Milner and Dopke (1997) and Schewe (1997) have written lengthy treatises on the *DSM-IV* diagnosis of paraphilia-NOS, elaborating on the many paraphilias that are appropriately embraced by that diagnosis. Similarly, Hudson and Ward (1997) and Ward, McCormack, Hudson, and Polaschek (1997) have written about the psychopathology, theory, assessment, and treatment of rapists. None of these scholars has suggested that the category of paraphilia-NOS may be appropriately used to diagnose the type of rape-related paraphilia that Doren advocates. On the contrary, Miller, Amenta, and Conroy (2005) observed:

> Numerous evaluators have utilized the diagnosis "paraphilia not otherwise specified" to apply to rapists. However, the definition of this appellation is so amorphous that no research has ever been conducted to establish its validity (in fact the word rape is not even mentioned in the Paraphilia NOS diagnostic description). How such a diagnosis would differentiate a class of rapists who suffer from a mental abnormality is very unclear. (p. 39)

Abel (1989) and Abel and Rouleau (1990) have presented arguments for and against a rape-related paraphilia being included in the *DSM*, pointing out that there are reasonable arguments on both sides of the controversy. However, though Abel (1989) specifically discussed the category of paraphilia-NOS, he did *not* suggest that it is appropriate for diagnosis of rapists. Polaschek (2003) has reviewed the history of the paraphilias classification in the various editions of the *DSM*, noting the omission of a diagnostic classification for non-sadistic rape. He contended that all of the paraphilia diagnostic categories in *DSM-IV-TR* have problems of conceptual validity, pointing out that these categories are sometimes under-inclusive and sometimes over-inclusive. He argued that adding a category for non-sadistic rape would simply make a bad situation worse, explaining:

> Many of the problems identified in diagnosing other paraphilias are perhaps even more pervasive with rape. Rapists are generally acknowledged to be the most heterogeneous of sexual offenders, and at the same time are difficult to distinguish from nonsexual violent offenders on many of the indices that are distinctive in child molesters. Although it is important to understand the reasoning of the *DSM* committee in continuing to omit rape, it would be premature to argue for its inclusion when the diagnoses currently offered are of so little value in management of sexual deviance. (p. 161)

Similarly, when Alder (1984) examined social and demographic variables in a sample of 985 incarcerated males to compare rapists to other sex offenders and to other property and violent offenders, she found, "[I]n general, rapists were most often similar to both serious property and violent offenders. Rapists differed most often from other sex offenders" (p. 157).

In summary, the weight of opinion among experts in the treatment of paraphilias is that the omission of non-sadistic rape from the paraphilias category in the *DSM* was, and continues to be, a deliberate decision of the American Psychiatric Association. None of these experts has published a statement supporting the use of the diagnosis of paraphilia-NOS for rapists. Thus, Doren (2002) appears to stand alone among published experts in defending this use of the diagnosis.

**The History of the *DSM* as it Relates to the Diagnosis of Paraphilia-NOS-Nonconsent**

In his argument favoring use of the category of paraphilia-NOS to diagnose rapists who are aroused by nonconsensual sex, Doren (2002) asked, "[W]hy, then, is there no separately listed paraphilia of this type in the current diagnostic manual (pp. 63-64)?" He offered answers to his rhetorical question, based on unpublished court testimony and personal communication from two forensic psychiatrists, Park Dietz and Fred Berlin. He suggested that a rape-related paraphilia diagnosis may have been omitted from the *DSM* because of "a fear that such an official diagnostic category could lead to widespread use of that diagnosis by rapists in attempts to be found not guilty by reason of insanity" and "strong opposition by those espousing a 'feminist theory' concerning rape, such that the idea was unacceptable that rape might be associated with a pathological condition" (pp. 63-64).

Doren's use of rhetorical questions and unpublished authorities suggests that there is a mystery as to why what he calls "a rape-related paraphilia" was not included in the *DSM.* In fact, the question regarding the inclusion of such a diagnostic category in the *DSM* was one of the most hotly debated and widely publicized issues ever considered by the drafters of the *DSM* – second only, perhaps, to the internationally publicized debate about the inclusion of homosexuality in the *DSM* in the early 1970s (Bayer, 1981). The debate and ultimate rejection of the diagnosis that Doren now defends is well documented in both the popular press (Goleman, 1985, Holden, 1986) and the professional literature (Williams, 1986; Ritchie, 1989; Kutchins & Kirk, 1989) – a historical fact that is curiously absent from Doren's 21-page argument favoring the use of the category of paraphilia-NOS to diagnose his suggested rape-related paraphilia.

In 1983, a committee of the American Psychiatric Association, called the Work Group to Revise *DSM-III*, was formed to revise the then-current, third edition of the *DSM – DSM-III* (APA, 1980; Williams, 1986). The chair of the Work Group was psychiatrist Robert Spitzer, the psychiatrist who had masterminded the drafting of *DSM-III*, and transformed the manual into the bible of psychodiagnosis that it is today (Spiegel, 2005). The work group proposed three new diagnoses that generated what the *New York Times* reported as "vigorous opposition" (Goleman, 1985). These proposed diagnoses were: masochistic personality disorder, premenstrual dysphoric disorder, and paraphilic rapism (Work Group to Revise DSM-III, 1985). The proposed diagnosis of paraphilic rapism was a rewording of a previous proposal to include in *DSM-III* a diagnosis of sexual assault disorder – a proposal that had been withdrawn after opposition from the American Academy of Psychiatry and the Law and other groups that argued that such a diagnosis would provide an insanity defense to defendants in rape prosecutions (Kutchins & Kirk, 1989).

The resurrected, proposed diagnosis of paraphilic rapism was defined as, "A persistent association, lasting a total of at least 6 months, between intense sexual arousal or desire, and acts, fantasies, or other stimuli involving coercing or forcing a nonconsenting person to engage in oral, vaginal, or anal intercourse" (Work Group to Revise DSM-III, 1985). Subsequently, the proposed diagnosis for a rape-based paraphilia was retitled paraphilic coercive disorder and redefined as:

A. Over a period of at least six months, preoccupation with recurrent and intense sexual urges and sexually arousing fantasies involving the act of forcing sexual contact (for example, oral, vaginal, or anal penetration); grabbing a woman's breast) on a nonconsenting person.

B. It is the coercive nature of the sexual act that is sexually exciting, and not signs of psychological or physical suffering of the victim (as in Sexual Sadism).

C. The individual repeatedly acts on these urges or is markedly distressed by them. (Work Group to Revise DSM-III, 1985)

Proponents of this proposed diagnosis argued, "[T]here has been a monolithic view of rapists, and it is important to distinguish subcategories that might lead to more specific treatment" (American Medical News Staff, 1986). Psychologist Judith Becker, one of the proponents of this proposed diagnosis, estimated that it would apply to approximately 20% of rapists (Holden, 1986).

The American Psychological Association, the American Orthopsychiatric Association, the National Association of Social Workers, and the National Organization of Women (Kutchins & Kirk, 1997) mounted strong opposition to the proposed diagnoses of paraphilic coercive disorder, masochistic personality disorder (later renamed self-defeating personality disorder), and premenstrual dysphoric disorder (later renamed late luteal phase dysphoric disorder) (Goleman, 1985). The U.S. Department of Justice, which rarely takes public policy positions on matters related to mental health, argued that the proposed diagnosis of paraphilic coercive disorder would be used by criminal defendants to avoid legal responsibility in criminal prosecutions for rape (Kutchins & Kirk, 1997). After opposition to the three proposed diagnoses was expressed at a meeting of the Work Group to Revise *DSM-III*, the group's chairman, Robert Spitzer, said, "We didn't anticipate the strong objections of many, both in psychiatry and psychology, to this proposal. The discussion was very heated" (Goleman, 1985).

In the wake of this powerful opposition, on June 28, 1986, the motion to include the three proposed disorders as official *DSM* diagnoses was voted down by the APA's Board of Trustees on a vote of 10-4 (Kutchins & Kirk, 1997). The APA trustees rejected the diagnosis of paraphilic coercive disorder, in part, "because of the preliminary nature of the data and the difficulty physicians have in differentiating paraphilic coercive disorder from other disorders" (Staver, 1986, p. 41). In contrast, the other two diagnoses that drew strong opposition – self-defeating personality disorder and late luteal phase dysphoric disorder – ended up in the appendix of *DSM-III-R,* in the section for "Proposed Diagnostic Categories Needing Further Study," but with diagnostic codes that allowed for billing third-party payers for treatment of these diagnoses (APA, 1987, pp. 367-374; Ritchie, 1989). No proposal to insert a rape-related paraphilia diagnosis was raised during the drafting of *DSM-IV* or *DSM-IV-TR* (F.S. Berlin, personal communication, April 28, 2005).

Despite the fact that the proposal for a diagnosis of paraphilic coercive disorder was expressly rejected for inclusion in the *DSM,* Doren (2004) has defended his use of an equivalent diagnosis – paraphilia-NOS-nonconsent -- by citing the discussion of a case study in a book entitled *DSM-IV-TR Casebook* (Spitzer, Gibbon, Skodol, Williams, & First, 2002), in which an imaginary case is presented of a repeat rapist who is aroused by the nonconsensual aspect of his rapes, but not by the suffering of his victims. The unidentified author of this case example, conceding that the diagnosis of paraphilic coercive disorder was considered by the APA but "has never been officially recognized," nevertheless suggests that the man's "disorder would be coded as a paraphilia not otherwise specified" (p. 173). Other case descriptions in the book describe the proper use of the paraphilia-NOS diagnosis as being for paraphilias that are "not common" (p.

88) and "rare" (p. 308) with examples of hypoxyphilia (sexual arousal to loss of oxygen) and necrophilia (sexual attraction to corpses), respectively. Again, a behavior as common as rape does not seem to fit in the same category as these extremely rare paraphilias.

Doren (2004) has testified under oath that this book is a publication of the American Psychiatric Association. In fact, the book is published by American Psychiatric Publishing, Inc., with the caveat, "Books published by the American Psychiatric Publishing, Inc., represent the views and opinions of the individual authors and do not necessarily represent the policies and opinions of APPI or the American Psychiatric Association" (Spitzer, Gibbon, Skodol, Williams, & First, 2002, p. iv). It is also noteworthy that the lead editor of this casebook was Robert Spitzer -- the chair of the APA work group that tried and failed to insert the proposed diagnosis of paraphilic rape disorder in the *DSM* in the mid-1980s (Kutchins & Kirk, 1997). A revised version of this casebook, which adds treatment recommendations, uses 31 of the cases from the earlier *DSM-IV Casebook*, but does not include the case on which Doren relies to justify his diagnosis of paraphilia-NOS (Spitzer, First, Gibbon, & Williams, 2004).

