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Nos. 67932-5 and 68998-3

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE

IN RE THE PERSONAL RESTRAINT OF:

Alan Meirhofer;

IN RE THE DETENTION OF:

Alan Meirhofer

PETITIONER'S REPLY BRIEF

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TABLE OF CONTENTS

A. PROCEDURAL HISTORY 1

B. ARGUMENT 2

A new trial should be granted because the State's new evidence shows that Mr. Meirhofer's primary diagnosis has changed and his actuarial risk assessment has dropped to well below 50%... 2

1. *The State's new evidence shows Mr. Meirhofer is no longer likely to reoffend* 3

2. *The State's new evidence shows Mr. Meirhofer no longer suffers from pedophilia* 6

C. CONCLUSION..... 10

TABLE OF AUTHORITIES

Washington Supreme Court Decisions

<u>In re Detention of Brooks</u> , 145 Wn.2d 275, 36 P.3d 1034 (2001), overruled on other grounds by <u>In re Detention of Thorell</u> , 149 Wn.2d 724, 72 P.3d 708 (2003).....	4
<u>In re Detention of Thorell</u> , 149 Wn.2d 724, 72 P.3d 708 (2003) ..	4, 5
<u>In re the Detention of Albrecht</u> , 147 Wn.2d 1, 51 P.3d 73 (2002)....	3
<u>In re the Detention of McCuiston</u> , 174 Wn.2d 369, 275 P.3d 1092 (2012)	1, 9
<u>In re the Personal Restraint of Lord</u> , 123 Wn.2d 296, 868 P.2d 835 (1994)	2, 4

United States Supreme Court Decisions

<u>Foucha v. Louisiana</u> , 504 U.S. 71, 112 S.Ct. 1780, 118 L.Ed.2d 437 (1992)	2, 8
<u>O'Connor v. Donaldson</u> , 422 U.S. 563, 95 S.Ct. 2486, 45 L.Ed.2d 396 (1975)	3

Constitutional Provisions

U.S. Const. amend. XIV	3
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A. PROCEDURAL HISTORY

Alan Meirhofer was committed in 2000 following a jury trial at which the State's experts reported he suffered from pedophilia and was 52-92% likely to reoffend. App. A at 10-12; App. B at 1.¹

In 2010 and 2011, the State's psychologist concluded that there was no longer sufficient evidence that Mr. Meirhofer had pedophilia and that according to the actuarial risk assessment tools, Mr. Meirhofer's risk of reoffense had plummeted to 20-30%. App. B at 12-13.

Mr. Meirhofer was nevertheless denied an evidentiary hearing under RCW ch. 71.09 because these changes did not occur through treatment, as required under the 2005 amendments to the statute. App. I. The Supreme Court held these amendments were constitutional because, inter alia, a confined person could file a PRP if new evidence showed he did not meet the criteria for commitment. In re the Detention of McCuistion, 174 Wn.2d 369, 275 P.3d 1092, 1101 n.6 (2012). Mr. Meirhofer thus filed a PRP the same day as his motion for discretionary review, and moved to consolidate the cases. The State did not oppose consolidation, and filed a single answer. This reply follows.

¹ Appendices A through K are attached to Mr. Meirhofer's PRP, filed June 15, 2012. Appendices L, M, and O are attached to this reply.

B. ARGUMENT

A new trial should be granted because the State's new evidence shows that Mr. Meirhofer's primary diagnosis has changed and his actuarial risk assessment has dropped to well below 50%.

As explained in Mr. Meirhofer's PRP, there are two independent reasons that a new trial is required in this case:

- (1) the State's primary diagnosis of Mr. Meirhofer has changed from pedophilia to "hebephilia," -- a diagnosis the State concedes is "controversial"; and
- (2) the State's actuarial risk assessment has changed dramatically; in 2000, the actuarial tools showed a 52-92% likelihood of reoffense, and in 2010 and 2011, the State's assessment showed only a 20-30% likelihood of reoffense.

A jury has never heard this new evidence, which would probably change the result of the commitment trial. See In re the Personal Restraint of Lord, 123 Wn.2d 296, 319-20, 868 P.2d 835 (1994) (PRP should be granted if new evidence would probably change the result of trial).

Commitment is unconstitutional unless the individual is both mentally ill and dangerousness. See Foucha v. Louisiana, 504 U.S. 71, 77, 112 S.Ct. 1780, 118 L.Ed.2d 437 (1992) (confinement improper where individual was dangerous but no longer suffered from psychosis); O'Connor v. Donaldson, 422 U.S. 563, 575, 95

S.Ct. 2486, 45 L.Ed.2d 396 (1975) (confinement improper where individual was mentally ill but not dangerous). Significant new evidence undermining either requirement would therefore mandate relief in the form of a new trial. Here, significant new evidence undermines both requirements, so there should be no question that a new trial is necessary under the Due Process Clause. See id.; U.S. Const. amend. XIV.

1. *The State's new evidence shows Mr. Meirhofer is no longer likely to reoffend.*

The State's primary strategy in response appears to be to remind the Court that Mr. Meirhofer committed heinous crimes 25 years ago. Answer at 2-7. Mr. Meirhofer served his prison sentence for these crimes, followed immediately by over 15 years at the Special Commitment Center. The State glosses over the problem that Mr. Meirhofer's continued commitment is unconstitutional unless he is currently dangerous. In re the Detention of Albrecht, 147 Wn.2d 1, 7, 51 P.3d 73 (2002). The State's bald claim that Mr. Meirhofer has a "continued interest in violent sexual offending" is unsupported by any citation to the record. Answer at 25. Indeed, the record shows quite the contrary.

