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SPECIAL ISSUE ARTICLE

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The admissibility of other specified paraphilic disorder (non-consent) in sexually violent predator proceedings

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Following the advent of sexually violent predator (SVP) legislation in the early 1990s, forensic evaluators began to apply diagnostic labels related to a paraphilic interest in rape as a mental condition predisposing individuals convicted of sexual offenses to recidivate. The most recent iteration of the concept, other specified paraphilic disorder (non-consent) (OSPD (non-consent)), is a commonly utilized diagnostic entity in SVP proceedings. Research on paraphilic interest in coercive sex has failed to define a valid methodology or set of criteria to make a diagnosis of OSPD (non-consent) and has repeatedly demonstrated that the diagnostic construct has poor interrater reliability. The state of the science pertaining to OSPD (non-consent) thus raises serious concerns regarding its admissibility in SVP proceedings. Indeed, there are recent cases in which courts have deemed it inadmissible. The forensic expert involved in SVP proceedings should understand admissibility concerns related to OSPD (non-consent) and how to address them in court.

1 | INTRODUCTION

Beginning with the passage of the Washington State Community Protection Act in 1990, jurisdictions throughout the USA established laws allowing for the post-imprisonment civil commitment of individuals convicted of sex offenses. After a legal finding that an individual meets the statutory definition of a sexually violent predator (SVP) or similarly worded condition, he is involuntarily transferred to a facility for an indefinite term. Requisite to all SVP laws is that the individual has a mental condition that predisposes him to sexually violent reoffending unless he is confined in a secured setting. The concept of a paraphilic interest in coercive sexual activity, previously referred to as

paraphilic coercive disorder and paraphilia not otherwise specified—non-consent, has frequently been utilized as grounds for civil commitment. Now enshrouded in the *DSM-5* terminology as other specified paraphilic disorder (non-consent) (OSPD (non-consent)), this construct continues to present in SVP civil commitment proceedings as evidence of a mental condition predisposing one to sexually reoffend.

Current research has failed to substantiate a valid method by which to diagnose a paraphilic interest in rape and the interrater reliability of the construct is poor. OSPD (non-consent) is being put to the test in court and has been the subject of recent admissibility hearings in various jurisdictions that utilize the *Frye* and *Daubert* standards. Some courts have deemed OSPD (non-consent) inadmissible, possibly signaling a change in courts' leniency with the use of the construct in SVP proceedings. This article will review SVP law, focusing on the definition of "mental abnormality" as a requisite finding for commitment. It will describe the concept of a paraphilic interest in coercive sex, including its history and current state of research. Finally, it will describe scientific and legal issues pertaining to the application of OSPD (non-consent) in SVP proceedings, review cases in which the admissibility of OSPD (non-consent) has been assessed, and provide evaluators with a guide by which to address admissibility concerns in court.

2 | OVERVIEW OF SEXUALLY VIOLENT PREDATOR LAW

SVP laws allow the state to civilly commit individuals convicted of sex offenses following completion of a prison term. Depending on the jurisdiction, statutes may utilize different terms to describe the committed individual, including sexually violent person, sexually dangerous person, sexual psychopathic personality, and sexually dangerous individual (Sreenivasan, Weinberger, & Garrick, 2003). Following the high-profile rape and murder of a seven-year-old boy in Tacoma, the state of Washington became the first in the USA to pass legislation allowing for the post-imprisonment civil commitment of individuals convicted of sex offenses (Lieb, 1996). The 1990 Community Protection Act authorized the state to transfer individuals determined to be "sexually violent predators" at the end of their criminal sentences to a Department of Social and Health Services facility inside a prison in Monroe, WA. Since that time, over 20 jurisdictions in the USA, including the Federal government, have passed SVP laws. After the state deems an individual an SVP, most commonly in a jury trial, he is subsequently transferred to a secured facility for an indeterminant term (Felthous & Ko, 2018).

The prototypical SVP law has various components. First, the individual to be considered for commitment must have a conviction for one of a variety of specified sexually violent offenses. In addition, the individual must have a mental condition related to his sexual offending. Finally, that mental condition must make the person a high risk for future sexually violent offending. The Missouri SVP law is a prototypical example. In the state of Missouri, an SVP is "any person who suffers from a mental abnormality which makes the person more likely than not to engage in predatory acts of sexual violence if not confined in a secure facility" (Missouri Revised Statutes, 2017). A mental abnormality is further defined 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." As of 2003, 12 other states utilized the same definition of the mental condition required for SVP commitment (Sreenivasan et al., 2003).

