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"Misuse of Diagnostic and Statistical Manual Diagnosis in Sexually Violent Predator Cases" by Allen Frances, MD

This article further rejects the use of "Other Specified Paraphilia disorders, nonconsent" and "Anti-Social Personality Disorder" for civil commitment.

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COMMENTARY

Misuse of Diagnostic and Statistical Manual Diagnosis in Sexually Violent Predator Cases

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Supreme Court rulings supporting the constitutionality of sexually violent predator (SVP) statutes require that evaluator's determine whether the rapist has a mental disorder (which justifies psychiatric commitment) or is just a common criminal (who cannot be preventively detained psychiatrically), but they offer no guidelines on making this crucial distinction. Until recently, state evaluators ignored the crucial fact that rape as a mental disorder has been rejected by the Diagnostic Statistical Manual of Mental Disorders (DSM) four times in the past 45 years (in DSM-III, DSM-IIIR, DSM-IV, and DSM-V). [redacted] Sreenivasan and colleagues suggest antisocial personality disorder as an appropriate standalone diagnosis to replace "paraphilia" and report it has been allowed in 19 states, although it has been disallowed in New York state courts and in the federal courts. [redacted]

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Sreenivasan and colleagues[1] usefully review differences among jurisdictions regarding the legitimacy of antisocial personality disorder (ASPD) as a qualifying diagnosis in sexually violent predator (SVP) cases. They find that ASPD has been allowable as a standalone diagnosis to support SVP psychiatric commitment in 19 states, but it has been disallowed in New York state courts and in the federal courts. The authors recommend that ASPD is a reasonable diagnosis to support SVP detention "when a pattern of offending is atypical, severe, and can be linked to the risk of further sexual offending" (Ref. 1, p 181), but it less viable "when it is manifested primarily by criminal behavior, the sex crimes are situational in context, ... or the disorder cannot be linked to sexual offending" (Ref. 1, p 181).

I have no quarrel with the authors' review of differing jurisdictional practice regarding the suitability of ASPD in SVP cases, but I disagree with their recommendations. In my view, ASPD is not an appropriate diagnosis in SVP cases because it overlaps almost completely with common criminality, holds only a very marginal place in psychiatric diagnosis, never serves as grounds for civil psychiatric commitment, and is never considered a valid psychiatric excuse to avoid prison for rape and therefore is not a legitimate psychiatric excuse for preventive incarceration after the criminal sentence has been served.

This article by Sreenivasan *et al.*[1] will likely be frequently used (and often misused) by prosecutors to support SVP commitments and will doubtless carry considerable weight with judges and juries.

The irony is that, until recently, ASPD was explicitly rejected as a standalone qualifying diagnosis by most SVP evaluators and was only very rarely used for this purpose. Recommending ASPD as a qualifying diagnosis in SVP cases has now gained urgency and support only because the previously preferred diagnosis in SVP cases, i.e., "other specified paraphilia, nonconsent," is rapidly losing its credibility and legitimacy. Promoting ASPD as a

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qualifying diagnosis is a last resort to support SVP commitments.

My experience and biases are quite different from the experiences and biases of Sreenivasan *et al.*[1] The authors have been frequent evaluators in SVP cases, most often called to testify by the state to support the appropriateness of SVP commitment. I have spent a good part of my career developing the Diagnostic and Statistic Manual of Mental Disorders (DSM) system of psychiatric diagnosis and trying to prevent its misuse in clinical, educational, research, and forensic settings. I have reviewed about 70 SVP cases and testified about the misuses of DSM in about half of these, always for the defense.

I will first discuss why paraphilia has lost purchase as a legitimate SVP-qualifying diagnosis, and then I will discuss the problems of using ASPD as its default substitute.

Misuse of Paraphilia in SVP Cases

As Sreenivasan *et al.*[1] point out, there are two related concerns about the way SVP statutes have been implemented: rapists who have completed their criminal sentence are detained indefinitely (often for life) via psychiatric incarceration even though they may have no real psychiatric illness; and the broad and ambiguous definition of "mental abnormality" in SVP statutes and Supreme Court ruling permits the misuse of psychiatric terminology. The Supreme Court rulings supporting the constitutionality of SVP statutes require that evaluators determine whether the rapists has a mental disorder, which can be used to justify psychiatric commitment, versus whether the rapist is just a common criminal who cannot be preventively detained psychiatrically, however dangerous he may seem. The Supreme Court offered no definition of mental abnormality or mental disorder, nor did they offer guidelines on how to establish whether acts of rape result from a psychiatric problem rather than from common criminality.[2, 3] In the absence of other guidance, expert witness evaluators on both sides of SVP cases have uniformly chosen to base their diagnosis on the DSM system of psychiatric diagnosis. Unfortunately, however, they far too often misunderstood how DSM is meant to be used and have carelessly misapplied its bales in SVP cases.

The misuse of psychiatric diagnosis in legal settings should occasion grave concern, but no great surprise. In a cautionary statement, written 40 years ago and placed prominently before the text of the DSM-III, we warned about the danger that this text could be misused in legal settings. These is a substantial risk that the diagnostic information contained in the DSM will be misunderstood because of the imperfect fit between the questions of concern to the law and the information contained in a clinical diagnosis. We stated explicitly that the DSM definitions of mental disorders were developed to meet clinical and research needs, not the needs of legal professionals. DSM is written by and for clinicians (who are untrained in the level of language precision required in legal documents) and is not written for a legal audience. Every subsequent edition of the DSM manual has reaffirmed and expanded this warning, but it is routinely ignored in court proceedings.