The State's new evidence shows that Mr. Meirhofer is only 20-30% likely to reoffend if released, and Mr. Meirhofer's new evidence shows the likelihood is even lower. App. B at 13 (State's actuarial assessment shows Mr. Meirhofer 20-30% likely to reoffend); App. C at 3 (Mr. Meirhofer's expert finds actuarials show likelihood of reoffense as low as 8%). Because the question at a commitment trial is "whether the probability of the defendant's reoffending exceeds 50 percent," this new evidence would likely change the result of a commitment trial, and the PRP should be granted. See In re Detention of Brooks, 145 Wn.2d 275, 298, 36 P.3d 1034 (2001), overruled on other grounds by In re Detention of Thorell, 149 Wn.2d 724, 72 P.3d 708 (2003).

The State claims that despite the fact that Mr. Meirhofer's statistical likelihood of reoffense plummeted to well below 50%, his continued commitment is constitutional because Dr. Saari still thinks he is dangerous based on "clinical judgment". Answer at 16. There are two key problems with this argument.

First, the question is not what one person thinks; the question is whether this new evidence would probably change the result of the trial. Lord, 123 Wn.2d at 319-20. Although a jury at a new trial would be entitled to believe Dr. Saari and disregard the

actuarial evidence, it is unlikely it would do so. The jury at Mr. Meirhofer's original trial committed him after hearing that the actuarial instruments predicted a 52-92% likelihood of reoffense. The jury at a new trial would hear evidence that the State's own actuarial assessment dropped from this range to only 20-30%. A jury must have the opportunity to weigh this significant new evidence against Dr. Saari's testimony.

Second, although the State claims "some experts" dispute the accuracy of actuarial instruments, Answer at 16, our supreme court has made clear that actuarial models "are more reliable than clinical judgment." Thorell, 149 Wn.2d at 757. Indeed, it was the State in Thorell who argued actuarial models are the best evidence of whether a person is currently dangerous. Id. at 757. The State even pointed out that "some experts have called for the complete rejection of clinical assessment in favor of purely actuarial assessment." Id. at 753-54. And the Washington Association for Treatment of Sexual Abusers (WATSA) joined the State in arguing that actuarial instruments "anchor" their risk assessments and that the failure to use such instruments constitutes an ethical violation for its members. Id. at 754. The probative value of actuarial assessments is "high" and "directly relevant" to whether an

individual meets the definition of “sexually violent predator”. *Id.* at 758. The Supreme Court agreed with the State’s claim, and so does Mr. Meirhofer. Because actuarial models are more reliable than clinical judgment and because the State’s actuarial models show Mr. Meirhofer’s likelihood of reoffense has plummeted to well below 50%, a new trial is required.

2. The State’s new evidence shows Mr. Meirhofer no longer suffers from pedophilia.

Although the change in risk assessment on its own requires a new trial, a second independent reason a new trial should be granted is the change in diagnosis. The State’s primary diagnosis in 2000 was pedophilia, but beginning in 2010 the State’s expert stated, “I do not think there is sufficient evidence to warrant a pedophilia diagnosis.” The expert changed the primary diagnosis to paraphilia NOS “hebephilia”. App. B at 12. This change in diagnosis, especially when combined with the significant drop in statistical likelihood of reoffense, would probably change the result of trial.

The State argues that hebephilia is a “valid” diagnosis, but concedes it is “controversial”. Answer at 26. The State also acknowledges that this alleged disorder is not in the Diagnostic and

Statistical Manual (DSM), and that many experts in the field have rejected it. Answer at 28-29. The State points out that some other experts believe it is a valid diagnosis, but does not explain why a jury would probably believe these experts over the experts who have rejected the diagnosis. A jury would probably believe the latter, given that the psychologists who have rejected the diagnosis are the authors of the authoritative source on mental disorders. App. J at 78-85.

The State then claims the change is merely one of "labeling," but this, too, would be a question for the jury. Answer at 20-22. The jury would not likely agree with the State's characterization. Contrary to the State's assertion, pedophilia and "hebephilia" differ both as to symptoms and as to general acceptance in the field. Pedophilia involves attraction to pre-pubescent children, whereas "hebephilia" is attraction to post-pubescent individuals. App. D at 17, 19. It is precisely because the latter is normal that, unlike pedophilia, hebephilia has been rejected as a valid diagnosis by preeminent psychiatrists. App. D at 18-19.

Nor does it matter that the secondary diagnoses have not changed. Answer at 19-20. The State cannot seriously claim that the jury at Mr. Meirhofer's original trial committed him based on

these diagnoses rather than the primary diagnosis of pedophilia. And at a new trial, the jury would hear evidence that many experts believe paraphilia NOS nonconsent is not a valid diagnosis and that, as the State concedes, it did not even qualify for the DSM. Answer at 28; Appendix L (in 2011 Psychiatric Times article, preeminent psychiatrist Allen Frances describes paraphilia NOS nonconsent as a “fake diagnosis”); Appendix M at 560 (in 2011 article in Journal of the American Academy of Psychiatry and the Law, two leading psychiatrists state that “paraphilia NOS nonconsent is not a legitimate mental order diagnosis”). The claim that a jury would likely commit Mr. Meirhofer based on “personality disorder NOS” is equally suspect. Answer at 20; Appendix N (Psychiatric Times article explaining that antisocial personality disorder is simply a label for criminality). Indeed, it would be unconstitutional to commit Mr. Meirhofer indefinitely based on a showing that he merely has “a personality disorder that may lead to criminal conduct.” Foucha, 504 U.S. at 82.

