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71343-4

No. 71343-4-I

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

IN RE THE DETENTION OF:

ROY STOUT

ON APPEAL FROM THE SUPERIOR COURT OF THE
STATE OF WASHINGTON FOR SKAGIT COUNTY

CORRECTED BRIEF OF APPELLANT

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COURT OF APPEALS DIV. ONE
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A. ASSIGNMENTS OF ERROR

The superior court's denial of Mr. Stout's motion for relief from judgment pursuant to CR 60(b)(11) was manifestly unreasonable because of the following extraordinary circumstances: (1) the rejection of rape as a mental disorder by the psychiatric community; (2) the meager three percent agreement rate among the State's experts regarding Mr. Stout's diagnoses; and (3) Mr. Stout's continued confinement without a trial when the basis for his commitment has changed.

B. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

A superior court may relieve a party from a final judgment, order or proceeding pursuant to CR 60(b)(11) for any reason that justifies relief from the operation of the judgment. This rule applies to situations involving extraordinary circumstances caused by irregularities unrelated to the action of the court. Did the trial court abuse its discretion when it denied Mr. Stout's motion for relief from the original commitment order where: (1) Mr. Stout presented evidence that the diagnosis under which he was civilly committed has been rejected by the psychiatric community as a legitimate diagnosis in the manner in which it was applied to him; (2) there is only a three percent

agreement rate among the State's experts regarding Mr. Stout's diagnoses; and (3) Mr. Stout is now being detained for a mental abnormality other than that for which he was initially committed?

C. STATEMENT OF THE CASE

Mr. Stout has been civilly committed under RCW 71.09 for over ten years. CP 128. At his initial commitment trial in 2003, the superior court¹ concluded that the combination of paraphilia not otherwise specified (NOS) non-consent and antisocial personality disorder caused Mr. Stout difficulty controlling his behavior. CP 126. "A paraphilia of this kind is a mental disorder that causes recurrent intense sexually arousing fantasies, urges and behaviors involving non-consenting adults, that lasts for more than six months, and results in negative consequences to the individual." CP 125.

The superior court's factual findings relied on the circumstances of Mr. Stout's prior offenses and testimony of the State's expert. *See* CP 117-27. The State's expert did not testify about fantasies or urges, instead relying exclusively on Mr. Stout's behaviors and acts to support

¹ Mr. Stout waived his right to a jury trial and elected to have the superior court judge act as the fact finder. CP 117.

his paraphilia NOS non-consent diagnosis. CP 279. The trial court found:

Mr. Stout has exhibited recurrent sexual *behaviors* involving non-consenting adults on several occasions. These *behaviors* occurred from at least 1990 through 1997, a period of longer than six months. These *behaviors* have resulted in legal consequences and disadvantages for Mr. Stout on numerous occasions.

CP 125 (emphasis added). The State's expert did not testify that Mr. Stout experienced urges or fantasies that evidenced an arousal to coercion. *See* CP 128, 279.

Since Mr. Stout's trial, the psychiatric community has overwhelmingly rejected rape as a mental disorder. CP 344. Paraphilic coercive disorder, which attempted to characterize rape as a mental disorder, has been rejected four separate times from the Diagnostic and Statistical Manual of Mental Disorders (DSM). *See* CP 280-81. State evaluators then began using paraphilia NOS non-consent to diagnose rape as a mental disorder for purposes of civil commitment, which contravened the intent of the DSM drafters. CP 344. This misuse of the paraphilia NOS non-consent diagnosis has been renounced by recent forensic psychiatry literature. *See id.*

Paraphilia NOS non-consent is regarded by many in the psychiatric community as the most controversial concept in civil

commitment evaluations. *Id.* The diagnosis has a long history of misinterpretation and misapplication and its function has only recently been clarified. *Id.* The chair of the DSM-IV Task Force has explained that paraphilia NOS non-consent cannot be diagnosed on the basis of behaviors alone, but requires “considerable evidence documenting that the rapes reflected paraphilic urges and fantasies linking coercion to arousal.” CP 344. This presently accepted notion represents a dramatic shift from how paraphilia NOS non-consent was diagnosed at the time of Mr. Stout’s initial commitment trial. The DSM-IV Task Force chair has made clear that a paraphilia NOS non-consent diagnosis can *never* be justified on the basis of acts alone. *Id.*

Based on this change in the psychiatric community’s understanding and application of the paraphilia NOS non-consent diagnosis, Mr. Stout moved the court for relief from judgment pursuant to CR 60(b)(11). CP 276. Mr. Stout argued that the subsequent repudiation of rape as a mental disorder and paraphilia NOS non-consent in the manner in which it was applied during his civil commitment proceedings constituted extraordinary circumstances that warrant vacation of the initial commitment order. CP 283. Mr. Stout provided the superior court with updated academic literature

establishing that paraphilia NOS non-consent had been misinterpreted and then misapplied to individuals that had committed acts of rape. CP 339-48. The superior court denied Mr. Stout's CR 60(b)(11) motion. CP 451.