SVPs have challenged the commitment laws on various grounds. In the case of *Kansas v. Hendricks*, Leroy Hendricks appealed his commitment as an SVP under the Kansas Sexually Violent Predators Act. He argued that his civil detention violated ex post facto and double jeopardy law. The Kansas State Supreme Court ruled that the Act's definition of mental abnormality did not satisfy substantive due process, rendering the Act invalid. The Supreme Court of the United States reversed the lower court's decision in a five-to-four split, finding that the state's definition of mental abnormality fulfilled substantive due process and limited commitment procedures to individuals who could not control their dangerousness. An important element of the SVP proceedings was to distinguish between dangerous sexual offenders and general violent recidivists to prevent civil commitment from becoming "a mechanism for

retribution or general deterrence" (*Kansas v. Hendricks*, 1997, p. 373). In addition, the Court ruled that the Act did not violate ex post facto or double jeopardy law because the proceedings were not criminal in nature.

The case of *Kansas v. Crane* clarified the extent to which an individual's "mental abnormality" must impair an individual's control over his sexually violent behavior. Michael Crane appealed his commitment as an SVP under the Kansas Sexually Violent Predators Act after he received diagnoses of exhibitionism and antisocial personality disorder (ASPD). The state's experts agreed that Mr. Crane's diagnoses did not "impair his volitional control to the degree he cannot control his dangerous behavior" (*Kansas v. Crane*, 2002, p. 417). The Kansas Supreme Court held the SVP Act unconstitutional based on the finding that Mr Crane had a personality disorder and no volitional impairment resulting in a loss of control. The US Supreme Court reversed the state's decision, noting that the lower court did not distinguish between the "purely 'emotional' sexually related mental abnormality and the 'volitional'" (p. 415) in *Hendricks*. The court also indicated that "there must be proof of serious difficulty in controlling behavior" (p. 413), as opposed to a complete lack of control resulting from the mental condition.

Some jurisdictions outside of the USA have established special detention schemes for certain individuals convicted of sexual offenses. Canada's Dangerous Offender designation may apply to a sexual offender whose criminal behavior demonstrates "a failure to control his or her sexual impulses and a likelihood of causing injury, pain or other evil to other persons through failure in the future to control his or her sexual impulses" (Canada, 2019, p. 994). The court may impose an indeterminate sentence in a penitentiary for individuals designated as Dangerous Offenders. Similarly, Australian jurisdictions allow for extended or indefinite criminal detention of sexual offenders (Keyzer & McSherry, 2015). For example, Western Australia's Dangerous Sexual Offenders Act of 2006 established a mechanism for the state to detain a sexual offender following completion of a prison term if he is found to be a "serious danger to the community" and if there is an "unacceptable risk" that he will recidivate if released to the community (Western Australia, 2006, p. 6). If the court identifies reasonable grounds that the individual is a serious danger, it must order an evaluation of the individual by two qualified experts, at least one of which must be a psychiatrist. As opposed to SVP law in the USA, neither Canada nor Western Australia require the individual to have an identified mental condition predisposing him to reoffend or engage in violence. Once committed, the individual remains in a penal facility and is not transferred to a treatment setting. Germany, on the other hand, allows for the detention of dangerous individuals convicted of sexual offenses in both penal institutions and secured treatment settings, in the latter case when an individual has a "mental disorder." The law does not specify the nature of this condition (Basdekis-Jozsa, Mokros, Vohs, Briken, & Habermeyer, 2013).

3 | MENTAL ABNORMALITY

Different jurisdictions utilize different terms to name the mental condition required for SVP commitment, including "mental abnormality," "mental abnormality or personality disorder," "mental disorder," "behavioral abnormality," and "diagnosed mental disorder," all of which have the same prototypical definition noted above (Sreenivasan et al., 2003). Arizona is unique in identifying specific disorders that qualify for SVP commitment, defining their "mental disorder" as "a paraphilia, personality or conduct disorder or any combination of paraphilia, personality disorder and conduct disorder that predisposes a person to commit sexual acts to such a degree as to render the person a danger to health and safety of others" (Arizona Revised Statutes, 2013). In all other statutes, then, the definition of the mental condition does not overlap well with the criteria or disorders present in the *Diagnostic and Statistical Manual of Mental Disorders*, as is often the case with legal definitions relating to mental conditions. Theoretically, any diagnostic entity—from the *DSM* or otherwise—could be used as grounds for committing an individual as an SVP in states other than Arizona. The identification of a mental condition and its linkage with risk make psychiatric participation in SVP proceedings necessary and relevant.

Though all but one SVP statute fail to delineate which diagnoses may be considered as a mental condition pursuant to SVP civil commitment, there are some disorders that are more clearly in line with the statutory definitions.