Additionally, the State’s claim that the trial judge believed its expert over Mr. Meirhofer’s is perplexing. Answer at 26. The trial court did no such thing. Originally, the judge ruled there was sufficient evidence to warrant a new trial. App. E at 2. The court

later ruled it could not order a new trial pursuant to the annual review process only because the changes did not stem from treatment, as required by the statutory amendments and approved by McCustion. Id. But given the judge's original ruling, if presented with a CR 60(b) motion (the trial court equivalent of a PRP), it probably would have granted a new trial. McCustion made clear that a collateral attack is the appropriate avenue for relief where new evidence shows an individual does not meet the due process requirements for continued commitment. 275 P.3d at 1101 n.6. This Court should therefore grant relief as requested in Mr. Meirhofer's PRP.

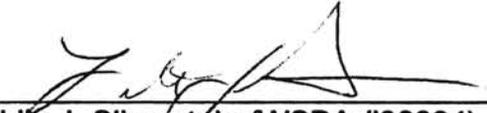
In sum, given the drastic changes in both diagnosis and risk assessment, new evidence exists which would probably change the result of a commitment trial. This Court should grant Mr. Meirhofer's PRP and remand for a new trial.

C. CONCLUSION

For the reasons set forth above and in his PRP, Mr. Meirhofer respectfully requests that this Court grant his PRP and remand for a new trial.

DATED this 17th day of October, 2012.

Respectfully submitted,



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APPENDIX L

DSM-5 Rejects Coercive Paraphilia: Once Again Confirming That Rape Is Not A Mental Disorder

By Allen Frances, MD | May 12, 2011

The proposal to include "coercive paraphilia" as an official diagnosis in the main body of DSM-5 has been rejected. This sends an important message to everyone involved in approving psychiatric commitment under Sexually Violent Predator (SVP) statutes. The evaluators, prosecutors, public defenders, judges, and juries must all recognize that the act of being a rapist almost always is an indication of criminality, not of mental disorder. This now makes four DSM's (DSM-III, DSM-III-R, DSM-IV, DSM-5) that have unanimously rejected the concept that rape is a mental illness. Rapists need to receive longer prison sentences, not psychiatric hospitalizations that are constitutionally quite questionable.

This DSM-5 rejection has huge consequences both for forensic psychiatry and for the legal system. If "coercive paraphilia" had been included as a mental disorder in DSM-5, rapists would be routinely subject to involuntary psychiatric commitment once their prison sentence had been completed. While such continued psychiatric incarceration makes sense from a public safety standpoint, misusing psychiatric diagnosis has grave risks that greatly outweigh the gain. Mislabeling rape as mental disorder in SVP cases allows a form of double jeopardy, constitutes a civil rights violation, and is an unconstitutional deprivation of due process. Preventive psychiatric detention is a slippery slope with possibly disastrous future consequences for both psychiatry and the law. If we ignore the civil rights of rapists today, we risk someday following the lead of other countries in abusing psychiatric commitment to punish political dissent and suppress individual difference.

This DSM-5 rejection of rape as mental disorder will hopefully call attention to, and further undercut, the widespread misuse in SVP hearings of the fake diagnosis "Paraphilia Not Otherwise Specified, nonconsent." Mental health evaluators working for the state have badly misread the DSM definition of Paraphilia and have misapplied it to rapists to facilitate their psychiatric incarceration. They have disregarded the fact that we deliberately excluded rape as an example of Paraphilia NOS in order to avoid such backdoor misuse. Not Otherwise Specified diagnoses are included in DSM only for clinical convenience and are inherently too idiosyncratic and unreliable to be used in consequential forensic proceedings.

Which brings us to one continuing problem raised by the DSM-5 posting. The sexual disorders work group proposes placing "coercive paraphilia" in an appendix for disorders requiring further research. We created such an appendix for DSM-IV. It was meant as a placement for proposed new mental disorders that were clearly not suitable for inclusion in the official body of the manual, but might nonetheless be of some interest to clinicians and researchers. In preparing DSM-IV, we had very strict rules and high hurdles for adding any new diagnosis- only a few suggestions made the cut, while close to 100 were rejected. Because it was no more than an unofficial tag along, we had no similar qualms about the appendix and felt comfortable including numerous rejected diagnoses in what seemed like a benignly obscure way that could do no harm.

If "Coercive Paraphilia" were like the average rejected DSM suggestion, it would similarly make sense to park it in the appendix- as has been suggested by the DSM-5 sexual disorders work group. This might facilitate the work of researchers and also provide some guidance to clinicians in assessing the vanishingly rare "black swan" rapist who does have a paraphilic pattern of sexual arousal.

But "coercive paraphilia" is not the average rejected DSM diagnosis. It has been, and is continuing to be, badly misused to facilitate what amounts to an unconstitutional abuse of psychiatry. Whether naively or purposefully, many SVP evaluators continue to widely misapply the concept that rape signifies mental disorder and to inappropriately use NOS categories where they do not belong in forensic hearings.

Including "Coercive Paraphilia" in the DSM-5 appendix might confer some unintended and undeserved back-door legal legitimacy on a disavowed psychiatric construct. Little would be gained by such inclusion and the risks of promoting continued sloppy psychiatric diagnosis and questionable legal proceedings are simply not worth taking.

The rejection of rape as grounds for mental disorder must be unequivocal in order to eliminate any possible ambiguity and harmful confusion. We did not include any reference to "coercive paraphilia" in DSM-IV, and it should not find its way in any form, however humble and unofficial, into DSM-5. The inclusion of "coercive paraphilia" in the DSM-5 appendix is a bad idea because the appearance of this white elephant anywhere in DSM-5 could be used to justify the use of Paraphilia NOS in SVP commitments.