D. ARGUMENT

The superior court abused its discretion when it denied Mr. Stout's motion for relief from judgment.

CR 60(b) provides a number of reasons upon which a trial court may relieve a party from final judgment, order, or proceeding. In addition to those reasons specifically listed, a trial court may grant this same relief for "any other reason justifying relief from the operation of judgment." CR 60(b)(11). A motion for relief from judgment for any other reason justifying relief is the catch all provision of the rule, by which trial courts may vacate judgments for reasons not identified in the rule's more specific subsections. *Tatham v. Rogers*, 170 Wn. App. 76, 100, 283 P.3d 583 (2012). This rule applies to situations involving extraordinary circumstances caused by irregularities unrelated to the action of the court. *Id.* at 100 (citing *Flannagan v. Flannagan*, 42 Wn. App. 214, 221, 709 P.2d 1247 (1985)).

A trial court's denial of a motion to vacate judgment is reviewed for abuse of discretion. *DeYoung v. Cenex Ltd.*, 100 Wn. App. 885,

894, 1 P.3d 587 (2000). A trial court abuses its discretion by exercising it on untenable grounds or for untenable reasons. *State ex rel. Campbell v. Cook*, 86 Wn. App. 761, 766, 938 P.2d 345 (1997).

Here, there are three independent bases upon which Mr. Stout should have been granted relief from judgment. While each basis alone necessitates relief from judgment, cumulatively these extraordinary circumstances make clear that the trial court abused its discretion when it denied Mr. Stout's CR 60(b)(11) motion.

1. Since Mr. Stout's initial commitment trial in 2003, the psychiatric community has definitively rejected the concept of rape as a mental disorder.

Mr. Stout was initially committed in 2003 based on a combination of paraphilia NOS non-consent and antisocial personality disorder. CP 360. Paraphilia NOS non-consent is regarded by many in the psychiatric community as the most controversial concept in sexually violent predator evaluations.² The paraphilia NOS non-consent diagnosis has a long and very misunderstood history. Frances

² Allen Frances, Shoba Sreenivasan, & Linda E. Weinberger, *Defining Mental Disorder When It Really Counts: DSM-IV-TR and SVP/SDP Statutes*, 36 J. Am. Acad. Psychiatry Law, Sept. 2008, at 375, 380. This article is attached as Appendix A.

et al., *supra* note 2. Recent literature in the field of forensic psychiatry outlines the past misapplication of this diagnosis. *See id.*

- a. Members of the DSM Task Force and Work Groups have clarified the paraphilia NOS non-consent diagnosis and advocated against its misapplication.

One source of misunderstanding was the DSM wording for “paraphilia.” *Id.* The source of this misinterpretation was the following language from the opening sentence of the paraphilia section in the DSM-IV-TR:

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.³

This sentence has been inaccurately interpreted to justify the diagnosis of paraphilia NOS non-consent based on the non-consenting nature of sexual behaviors. Frances & First, *supra* note 3.

Rather, the term “nonconsenting persons” as used in the DSM was not intended to include rape. *Id.* at 557. Instead, the term describes only the victims of exhibitionism, voyeurism, frotteurism, and pedophilia. *Id.* In reality, it was the deliberate intent of the DSM-

³ Allen Frances & Michael B. First, *Paraphilia NOS, Nonconsent: Not Ready for the Courtroom*, 39 J. Am. Acad. Psychiatry Law, Dec. 2011, at 555, 556.

IV drafters to exclude any reference to rape as a paraphilia. *Id.* Rape was neither included as a coded diagnosis nor provided as an example of paraphilia. Frances et al., *supra* note 2. This prior misinterpretation of the phrase “nonconsenting person” resulted in clinicians treating rape as a mental disorder despite the fact that the DSM drafters’ objective was just the opposite. *Id.*

Another misconception among clinicians concerning paraphilia NOS non-consent was that it could be assigned based on rape behaviors alone. *Id.* It is now well understood that acts alone can never be paraphilic. *Id.* The essential features of paraphilia are “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors.” *Id.* “Behaviors” may signify the culmination of urges and fantasies, but they are insufficient on their own to warrant a diagnosis of paraphilia NOS non-consent. Frances et al., *supra* note 2. This distinction is necessary to separate paraphilia from opportunistic criminality. *Id.* “Some rapes may be triggered by opportunity, others may occur in the context of intoxication-related disinhibition, and some may reflect character disorder or other nonparaphilic pathology.” *Id.*