First and Halon noted in 2008 that the paraphilias come closest to matching the statutory criteria for a mental condition, "even though none has the requisite predisposition to act on the paraphilic fantasies and urges nor do they involve volitional impairment in doing so" (First & Halon, 2008, pp. 444). Oftentimes a combination of diagnoses may be considered necessary to meet the statutory definition of the mental condition. For example, in *Kansas v. Crane*, the state's experts opined that the combination of exhibitionism and ASPD resulted in Mr Crane's difficulty controlling his sexually violent behavior, but that exhibitionism alone would not have. Regardless of the diagnosis identified or provided, the crucial element required to commit someone as an SVP is to identify a causal link between the disorder(s) and the person's risk for sexually violent reoffending (Weinberger, Sreenivasan, Azizian, & Garrick, 2018).

Some specific mental conditions have received attention as controversial grounds for post-imprisonment civil commitment of individuals convicted of sexual offenses. The first is ASPD. Sreenivasan et al. (2003) noted that committing an individual as an SVP on the basis of an ASPD diagnosis may be problematic for various reasons. Individuals with ASPD may not benefit from treatment, thus calling into question the use of psychiatric facilities to detain criminals with a poor prognosis. Indeed, an American Psychiatric Association Task Force composed of experts in the field of the evaluation and treatment of individuals convicted of sex offenses published a report in which they firmly opposed the use of civil commitment for such persons. They wrote that "societal concerns about the need for punishment and incapacitation of dangerous sex offenders should be met through customary sentencing alternatives within the criminal justice system and not through involuntary civil commitment statutes" (American Psychiatric Association, 1999, pp. 176). The Supreme Court, however, has overridden this concern by finding that the detainment of an individual for whom treatment is not available does not violate his constitutional rights. In the opinion of *Kansas v. Hendricks*, the court opined "[W]e have never held that the Constitution prevents a State from civilly detaining those for whom no treatment is available, but who nevertheless pose a danger to others" (p. 366). Thus, ASPD alone can qualify as a mental condition for SVP commitment. Other experts note that ASPD is an indicator of general criminality, with common findings including the violation of the rights of others, legal difficulties, and personality characteristics like deceitfulness, impulsivity, and recklessness. Since ASPD lacks any requisite sexual disturbance or abnormality and most individuals with ASPD do not commit sex crimes, they argue, it should not be used as the sole diagnosis in defining a mental abnormality in SVP civil commitment proceedings (Vognsen & Phenix, 2004).

4 | THE NON-CONSENT PARAPHILIA

A second construct to receive critical attention for its use as a mental condition in SVP proceedings is a paraphilic interest in coercive sex or rape. This concept has never been a *DSM* diagnosis and, as discussed below, has been specifically barred from the *DSM* in many of its iterations. Despite this, the name of the construct has evolved over time from its early origins as rapism, biastophilia, or paraphilic coercive disorder (PCD) to *DSM*-styled titles of paraphilia not otherwise specified (non-consent) (PNOS (non-consent)) and the current other specified paraphilic disorder (non-consent) (OSPD (non-consent)). Perhaps the first description of a paraphilia related to coercive sex was offered by John Money 1984, a psychologist who published his own idiosyncratic taxonomy of paraphilias in a 1984 article entitled "Paraphilias: Phenomenology and classification" in the *American Journal of Psychotherapy*. Within the article, Dr Money utilized four different names to label the same concept—rapism, biastophilia, biastophilic rapism, and raptophilia—which he classified under the "predatory paraphilias." He described the purported phenomenon as follows:

> The most notorious of the predatory paraphilias is biastophilic rapism or raptophilia. The biastophilic lovemap prescribes that the partner, typically a stranger, should be unsuspecting of what is about to happen, and should be maximally terror-stricken and resistant, until the fantasy enactment has run its course.

> Biastophilia may include breaking and entering, and stealing things as well as stealing sexual intercourse by force. The things stolen may be of value, or they may be more in the nature of tokens. In some cases, stealing alone takes place as a substitute for genital intercourse (p. 169).

Though he could not have known it at the time, in creating such a vague and all-encompassing "rape paraphilia" that did not even require intercourse of any sort, Dr. Money foreshadowed the widespread application of a similarly ill-defined rape paraphilia in SVP civil commitment proceedings.