APPENDIX M

Paraphilia NOS, Nonconsent: Not Ready for the Courtroom

Allen Frances, MD, and Michael B. First, MD

Sexually violent predators (SVP) constitute a serious potential risk to public safety, especially when they are released after too short a prison sentence. Twenty states and the federal government have developed a seemingly convenient way to reduce this risk. They have passed statutes that allow for the involuntary (often lifetime) psychiatric commitment of mentally disordered sexual offenders after prison time is up. In three separate cases, the Supreme Court has accepted the constitutionality of this procedure, but only if the offender's dangerousness is caused by a mental disorder and is not a manifestation of simple criminality. The idea that paraphilic rape should be an official category in the psychiatric diagnostic manual has been explicitly rejected by Diagnostic and Statistical Manual of Mental Disorders (DSM)-III, DSM-III-R, DSM-IV, and, recently, DSM-5. Despite this, paraphilia NOS, nonconsent, is still frequently used by mental health evaluators in SVP cases to provide a mental disorder diagnosis that legitimizes psychiatric commitment and makes it appear constitutional. This commentary will show how the diagnosis paraphilia NOS, nonconsent, is based on a fundamental misreading of the original intent of the DSM-IV Paraphilia Workgroup and represents a misuse of psychiatry, all in the admittedly good cause of protecting public safety.

J Am Acad Psychiatry Law 39:555–61, 2011

The legal system unwittingly created a dilemma for itself 30 years ago when it adopted fixed sentencing as a civil rights reform. Replacing indeterminate sentencing was a well-intended effort to provide consistency and to reduce possibly biased judicial discretion. As often happens, the solution to correct one serious problem caused another. Fixed sentencing had the unfortunate, unintended consequence of greatly reducing prison time for the most dangerous sexual offenders. The fixed sentence for rape was set at about seven years (determined by averaging the previously widely varying indeterminate sentences, so as not to affect the number of needed prison beds). The worst offenders (who would have been incarcerated much longer if judges had had their usual discretion) got a big break and were on the loose in the prime of life. There was understandable public out-

rage when recently released offenders reoffended, sometimes in the most horrible ways imaginable.

Twenty states and the federal government attempted to fill the public safety breach by passing statutes allowing for the continued incarceration of a particularly dangerous offender, but only if he could be demonstrated to have a mental disorder that was responsible for predisposing him to be at continuing risk for recidivism. Any incarceration beyond the allotted prison sentence could not be justified constitutionally under criminal auspices, because it would be a double-jeopardy infringement of civil liberties and preventive detention. Instead, the commitment had to be civil and psychiatric and was justified by the long (but not really very pertinent) precedent of involuntary psychiatric commitment for the acutely dangerous mentally ill.

The constitutionality of the SVP statutes has been frequently challenged at the state level and at the Supreme Court.^{1,2} The most pertinent Supreme Court case (*Kansas v. Hendricks*¹) led to a five-to-four narrow and hedged acceptance of the statutes. Justice Kennedy, in his separate concurring opinion, made clear that his swing vote was predicated on the presence of mental disorder as a condition of commitment. Being dangerous is not enough, since released criminals are also potentially dangerous. There is no

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Disclosures: Dr. Frances was chair of the DSM-IV Task Force and has provided testimony on behalf of the defense in SVP commitment cases. Dr. First was editor of text and criteria for DSM-IV, and editor and co-chair of the DSM-IV-TR and has performed forensic evaluations on behalf of the defense in SVP commitment cases.

constitutional justification for civil psychiatric commitment unless a mental disorder is present. The statutes cannot be used to detain common criminals who remain dangerous.

The trick is how to define mental disorder so that it separates those eligible for psychiatric commitment from the common run of criminals who must be released for constitutional reasons when their time is up, regardless of the risk they continue to pose. The rub is that there is no good, conceptually clear, and operational definition of mental disorder, either in psychiatry or in the law. The Supreme Court made clear that the legal system need not be limited to medical or psychiatric definitions, but then completely dodged the crucial question of how mental disorder should be defined and diagnosed in legal proceedings. Presumably, the definition would be left to the states to decide, but that it does not help very much. The state statutes all use almost exactly the same words to define mental disorder and do it in language that is impossibly vague and provides no real guidance. Nor can we look to the medical community for much help in providing a bright line. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Revision, Text Revision, (DSM-IV-TR),³ introduction states that "it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder'." It "lacks a consistent operational definition that covers all situations" [Ref. 3, p xxx].

In summary, the legal system is using questionably constitutional civil commitment statutes as a bailout to solve the problem created by fixed sentencing (and the resulting short prison terms for the most dangerous sex offenders). The legitimacy of the statutes depends completely on the offender's having a mental abnormality, but the states' definition of what is meant by "mental abnormality" is, as just stated, impossibly vague. The Supreme Court has refused to take advantage of its several opportunities to produce a clear legal definition. Lacking an operational legal definition of mental abnormality, the default position for mental health SVP evaluators and for the courts is to rely on the DSM-IV-TR. In practice, the statutes are triggered only if it can be determined that the offender qualifies for a DSM-IV-TR diagnosis.

Which brings us to the purpose of this commentary: to explain why the widespread use of paraphilia NOS, nonconsent, as a qualifying diagnosis in mental health proceedings is inappropriate and based on

a misunderstanding of the wording and intent of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).⁴

The Origins of Paraphilia NOS, Nonconsent, as Grounds for Civil Commitment

As Chair and Editor of the Text and Criteria in DSM-IV, we are ultimately responsible for much of the confusion. The wording of the DSM-IV Paraphilia section was written long before the issue of SVP commitment arose and was written with clinicians, not forensic proceedings, in mind. We were not aware of the consequential problems that would later arise from the fact that the section lacked the clarity and precision necessary for legal purposes. The inartful wordings allowed many evaluators in SVP determinations to misread seriously what DSM-IV was actually trying to convey.⁵ The DSM-IV Paraphilia Workgroup had definitively rejected the claim that rape should be considered a mental disorder, but a misreading of the poorly worded paraphilia section allowed evaluators to form just the opposite impression: that rape could often be considered a form of paraphilia. There was then an unfortunate snowballing, fad effect. The fact that paraphilia NOS, nonconsent, has been widely used (really misused) by the community of SVP evaluators has given it an undeserved aura of authority and acceptability.