The confusion regarding paraphilia NOS non-consent has recently been clarified in the psychiatric community. *See id.* In order

for a paraphilia NOS non-consent diagnosis to be merited, it requires “considerable evidence documenting that the rapes reflected paraphilic urges and fantasies linking the coercion to the arousal.” *Id.* Paraphilia NOS non-consent has been deemed an inherently weak construct because of its lack of a defined set of criteria. *Id.* at 381. The psychiatric community expressed serious concern about the danger that clinicians would misuse the DSM by applying an idiosyncratic interpretation of behaviors to shoehorn individuals for the purpose of justifying civil commitment. *Id.*

The inference that a rapist is motivated by paraphilia should never be made entirely on the fact that he committed rape. Frances & First, *supra* note 3, at 558. However, state 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.” *Id.* at 559. Paraphilia NOS non-consent is not a legitimate mental disorder diagnosis according to the drafters of the DSM. *Id.* at 560.

At Mr. Stout’s motion for relief from judgment, the State argued that paraphilia NOS had previously been unsuccessfully challenged in *In re Det. of Young*, 122 Wn.2d 1, 857 P.2d 989 (1993). RP 16.

However, *Young* was decided when “pathologically driven rape” was not *yet* included in the DSM-III-R. 122 Wn.2d at 28. At the time of Mr. Stout’s motion for relief from judgment, paraphilia characterized by rape behavior had been specifically *rejected* by the DSM. Frances & First, *supra* note 3. “What is critical for our purposes is that the psychiatric and psychological clinicians who testify in good faith as to the mental abnormality are able to identify sexual pathologies that are as real and meaningful as the other pathologies already listed in the DSM.” *Id.* (citing Alexander D. Brooks, *The Constitutionality and Morality of Civilly Committing Violent Sexual Predators*, 15 U. Puget Sound L. Rev. 709, 733 (1992)).

The State’s reliance on *Young* is misplaced. The *Young* decision stands for the principle that just because a pathology has not yet been included in the DSM does not necessarily mean that the diagnosis should be rejected. *See id.* *Young* does not promote the notion that once the DSM and psychiatric community has explicitly and overwhelmingly rejected a pathology, such as rape as a mental disorder, it still may be used to indefinitely confine someone. The literature and research demonstrates that paraphilia NOS non-consent is regarded drastically differently today than it was in 2003.

Mr. Stout did not have the benefit of presenting this reexamination and rebuff of rape as a mental disorder to the fact finder in his initial commitment trial. Homosexuality was once considered a mental disorder and included in the DSM.⁴ Homosexuality was removed from the DSM in 1973 and is no longer considered a mental disorder. Spitzer, *supra* note 4. As the Supreme Court has recognized, “The DSM is, after all, an evolving and imperfect document.” *Young*, 122 Wn.2d at 28. Denying Mr. Stout’s motion for a new trial is the equivalent of denying a new trial to an individual civilly committed for homosexuality in the 1970s.

The scrutiny, skepticism, and ultimate rejection of paraphilia NOS non-consent and its past misapplication illustrates the extraordinary circumstances that justify Mr. Stout’s relief from the initial commitment order.

b. *The refusal to include paraphilic coercive disorder in the DSM-5 further confirms that rape is not a mental disorder.*

Rape as a paraphilia was first suggested as paraphilic coercive disorder. Frances & First, *supra* note 3, at 558. A recent proposal to

⁴ R.L. Spitzer, *The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues*, Am. J. Psychiatry, Feb. 1981, at 210.

include paraphilic coercive disorder as an official diagnosis in the DSM-5 was rejected. *Id.* In a recent article, the chair of the DSM-IV Task Force and the editor and co-chair of the DSM-IV commented on this rejection:

That the proposal to include coercive paraphilia as an official diagnosis in the main body of the 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.

Id. at 558-59.

Paraphilic coercive disorder's rejection from the DSM-5, reflecting the psychiatric community's refusal to classify rape as a mental disorder, further demonstrates the shift that has occurred since Mr. Stout's initial commitment trial in 2003. The fact that Mr. Stout remains indefinitely confined based on a diagnosis that was controversial in the past and fully rejected today is an extraordinary circumstance that justifies relief from his original commitment order.

As such, the superior court abused its discretion when it denied Mr. Stout's CR 60(b)(11) motion.

2. The meager three percent agreement rate regarding Mr. Stout's diagnoses among the State's experts constitutes an extraordinary circumstance that merits relief from judgment.

The erratic diagnoses offered by the State's experts over the years further substantiates the flawed nature of the paraphilia NOS non-consent diagnosis. At Mr. Stout's initial commitment trial, the State's expert, Dr. Packard, testified that the combination of paraphilia NOS non-consent and antisocial personality disorder caused Mr. Stout difficulty controlling his behavior. CP 126. Dr. Wollert, an expert who conducted a psychological evaluation of Mr. Stout in 2013 and reviewed all of his prior diagnoses, concluded that Dr. Packard's diagnosis was based on two erroneous assumptions.⁵ CP 307-08.