Dr. Money's rape paraphilia received some subsequent support from other experts in the field. In a chapter in the *Handbook of Sexual Assault* published in 1990, Gene Abel and Joanne-L. Rouleau wrote a section entitled "Rape as a paraphilia," in which they argued that their clinical experience with paraphilic individuals provided support for the concept of paraphilic rape. They noted that some individuals reported having "recurrent, repetitive, and compulsive urges and fantasies to commit rapes" (p. 18); that 50% of individuals who rape have the onset of such an interest by age 21, similar to age of onset of other paraphilias; and that they were able to reliably distinguish between rapists and non-rapists using penile plethysmography (PPG) (Abel & Rouleau, 1990). Most individuals with paraphilic disorders develop atypical sexual interests around puberty and the onset of sexual arousal, however (Thibaut et al., 2010), and the alleged ability of Abel and Rouleau to distinguish between rapists and non-rapists was based on PPG responses of seven of each (Hays, Roberts, Solway, Feldman, & Texas Research Institute of Mental Sciences, 1981). Despite the limited evidence in support of a rape paraphilia, Abel and Rouleau argued that the authors of *DSM-III-R* failed to include a rape paraphilia in the text because "psychiatry and psychology have had limited contact with the more aggressive sex offenders" (p. 19), thus yielding less clinical information about such individuals, and that society was unwilling to accept the idea that rape may be motivated by a mental disorder (Abel & Rouleau, 1990). They wrote:

> As the ability of the victim to ward off a sex offense decreases (such as in pedophilia) or the degree of force increases during the perpetration of the crime (such as in sadism and rape), our culture is less accepting of psychiatric justification for such crimes and is more in favor of punishment through the criminal justice system (p. 19).

Ironically, the establishment of SVP law has provided "our culture" with a psychiatric justification to apply unsubstantiated diagnostic labels to individuals convicted of rape for the purpose of indefinite civil commitment.

The question of whether to include a diagnosis related to a paraphilic interest in rape in the *DSM* has existed since the publication of *DSM-III*. The history of paraphilic rape and its repeated rejection from inclusion in the *DSM* has been thoroughly documented elsewhere (Frances & First, 2011; Zander, 2008). Briefly, paraphilic coercive disorder was first suggested for inclusion in *DSM-III* at a 1976 preparatory conference for the edition, but was rejected. It was again proposed for inclusion in *DSM-III-R* and was given significant consideration, including a conference involving proponents and critics of its admission into the text. The diagnosis was again rejected due to the lack of convincing research on the topic. Not only was the proposed disorder not considered for inclusion in *DSM-IV*, but any reference to rape was kept out of the paraphilia NOS category to prevent "a backdoor entry of this questionable diagnosis" (Frances & First, 2011, p. 558). Most recently, the paraphilias sub-workgroup of the *DSM-5* considered adding paraphilic coercive disorder to the paraphilic disorders chapter. According to Stern (2010), the proposed criteria for the diagnosis were as follows:

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies or sexual urges focused on sexual coercion
B. The person is distressed or impaired by these attractions, or has sought sexual stimulation from forcing sex on three or more nonconsenting persons on separate occasions
C. The diagnosis of Paraphilic Coercive Disorder is not made if the patient meets criteria for a diagnosis of Sexual Sadism Disorder

The workgroup ultimately rejected the concept of a non-consent paraphilic disorder for *DSM-5*, however, and did not refer to rape in the description of the OSPD category. It was also excluded from the Conditions for Further Study appendix of *DSM*-5 due to a lack of sufficient research support (Frances & First, 2011).

The International Classification of Diseases (ICD), the diagnostic system used in many countries outside of the USA, similarly has not acknowledged the presence of a paraphilic disorder related to coercive sex or rape (Krueger et al., 2017). Now in its 11th iteration, the ICD-11 describes the diagnosis Coercive Sexual Sadism Disorder as "a sustained, focused and intense pattern of sexual arousal—as manifested by persistent sexual thoughts, fantasies, urges or behaviours—that involves the infliction of physical or psychological suffering on a non-consenting person" (World Health Organization, 2019). This description dovetails with *DSM-5*'s sexual sadism disorder. The "non-consenting" element of the definition serves to distinguish the diagnosis from consensual sexual sadism and masochism, not to denote a specific paraphilic interest in coercion. The ICD-11 also includes a category entitled "other paraphilic disorder involving non-consenting persons." The Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH) created this category to diagnose paraphilic disorders related to a sexual focus on others "whose age or status renders them unwilling or unable to consent" (p. 1540), but that are not better described elsewhere in ICD-11. Examples include zoophilia and necrophilia. This category represents a catch-all category for unspecified diagnoses, similar to *DSM-5*'s OSPD category, not a disorder related to a paraphilic interest in coercive sex (Krueger et al., 2017).

How did a theoretical diagnostic entity so lacking in support from the psychiatric community become widely used in SVP civil commitment proceedings? Well after its rejection from *DSM-III*, *DSM-III-R*, *DSM-IV*, and *DSM-IV-TR*, a psychologist named Dennis Doren published a book in 2002 titled *Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond*, in which he wrote that applying a diagnosis of paraphilia NOS (non-consent) is appropriate when an evaluee "has repetitively and knowingly enacted sexual contact with nonconsenting persons over a period of at least six 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" (Doren, 2002, p. 67). Though one would not expect a single psychologist's misappropriation and misapplication of phrasing from the *DSM* to a diagnostic entity repeatedly rejected by the authors of the same text to have an impact on the diagnosis of forensic evaluees, some have indicated that his book played a major role in popularizing the use of the diagnosis in SVP civil commitment proceedings (Zander, 2008).