Doren's citation to a publication that he misidentified as that of the American Psychiatric Association is ironic, given that an APA task force report (Zonona et al., 1999) contradicts Doren's assertions about the appropriateness of diagnosing a rape-related paraphilia, explaining:

> Whether or not any rapist has a paraphilia represents a controversial issue in the research literature. *DSM-IV* has not classified paraphilic rapism as a mental disorder. Some researchers believe that a small group of rapists have diagnostic features similar to those with other paraphilias. The ability to make the diagnosis with a sufficient degree of validity and reliability remains problematic. In addition, other research has shown that many rapes are not the product of primary sexual interests, but rather represent an exercise in power and control (pp. 169-170).

In summary, Doren's position that a non-sadistic-rape-related paraphilia can be diagnosed by using the *DSM-IV-TR* category of paraphilia-NOS is contrary to: (a) the intent of the drafters of the *DSM*, as reflected in the wording and drafting history of the manual; and (b) the consensus of scholarly opinion regarding the appropriate use of that diagnostic category.

**Conceptual Validity Problems with the Diagnosis of Paraphilia-NOS-Hebephilia**

Doren (2002, pp. 80-81) also advocated the use of a variant of his paraphilia-NOS-nonconsent, diagnosis for cases in which the diagnosed adult has had sexual contact with a post-pubescent adolescent. He called this diagnosis *paraphilia-NOS-sexually-attracted-to-adolescents* or *paraphilia-NOS-hebephilia* (pp. 80-81). Doren acknowledged that research shows that sexual attraction to adolescent girls is displayed by one-third of nonoffending adult men (Barbaree & Marshall, 1989). He addressed the issue of conceptual validity of the diagnosis of paraphilia in adults who are sexually attracted to adolescents as follows:

> Is there evidence that a paraphilia related to this attraction exists? After all, if such an attraction is itself not uncommon even among "the average nonoffending man," then can we say that the attraction represents a pathological condition? The answer to this question lies in the degree to which someone is repetitively or chronically impaired by that attraction, not the attraction per se... Some people do not stop acting in ways that cause repetitive negative effects of their attraction to adolescents... Despite serious consequences to them (i.e. impairment) due to their earlier behavior, these people continue to seek sexual contact with adolescents. Consensual adult relationships may not be pursued at all. Sexual contact with adolescents repeatedly occurs despite the ongoing risk of legal consequences and inability to maintain such relationships on a long-term basis due to the adolescents' growing beyond the age of interest. These people show the characteristics of

> hebephilia, more formally called paraphilia NOS, sexually attracted to adolescents. (Doren 2002, pp. 80-81)

Thus, Doren argued that the diagnosis of paraphilia-NOS-hebephilia is justified primarily by what he refers to as the "impairment" or "consequences" of the adult's sexual attraction to adolescents, not the sexual attraction itself. This argument harkens the diagnostic validity questions raised about the paraphilias previously herein: is it conceptually valid to label a behavior a mental disorder when it is primarily defined by the societal intolerance of it? If the answer to this question were in the affirmative, then it would be arguably justified to redesignate homosexuality as a mental disorder, since there continues to be widespread intolerance of homosexuality, as evidenced by the strong public backlash against the idea of homosexual marriage.

The highly publicized case of Mary Kay Letourneau would appear to qualify for Doren's diagnosis of paraphilia-NOS-hebephilia. Ms. Letourneau, a married Seattle schoolteacher, was convicted of sexually assaulting a post-pubescent 13-year-old boy when she was 34 (Noe, n.d.). The evidence in the case showed that, not only did the boy agree to have sexual relations with Ms. Letourneau, he pursued her after making a bet with a friend that he could seduce her (Noe, n.d.). She ended up losing her job, losing custody of her children, and serving 7 years in prison – much of it in solitary confinement for insisting on communicating with the boy -- certainly the "serious consequences" that would qualify for Doren's paraphilia-NOS-hebephilia diagnosis. She also bore two of the young man's children (Noe, n.d.) However, she was not subjected to Washington's SVP law. Instead, when her young lover turned 21, the couple reunited and eventually married (Anderson, 2005; Mitchell, 2005).

SVP commitment evaluators often use the diagnosis of paraphilia-NOS-hebephilia when the adolescent with whom the adult had sexual contact was under the legal age of consent, and the adult has been convicted of the form of sexual assault sometimes referred to as "statutory rape." There are numerous problems of conceptual validity that arise from the use of this diagnosis in this context. First, as noted previously regarding Doren's diagnosis of paraphilia-NOS-nonconsent, it seems counterintuitive that rare disorders like klismaphilia and urophilia would be listed as examples of the appropriate use of the paraphilia-NOS diagnosis instead of the more common behavior of adult-adolescent sexual activity if the diagnosis were intended to embrace this latter behavior.

Second, there is no professional consensus that the adult-adolescent sexual behavior that Doren diagnoses as paraphilia-NOS-hebephilia is a paraphilia at all. Although Doren (2002) cited one study that shows that some men are exclusively attracted to adolescent girls (p. 81), he cited no authorities for his simple assertion that repeated adult sexual attraction to adolescents is a mental disorder. Textbooks used for instruction about paraphilias contain no discussion of adult-adolescent sexual attraction as a *DSM*-diagnosable paraphilia (Abel, 1989). For example, the classic textbook, *Sexual Deviance: Theory, Assessment, and Treatment*, edited by D. Richard Laws and William O'Donohue (1997), and authored by 36 of the leading experts on paraphilias, has 500 pages of detailed discussion of every paraphilia identified in *DSM-IV-TR*, but there is no mention of either hebephilia or what Doren (2002) referred to as "sexually attracted to adolescents" (p. 80) being the basis for a diagnosis of paraphilia-NOS or any other diagnosis.

On the contrary, Marshall (1997) asserted that, since "our findings from phallometric studies of sexual preference wherein all subjects (offenders and nonoffenders) respond to persons displaying full secondary sexual features (i.e., teenagers over age 14 years) in the same way as they do adults," "we have always used age 14 years as the upper limit for defining a victim as a

child," (p. 156). He maintained that adults who sexually assault adolescents should be considered diagnostically in the same way as adults who sexually assault other adults. Marshall's research-based distinction suggests that, in clinical or forensic practice, adult-pubescent sexual behavior would not be diagnosable if it is mutual, even if it is not "consensual" in the technical, legal sense that defines an arbitrary age of legal consent.

The fact that the legal age of consent for sexual activity varies from jurisdiction to jurisdiction also has implications for the conceptual validity of Doren's diagnosis of paraphilia-NOS-hebephilia. Doren (2002) asserted that, when a middle-aged person who seeks out 16-year-olds for sexual gratification and gets "into legal trouble when he resides in some states and social trouble ... no matter where he goes," this person would have a "paraphiliac condition" (paraphilia-NOS-hebephilia), though he would not be committable as an SVP in a state where the legal age of consent is 15 (p. 81). Under this analysis, diagnosis of psychopathology is wholly dependent upon the social response to the behavior that constitutes the diagnosis. If a 22-year-old man has mutual sexual relations with a 15 year-old in a state where he "gets into legal trouble," he qualifies for Doren's diagnosis of paraphilia-NOS-hebephilia. If this 22-year-old man moves to a state where the age of legal consent for sexual relations is 15 but he happens to have a boss who disapproves of his sexual relationship with a 15-year-old, would he still qualify for Doren's diagnosis? What if he moves to a community where he violates no law or offends no one with his sexual relationship with the 15-year-old? Should the definition of what constitutes a mental disorder vacillate depending on the ever-changing whims of legislators, employers, or judgmental neighbors?

A defense lawyer has written about an SVP case that he won despite a forensic psychologist's diagnosis of his client as having paraphilia-NOS-hebephilia. This diagnosis was based on the man successively having had two wives, ages 14 and 15, in states where the legal age for marriage was 14. The lawyer commented as follows:

> Sex in Iowa between a 15-year-old girl and a 25-year-old man is not a crime. Cross the state line to Wisconsin, and it is a felony. What happens if the act starts in a boat on the Iowa side of the Mississippi and is completed on the Wisconsin side? (J. Wabaunsee, personal communication, June 16, 2005).

Would Doren's diagnosis change at the midpoint of the Mississippi River? The previous discussion of the prevalence of "child brides" and other culturally accepted manifestations of adult-adolescent sexual behavior throughout history and today calls into question the legitimacy of diagnosing such behavior as pathological. In addition, the contextual variability of Doren's diagnosis of paraphilia-NOS-hebephilia, would appear to contradict the admonition in *DSM-IV-TR* that says, "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..." (APA, 2000b, p. xxxi). The paucity of support for Doren's paraphilia-NOS-hebephilia diagnosis in the *DSM* and in the professional literature, as well its contextual variability, suggests that it lacks conceptual validity.

**Reliability Problems with the Diagnosis of Paraphilia-NOS**

Given that the diagnosis of paraphilia-NOS, as it is applied to rapists or adults who have sexual contact with adolescents, has not been recognized outside of the SVP commitment context, it is not surprising that there is no published research reporting the interrater reliability of this diagnosis in clinical practice, research settings, or in any context other than SVP cases. The one study that has reported on the interrater reliability of the diagnosis of paraphilia-NOS is the one

done by Levenson (2004b), who looked at the cases of 295 sex offenders who were evaluated by two independent psychologists or psychiatrists hired by an independent agency to assess whether the men should be referred for SVP commitment. Levenson found that that the diagnosis of paraphilia-NOS had an interrater reliability kappa coefficient of only 0.36, which falls well into the "poor" category of reliability defined by Bloom, Fischer, and Orme (1999). In fact, even when Levenson collapsed all of the data for *any* diagnosis of a paraphilia, i.e., pedophilia, paraphilia-NOS, exhibitionism, or sexual sadism, into one broad category in order to boost the reliability coefficient, it still was only 0.47 – still well into the "poor" category of reliability.

The poor interrater reliability found by Levenson for the paraphilia-NOS diagnosis, and, indeed, of all paraphilia diagnoses, is consistent with findings by Marshall, Kennedy, Yates, and Serran (2002), who looked at interrater reliability for the diagnosis of sexual sadism. As explained previously herein, the *DSM* criteria for this diagnosis are much more specific than for Doren's paraphilia-NOS-nonconsent diagnosis; sexual sadists represent a small subset of rapists who are specifically aroused by the suffering of the victim. Given the greater specificity of the sexual sadism diagnosis, one would expect better interrater reliability, since more precise diagnostic criteria give the diagnostician less latitude in making a judgment. Apparently, this is not the case. Marshall et al., found that the rate of agreement among 15 expert forensic psychiatrists reviewing the cases of 12 sex offenders produced a kappa coefficient of only 0.14 – "clearly well below acceptable levels" (p. 673). These researchers concluded:

> These results do not encourage confidence in the reliability of the diagnosis of sexual sadism as it is applied to sexual offenders... The level of agreement across the diagnosticians in this study does not meet the necessary standards for such an important diagnosis as sexual sadism, given the consequences of making this diagnosis... [T]his diagnosis might ensure that the referred offenders would be found to meet criteria for the designation as sexually violent predators, and it is possible the diagnosis may override other considerations. (p. 674)

**General Validity Issues With the Diagnosis of Personality Disorders**

Of the 17 states with SVP laws, 11 states (Arizona, Florida, Kansas, Massachusetts, Minnesota, New Jersey, North Dakota, Pennsylvania, South Carolina, Virginia, and Washington) specify that a "personality disorder" may be the basis for a civil commitment (Miller, Amenta, & Conroy, 2005; 42 Pennsylvania Consolidated Statutes, § 6401, 2004). For some of the remaining six states, courts have construed the civil commitment standards of "mental abnormality" or "mental disorder" to include personality disorders (see, e.g.: *Wisconsin v. Adams,* 1998). With the exception of Massachusetts, the states that specify "personality disorder" as a criterion for committability do not define that term statutorially. However, as Doren (2002) noted, "Presumably, evaluators are left to interpret the term significantly in keeping with the same diagnostic phrase in the *Diagnostic and Statistical Manual*" (p. 13).