Much has been made in legal settings of the wording of the opening sentence of the DSM-IV-TR paraphilia section. "The essential features of a paraphilia are recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons" (Ref. 3, p 566). This sentence has been erroneously taken to be some kind of authoritative DSM-IV-TR definition of paraphilia and is then used to justify the diagnosis of a qualifying mental disorder called paraphilia NOS, nonconsent, under the mistaken assumption that the text implies that the DSM-IV-TR recognizes the existence of an arousal pattern focused on the nonconsenting nature of the sexual behaviors.

In fact, it was never anticipated that the opening sentence of the section would be considered a forensic definition of paraphilia or be used in determining the suitability of long-term psychiatric incarceration.

tion.⁶ It was meant instead as no more than a simple table of contents to summarize the specific types of paraphilias included in the DSM-IV, sorting them by deviant arousal pattern into convenient categories. "Nonhuman objects" referred to fetishism and transvestic fetishism; "suffering and humiliation" covered sadism and masochism; and "children and other nonconsenting persons" covered pedophilia, exhibitionism, voyeurism, and frotteurism, all of which happen to involve nonconsenting individuals.

Doren provides the clearest and most influential illustration of mistaken interpretation of these sentences. Noting that "for whatever reasons, the DSM-IV failed to enumerate separately a paraphilia related to raping," he poses the question, "does this mean that DSM-IV totally omits such a condition?" (Ref. 5, p 65). Doren answers his own question with an authoritative-sounding "no," asserting that "the DSM-IV does include a paraphilia related to rape within its definitional paragraphs" (Ref. 5, p 65). After quoting the introductory sentence noted above, he concludes that "this set of phrases clearly relates to defining characteristics of voyeurism and exhibitionism" and "also define a type of 'nonconsent,' however, that pertains to raping as well" (Ref. 5, p 65).

As noted above, this was most certainly not our intention. The phrase was not at all meant to include rape and instead describes only the victims of exhibitionism, voyeurism, frotteurism, and pedophilia. In fact, it was the deliberate intent of DSM-IV to exclude any reference in DSM-IV to rape as a paraphilia. That is why rape is not listed under the various examples of paraphilia NOS and is not listed in the DSM-IV Index.

Complicating matters, a small editing mistake in the DSM-IV A criterion for paraphilias (i.e., the erroneous use of "or" instead of "and" to join the list of fantasies, sexual urges, behaviors)⁷⁻⁹ has encouraged some forensic evaluators to claim that a diagnosis of paraphilia NOS, nonconsent, can be made based solely on the fact that the person committed rape, without any attempt to establish that the person is in fact sexually aroused by nonconsensual sex. Indeed, noting that "evaluators do not typically enjoy the benefit of a truly honest disclosure of the subject's sexual fantasies and urges," Doren recommends that "examiners most commonly need to rely on documentation of the subject's behaviors alone instead"

(Ref. 5, p 66). Again, this was not the intent of DSM-IV.

The Forensic Misuse of NOS Categories

DSM-IV includes 46 not otherwise specified categories to allow clinicians to diagnose and code patients who do not fit well into any of the official categories. This is based on clinical judgment alone, with no criteria provided. NOS diagnoses apply for presentations that are subthreshold, atypical, of uncertain etiology, or based on insufficient information. The NOS categories are provided because psychiatric presentations are so various and idiosyncratic. It would be impossible to have specific labels for every conceivable presentation. Not otherwise specified diagnoses are meant to be no more than residual wastebaskets provided by DSM-IV to encourage research and for the convenience of clinicians when coding patients who do not fit within one of the specific DSM-IV categories.

Here is all that DSM-IV-TR says about paraphilia NOS: "A residual category, Paraphilia Not Otherwise Specified, includes other Paraphilias that are less frequently encountered" (Ref. 3, p 567) and "examples include, but are not limited to telephone scatologia, necrophilia, partialism, zoophilia, coprophilia, klismaphilia, and urophilia" (Ref. 3, p 576). DSM-IV specifically did not include either rape or nonconsent as an NOS example, because paraphilic rapism had been considered and ruled out as a paraphilia in Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III),¹⁰ Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R),¹¹ and DSM-IV.^{4,12} We did not want to provide any backdoor opening for its use via NOS.

The problem is that paraphilia NOS has been widely misapplied in SVP hearings to criminals who have no mental disorder by evaluators who have misinterpreted DSM-IV. Psychiatric diagnoses from the DSM-IV-TR are generally considered admissible in court because they are accepted by the field at large as widely recognized, clinically valid categories that can be reliably assessed. By virtue of their residual and idiosyncratic nature, cases given the label of NOS are by definition outside of what is generally accepted by the field as a reliable and valid psychiatric disorder. Furthermore, the NOS categories do not have criteria sets and therefore can never be diagnosed reliably. Because it is unlikely that different evaluators would

agree on a paraphilia NOS diagnosis, there is no reason to accept the NOS diagnosis of any given evaluator. The use by evaluators of the paraphilia NOS diagnosis fails to satisfy the standards that should be required for expert testimony. Clearly this misuse must be corrected if we are to protect the integrity of psychiatric diagnosis and the inviolability of constitutionally guaranteed civil rights.

The question arises of whether paraphilia NOS, nonconsent, should ever play a role in SVP proceedings (i.e., whether it should ever be allowed by judges and ever be taken seriously by juries). The argument for not entirely excluding paraphilia NOS is that, very occasionally, there may be a rapist whose behavior actually is motivated by paraphilia (i.e., he is able to achieve sexual arousal only or primarily when fantasizing about or performing the act of rape). The argument for rejecting all forensic use of the diagnosis paraphilia NOS, nonconsent, is that allowing these exceptions provides a backdoor invitation to its continued shameful and widespread misapplication to all the many rapists who receive the diagnosis despite being no more than simple criminals. The sad history of SVP evaluations makes compellingly clear that any opportunity for misuse of paraphilia NOS is likely to be seized on to justify unwarranted psychiatric commitment.