5 | THE CURRENT STATE OF RESEARCH ON COERCIVE SEXUAL INTEREST

5.1 | Diagnostic validity

A diagnosis is considered valid if its criteria can accurately define a disorder and distinguish it from other disorders. Research pertaining to the validity of the concept of a paraphilic interest in rape has historically involved the use of PPG to assess the rape index, or the ratio of a man's penile tumescence when he is subjected to coercive sexual stimuli to the tumescence when he is exposed to scenarios involving consensual sex (Knight, 2010). Theoretically, a man with a paraphilic interest in rape would be more likely to be sexually aroused to depictions of coercive sex than a man without a paraphilic interest in rape, and therefore he would have a higher rape index. Research has identified various problems with relying on the rape index as an indicator of a paraphilic interest in coercive sex. There is evidence that a man's sexual responsivity to coercive stimuli may be related to failure of inhibition by coercive elements of scenarios, as opposed to a genuine arousal to them. Since a paraphilic interest by definition requires sexual arousal to a stimulus, failure of inhibition would not indicate a paraphilic sexual interest (Knight, Sims-Knight, & Guay, 2013). Because of this, one researcher has suggested diagnosing paraphilic coercive disorder only in individuals who demonstrate greater penile tumescence to coercive stimuli than consensual stimuli, or have a rape index greater than

one (Thornton, 2010). Such a division would be arbitrary, simplistic, and fail to address other elements that might influence one's sexual responsivity to coercive stimuli. Another reason why the concept of a paraphilic interest in rape is not valid is the inability to distinguish it from related disorders, such as sexual sadistic disorder. There is emerging evidence that interest in coercive sex exists on an "agonistic continuum" including sexual sadism and that there is no natural boundary separating the two (Longpre, Knight, & Guay, 2018). The researchers involved in characterizing the agonistic continuum have therefore recommended that OSPD (non-consent) not be admissible in SVP civil commitment proceedings.

Because there is no valid method by which to define a paraphilic interest in rape, or to distinguish it from relevant related diagnostic constructs, any criteria used to make a diagnosis of OSPD (non-consent) are unfounded. This fact has not stopped various authors from proposing their own, idiosyncratic diagnostic criteria (Doren, 2002; Thornton, 2010). More concerning, in reports to the court evaluators state that they use "diagnostic criteria" from the *DSM-5* to make a diagnosis of OSPD (non-consent), even though no such criteria exist and the concept was rejected from inclusion in any part of *DSM-5*. Such behavior is unethical and misleading to the courts, as it suggests that OSPD (non-consent) is a valid diagnostic construct recognized by the psychiatric community.

5.2 | Interrater reliability

Given the lack of any valid means by which to diagnose OSPD (non-consent), it is not surprising that evaluators rarely agree on the presence of the construct in a given individual. Studies conducted in various jurisdictions have consistently demonstrated that OSPD (non-consent) has poor interrater reliability (Levenson, 2004; Perillo, Spada, Calkins, & Jeglic, 2014; Wollert, 2017). This problem has not improved over time. In a study of 190 male sexual offenders in Florida receiving two SVP evaluations between May 2013 and June 2017 (N = 380 evaluations), there were a total of 68 non-consent diagnoses (18%). Interrater reliability of the diagnosis, as measured by the Kappa coefficient, was a mere 0.18 (Graham, 2018). This means that, even if one accepts the theoretical construct of a rape paraphilia, its diagnosis is so inconsistent that two evaluators are unlikely to agree on its presence or absence. Wollert (2017) estimated that the likelihood of two evaluators agreeing on the diagnosis is chance. In fact, in a series of recommendations for how to improve diagnostic reliability in SVP evaluations, he stated that "psychologists who undertake SVP evaluations should no longer diagnose any SVP respondent as suffering from PNOSN [paraphilia NOS, non-consent]" (p. 185).

6 | THE USE OF OSPD (NON-CONSENT) IN SVP COMMITMENT

Since OSPD (non-consent) has a poor research basis to support its use in general and in SVP commitment proceedings specifically, the prevalence of the label among committed SVPs is highly concerning. As of 2007, 43% of sexually violent predators held in the state of Washington had a non-consent diagnosis (Jackson & Richards, 2007). Currently, of the approximately 1000 SVPs hospitalized at Coalinga State Hospital in California, an estimated 35% bear the non-consent specifier (Allen Azizian, Senior Psychologist, Department of State Hospitals, California, 2019, personal communication). A similar percentage of SVPs in Missouri are committed on the basis of non-consent (Amy Clay, District Defender, Commitment Defense Unit, Missouri State Public Defender, 2019, personal communication). In 2014 one in five SVPs in Wisconsin were reported to have OSPD (non-consent) (*State of New York v. Jason C.*, 2016).