*DSM-IV-TR* (APA, 2000b) includes 10 personality disorders (pp. 685-729). The manual defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (p. 685). In fact, recent longitudinal research questions the defining elements of personality disorders as being "enduring" and "pervasive and inflexible." Lenzenweger, Johnson, and Willett (2004) followed 250 subjects for personality disorder features at three points over a 4-year period, and concluded:

> From the perspective of individual growth curve analysis, PD [personality disorder] features show considerable variability across individuals over time. This fine-grained analysis of individual growth trajectories provides compelling evidence of change in PD features over time and does not support the assumption that PD features are traitlike, enduring, and stable over time. (p. 1015)

The personality disorders are categorized in *DSM-IV-TR* (APA, 2000b) separately from "clinical disorders" (p. 27), with clinical disorders being coded on what the manual refers to as "Axis I" and personality disorders being coded on "Axis II" (pp. 28-29). Axis I includes the major mental illnesses (schizophrenia, bipolar disorder, major depressive disorder, etc.), substance abuse disorders, anxiety disorders, and "other conditions that may be the focus of clinical attention" (APA, 2000b, pp. 27-30)). Axis II is the category reserved for the diagnoses of mental retardation and personality disorders, two categories that share the following essential features: early onset and their enduring, pervasive, and, perhaps, untreatable nature. The justification for placing the personality disorders on Axis II was to ensure "that consideration will be given to the[ir] possible presence ... that might otherwise be overlooked" (APA, 2000b, p. 28) and "to facilitate empirical research" (Gruenberg & Goldstein, 2003, p. 146). The exclusion of the personality disorders from the Axis I category of "conditions that may be the focus of clinical attention" implies that they are less likely to receive "clinical attention," i.e., that they are less likely to be treated. As Livesley (2003) observed, "The development of a separate axis created the impression that there are fundamental differences between personality disorders and other mental disorders. This idea encourages discrimination toward those with personality disorder and has led to problems in funding treatment" (p. 164).

Among psychologists and psychiatrists, the personality disorders may be the single most controversial diagnostic category in the *DSM*. For example, in a survey of 146 psychologists and psychiatrists in 42 countries, Maser, Kaelber, and Weise (1991) asked respondents to rate their satisfaction with the *DSM* diagnostic categories. "The personality disorders led the list of diagnostic categories with which respondents were dissatisfied" (p. 275), with 56% expressing dissatisfaction; only half as many respondents cited the second most frequently criticized category (mood disorders). One of the primary reasons for the controversial nature of the personality disorders has to do with the fact that, contrary to the assertion in *DSM-IV-TR* that personality disorders "are qualitatively distinct syndromes," they appear instead to "represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another" (APA, 2000b, p. 686). Summarizing the research reported in eight different studies, 10 experts on the personality disorders collectively concluded:

> Researchers have been unable to identify a qualitative distinction between normal personality functioning and personality disorder. *DSM-IV* provides specific and explicit rules for distinguishing between the presence and absence of each of the personality disorders ... but the thresholds for diagnosis provided in *DSM-IV* are largely unexplained and are weakly justified ... The maladaptive traits included within the diagnostic criteria for the *DSM-IV* personality disorders appear to be present within members of the general population who would not be diagnosed with a *DSM-IV* personality disorder. (First, Bell, Cuthbert et al., 2002, p. 125)

Klonsky (2000) also criticized the *DSM* diagnostic classifications for personality disorders, arguing that the personality disorder criteria in *DSM-IV* (which are identical to the criteria in *DSM-IV-TR*), have a weak empirical basis. Klonsky maintained,

> Given the discrete DSM personality disorder categories, one might assume that they are as understood and easily classified as medical diseases. This is not the case, however. The DSM-IV classification of personality disorders is plagued by extensive diagnostic overlap, limited evidence

> of validity, and generally poor empirical support. As a result, to accept the DSM personality disorder classification system at face value is to embrace several untested assumptions. (p. 1616)

Because personality disorders categorize behavior that differs from normal behavior only by its degree of expression of universal traits, rather than based on qualitative behavioral differences, the conceptual validity of these categories is inherently suspect. Unlike psychotic disorders, which by their defining symptomatology -- such as hallucinations and delusions -- are qualitatively different from normal behavior, personality disorder diagnoses are much more likely to be conceptually invalid, because their behavioral manifestations are exhibited by many people considered to be normal. This principle will be illustrated by discussion of the conceptual validity problems with the diagnosis of antisocial personality disorder in general and in SVP commitment cases.

**General Validity Issues with the Diagnosis of Antisocial Personality Disorder**

Michael Crane, the Kansas sex offender whose case led to the U.S. Supreme Court's decision in *Kansas v. Crane* (2002), was diagnosed with exhibitionism and antisocial personality disorder when Kansas sought his commitment under that state's SVP commitment law (p. 411). The diagnostic criteria for antisocial personality disorder in *DSM-IV-TR* (APA, 2000b) require:

> A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
>
> (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
> (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
> (3) impulsivity or failure to plan ahead
> (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
> (5) reckless disregard for safety of self or others
> (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
> (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another.
>
> B. The individual is at least age 18 years.
>
> C. There is evidence of Conduct Disorder with onset before age 15 years.
>
> D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode. (p. 706)

Although the personality disorders comprise the most controversial of the major diagnostic categories in the *DSM*, of the 10 personality disorders listed in the manual, Frances (1980) called antisocial personality disorder "the most controversial of all the personality disorders" (p. 1053) in 1980. Twenty-one years later, in 2001, he again declared, "The most fundamental question concerning antisocial personality disorder is whether it should be considered a mental disorder and be included in *DSM-IV*" (Francis & Ross, 2001, p. 293). Francis was the chair of the APA's Task Force on DSM-IV (Francis & Ross, 2001, p. iii). Similarly, Rogers, Salekin, Sewell, and Cruise (2000) observed, "The conceptualization of antisocial personality disorder has sparked controversy and defied consensus for the past three decades" (p. 234). Much of the controversy about the diagnosis of antisocial personality disorder stems from its arguable over-inclusiveness, and, hence, its questionable conceptual validity as a mental disorder.

The over-inclusiveness of the diagnosis of antisocial personality disorder apparently was a major concern of the U.S. Supreme Court justices deciding *Kansas v. Crane* (2002). When the U.S. Supreme Court justices were considering the oral arguments of the two lawyers who litigated the *Crane* case before the Court, Justice Ginsburg expressed concern about the large number of people who would appear to qualify for the *DSM-IV-TR* definition of antisocial personality disorder, observing, "... they say pick three out of a list of seven, you could pick out habitually doesn't work, doesn't pay debts, is reckless, irritable...*There are a lot of ordinary people who would fit that description*" (*Kansas v. Crane* Oral Argument, 2001, pp. 8-9) [italics supplied]. Later in the oral argument, Justice O'Connor pointed out that a prosecution expert in the trial of the case had testified that 75% of the male prison population in the U.S. was diagnosable with antisocial personality disorder (p. 15). When the Kansas Attorney General acknowledged that a sex offender satisfying the criteria for antisocial personality disorder could be committed as an SVP, another justice, apparently astonished, by how easily this diagnosis could result in civil commitment, simply responded, "Wow" (p. 15). In the majority decision in *Crane,* the Court favorably cited research showing that 40 to 60% of the male prison population in the U.S. is diagnosable with antisocial personality disorder (*Kansas v. Crane,* 2002, p. 412).

Thus, some of the justices on the U.S. Supreme Court had strong concerns about the conceptual validity of the diagnosis of antisocial personality disorder as it could be applied in SVP commitment cases. This should not have been surprising considering that, just 10 years earlier in *Foucha v. Louisiana* (1992), the Court had held that a diagnosis of antisocial personality disorder was an insufficient "mental illness" to justify the civil commitment of an insanity acquittee whose commitment was ending. In the *Foucha* and *Crane* decisions, the Supreme Court expressed concerns that Mr. Foucha and Mr. Crane, both of whom were diagnosed as having antisocial personality disorder, were, by virtue of that diagnosis, indistinguishable from most other men imprisoned in the United States. In *Foucha*, Justice White, writing for a plurality of the Court, noted that Mr. Foucha was similarly situated to other prisoners about to be released from confinement, adding, "Many of them will likely suffer from the same sort of personality disorder that Foucha exhibits" (p. 85).

The Court's concern about the large percentage of prisoners who are diagnosable with antisocial personality disorder is factually based, as innumerable studies have confirmed. For example, Fazel and Danesh (2002) reported that, in a survey of studies involving 23,000 prisoners, 47% were diagnosed with antisocial personality disorder. Widiger and Corbitt (1995) reviewed five studies that reported the prevalence of antisocial personality disorder in incarcerated male populations at between 49% and 80%. Moran (1999) reported the proportion of prisoners diagnosed with antisocial personality disorder at 60%, commenting, "Such high prevalence estimates raise important questions about the validity of the diagnosis and the medicalization of criminality" (p. 234). After a comprehensive review of the research concerning the epidemiology of antisocial personality disorder, Moran (1999) concluded:

> [T]he diagnosis of antisocial personality disorder is problematic and has questionable validity. In particular, the criteria overlap greatly with those for criminality and substance abuse, leading to possible overdiagnosis of the disorder in prisoners and drug addicts. In addition, crucial longitudinal data, which would help validate the diagnosis, are lacking. (p. 239)

Toch (1998) came to a similar conclusion after analyzing the ease with which the diagnostic criteria for antisocial personality disorder could apply to practically any criminal offender:

> With respect to differential diagnosis in the prison, the APA [in the *DSM*] suggests that "lack of empathy, inflated self-appraisal, and superficial charm" may provide relevant cues. However, since only three diagnostic criteria suffice for a defensible diagnosis, a juvenile record and an offense career, aggressivity, impulsivity, a checkered work history, and/or lack of demonstrable repentance – which can be found in any prison dossier chosen at random – are more than enough for formal diagnostic purposes. In other words, *almost any offender in a correctional setting is hypothetically entitled to a diagnosis of antisocial personality disorder*. (p. 149)

Robins, Tipp, and Przybeck (1991) have maintained that the diagnosis of antisocial personality disorder does not medicalize criminal behavior, arguing that, if this were the case, more persons so diagnosed would have a criminal history. Although acknowledging that "about half of all prison residents meet criteria for the disorder" (p. 289), they point to data that show that, in the general community, factors that show a higher positive correlation with the diagnosis of antisocial personality disorder than criminal history include employment problems, violence, multiple moving traffic offenses, and marital problems. These findings are echoed in *DSM-IV-TR* (APA, 2000b), which acknowledges that the diagnosis "appears to be associated with low socioeconomic status and urban settings" (p. 703).