If paraphilia NOS, nonconsent, is ever allowed in court, it should only be when supported by incontrovertible evidence that fantasizing or performing a rape is a specific and necessary sexual stimulus for the rapist. Such evidence should include that rape scenarios are the primary focus of an offender's sexual arousal, that rape has been his major form of sexual activity, and that he has demonstrated a strong and sustained preference for and reliance on rape pornography. Such evidence must be direct, not inferential. The inference that a rapist is motivated by paraphilia if it is based entirely on the fact that he has committed rape should never be allowed. The evidence supporting an NOS diagnosis should necessarily be much stronger and more unequivocal than that required to support an official DSM diagnosis, both because the paraphilia NOS diagnosis is so inherently unreliable and because it has been so universally abused by evaluators. Any significant doubt or lack of clarity in the documentation suggests that paraphilia NOS is overused and misapplied. It is imperative that SVP evaluators be retrained on the proper use of the DSM-IV diagnosis of paraphilia and that their

work be subjected to quality control and reliability testing.

Paraphilic Coercive Disorder: A Four-Time DSM Reject

Paraphilic coercive rapism was first suggested at a conference in 1976 during the preparation of DSM-III. It was rejected. It was suggested again in 1986 during the preparation of DSM-III-R and was again rejected. The evidence presented was extremely thin—a few small plethysmograph studies suggesting that rapists were differentially aroused by images of coercive sex.¹³⁻¹⁵ Moreover, women's committees within and without the American Psychiatric Association were concerned that rape would be reconceptualized from a crime to a mental disorder. They were fearful that this would provide rapists with a psychiatric excuse to offload responsibility and were concerned that the diagnosis might be misunderstood and misused in forensic settings. A 1986 Washington, D.C., conference brought together proponents and critics of the proposal. DSM-III-R had a permissive attitude generally biased in favor of new diagnoses, but the overwhelming consensus was against coercive paraphilic rapism. The evidence for it was too weak, there was no particular need for it, and the risks of misuse were too great.

There was no support for including coercive rapism in DSM-IV, no suggestions for its inclusion, no perceived need, and no upwelling of convincing research. The absence of support, combined with continued concerns about potential misuse and a much higher threshold for adding new diagnoses guaranteed that rape would have no place in DSM-IV. We also consciously decided not to include any reference to rape among the diagnoses covered by paraphilias NOS, for fear it would allow a backdoor entry of this questionable diagnosis.

That the proposal to include coercive paraphilia as an official diagnosis in the main body of DSM-5 has recently been rejected confirms the previous decisions to reject paraphilic rape that were made for DSM-III, DSM-III-R, and DSM-IV. It is unanimous: a rapist is not someone who has a mental disorder and psychiatric commitment of rapists is not justified. This is an important message to everyone who is involved in approving psychiatric commitment under sexually violent predator (SVP) statutes. The evaluators, prosecutors, public defenders, judges, and juries must all recognize that the act of being a

rapist is almost always an aspect of simple criminality and that rapists should receive longer prison sentences, not psychiatric hospitalizations.

The DSM-5 rejection of paraphilic coercive disorder as an official category was necessary because the rationale and the supporting evidence were so thin.^{16,17} The proposal was supported by only a few very preliminary studies reporting differential sexual arousal, with rapists tending to have heightened arousal to coercive sexual stimuli.¹⁸⁻²¹ It is not at all clear why this differential arousal pattern (assuming it holds in larger and better controlled studies) should by itself constitute grounds for establishing a mental disorder. The observation that those who have raped tend to be more excited and less inhibited by coercive cues does not prove that they have a stable paraphilic pattern of intense, recurrent urges geared to coercion as a specific trigger. Furthermore, studies^{22,23} have suggested that the factor best differentiating rapists from nonrapists is the absence of the usual inhibitory effect of coercion on sexual arousal, rather than coercion being the focus of sexual arousal (which is the fundamental feature of a paraphilia). Lack of inhibition speaks to criminality, rather than paraphilia.

Even more to the point, there is no research to guide how a criteria set for paraphilic coercive disorder should be written and whether it could ever be reliably diagnosed. Reliability of paraphilia diagnoses in SVP commitment settings has already been shown to be problematic for even the established DSM-IV paraphilias.²⁴ Recall that the Supreme Court ruling in *Hendricks* supporting the constitutionality of SVP statutes rests exclusively on the distinction between mental disorder (which can be used to justify civil psychiatric commitment) and everyday criminality (which is not a constitutionally acceptable cause for further incarceration, however dangerous the individual). We have no research evidence whatsoever that forensic raters can reliably agree when attempting to sort rapists into one of these two groups. This lack of proven reliability is especially troubling when we consider the huge consequences that can follow in the legal system from what would necessarily be an untrustworthy diagnosis. The differential diagnosis of rape behavior would have to include rape for gain (e.g., by pimps or sex traffickers), opportunistic rape, date rape, gang rape, rape for dominance, rape under the disinhibiting influence of substances, rape related to an antisocial personality pattern of criminality,

and rape influenced by other mental disorders (e.g., mania or mental retardation). It seems very uncertain that SVP evaluators can reliably pick out the rare paraphilic rapist from this array, assuming that such individuals exist at all.

We also have no information on the predictive validity of the proposed paraphilic coercive disorder. Are individuals so classified more or less likely to repeat offend? Are they more or less likely to participate in and gain from treatment? What kind of treatment, if any, works? This body of research literature in its very most formative stages of development and nowhere near ready to support a diagnosis with such inherent risks of forensic misuse.