In 2014, King, Wylie, Brank, & Heilbrun published a study of case law opinions involving paraphilia NOS, non-consent. They identified 199 opinions reported up until January 1, 2012 and were able to conduct extensive analysis on 127 opinions. The first-ever recorded mention of non-consent in case law occurred in 1998. The number of references to the construct grew to approximately 30 per year by 2011. Non-consent was disproportionately represented in cases from the states of New Jersey, Washington, Minnesota, and Wisconsin. Perhaps most illuminating is the

documented basis for making the diagnosis. In 24.6% of cases, the diagnosis was based on behavior-based reasoning. In 16.4% the diagnosis was made due to the respondent's statements. In 56.6% of cases, however, it was unclear how a non-consent diagnosis was made. This is not surprising, given the lack of a valid method of diagnosing the construct. The non-consent paraphilia was held to be admissible and sufficient in 12.7% of 126 cases. In 77.0% of cases there was no challenge raised to the diagnosis' admissibility. The authors noted that "a court actually reaching the issue of whether PNOSN is a legitimate paraphilia was an infrequent occurrence" (p. 302). Common legal bases for holding the diagnosis admissible included that the diagnosis is not so unfounded as to violate due process, that the practice of psychological evaluation is generally considered sound such that individual diagnoses' admissibility do not require testing, and that SVP diagnoses do not require the same rigor as clinical diagnoses.

Apart from the court-related factors mentioned above, what factors have contributed to OSPD (non-consent)'s use in SVP proceedings? Perhaps there are psychological factors that have prompted evaluators to label rapists as mentally ill. There are no published studies examining the reasons why evaluators apply OSPD (non-consent) as a mental condition in SVP commitment proceedings. There are a few likely potential explanations, however. One is that evaluators are hesitant to deem high-risk individuals convicted of sex offenses ineligible for SVP commitment. Potential psychological mechanisms could be a fear of recidivism or a well intentioned (but misdirected) desire to protect society from high-risk rapists. Another possible reason for the widespread use of OSPD (non-consent) is the evaluator's need to substantiate his or her opinion that an offender meets the criteria for commitment as an SVP when the primary psychiatric diagnosis present is ASPD. Indeed, some authors who regard ASPD as an insufficient basis for the requisite mental condition argue that an offender with ASPD who stalks neighborhoods looking for women to rape is "obviously aroused by forced sex" and that "it would no doubt be more informative to the court to discuss how this… individual clearly demonstrates deviant sexual arousal to forced sex." They conclude that "an ongoing clear and special lust for the aggressive taking of sex, or a sexualized hostility toward women, leads to the diagnosis of paraphilia" (Vognsen & Phenix, 2004, p. 442). How a history of repeated, predatory rapes or hostility toward women automatically indicates that an individual has a paraphilia is unclear, and the authors fail to explain their reasoning. If other SVP evaluators hold the same diagnostic bias, however, it could explain why repeat rapists with ASPD (or even those without ASPD) receive a diagnosis of OSPD (non-consent).

7 | ISSUES REGARDING OSPD (NON-CONSENT)'S ADMISSIBILITY

The most common legal standards for the admissibility of expert testimony in the USA are the *Frye* and *Daubert* standards, or a modified version thereof. *Frye* established that expert testimony is admissible so long as the opinions offered are "sufficiently established to have gained general acceptance in the particular field in which it belongs" (*Frye v. United States*, 1923). In *Daubert*, the Supreme Court noted that it is the trial court judge's role as gatekeeper to ensure that expert testimony is "relevant to the task at hand" and rests on a "reliable foundation." In addition, the court identified five factors that may be considered in determining whether scientific evidence is admissible: (1) whether the theory employed by the expert is generally accepted in the scientific community, (2) whether it has been subjected to peer review and publication, (3) whether it can be or has been tested, (4) whether it has an acceptable known or potential error rate, and (5) whether there are standards controlling its operation. (*Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 1993).