These findings, though failing to refute the argument that the diagnosis of antisocial personality disorder pathologizes criminality, appear to raise further questions about the conceptual validity of the diagnosis. Because all of the factors that Robins et al., identified as being highly associated with the diagnosis of antisocial personality disorder are examples of behaviors that are diagnostic of the disorder, the questions raised are whether this diagnosis is simply a catchall for persons with socially problematic behavior rather than psychopathology. In other words, the findings of Robins et al., arguably increase the questionability of the conceptual validity of the diagnosis of antisocial personality disorder by pathologizing employment problems, violent behavior, marital problems, and even traffic offending. *DSM-IV-TR* (APA, 2000b) gives short shrift to the substantial socioeconomic underpinnings of the diagnosis of antisocial personality disorder, simply advising, "In assessing antisocial traits, it is helpful for the clinician to consider the social and economic context in which the behaviors occur" (p. 704).

An examination of the criteria set forth in *DSM-IV-TR* (APA, 2000b) for diagnosing antisocial personality disorder reveals several grounds for questioning the conceptual validity of this diagnosis (p. 706). Criterion A lists seven sub-criteria, from which three must be chosen to establish Criterion A. Sub-criterion A(1) requires "failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest" (p. 706). The manual fails to specify such seemingly critical issues as the number or seriousness of the required "acts that are grounds for arrest," how often they need to have been repeated, over what timeframe they occurred, or even that the "grounds for arrest" did not result in the cases being dismissed based on an acquittal. Conceivably the behavior of a parking ticket scofflaw could satisfy sub-criterion A(1), because nonpayment of parking ticket fines can be the basis for arrest in many jurisdictions (Paschenko, 2005).

Sub-criterion A(2) requires "deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure" (p. 706). Again, *DSM-IV-TR* is silent as to the number, seriousness, or frequency of the deceitful behaviors required. If a hypothetical 25-year-old parking ticket scofflaw repeatedly lied to his wife and employer about his arrests for both illegal parking and shoplifting, he would apparently satisfy sub-criterion A(2). Sub-criterion A(3) requires that the candidate for a diagnosis of antisocial personality disorder exhibit "impulsivity or failure to plan ahead" (p. 706). Perhaps our hypothetical parking ticket scofflaw has parked

illegally, because of his "failure to plan ahead" in a way that would allow him to park legally. And, since our hypothetical parking ticket scofflaw is over 18 years of age, and does not satisfy diagnostic criteria for schizophrenia or manic episode, he satisfies criteria B and D, meaning that he is now three-fourths of the way to a full diagnosis of antisocial personality disorder.

*DSM-IV-TR* (APA, 2000b) criterion C for a diagnosis of antisocial personality disorder requires that there "is some evidence of Conduct Disorder ... with onset before age 15 years" (p. 706). Conduct disorder is a *DSM-IV-TR* diagnosis that applies to children who, during a 12-month period, exhibit 3 of 15 possible behaviors that show a "repetitive pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated" (pp. 98-99). Among the listed behaviors that can satisfy this diagnostic criterion are shoplifting, truancy, and staying out at night despite parental prohibitions. The behaviors must cause "clinically significant impairment in social, academic, or occupational functioning" (p. 99).

Let's say our hypothetical parking ticket scofflaw, from age 12 to 13, repeatedly stayed at a friend's house overnight, against his parents' wishes. During this time, he also skipped school 10 times and shoplifted five times. As a result of his truancy, his grades went from a straight "A" average to a "C" average, which would arguably be a clinically significant impairment in academic functioning. Though this case presentation may fall slightly short of qualifying for a complete diagnosis of conduct disorder, a retrospective determination of whether there was "evidence of conduct disorder" for purposes of making a diagnosis of antisocial personality disorder in an adult only requires that the person "have had a history of *some* symptoms of Conduct Disorder before age 15 years" (p. 702) [italics supplied]. In other words, not all of the diagnostic prerequisites for a diagnosis of conduct disorder are required for a diagnosis of antisocial personality disorder.

Thus, our 25-year-old parking ticket scofflaw would qualify for a diagnosis of antisocial personality disorder because of his unpaid parking tickets and shoplifting (sub-criterion A(1)); his repeated lying about these offenses to his wife and employer (sub-criterion A(2)); his failure to plan ahead so as to avoid the need to park illegally (sub-criterion A(3)); his being over age 18 (criterion B); his 1 year of childhood truancy, shoplifting, and violating his parents wishes about staying overnight with a friend – criteria for diagnosing conduct disorder (criterion C); and his lack of a diagnosis of either schizophrenia or manic episode (criterion D). Though not necessary to qualify for the diagnosis, he would also appear to satisfy sub-criterion A(6), since his repeated nonpayment of his parking tickets arguably constitutes "consistent irresponsibility, as indicated by repeated failure ... to honor financial obligations" (p. 706). Though this hypothetical example may appear to be an exaggerated application of the diagnosis of antisocial personality disorder, when one considers that this diagnosis may be an essential factor leading to a potentially-lifetime SVP commitment, consideration of the potentially extreme reach of the diagnosis is warranted.

The body of scholarly research about the diagnosis of antisocial personality disorder is rich with data questioning its conceptual validity. Rogers and Dion (1991) reviewed the significant changes in the diagnostic criteria for antisocial personality disorder through *DSM-III-R,* pointing out that these redefinitions of the diagnosis had no empirical basis, and that the diagnosis lacked descriptive consistency and diagnostic validity. The lack of an empirical basis for the diagnosis of antisocial personality disorder was also noted by Hare and Hart (1995), who observed that the revised criteria for *DSM-IV* were never field-tested.

As the foregoing hypothetical example with our parking ticket scofflaw illustrates, much of the problem with the diagnostic validity of antisocial personality disorder comes from the

*DSM-IV-TR* diagnostic criteria. First, as Rogers and Dion (1991) demonstrated, the expansiveness of the diagnosis is, in part, a function of the huge number of diagnostic criterion permutations possible with the antisocial personality disorder category and its linked diagnosis of conduct disorder. Rogers, Salekin, Sewell, and Cruise (2002) commented on this problem with the diagnosis of antisocial personality disorder, noting, "*DSM-IV* continues to offer a bewildering array of diagnostic possibilities with 3.2 million variations" (p. 237).

A related issue with respect to the diagnostic criteria is that the seriousness of specified behaviors ranges from low (*e.g.*, failure to plan ahead, truancy, etc.) to high (*e.g.,* reckless disregard for safety of others). A comment on this aspect of the *DSM-III-R* criteria for antisocial personality disorder is also applicable to the *DSM-IV-TR* criteria: "[O]ur current understanding of antisocial personality disorder appears to be thoroughly muddled, with endless variations that are treated as if they were equal under the rubric of antisocial personality disorder" (Rogers, Dion, & Lynett, 1992, p. 686). Widiger, Frances, Spitzer, and Williams (1988) proposed that the diagnostic validity of personality disorder diagnoses be improved by weighting criteria, but this has not happened with respect to the diagnosis of antisocial personality disorder. Furthermore, critical diagnostic terms that could limit the application of the diagnosis, such as "pervasive pattern," are undefined. Given such factors that allow wide variability in the diagnosis of antisocial personality disorder, it should not be surprising that some questionable applications, such as the foregoing hypothetical case of the parking ticket scofflaw, are possible.

Another problem of diagnostic validity with the diagnosis of antisocial personality disorder is acknowledged in *DSM-IV-TR* (APA, 2000b), which states,

> Concerns have been raised that the diagnosis may at times be misapplied in settings in which seemingly antisocial traits may be part of a protective survival strategy. In assessing antisocial traits, it is helpful for the clinician to consider the social and economic contest in which the behaviors occur. (p. 704)

Here, again, *DSM-IV-TR* merely offers "helpful" advice on the issue of cultural and contextual factors that may profoundly influence diagnosis, rather than setting forth required criteria that might avoid misapplication of the diagnosis to a person whose "acts that are grounds for arrest" may be justified by the need to survive in an impoverished, violent urban environment. The failure of the diagnosis of antisocial personality disorder to definitively distinguish between unlawful behaviors that are contextually adaptive from those that are not has been questioned by Cunningham and Reidy (1998):

> This raises a question of whether the prevalence of antisocial personality disorder criteria behaviors, particularly illegal behaviors and arrests, in a given subculture or locale are critically important to consider before concluding that individual histories containing these high frequency criminal behaviors represent antisocial personality disorder. In other words, if a behavior pattern represents a widespread social phenomenon, i.e. criminality, is it appropriate to diagnose the individual expression of these traits as a personality disorder? For example, Ogletree, Prosser, Smith, and Talley (1995), described that on any given day between 42% and 58% of the African-American males aged 18-35 in Washington, DC, and Baltimore, MD, respectively, are involved in the criminal justice system. (p. 337)

The shameless, inner-city drug dealer who manages to stay out of prison by conning and being aggressive toward others certainly exhibits socially undesirable behavior, but should he be considered mentally disordered with antisocial personality disorder if the behavior results in an improved chance at survival? Behavior that is morally and legally indefensible does not necessarily equate with a defensible definition of mental disorder.

Contextual and cultural factors also impact a diagnosis of conduct disorder, which is a prerequisite for a diagnosis of antisocial personality disorder. Hsieh and Kirk (2003) presented 483 U.S. psychiatrists with three hypothetical cases that technically met the *DSM-IV* diagnostic criteria for conduct disorder. However, one of the case descriptions made it clear that the adolescent male's questionable behavior was heavily influenced by his social context, was survival-based, and was not present when he was removed from the social context. There was a 50-50 split between psychiatrists who diagnosed the young man as conduct disordered and those who did not. This suggests that a conduct disorder diagnosis may lack conceptual validity, in practice. This invalidity also would be inherent in an antisocial personality disorder diagnosis that is necessarily grounded in evidence of conduct disorder. As Hare and Hart (1995) declared, "Ignoring the impact of the conduct disorder criterion on antisocial personality disorder diagnoses can be risky" (p. 129).