SVP cases have brought out the very worst in the always fraught relationship between psychiatric diagnosis and the law. The wording of the paraphilia section, while precise enough for clinical purposes, has proven to be harmfully imprecise when (mis)applied to SVP cases. Until recently, [redacted] The first proposal for a coercive paraphilia was made in 1976 as part of the deliberations that led to the publication of DSM-III, and it was rejected. A similar proposal was again made in 1986 as part of the deliberations that led to DSM-IIIR, and it was again rejected. Coercive paraphilia was not included in DSM-IV, and I was again proposed and rejected for DSM-5. The repeated rejections have been so complete that coercive paraphilia has never appeared as one of the many examples used to illustrate which diagnoses might be appropriate under other specified paraphilic disorder and has never been considered worthy for inclusion in the DSM appendix listing Conditions for

Further Study. The American Psychiatric Association also issued a report cautioning against the improper use of psychiatric diagnosis in SVP cases.[4]

There are many reasons why coercive paraphilia has been so roundly and so consistently rejected. For rape ever to serve as grounds for diagnosing paraphilia, the act of forcing sex would itself have to be the preferred or necessary stimulus for the rapists to achieve sexual arousal, not just a means of enforcing compliance or incidental to the context. Rape as a crime is all too common and occurs in many different contexts (opportunistic rape, date rape, gang rape, wartime rape, rape under the disinhibiting influence of substances, and rape for gain). In contrast, a stereotypical specific sexual arousal pattern, triggered only by coercion, is very rare, it is exist at all. [redacted] [5-8]

There is also no research on how paraphilia, nonconsent should be defined and diagnosed. Evaluators purporting to provide expert testimony cannot possibly reliably pick out the extremely rare paraphilic rapist (assuming that such individuals exist at all) from the wide array of other, much more common factors associated with simple criminal rape. As a result, the diagnosis of coercive paraphilia cannot be, and is not, made reliably in forensic settings. Different evaluators, even those hired by the state, routinely fail to agree on the diagnosis, and it is usually made carelessly, without rationale, without differential diagnosis, and without review of literature.

State evaluators also fail to understand, and honor, the fact that the many "nonspecified" labels accompanying all the sections of DSM are provided purely for clinical purposes, not for use in forensic settings where much greater precision and reliability is required. Nonspecified labels are necessary as place-holders and for reimbursement in uncertain clinical situations that do not yet allow for an official diagnosis, but they are inherently unreliable and useless in forensic settings because they do not provide explicit defining criteria sets, as do all of the specified diagnoses included in the DSM. [redacted] Consequential forensic decisions, with lifelong implications, should never be made based on such subjective and biased diagnosis.

Until recently, this striking disconnect existed between proper psychiatric diagnosis and the improper use of the label "other specified paraphilia" that was so frequently offered as the justification for SVP commitment. The community diagnostic standard, as exemplified by DSM, has always soundly rejected the notion that rape be considered a mental disorder. But state evaluators continued to misuse paraphilia as a misguided excuse for SVP commitment. [redacted]

ASPD and Psychiatric Commitment

Now that paraphilia, nonconsent is rapidly losing traction as justification for committing rapist under SVP statutes, evaluators are switching their attention to the possibility that ASPD can replace it as a standard diagnosis in SVP cases. [redacted] it is inconsistent to rule that the ASPD offender had sufficient volitional control to be held responsible for his crimes (resulting in his receiving the prison sentence), and then to rule years later that he is no longer in volitional control (and therefore can be forced involuntarily into a hospital). [redacted] Furthermore, many ASPD Diagnosis in SVP cases are rendered inaccurately because it is often impossible to establish the history of childhood conduct disorder (as required by the DSM definitional criteria) or the diagnosis of ASPD is not still current because the offender has matured or aged out of it. Finally, ASPD has been included in DSM for historical reasons only; it is not included in *International Classification of Diseases, 11th Revision,* it was almost excluded from DSM-5, and it is not part of the practice of psychiatry and is not treatable. [10-13]

[redacted] The Supreme Court decisions confirming the constitutionality of SVP statutes have relied on the appropriateness of civil commitment for psychiatric disorders. The justices made clear that SVP commitment was not meant to be applied to criminals in general, but instead was to be reserved only for those rapists who have an additional mental abnormality that predisposed them to rape. As defined by DSM-5, ASPD is essentially equivalent to criminality and therefore provides no appropriate additional ground to support psychiatric commitment.

Conclusion

[redacted] A corollary lesson is that the worst possible misuse of DSM is in adversarial forensic settings. And sadly, in my experience, the worst possible misuse of DSM in forensic settings occurs in SVP cases. Sreenivasan and colleagues[1] offer what may seem like common sense recommendation to avoid what they recognize could easily become the serious misuse of ASPD as a broad brush that would instantaneously make all criminal rapists edible for SVP commitment. [redacted]

The recommendations proposed by Sreenivasan *et al.*[1] for restricting the ubiquity of ASPD diagnosis in SVP cases are well meaning but impractical. They suggest limiting the ASPD diagnosis as justification for psychiatric commitment only to those rapists whose sexual crimes outweigh the nonsexual. This splitting of hairs is an inherently unreliable distinction that will not work in practice. Painful past experience teaches that if ASPD is accepted at all as a standalone diagnosis, it will soon be applied to every case. Rape will, for sake of correctional convenience and despite strong psychiatric opposition, be inappropriately converted from crime to metal disorder. And painful past experience in other countries teaches us that there is a dangerous slippery slope from correctional misuse of psychiatric diagnosis to its political misuse.

[redacted]

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