Though it is ultimately up to the courts to determine whether expert testimony meets admissibility standards, a review of OSPD (non-consent) against the *Frye* standard and various *Daubert* elements suggests that the construct does not reach either standard. For OSPD (non-consent) to meet admissibility criteria in jurisdictions that utilize the *Frye* standard, the construct must have general acceptance in the relevant field. This raises the question as to what field would be most relevant when examining mental condition-related testimony in SVP proceedings. One might argue that the widespread use of OSPD (non-consent) in SVP civil commitment proceedings means that it has gained general acceptance in the field of SVP evaluators. Ironically, two of the primary researchers who have studied the

concept of a non-consent paraphilia have argued that its extensive use in civil commitment hearings "leads to inconsistent diagnostic practice and may produce diagnostic decisions that are over-inclusive and without empirical foundation" (Knight & Thornton, 2011). Furthermore, those studying the agonistic continuum on which a sexual interest in coercive sex is now conceptualized argue that the diagnosis should not be admissible (Longpre et al., 2018). The concept has clearly not gained general acceptance within the psychiatric field at large, given its repeated rejection from the *DSM*. Apart from SVP evaluators who develop their own idiosyncratic, invalid criteria for the diagnosis, OSPD (non-consent) does not appear to be generally accepted in any scientific field.

OSPD (non-consent) similarly fails to satisfy most of the other *Daubert* criteria. The construct's lack of validity indicates that it cannot be formally tested. There is no standardized set of criteria, whether *DSM* styled or based on psychophysiologic measures, that can identify a paraphilic interest in rape. One cannot test what one cannot identify. Similarly, because there are no valid criteria by which to make the diagnosis, there is no standard controlling its application in SVP civil commitment proceedings. Even if one accepts the construct as valid, however, it has such poor interrater reliability that the error rate is necessarily high (Wollert, 2017). The one *Daubert* criteria that OSPD (non-consent) may satisfy is that it has been subjected to peer review and publication, though much of the available literature identifies substantial problems with the construct and its use in sexual offender civil commitment (Frances & First, 2011; Levenson, 2004; Perillo et al., 2014; Wollert, 2017; Zander, 2008).

8 | RECENT ADMISSIBILITY CHALLENGES

Some recent cases highlight the problems related to OSPD (non-consent)'s admissibility and demonstrate various ways in which the forensic expert can address the construct in reports and testimony. In *State of New York v. Jason C.*, SVP respondent Jason C. alleged that OSPD (non-consent) was not generally accepted by the relevant scientific community and should be precluded under *Frye*. Jason C. had a history of four convictions for sexual assault involving physical violence during forced sex acts with both girlfriends and strangers. While serving time for his fourth conviction, the state filed a petition to civilly commit him. A psychologist from the New York State Office of Mental Health evaluated Mr C and diagnosed him with ASPD and alcohol use disorder, severe, in a controlled environment. A court-appointed psychologist also evaluated Mr C and diagnosed him with ASPD and OSPD (non-consent).

At the *Frye* hearing, three experts testified on the state's behalf and three testified on the respondent's behalf. One of the state's experts, David Thornton, presented PPG data, a paraphilic rape rating scale study, and a self-report study in support of OSPD (non-consent). He later indicated that he and one of the respondent's experts, Raymond Knight, had proposed that OSPD (non-consent) exists on a continuum with sexual sadism and that the disorders are not distinct categories. The court ultimately determined that the non-consent specifier is not generally accepted "within the psychological community" and offered three explanations for its reasoning. First, it indicated that there is no clear definition or criteria for the proposed disorder, citing each of the three experts' own, idiosyncratic definitions for the construct and their disagreement in the naming, wording, and criteria for the non-consent specifier. The opinion reads, "Within the research literature, it was clear that there were differing criteria even among those working within the SVP community, which is where this diagnosis is being used if not exclusively, then clearly predominantly" (p. 21). Second, the court indicated that the non-consent diagnosis cannot be reliably distinguished from other motivations for rape, including antisociality and sexual sadism, even based on the proffered PPG studies. Third, the court noted that the studies provided by the state did not reflect a "wide, significant, well-rounded body of research" (p. 29) that supports OSPD (non-consent). Specifically, the court found problematic the few researchers studying the construct and its poor diagnostic validity and interrater reliability. In addition to these factors, the court indicated that it did not find other states' use of OSPD (non-consent) persuasive because of the limited challenges to its admissibility thus far. In addition, non-consent's rejection from the *DSM* and circumscribed use only in SVP proceedings do not suggest general acceptance by the relevant scientific community. Put more directly, the court wrote:

> This Court cannot help but ask, if this disorder exists, why isn't there convincing evidence that it exists outside the realm of civil commitment? If this disorder is a matter of the human condition, then shouldn't this paraphilia be seen outside of SVP proceedings? (p. 36)

In the case of *In Re Stanley Williams*, a man undergoing SVP commitment proceedings in Missouri filed to exclude evidence regarding his paraphilic rape diagnoses, which resulted in a *Daubert* hearing. Prior to his release from the Missouri Department of Corrections, Stanley Williams underwent an evaluation by a state-appointed psychologist who diagnosed him with OSPD (non-consent) and ASPD. A subsequent Department of Mental Health evaluator found that Mr Williams did not suffer from a "mental abnormality" as defined by Missouri statute. The state obtained a second evaluation by a psychologist, who diagnosed Mr. Williams with "Other Specified Paraphilic Disorder, Coercive Type" and ASPD. At the *Daubert* hearing, the DOC psychologist testified that the definition she used to diagnose Mr Stanley had been rejected from the *DSM* and that there is no agreed upon definition for the purported disorder. The respondent's experts discussed the low interrater reliability of the diagnostic construct and research (summarized above) rejecting the categorical method of diagnosing OSPD (non-consent).