Wakefield, Pottick, and Kirk (2002) questioned the conceptual validity of the diagnosis of conduct disorder that ignores the social context of when an adolescent's behavior may qualify for a strict application of the criteria for this diagnosis:

> Consider, for example, the following two cases: a 12-year-old boy joins a gang for self-protection in a threatening neighborhood and over a period of time engages in gang-related antisocial activity; a 13-year-old girl avoids familial sexual abuse by repeatedly lying, staying out at night, and running away from home. In both cases the youth qualifies for a conduct disorder diagnosis, according to the DSM-IV criteria, but may have no internal dysfunction. Should such adolescents be considered to have a mental disorder? (p. 381)

These writers noted that, though the text of the *DSM* encourages consideration of contextual factors, the diagnostic criteria do not require it. This deficit negatively impacts the conceptual validity of both the diagnosis of conduct disorder and the diagnosis of antisocial personality disorder that incorporates the diagnostic criteria of conduct disorder. Again, since the diagnostic criteria for antisocial personality disorder do not require consideration of social context (though the text advises doing so) the problem is compounded with respect to the diagnostician's evaluation of the adult antisocial behavior.

Finally, the diagnostic validity of antisocial personality disorder is also muddied by the considerable overlap between its diagnostic criteria and those of substance abuse disorders (Knop, Jensen, & Mortensen, 1998; Vaglum, 1998). For example, the criteria for a diagnosis of substance abuse include: hazardous behavior; arrests; failure to fulfill major role obligations at work, school, or home; and physical fights (APA, 2000b, p. 199), all of which are equivalent to criterion behaviors diagnostic for antisocial personality disorder (and its incorporated diagnosis of conduct disorder). Noting this equivalency of the criteria for the two disorders, Widiger and Corbitt (1995) concluded, "It is then difficult to determine which (if any) direction of causality has occurred when one assesses the covariation" (p. 110). In other words, with a substance abuser who engages in antisocial behavior, it is impossible to determine if the cause of this behavior is antisocial personality disorder, substance abuse disorder, or both. Therein lies the problem of conceptual validity with respect to the diagnosis of antisocial personality disorder in a person whose antisocial behavior is related to his/her substance use.

**Specific Validity Issues in SVP Cases with the Diagnoses of Antisocial Personality Disorder and Personality-Disorder-NOS-With-Antisocial-Features**

Despite the concerns expressed by the U.S. Supreme Court in *Foucha* and *Crane* about the possible overbreadth of the diagnosis of antisocial personality disorder, the Court has not, since *Foucha*, specifically addressed the issue of whether antisocial personality disorder is a constitutionally adequate basis for civil commitment. Instead, in *Crane*, the Court held that, in SVP commitment cases, "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" (*Kansas v. Crane,* 2002, p. 413). Given the aforementioned conceptual ambiguity inherent in the diagnosis of antisocial personality disorder, and the high prevalence of this diagnosis in the population of criminal offenders, it is highly questionable as to whether this diagnosis would ever allow a finding that "the severity of the mental abnormality" is "sufficient to distinguish the dangerous sexual offender" subject to civil commitment from "the dangerous but typical recidivist convicted in an ordinary criminal case."

As a result of the Supreme Court's leaving the door open to the use of antisocial personality disorder as a criterion for SVP commitment, this diagnosis has been the basis for many SVP commitments. In a study of the cases of 229 sex offenders considered for SVP commitment in Florida, Levenson (2004a) found that the diagnosis of antisocial personality disorder was second only to the diagnosis of paraphilia-NOS in its association with a recommendation for civil commitment; 48% of the men recommended for SVP commitment carried this diagnosis. Similarly, Becker, Stinson, Tromp, and Messer (2003) found that 40% of a sample of 120 sex offenders facing SVP commitment in Arizona was diagnosed with antisocial personality disorder. Fitch (2003) reviewed diagnostic data for men committed as SVPs in 14 states, and found that in 12 of those states, at least 65% of sex offenders committed had a personality disorder diagnosis, and, of that percentage, as many as 90% had a diagnosis of antisocial personality disorder.

The files of 193 sex offenders who had been evaluated by Wisconsin Department of Corrections psychologists for SVP commitment between 1995 and 2005 were reviewed for this article to determine prevalence of diagnosis. Of that number, 59 (31%) had a diagnosis of antisocial personality disorder as at least one of their diagnoses. Of 242 men committed to Wisconsin's SVP facility on June 10, 2005, 102 (42%) had a firm or provisional diagnosis of antisocial personality disorder (L.G. Sinclair, personal communication, June 10, 2005). Of these 242 men committed as SVPs in Wisconsin, 141 (58%) had firm or provisional diagnoses of a substance abuse disorder (L.G. Sinclair, personal communication, June 10, 2005). This statistic is relevant to the previous discussion about the diagnostic validity problems created by the overlapping diagnostic criteria for antisocial personality disorder and substance abuse disorders.

Sreenivasan, Weinberger, and Garrick (2003) observed, "The matter of where antisocial personality disorder fits in the civil commitment of sex offenders has been long debated" (p. 474). They noted that the old sexual psychopathy commitment laws fell into disfavor because so many antisocial sex offenders, who were unamenable to treatment, were committed under those laws. However, under the SVP laws enacted in the 1990s and sanctioned by *Hendricks* and *Crane*, "amenability for treatment" has been replaced by "the primacy of the need to protect society" (Sreenivasan, Weinberger, & Garrick, 2003, p. 475).

Several state appellate courts have explicitly sanctioned SVP civil commitment based on a diagnosis of antisocial personality disorder, even in the absence of any other diagnosis. For example, the Wisconsin Court of Appeals held, in *Wisconsin v. Adams* (1998), that a diagnosis of antisocial personality disorder "uncoupled with any other diagnosis" could satisfy statutory and constitutional due process requirements for an SVP commitment, if it was "substantially probable that the person will engage in acts of sexual violence" (p. 338). In rejecting arguments that the diagnosis of antisocial personality disorder was overly broad and therefore unconstitutional, the Court ruled that, even if the diagnosis is common, "The countless citizens who suffer from it are not *ipso facto* vulnerable to commitment ... Only the relatively few who *also* satisfy the remaining criteria ... may be found to be sexually violent persons" (p. 341). Similarly, the Iowa Supreme Court rejected a challenge to an SVP commitment in which the only diagnosis was antisocial personality disorder (*Iowa v. Barnes*, 2004). The appellant had unsuccessfully argued that, because the diagnostic criteria for antisocial personality disorder say nothing about sex offending, the diagnosis was insufficient to support a finding of "mental abnormality." The Court held, "[T]he statute does not require a sexually violent predator to have a condition that causes people *in general* to sexually offend. Rather, it requires an individualized inquiry: whether the mental abnormality makes the *particular individual* likely to commit sexually violent offenses" (p. 460).

Sreenivasan, Weinberger, and Garrick (2003) maintained that because SVP commitments based on a diagnosis of antisocial personality disorder have been upheld by some state courts, forensic evaluators should be prepared to recommend SVP commitment for persons so diagnosed. However, Vognsen and Phenix (2004) disagreed with this position, arguing, "[E]ven when state SVP ... laws allow for broad interpretation of mental disorders, it is not clinically appropriate to make a finding of SVP ... without a diagnosis of paraphilia" (p. 440). They explained that, though most SVP candidates are pedophiles or other persons with a clearly diagnosable paraphilia, the rapist who "takes what he wants when he pleases" is "more of a diagnostic challenge:"

> 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 ... unless he took special pleasure in the aggressive taking of sex. In the latter scenario, an additional diagnosis of paraphilia is indicated. (p. 441).

Vognsen and Phenix did not identify the paraphilia that they would diagnose for such a rapist, perhaps not wanting to raise the aforementioned controversy about giving rapists the diagnosis of paraphilia-NOS. They concluded their argument against basing an SVP recommendation solely on a diagnosis of antisocial personality disorder, stating,

> [S]tatutory and case law do not exclude antisocial personality disorder from being a qualifying condition for SVP... Indeed, statutory and case laws do not preclude diagnoses such as caffeine-related disorders from being considered in an SVP... 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. (p. 442)

Doren (2002), like Sreenivasan, Weinberger, and Garrick (2003), maintained that a diagnosis of antisocial personality disorder (or another personality disorder) may legitimately be the only diagnosis to justify an SVP recommendation. His position is straightforward:

> If an offender has almost solely done non-sexual offending, which he has shown many times, and his sexual offending has been minimal, then his diagnosis is more likely to be a personality

> disorder versus a paraphilia. Similarly, a criminal record that is almost solely sexual in nature, involving many sexual crimes and few nonsexual crimes, should lead the evaluator toward a paraphilia diagnosis. (p. 93)

With regard to the difference between Doren's (2002) paraphilia-NOS-nonconsent diagnosis and a diagnosis of antisocial personality disorder, Doren advised,

> Trying to make this differentiation can almost feel like one needs to get inside the offender's head to see if he is paying enough attention to his sexual victims' plight during his assaults. If he shows little attention to his victims, then there is solely a personality disorder. If he shows a lot of attention (during which the perpetrator is also showing arousal), then a paraphilia diagnosis may be considered appropriate. (p. 94)

Although it is curious that Doren apparently finds getting "inside the offender's head" more unusual in this diagnostic determination than in others, it is even more striking that he omits from his diagnostic calculus the possibility that getting 'inside the offender's head" may reveal that the offender is not diagnosable with *any* mental disorder -- he may simply be a rapist. Although this observation harkens the previous discussion about Doren's questionable use of the paraphilia-NOS-nonconsent diagnosis, it also has relevance to his advice to SVP evaluators about the diagnosis of personality disorders, in general, and antisocial personality disorder, in particular.

With regard to the general requirements set forth in *DSM-IV-TR* (APA, 2000b, p. 689) for diagnosing a personality disorder, Doren (2002) informed SVP evaluators that a personality disorder requires the following:

> [A]n enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture ... manifested in two (or more) of the following areas: (1) cognition ... (2) affectivity ... (3) interpersonal functioning ... (4) impulse control ... across a broad range of personal and social situations ... [that] leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning. [Doren, 2002, p. 88, citing *DSM-IV* (APA, 1994b, p. 633)]

After thus paraphrasing the general requirements for the diagnosis of a personality disorder in the *DSM*, Doren (2002) advised SVP evaluators, "This definition can be employed as an overall model for determining when the specific criteria within a personality disorder have been reached" (p. 88).