Which brings us to one continuing problem raised by what has been posted on the DSM-5 web site regarding paraphilic coercive disorder. The DSM-5 Paraphilia Subworkgroup proposes placing coercive paraphilia in an appendix for disorders requiring further research. The research appendix was meant as a placement option for proposed new mental disorders that were clearly not suitable for inclusion in the official body of the manual, but might nonetheless be of some interest to clinicians and researchers. In preparing DSM-IV, we had very strict rules and high hurdles for adding any new diagnosis: only a few suggestions made the cut, while close to 100 were rejected.²⁵ Because it was no more than an unofficial tag along, we had no similar qualms about including some of the rejected diagnoses in the appendix. This seemed like a benignly obscure way to encourage further research.

If paraphilic coercive disorder were like the average rejected DSM suggestion, it would similarly make sense to park it in the appendix, as has been suggested by the work group. This might facilitate the work of researchers and also provide some guidance to clinicians in assessing the rare rapist who does have a paraphilic pattern of sexual arousal. Paraphilic coercive disorder, however, is not the average rejected DSM diagnosis. It has been, and continues to be, badly misused to facilitate what amounts to an unconstitutional abuse of psychiatry. Whether naively or purposefully, many SVP evaluators continue to widely misapply the concept that rape signifies mental disorder and to inappropriately use NOS categories where they do not belong in forensic hearings. Including paraphilic coercive disorder in the DSM-5 appendix and suggesting it as a possible example of the proposed other specified paraphilic disorder category would confer an undeserved backdoor legal

legitimacy on a disavowed psychiatric construct. Little would be gained by such inclusion, and the risks of promoting continued sloppy psychiatric diagnosis and questionable legal proceedings are simply not worth taking. The rejection of rape as grounds for civil commitment must be unequivocal, to eliminate any possible ambiguity and harmful confusion. We did not include any reference to paraphilic coercive disorder in DSM-IV, and it should not find its way in any form, however humble and unofficial, into DSM-5. The inclusion of paraphilic coercive disorder in the DSM-5 appendix is a bad idea because the appearance of this white elephant anywhere in DSM-5 could be used to justify the use of paraphilia NOS in SVP commitments.

Conclusions

Rape is always a crime and is never, by itself, sufficient evidence of a mental disorder. There was little interest (and very limited research) in the psychiatric status of rape until it became a convenient way to subject rapists to involuntary psychiatric commitment after their prison sentences had been served. Inappropriately redefining rape as a mental disorder helped to close the legal loophole created when fixed sentencing drastically reduced the prison terms of the worst sexual offenders. The recent widespread misuse of the diagnosis paraphilia NOS in SVP hearings has resulted from a misinterpretation of the intent of DSM-IV-TR. Its overuse represents an inappropriate medicalization of criminal behavior to serve a practical public safety purpose.

The intentions of SVP evaluators are well meaning and honorable: to protect society in a way that has also been sanctioned as constitutional by the Supreme Court.²⁶ Paraphilia NOS, nonconsent, is not a legitimate mental disorder diagnosis and seems more an excuse for keeping dangerous sex offenders locked up. Certainly, no one wants rapists set loose on the streets prematurely, but better solutions than paraphilia NOS, nonconsent, must be found. The misuse of psychology and psychiatry to bail out a legal system loophole has its own set of dire professional and civil liberty risks. The violation of constitutionally guaranteed rights via a mental disorder gambit is a slippery slope tempting state misuse of the mental health professions in other ways. Mental health professionals in other countries have been turned into state-sponsored tools in the oppression of political dissidents. Mental health professionals in this country are currently filling ethically questionable roles in the interrogations of suspected terrorists.

The collaboration between the legal system and mental health professions is necessary and usually extremely beneficial, but it works only if the mental health professions jealously guard the independence and integrity of their judgments. Even the best intended misuse of psychiatric diagnosis to curb risks to society is not worth the cost. The good and necessary cause of protecting public safety can be much better and more honestly served in other ways that avoid paraphilia NOS, nonconsent. Going forward, the obvious fix is to reinstate the use of indeterminate sentencing, allowing long prison terms when it seems appropriate. Fortunately, this is the current trend, and the SVP statutes will be less necessary in the future as sentences become longer. This still leaves the interim problem of how best to apply the statutes to those prisoners or parolees who were sentenced under the previous system. There is no easy answer, but paraphilia NOS, nonconsent, is the wrong answer.

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APPENDIX O

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Should Having Antisocial Personality Qualify A Rapist For SVP Commitment?

By Allen Frances, MD | July 15, 2011

Those of you who have been following the SVP controversy know that "Paraphilia NOS, nonconsent" (PNOS) is a fake diagnosis that is losing traction as justification for committing rapists to psychiatric hospitals. PNOS was based on a fundamental misreading of DSM IV and was an egregious example of inexpert diagnosing that should never have received any credibility as expert testimony. The PNOS fad developed only as a means to expedite SVP proceedings—misusing psychiatric diagnosis and commitment to conveniently park about-to-be-released criminals.

Fortunately, everyone seems finally to be waking up to the fact that rape is a crime, not a mental disorder. The ultimate downfall of "Paraphilia NOS" was sealed recently when DSM 5 rejected "coercive paraphilia" as a diagnosis—the fourth resounding DSM rejection of this fatally flawed concept. Hopefully, before long "Paraphilia NOS, nonconsent" will be totally discredited and disallowed in SVP hearings.