The court determined that OSPD (non-consent) failed to meet the *Daubert* factors and that it is not a product of reliable principles and methods. Noting that OSPD (non-consent) is not generally accepted within the relevant scientific community regardless of the wastebasket approach by which experts utilize the OSPD category, Judge Bruce Hilton wrote that "merely leaving room for acceptance of PCD [paraphilic coercive disorder] as a diagnosis does not indicate general acceptance" (p. 5). The court found that the categorical diagnostic approach taken by the state's experts had a high error rate due to poor interrater reliability, lacked support by peer-reviewed publications, and could not be tested in its ability to distinguish between those with OSPD (non-consent) and those without. In a criticism of the state's experts' use of diagnostic terminology specifically excluded from the *DSM*, Judge Hilton wrote, "Using diagnostic language which has been rejected from inclusion in the *DSM* does not indicate general acceptance by the relevant community, but rather an unwillingness to accept the given methods and language in question" (pp. 5–6). Ultimately, the court found OSPD (non-consent) and "Other Specified Paraphilic Disorder, Coercive Type" inadmissible and excluded related testimony at the civil commitment trial.

TABLE 1 Addressing OSPD (non-consent) admissibility factors

Admissibility factor	Evidence regarding factor	References
Testability	• There are no valid diagnostic methodologies or criteria • Currently utilized methodologies are idiosyncratic and lack evidence to support their use	• American Psychiatric Association, 2013 • Frances & First, 2011 • Zander, 2008
Subject to publication and peer-review	• Paraphilic interest in coercive sex remains a topic of ongoing publication and research • Current research does not support categorical diagnosis	• Knight et al., 2013 • Longpre et al., 2018
Known or potential error rate	• Studies demonstrate poor interrater reliability	• Graham, 2018 • Levenson, 2004 • Perillo et al., 2014 • Wollert, 2017
General acceptance in relevant community	• Repeatedly rejected from inclusion in the *DSM* since the publication of *DSM-III* • Rejected from text related to *DSM-5* OSPD category • Rejected from Conditions for Further Study in *DSM-5*	• American Psychiatric Association, 2013 • Frances & First, 2011 • Zander, 2008

9 | ADDRESSING OSPD (NON-CONSENT) IN SVP COMMITMENT PROCEEDINGS

Regardless of one's position on the legitimacy of the concept of paraphilic interest in rape, the state of the science does not support its use in SVP civil commitment. As the cases above demonstrate, experts testifying in favor of the construct (including those widely recognized as leading researchers on the topic) are incapable of describing a method of making a diagnosis of OSPD (non-consent) that is valid, reliable, and supported by the evidence. The reason for this is that there is no such method.

Forensic psychiatrists involved in SVP civil commitment proceedings should be aware of the diagnostic issues related to OSPD (non-consent), as they may be required to submit reports or testify at admissibility hearings regarding such matters. Table 1 provides a guideline for addressing the various admissibility factors as they relate to OSPD (non-consent). Forensic psychiatrists may consider structuring their arguments around the evidence pertaining to each admissibility factor if faced with an evaluee who has received a diagnosis of OSPD (non-consent).

10 | CONCLUSION

OSPD (non-consent) may see increasing challenges in court in the coming years as would-be SVPs successfully question its admissibility. Though it is ultimately the decision of courts whether OSPD (non-consent) meets the admissibility standard in each jurisdiction, it is important for the forensic psychiatrist participating in SVP commitment proceedings to understand the history and science behind the diagnostic construct. Forensic psychiatrists may play a role in properly educating the court about OSPD (non-consent)'s rejection from the *DSM* and recent studies pertaining to its diagnostic validity and reliability. The weight of the scientific evidence does not support the use of OSPD (non-consent) in SVP proceedings, where ill-founded diagnoses can result in the indefinite civil commitment of individuals convicted of sex offenses. That some evaluators continue to utilize this diagnostic construct is at the least an unethical, misguided effort to prevent the release of dangerous, imprisoned rapists, though arguably tantamount to an abuse of psychiatric diagnosis and civil commitment.

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