What Doren omitted from his explanation of the *DSM-IV-TR* (APA, 2000b) general requirements for diagnosing a personality disorder are the following key criteria:

> B. The enduring pattern [of inner experience and behavior that deviates markedly from the expectations of the individual's culture] is inflexible and pervasive across a broad range of personal and social situations.
>
> D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.
>
> E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
>
> F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma). (p. 689)

These omissions are critical to Doren's recommendation to SVP evaluators as to what to do when there is no evidence of an SVP candidate's conduct disorder before age 15, as required by *DSM* criteria for a diagnosis of antisocial personality disorder. In this regard, Doren (2002) advised evaluators as follows:

> The inappropriateness of diagnosing antisocial personality disorder under such circumstances, however, does not preclude using a different diagnosis that the evaluator can document. Assuming that one can show that a subject has the long-term pattern of antisociality in his adulthood, then one can still diagnose a *personality disorder not otherwise specified (NOS) with antisocial features*. The only difference between this diagnosis in this situation and the specific antisocial personality disorder is that the NOS form means that the complete set of diagnostic criteria for a specific disorder was not found but that a personality disorder was still found. If the examiner can demonstrate how the general diagnostic criteria for a personality disorder are still met, despite the lack of before-age-18 information, then this alternative diagnosis is quite appropriate. (p. 90)

An example of Doren's use of this diagnosis was reported in the case of *Flowers v. Thornton* et al. (2001). In that case, Doren's recommendation favoring SVP commitment was based on a diagnosis of antisocial personality disorder. However, when commitment respondent Flowers questioned the finding of evidence of pre-age-15 conduct disorder required for that diagnosis, another psychologist informed him that his diagnosis was being changed from antisocial personality disorder to personality-disorder-NOS-with-antisocial-features:

> [T]his change was made because I had not located evidence of a Conduct Disorder. Your history of adult criminal behavior was sufficient for a diagnosis of Personality Disorder NOS with Antisocial Features. Dr. Doren and I both recognize that such a difference is inconsequential in terms of meeting Chapter 980 [SVP] requirements. (p. 4)

Doren's solution of substituting a diagnosis of personality-disorder-not-otherwise-specified-with-antisocial-features for a diagnosis of antisocial personality disorder when "before-age-18 information" is lacking would be valid if one relies only on the *DSM*-required general criteria for a diagnosis of a personality disorder that he quotes in his book. However, if one includes the four criteria that he omitted from that quotation, the Doren-recommended diagnosis fails, because criterion D of the general diagnostic criteria for a personality disorder in *DSM-IV-TR* requires that "The pattern [of inner experience and behavior that deviates markedly from the expectations of the individual's culture] is stable and of long duration, *and its onset can be traced back at least to adolescence or early adulthood*" (APA, 2000b, p. 689) [italics supplied]. Thus, a lack of "before-age-18 information" would preclude a diagnosis of personality-disorder-NOS.

The diagnosis of personality-disorder-NOS is commonly made in SVP commitment cases. By its broadly encompassing nature, this diagnosis may be used for cases in which the criteria for *any* personality disorder are not fully met; its use would not be limited to cases in which the full criteria for antisocial personality disorder are unmet. In reviewing the cases of 120 Arizona sex offenders facing SVP commitment, Becker, Stinson, Tromp, and Messer (2003) found that 42% carried the diagnosis of personality-disorder-NOS. Of 229 men who were recommended for SVP commitment in Florida, Levenson (2004a) found that 28% had been diagnosed with personality-disorder-NOS.

The files of 193 sex offenders who had been evaluated by Department of Corrections psychologists for SVP commitment in Doren's home state of Wisconsin between 1995 and 2005 were reviewed for this article to determine prevalence of diagnosis. Of that number, 61 (32%) had a diagnosis of personality-disorder-NOS as at least one of their diagnoses. Of 242 men

committed to Wisconsin's SVP facility on June 10, 2005, 94 (39%) had a firm or provisional diagnosis of personality-disorder-NOS; of that number, 84 (35% of the total) included the specifier "with antisocial features" (L.G. Sinclair, personal communication, June 10, 2005). If evaluators in SVP cases nationally are making the error in using this diagnosis that Doren (2002) made in his book, many SVP commitments may rest on an invalid diagnostic foundation.

**Reliability of the Diagnoses of Antisocial Personality Disorder and Personality-Disorder-NOS-With-Antisocial-Features in SVP Cases**

Although the diagnosis of antisocial personality disorder has been touted as "the only personality disorder diagnosis to consistently obtain at least adequate to good levels of interrater reliability in clinical practice" (Widiger et al., 1996), the evidence regarding the reliability of this diagnosis is, at best, variable. For example, Rogers, Duncan, Lynett, and Sewell (1994) found good reliability for the diagnosis of antisocial personality disorder in only 3 of 13 studies that they reviewed. In the field trials of this diagnosis for *DSM-IV*, interrater reliability kappa coefficients for the diagnosis of antisocial personality disorder were highly variable, ranging from 0.37 to 1.0, with only three of nine measures exceeding the 0.75 level that Bloom, Fischer, and Orme (1999) consider to be evidence of good reliability. The field trial researchers admitted, "These results are at times lower than has been obtained in other studies using semi-structured interviews, but it should be noted that very few personality disorder studies have used independently administered interviews to assess reliability" (p. 8). However, given that diagnoses reached in clinical practice or forensic settings are generally based on independent – rather than joint -- interviews, the highly variable results of this study are probably more reflective of the real world application of the diagnosis of antisocial personality disorder than was the case with some other studies showing higher reliability rates.

In Levenson's (2004b) real world analysis of interrater reliability of the SVP evaluations of 295 Florida sex offenders, she found that the reliability coefficient for the diagnosis of antisocial personality disorder was 0.51[7] – well into the "poor" category of interrater reliability defined by Bloom, Fischer, and Orme (1999), and comparable to much of the reliability data found for this diagnosis in the *DSM-IV* field trials (Widiger et al., 1996). The interrater reliability for the diagnosis of personality-disorder-NOS was even worse, with a kappa of 0.23. It is not known how many of the personality-disorder-NOS diagnoses in this study were made because the diagnostician felt that the examinee's history fell short of satisfying the diagnostic criteria for antisocial personality disorder.

[7] This statistic was inadvertently omitted from Professor Levenson's (2004b) article (Jill Levenson, Ph.D., personal communication, May 30, 2005).

# III. Other Factors Influencing the Validity of Civil Commitment Without Psychosis

## *How Does the "Volitional Impairment" Requirement Affect Civil Commitment Without Psychosis?*

**The Volitional Impairment Requirement of *Crane* Compared tothe Volitional Prong of the Insanity Defense.**

In *Kansas v. Crane* (2002), the U.S. Supreme Court attempted to increase the validity of the concept of "mental disorder/abnormality" as the basis for civil commitment of sex offenders by setting forth the following requirements:

> [T]here 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. (p. 413)

This standard of "serious difficulty in controlling behavior" is a volitional impairment test that is comparable to the volitional prong in the standard for determining mental responsibility versus insanity in criminal cases. The American Law Institute's (ALI) Model Penal Code (Melton, Petrila, Poythress, & Slobogin, 1997) set forth the following insanity test for criminal responsibility in 1962:

> A person is not responsible for criminal conduct if, at the time of such conduct, as a result of mental disorder or defect, he lacks substantial capacity either to appreciate the criminality of his conduct or conform his conduct to the requirements of the law. (p. 192)

In the ALI test, the "lacks substantial capacity to appreciate the criminality of his conduct" element is generally referred to as the "cognitive prong," and the "lacks substantial capacity to conform his conduct to the requirements of the law" element is referred to as the "volitional prong" (Melton et al., 1997, pp. 198-201). Although many states adopted the ALI test or an equivalent insanity standard, other states adopted only a cognitive test called the M'Naghten rule (named after a 19th century British case). However, after John Hinkley's successful use of a volitional-impairment-based insanity defense in his trial for his attempted assassination of President Reagan, the volitional impairment standard fell into disfavor and was abolished for criminal cases heard in federal court and in some states' courts (Melton et al., 1997). The American Psychiatric Association (1983) advocated the abolition of the volitional test for insanity, stating,

> The line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk... The concept of volition is the subject of some disagreement among psychiatrists. Many psychiatrists therefore believe that psychiatric testimony (particularly that of a conclusory nature) about volition is more likely to produce confusion for jurors than is psychiatric testimony relevant to a defendant's appreciation or understanding. (p. 685)

An irony of the U.S. Supreme Court's adoption of a volitional impairment standard as a prerequisite for civil commitment in SVP cases is that it happened in the wake of the federal government and many states abolishing the volitional prong of their insanity defense standards.

In SVP states that still have a volitional prong in their insanity defense standards, a criminal defendant charged with child molestation could raise an insanity defense, arguing that because of the mental disease of pedophilia, he was unable to conform his conduct to the requirements of the law. If this insanity defense failed, based on the state's likely presentation of forensic expert testimony to refute it, and the defendant was convicted, after serving his sentence to imprisonment, the state could then bring an SVP commitment action against him, alleging, as required by *Crane*, that he then had a mental disorder that caused a serious difficulty in controlling his behavior – a position diametrically opposed to the one it had taken at the original trial, except for the intervening time period of criminal incarceration. Similarly, in SVP states lacking a volitional impairment prong for their insanity defense standard, although a defendant would be precluded from arguing that he lacked mental responsibility because his paraphilia prevented him from conforming his conduct to the requirements of the law, the state could, years after getting him convicted and sentenced, obtain his SVP commitment based on a finding that, at the time of the civil commitment proceeding, he had serious difficulty controlling his paraphilic behavior. A justice of the Minnesota Supreme Court decried this logical inconsistency, declaring,

> To allow the state to first choose the criminal sanction, which requires a finding of a specific state of mind, and when that sanction is completed, to choose another sanction which requires a finding of the opposite state of mind, is a mockery of justice. *In re Linehan* (1994, pp. 615-616)

A further irony of this logical inconsistency is that, though many states specifically exclude antisocial personality disorder as a basis for an insanity defense (Melton et al., 1997, p. 196), they allow it as the sole diagnostic basis for an SVP commitment. Wisconsin is one such state (*Simpson v. Wisconsin,* 1974; *Wisconsin v. Adams,* 1998).

**Does the *Hendricks*/*Crane* Volitional Impairment Requirement Improve Diagnostic Validity?**

As explained previously herein, prior to the enactment of SVP commitment laws in the 1990s (and the sexual psychopathy commitment laws that preceded them), civil commitment in the United States was generally based on a finding that the person had a psychotic disorder. Similarly, most successful insanity defenses, and the involuntary commitments that result from them, are based on diagnoses of psychotic disorders. In a review of diagnostic data from six different studies, Melton et al. (1997) concluded, "[T]he presence of a major psychosis is usually required for the insanity defense to succeed. This conclusion is especially valid in more recent years..." (p. 216).