Fortunately, the tide seems to be turning fast. Last week, the California Department of Mental Health (DMH) abruptly reversed its long standing policy of encouraging the diagnosis of Paraphilia NOS. Previously, its state employed evaluators were instructed that a diagnosis of Paraphilia was necessary to qualify for SVP commitment. The Department has now recanted in a new memo giving evaluators just the exact opposite instructions—that diagnoses other than Paraphilia must now be considered in SVP commitments. This sudden about face represents a clear surrender by the DMH, an implicit admission that PNOS is a misguided concept losing its power to fool juries.

The DMH memo applies clear pressure on its evaluators to find a substitute justification for SVP commitment. They will now probably resort to the frequent use of Antisocial Personality Disorder (ASPD) as the new go-to diagnosis. ASPD is already allowed as an SVP qualifying disorder in some states, but (at least until now) it has been considered non-qualifying in California and in many others. This lack of consistency cries out for testing at the appellate level in both the state and the federal courts. The appropriateness of ASPD as an SVP diagnosis touches on fundamental constitutional questions of due process and double jeopardy and should not be settled inconsistently across states or arbitrarily by evaluators or juries not equipped to deal with the complex legal issues that must be resolved. Moreover, policy on something this important should not be arbitrary and subject to the fickle and unexplained fiat of DMH memos.

There are cogent arguments both for and also against ASPD as grounds for SVP commitment. This is a debate with no obvious or easy right answers. Three plausible arguments support accepting ASPD as an SVP statutory mental disorder: 1) Unlike "coercive paraphilia" and "hebephilia," ASPD is not a faked

and ad hoc diagnosis—it is an official category that is included in DSM IV and thus has its sanction as a mental disorder; 2) ASPD can be diagnosed with reasonably good reliability- so that experts are likely to agree sufficiently on its presence or absence; and 3) ASPD is correlated with criminal behavior, including sexual offenses, and may be a predictor of future recidivism (although admittedly a weak one that accounts for only about 10% of the variance in who will and who won't offend again).

In opposition, there are four arguments against considering ASPD to be a qualifying SVP diagnosis: 1) the DSM IV definition of ASPD is mostly a cataloging of criminal behaviors, making ASPD extremely common among sex offenders and not useful in distinguishing between common criminality and mental abnormality- a distinction clearly required by the Supreme Court; 2) Since ASPD doesn't allow an offender to avoid prison, why later should it justify his psychiatric incarceration; it is inconsistent to rule that the ASPD offender had sufficient volitional control to be held responsible for his crimes (resulting in him receiving the prison sentence), while years later ruling that he is now no longer in volitional control (and therefore can be forced involuntarily into a hospital); 3) there are no other circumstances where ASPD is ever grounds for psychiatric commitment (or for any other type psychiatric hospitalization); 4) many ASPD diagnoses 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) and/or whether the diagnosis of ASPD is still current vs whether, as often happens, the offender has matured, mellowed, or aged out of it.

There are arguments for and against allowing ASPD based on differing interpretations of the words "predisposition" and "volitional" as these appear in the statute. The contrasting points of view cancel out and the debate about what "volition" or "predisposition" mean is essentially meaningless. These words have been routinely included in the SVP statutes without any precise definition; they are impossible to operationalize or assess reliably; and there is no scientific literature to provide any guidance in using them. Each psychologist and each jury member will inevitably be left to make up his own definition of volition, with any one person's guess being just as good as any other's. I think the "volition" portion of the statute is useless- far too vague to give any help at all in deciding whether ASPD should qualify as an SVP diagnosis.

Taking all the above arguments into account, my personal view is that ASPD should not have the status of an SVP diagnosis for two reasons that trump all else: (1) ASPD is far too overlapping with simple criminality; and (2) if ASPD does not excuse someone from getting locked up in prison, it is inconsistent to use it as a convenient excuse to keep someone locked up in hospital once his sentence has been fairly served.

The fact that ASPD is included in DSM IV does not mean that it defines anything beyond a criminal lifestyle. Using ASPD in SVP cases may sometimes serve the cause of public safety, but it compromises the equally important cause of due process.

The status of ASPD in SVP cases is fundamentally a legal (not a psychiatric) issue- one that should be settled by the appellate courts, not on an ad hoc and poorly informed basis, case by case, by ill equipped mental health professionals and juries. Neither psychologists nor juries are remotely qualified to evaluate the proper legal standing of ASPD under the strict conditions imposed by the Supreme Court in rulings that have only narrowly accepted the constitutionality of SVP statutes. The Court explicitly requires that the distinction be made between the mental ill and the simply criminal- SVP psychiatric commitment has been declared constitutional for the former, but would be a violation of the civil rights of the latter.

ASPD straddles this boundary in the most remarkably awkward way. Yes, ASPD has been included as a mental disorder in DSM IV, but it's DSM IV definition is really nothing more than a pattern of sustained

criminality that characterizes the majority of run-of-the-mill rapists. Ultimately only the Supreme Court can resolve this unfortunate and puzzling conundrum that lies at the heart of the application of SVP statutes. We need it to provide the necessary clarification of its previous rulings by explaining whether the law regards ASPD more as a mental disorder or more as simple criminality.

Clearly the decision about ASPD should not be made case by case by a mental health professionals or by a jury. Appellate courts are needed to decide this essentially legal, not psychiatric, issue. I fully realize that getting the question in their hands will not be easy and, once there, judges are unlikely to want to make a clear and specific stand. So we may be stuck with the chaotic current mayhem for some time.

But however difficult the ASPD question, it is a big step forward to be having this discussion since it marks the beginning of the end of the unfortunate and misguided "Paraphilia NOS" fad.

**IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION ONE**

IN RE THE DETENTION OF)	
)	
ALAN MEIRHOFER;)	
)	
)	NO. 67932-5
)	NO. 68998-3 ✓
IN RE THE PERSONAL RESTRAINT PETITION OF)	
)	
)	
ALAN MEIRHOFER.)	
)	

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