However, as shown, SVP commitments are based on diagnoses of paraphilias and personality disorders that have very poor conceptual validity and poor interrater reliability. Does the volitional impairment requirement of *Crane* increase the validity of the diagnoses in SVP cases so as to justify basing SVP commitments on these diagnoses? To what extent is volitional impairment a feature of paraphilias and personality disorders? Doren (2002) described the volitional impairment inherent in antisocial personality disorder as follows:

> So what is a meaningful way to describe the impairment represented by a diagnosed mental condition? .... The evaluator starts with the basic way in which everyone makes decisions. We essentially form a decision equation in our heads. We consider everything we know about the pros and cons of one action versus another, with some considerations being weighed more heavily than others... Likewise, when we learn of relevant considerations that we did not know of before, we add them to our decision-making process... [A]n antisocial personality disordered individual tends to see the negative outcomes from his (antisocial) acts as reflective of other people's doings, not his own. The victim "asked for it" and so should not have reported the perpetrator to the police. The judge was unfair. Witnesses lied on the stand. Any variety of attributions is made that serve to

> diminish the person's ability to learn that his actions caused him an undesired outcome. Without the process of self-attribution, there is no learning to cause future changes in his "mental equation" except perhaps how better not to get caught. The person's willingness to repeat the same behaviors does not reflect the experiential updating characteristic of the rest of us. (pp. 16-17).

Doren (2002) analyzed the volitional impairment inherent in the paraphilias as follows:

> Another way to phrase this same perspective on volitional impairment is that the person's desire for sexual contact involving children and/or violence is sufficiently strong that it overwhelms the individual's ability to consider various options and consequences. The strength of this desire, although not "irresistible" ... becomes the basis for his deciding to sacrifice concerns for the consequences of his actions to himself and others. It is not desire per se that is the problem, but the strength of the desire relative to other actively considered options. (p. 17).

The problem with each of Doren's analyses is that they have little or no basis in the diagnostic criteria or text explanations in *DSM-IV-TR*. The failure of self-attribution characteristic that is central to Doren's analysis of volitional impairment in antisocial personality disorder is not covered by any of the diagnostic criteria in *DSM-IV-TR*, and it receives only passing mention in the 4-page text describing the diagnosis. In the scholarly literature, there is almost no mention of antisocial personality disorder as a failure of self-attribution, or as an impairment of volition. In fact, the tenor of the *DSM-IV-TR* text description of persons with this diagnosis suggests not that they have a "serious difficulty in controlling behavior" (*Kansas v. Crane*, 2002), but rather that they purposefully choose to behave in a socially unacceptable way. "Impulsivity" – the one behavior arguably most tied to volitional impairment -- is one of many available diagnostic criteria for antisocial personality disorder, but it is not required to make the diagnosis.

Similarly, Doren's volitional impairment theory that paraphilia "overwhelms the individual's ability to consider various options and consequences" is unsupported by the diagnostic criteria or text of *DSM-IV-TR*, or by the scholarly literature. Again, none of the paraphilias require any type of volitional impairment or inability to control impulses to make a diagnosis. Indeed, the whole concept of volitional incapacity is foreign to any of the *DSM-IV-TR* text descriptions or criteria for the diagnoses commonly applied to persons in SVP commitment proceedings. In fact, the manual cautions diagnosticians as follows:

> [T]he 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. (p. xxxiii)

Because diagnosticians have no guidance as to how the volitional impairment requirement of *Crane* is to mesh with a *DSM* diagnosis, they may resort to inappropriate *post hoc* reasoning that, because the examinee has repeated sex crimes, he or she must have a volitional impairment. Such reasoning requires ignoring all of the evidence of the examinee's ability to control his or her behavior, such as by concealing the crime, being selective about when and against whom he committed it in order to avoid detection, etc. Ironically, some of the same forensic examiners who are quick to assume volitional impairment in SVP cases would never find it in a defendant asserting an insanity defense in the criminal prosecution of the underlying sex crime.

Although the scholarly literature involving the volitional prong of the insanity defense is voluminous, the literature regarding the volitional impairment requirement in SVP cases is sparse. Mercado, Schopp, and Bornstein (2005) undertook one of the few reviews of this

literature. After an extensive review of the legal definitions of volitional impairment and the empirical research in psychology regarding this concept, they concluded as follows:

> While the *Crane* decision requires some evidence of volitional impairment to legitimize postsentence sex offender civil commitment schemes, we have little information on exactly what it means to be able to control one's conduct, other than subjectively defined loss of control or history of failure to control conduct, which the Supreme Court appeared to rely upon in *Hendricks*... Following *Crane*, the evaluation of an offender's volitional capacity will be increasingly important for decision-making concerning SVPs. Indeed, mental health professionals will likely be asked to provide testimony or report relative to whether an individual is able to control his or her behavior. Unfortunately, clinicians have no meaningful understanding of the mental components underlying individual control. Legal precedent, theoretical literatures, empirical research, and practice guidelines all lack clear operationalizations or conceptions of the criteria relevant to volitional impairment. Instead, there is pervasive ambiguity and uncertainty, with frequent overlap between the notions of impulsive behavior and low self-control. (p. 306)

An empirical study that examined the operationalization of the volitional impairment standard, and the other criteria for SVP commitment, found results that call into question the validity of these standards. Jackson, Rogers, and Shuman (2004) examined the SVP evaluations of 88 forensic psychologists who reviewed interviews and case histories of six sex offenders who were likely candidates for SVP commitment. The researchers had 5 years of follow-up data that showed whether or not the examinees actually re-offended. In addition to finding that the accuracy of the risk assessments of these experts was only 53% (slightly better than chance), the researchers found, "Importantly, ratings of volitional impairment were unrelated to the presence of mental abnormality ... indicating that clinicians apparently failed to conform their ratings to the legal definition of mental abnormality" (pp. 122-123). The researchers, noting the lack of specificity about the "serious inability to control behavior" standard of *Crane*, stated, "This lack of operationalization likely leads to interpretations of the standard that differ across jurisdictions and experts, ... decreasing the reliability and validity of experts' conclusions" (p. 125).

In light of the paucity of support in the *DSM* or in the scholarly and empirical literature for the concept of volitional impairment as a meaningful factor for the diagnoses generally applied in SVP cases, this concept can hardly be said to validate these diagnoses. On the contrary, it may confound them, as illustrated by the research of Jackson, *et al.* (2004), further casting doubt on the validity of civil commitment of persons who are not psychotic.

## *The Implications of "Not Otherwise Specified" (NOS) Diagnostic Categories and Other Features of the DSM that Allow for Diagnosis of Questionable Validity*

Bayer and Spitzer (1985) described the third edition of the *DSM -- DSM-III* (APA, 1980) – as follows:

> The adoption of *DSM-III* by the American Psychiatric Association (APA) has been viewed as marking a signal achievement in psychiatry. Not only did the new diagnostic manual represent an advance toward the fulfillment of the scientific aspirations of the profession, but it indicated an emergent professional consensus over procedures that would eliminate the disarray that has characterized psychiatric diagnosis. (p. 187)

The biggest difference between *DSM-III* and the two previous editions of the manual was "the development and testing of criteria that would permit different clinicians ... to make the same diagnosis for the same patient" (Hyman, 2003). Although *DSM-I* (APA, 1952) and *DSM-II* used brief, generally-worded paragraphs to describe mental disorders, *DSM-III* and its successor editions used "operationalized sets of criteria based on symptoms and signs" (Hyman, 2003, p. xi). As Hyman (2003) has declared,

> It is difficult to overstate the importance for clinical care of replacing idiosyncratic diagnostic criteria with shared, operationalized criteria. With this change, a patient whose condition was diagnosed as schizophrenia in one hospital or clinic would very likely receive the same diagnosis in another... (p. xi)

Although the claims that *DSM-III* led to dramatic increases in diagnostic reliability were inflated (Kirk & Kutchins, 1992), the increased specification of the criteria needed to define and diagnose mental disorders was an improvement over the previous "idiosyncratic" system of diagnosis (Hyman, 2003). Yet, there remains in *DSM-IV-TR* one type of diagnosis that contains none of the specific criteria that transformed the *DSM* by increasing diagnostic reliability. These are the 44 diagnoses for mental conditions that are in the "not otherwise specified" (NOS) category of diagnosis.

As documented previously herein, in SVP commitments, a large percentage of such commitments are based on diagnoses that fall in the NOS category. For example, in Wisconsin, of 193 SVP evaluations reviewed for this study, 133 – 69% -- were based, at least in part, on a diagnosis of either paraphilia-NOS (37%) or personality-disorder-NOS (32%). As shown by Levenson (2004b), these same NOS diagnoses, also commonly used in SVP commitment cases in Florida, result in very poor interrater reliability among forensic expert examiners – hardly an example of the achievement of diagnostic reliability proclaimed by the authors of *DSM-III.*

The NOS category has not been the subject of much empirical research or scholarly study, but much of what has been written has been highly critical. Maser and Patterson (2002) referred to the NOS category of *DSM* diagnosis as "less of a real diagnostic category than a receptacle for miscellaneous symptoms" (p. 864). Similarly, Verheul and Widiger (2004) noted that the category "has, at times, been characterized derogatorily as the wastebasket diagnosis for persons who fall between the cracks of the more specifically defined diagnostic categories" (p. 310). *DSM-IV-TR* (APA, 2000b) states that the NOS category of diagnosis may be appropriately used in the following four situations:

- The presentation conforms to the general guidelines for a mental disorder in the diagnostic class, but the symptomatic picture does not meet the criteria for any of the specific disorders. This would occur either when the symptoms are below the diagnostic threshold for one of the specific disorders or when there is an atypical or mixed presentation.
- The presentation conforms to a symptom pattern that has not been included in the DSM-IV Classification but that causes clinically significant distress or impairment. Research criteria for some of these symptom patterns have been included in Appendix B ("Criteria Sets and Axes Provided for Further Study"), in which case a page reference to the suggested research criteria set in Appendix B is provided.
- There is uncertainty about etiology (i.e., whether the disorder is due to a general medical condition, is substance induced, or is primary).

- There is insufficient opportunity to complete data collection (e.g., in emergency situations) or inconsistent or contradictory information, but there is enough information to place it within a particular diagnostic class (e.g., the clinician determines that the individual has psychotic symptoms but does not have enough information to diagnose a specific Psychotic Disorder. (p. 4)

The first condition, which allows for an NOS diagnosis whenever "the general guidelines for a mental disorder in the diagnostic class" are met, effectively obviates the need for the specific diagnostic categories. In effect, this provision says to diagnosticians, "Why bother adhering to the required criteria for a specific diagnosis when the general categorical guidelines will do?" A diagnosis need not be based on even a single diagnostic criterion of the specific disorders; the general "guidelines" are sufficient. The second condition is even broader, because it does not even require that the NOS diagnosis conform to the general guidelines of any diagnostic category. Thus, a diagnosis of paraphilia could be made even if the general guidelines for that diagnostic category were not met, as long as the diagnosed person has experienced some "impairment," such as a criminal arrest. The third and fourth conditions allow a diagnosis of mental disorder when there is uncertainty as to etiology or other information needed to make a diagnosis – again, an invitation to apply a diagnosis whenever specific diagnostic criteria are unmet.

The following language in *DSM-IV-TR* (APA, 2000b) worsens the problem of diagnostic validity by undermining the specificity of diagnostic criteria:

> The specific diagnostic criteria included in *DSM-IV* are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion. For example the exercise of clinical judgment may justify giving a certain diagnosis to 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. (p. xxxii)

Thus, whether a diagnostician wishes to apply a specific diagnosis or an NOS diagnosis, s/he may ignore the diagnostic criteria, because they are merely "guidelines." Doren (2002) encourages SVP evaluators to keep in mind this "license for going beyond the enumerated characteristics for a diagnosis," but cautions that it should be used "quite carefully" (p. 56).

Finally, if the NOS categories and the "the diagnostic criteria are only guidelines" provision of *DSM-IV-TR* aren't sufficient to allow application of a diagnosis to just about anyone, the ultimate diagnostic catchall is found in the *DSM-IV-TR* diagnosis coded 300.9 and called *unspecified mental disorder (nonpsychotic),* which can be applied as follows:

> 1) for a specific mental disorder in the DSM-IV Classification, 2) when none of the available Not Otherwise Specified categories is appropriate, or 3) when it is judged that a nonpsychotic mental disorder is present but there is not enough information available to diagnose one of the categories provided in the Classification. In some cases, the diagnosis can be changed to a specific disorder after more information is obtained. (p. 743)

Obviously, these three *DSM* invitations to create a diagnosis do little to encourage diagnostic validity. And, because the invention of diagnoses is limited only by the imagination of the diagnostician, the likelihood of interrater reliability is very low.

# IV. Civil Commitment Without Psychosis: What Does the Future Hold? Forecasts, Recommendations, and Conclusion

## *The Hendricks-Crane Rationale Applied Beyond SVP Commitment*

This article has examined the psychodiagnostic implications of allowing civil commitment when the person facing commitment does not have a psychotic disorder. SVP commitments were the paradigm for this analysis. We have seen that, in this context, civil commitment is usually based on diagnoses of paraphilias and personality disorders – two controversial diagnostic categories with low conceptual validity and poor interrater reliability. These problems of diagnostic validity and reliability are then worsened by reliance on NOS diagnoses, which have been aptly characterized as "less of a real diagnostic category than a receptacle for miscellaneous symptoms" (Maser and Patterson, 2002, p. 864).

These implications of allowing civil commitment without psychosis potentially go well beyond the SVP context, because nothing in the U.S. Supreme Court's decisions in *Hendricks* and *Crane* limits the rationale of those decisions to the civil commitment of sex offenders. The future ramifications of *Hendricks* and *Crane* in the United States are already being modeled in the country from which our legal system was derived. In England, the Mental Health Act (1983) allows for civil commitment of persons with "psychopathic disorder," which is defined as "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned" (part 1, sec. 1(2)). In order to be committed as a person with a psychopathic disorder, it must be found that "treatment is likely to alleviate or prevent a deterioration of his condition" (part 2, section 3(2)a). A civil commitment order under this law can be for an initial 6-month term, with recommitment for another 6-month term, and subsequent commitments for 1-year terms (part 2, section 3).

In 2000, the British government proposed the elimination of the requirement that treatment be likely to alleviate or prevent deterioration of the person's condition, explaining,

> Individuals who present a risk to others because of their severe personality disorder are rarely detained under the Mental Health Act 1983 because they are assessed as being unlikely to benefit from the sorts of treatment currently available in hospital. (Secretary of State for Health and the Home Secretary, 2000, p. 9)

Over 50 mental health organizations, including the Royal College of Psychiatrists, mounted strong opposition to the proposed legislation (Kmietowicz, 2002). As of this writing, the proposal is still being pending before Parliament (Meek, 2005). Nevertheless, the government has proceeded under the existing Mental Health Act to create a "DSPD Programme" that allows for involuntary treatment and confinement of "dangerous people with severe personality disorders" who have been detained under criminal law or the Mental Health Act (DSPD Programme, 2005a). The government is prepared to confine 320 such persons in "high secure" facilities. The eligibility criteria for such confinement are as follows:

> Individuals are considered to meet the criteria for admission to DSPD high secure services if they are assessed as being more likely than not to re-offend, resulting in serious physical or psychological harm from which the victim would find it difficult or impossible to recover. The risk

> of re-offending must also be linked to the presence of a severe personality disorder. (DSPD Programme, 2005b)

In the United States, expanding the scope of civil commitment to cover nonpsychotic persons who are not sex offenders is being discussed in the professional literature. One group of writers has urged legislators to consider allowing civil commitment of "lethal predators," whom they define as follows:

> These are men (in almost every case) who have killed at least once and are likely to keep killing as long as they are free to do so. They are deliberate, sadistic, and often highly intelligent. Their crimes tend to be carried out in a ritualistic manner, have a strong sexual component, and often involve rape or torture. They are hunters. They plan, then pursue, charm, capture, torture, and kill their prey, at times leaving the bodies in poses that express and symbolize the feelings of power and intense pleasure they have achieved in the act of killing... Though mentally abnormal ... they are not legally insane. They understand their misbehavior, know the difference between right and wrong, and can choose when to act upon their urges – and thus are criminally responsible for their acts. (Ochberg, Brantley, Hare, Houk, Ianni, James, O'Toole, & Saathoff, 2003, p. 122)

Other writers have suggested (without advocating) that the *Hendricks* rationale could be applied to the civil commitment of substance abusers (Krongard, 2002), domestic violence offenders (Estes, 1998), terrorists, shoplifters, and arsonists (Winick, 1998).

Despite the American Psychiatric Association's strong opposition to SVP commitment laws (APA, 1995; Zonona et al., 1999), the APA's *DSM* offers a wide array of diagnoses that could be used to satisfy the "mental disorder/abnormality" element of any new *Hendricks*-inspired civil commitment law. As explained previously herein, the diagnosis of antisocial personality disorder could embrace most repeat criminal offenders who could be subject to such a civil commitment law. The *DSM* diagnosis of alcohol abuse (APA, 2000b, p. 214) could be the diagnostic basis for civilly committing repeat drunken drivers. The *DSM* diagnoses of pyromania and kleptomania (APA, 2000b, p. 669, p. 671) could be used to civilly commit arsonists, and shoplifters or other thieves, respectively. Persons who engage in illegal gambling could be committed based on having the *DSM* diagnosis of pathological gambling (APA, 2000b, p. 674). Persons with a history of assault crimes could be committed based on the *DSM* diagnosis of intermittent explosive disorder (APA, 2000b, p. 667). For persons whose criminal or troublesome behavior does not fit into a specific diagnosis, the categories of personality-disorder-not-otherwise-specified (APA, 2000b, p. 729) or impulse-control-disorder-not-otherwise-specified (APA, 2000b, p. 677) would often suffice. If all else fails, there is always the ultimate *DSM* catchall diagnosis: unspecified mental disorder (nonpsychotic) (APA, 2000b, p. 743).

## *Recommendations for Curtailing the Diagnostic Validity Problems Caused by Allowing Civil Commitment of Persons Who Are Not Psychotic*

Despite its protestations against SVP commitment laws, the American Psychiatric Association has abetted these laws, and, potentially, a trend toward derivative commitment laws, by publishing the bible of psychodiagnosis that is critical to the implementation of these laws. The APA attempts to distance *DSM-IV-TR* (APA, 2000b) from its forensic implications with the following cautions:

> When the *DSM-IV* categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These

> dangers arise because of the imperfect fit between the questions of ultimate concern in the law and the information contained in a clinical diagnosis. 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 a person meets a specified legal standard ... 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. (pp. xxxii-xxxiii)

Here the APA is saying that, psychodiagnosis, alone, is insufficient to satisfy legal standards for civil commitment and other legal dispositions. *DSM-IV* then goes on to point out that diagnoses do not imply the etiology of the diagnosed condition, nor do they imply that anything about whether the diagnosed person "is (or was) unable to control his or her behavior at a particular time" (p. xxxiii). This latter qualification is the APA's attempt to distance diagnosis from the volitional prong of insanity defense standards, but it could also apply to *Hendricks*/*Crane* volitional impairment standards.

Having made these appropriate qualifications to the use of psychodiagnosis in forensic applications, *DSM-IV* (2000b) then backtracks by encouraging such use, saying:

> When used appropriately, diagnoses and diagnostic information can assist decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-IV may facilitate the legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. (p. xxxiii)

In condemning the "misuse of diagnostic terminology and methods" in SVP commitment cases, an APA task force has declared,

> Psychiatrists have recognized that only persons with severe mental disorders should be subject to civil commitment. Diagnostic skills are called on to ascertain whether substantial impairments and broad deterioration of cognitive or affective processes are present. Moreover, psychiatrists must exercise their judgment regarding whether hospitalization is medically justifiable... (Zonona et al., 1999, pp. 173-174).

By grafting this APA task force position into the immediately preceding *DSM-IV-TR* statement about the appropriate use of diagnosis in the forensic context, the APA could take a meaningful stand on the questionable use of diagnosis documented in this article.

The APA should also add to the *DSM* a caveat that current evidence as to the conceptual validity and interrater reliability of psychodiagnosis does not support the reliance on diagnoses of nonpsychotic disorders as the basis for civil commitment. In addition, the APA should amend the provisions in the *DSM-IV-TR* (APA, 2000b) regarding appropriate use of NOS categories (p. 4) and the diagnostic-criteria-as-guidelines language (p. xxxii) to state that these provisions should never be used to justify civil commitment. These recommended amendments would harmonize the APA's public policy positions regarding the appropriate use of diagnosis in civil commitment with its highly-influential manual of psychodiagnosis.

## *Conclusion*

This article has examined the diagnostic implications of allowing civil commitment based on non-psychotic disorders – a practice that was rare in the United States prior to the rise of SVP commitment laws in the 1990's and the sanctioning of those laws by the U.S. Supreme Court in the *Hendricks* and *Crane* decisions. These commitments are based on two diagnostic categories – the paraphilias and the personality disorders – that are among the most controversial, and that have the most questionable validity, of all the mental disorders in the *DSM*. The problem of diagnostic validity in SVP cases is often exacerbated by the fact that many forensic examiners start with diagnoses with poor validity and poor reliability, and they then decrease the diagnostic validity and reliability even further by using NOS categories and by dispensing with *DSM*-required criteria on the grounds that such criteria are mere "guidelines."

U.S. Supreme Court Justice Kennedy, in his concurring opinion supporting his tie-breaking vote in *Kansas v. Hendricks* (1997), warned, "...[I]f it were shown that mental abnormality is too imprecise a category to offer a solid basis for concluding that civil detention is justified, our precedents would not suffice to validate it" (p. 373). Civil commitment laws that rely on conceptually invalid and unreliable psychodiagnosis not only fail Justice Kennedy's test, they disgrace the professionals who employ the diagnosis, and subject committed persons to injustice.

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