Dr. Packard's first inaccurate assumption was that the relevant professional community accepted paraphilia NOS non-consent as a reliable mental disorder. CP 308. This assumption was mistaken because of the rejection of paraphilic coercive disorder, and by extension of paraphilia NOS non-consent when diagnosed on the basis

⁵ Dr. Wollert's psychological evaluation of Mr. Stout dated May 7, 2013 is attached as Appendix B.

of behaviors alone, as an authorized DSM diagnosis. CP 309; *see supra* Section D(1). Rape is no longer considered a reliable mental disorder by the psychiatric community. *Id.*

The second incorrect assumption was that members of the relevant professional community would be able to reliably diagnose Mr. Stout with a combination of paraphilia NOS non-consent and antisocial personality disorder. CP 307. There has been only a three percent agreement rate among State's experts regarding Mr. Stout's diagnoses. CP 308. This agreement rate is far below a reasonable degree of professional certainty. *Id.* Mental health professionals have been unable to reliably identify diagnoses in Mr. Stout's case. *Id.*

The inability to reliably diagnose Mr. Stout is most dramatically illustrated by Dr. Spizman's annual reports. CP 137-38, 250-51. In his 2011 report, Dr. Spizman acknowledged that while he previously diagnosed Mr. Stout with paraphilia NOS non-consent, he subsequently became uncertain because "the assaults did not clearly indicate a desire for non-consensual sexual activity." CP 250. The fact that the same evaluator could one year render the diagnosis and retract that diagnosis the following year based on the exact same facts exposes the problematic nature of Mr. Stout's indefinite confinement based on these

prior diagnoses. This further evidences the extraordinary circumstances that merit relief from judgment.

3. It is unconstitutional to continue to detain Mr. Stout without a trial where the basis for his commitment has changed.⁶

At the initial commitment trial, the superior court concluded that “the combination of paraphilia (NOS) non-consent with anti-social personality disorder causes [Mr. Stout] serious difficulty in controlling his behavior of engaging in sex with non-consenting others.” CP 126. Mr. Stout’s mental abnormality was therefore regarded as the product of a combined diagnosis. *See id.*

Since his commitment, the State’s experts have expressed uncertainty regarding the applicability of a paraphilia NOS non-consent diagnosis by indicating that it should be ruled out (i.e., additional information must be considered before the diagnosis can be made or ruled out). CP 224, 250. The antisocial personality disorder diagnosis also came under question when Dr. Spizman characterized it as provisional (i.e., further information may indicate that this diagnosis is

⁶ On May 8, 2014, the Supreme Court heard oral argument in *In re Det. of Meirhofer*, Supreme Court No. 892512. One of the issues of contention between the parties in *Meirhofer* is whether an individual committed under RCW 71.09 may continue to be detained on a different basis than that under which he was initially committed.

not warranted). CP 251. The only diagnosis remaining is Dr. Yanisch's antisocial personality disorder diagnosis from the most recent annual report. CP 224. Dr. Yanisch asserted that he saw no compelling reason to change Mr. Stout's prior diagnoses. CP 224. He then referred the "interested reader" to Dr. Spizman's 2011 annual review report, which did not contain an antisocial personality disorder diagnosis. *Id.*; CP 251.

At best, the most recent report shows that Dr. Yanisch was doubtful about the applicability of one of the two diagnoses that make up Mr. Stout's compound diagnosis. CP 224. This creates uncertainty regarding whether the full combination of diagnoses necessary to Mr. Stout's "mental abnormality" are currently active.

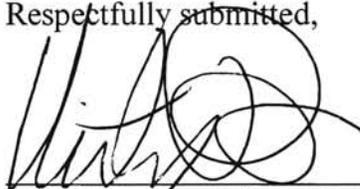
Mr. Stout is thus being detained for a mental abnormality other than that for which he was initially committed. At a minimum, this change in diagnosis warrants a full trial on the merits concerning Mr. Stout's continued confinement. A jury must have the opportunity to weigh the experts' competing claims regarding the validity of this new diagnosis and, as such, Mr. Stout should be granted a new trial.

E. CONCLUSION

This Court should reverse the superior court's ruling denying Mr. Stout's CR 60(b) motion and remand for further proceedings.

DATED this 26th day of August, 2014.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Whitney Rivera', written over a horizontal line.

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APPENDIX A

Defining Mental Disorder When It Really Counts: DSM-IV-TR and SVP/SDP Statutes

Allen Frances, MD, Shoba Sreenivasan, PhD, and Linda E. Weinberger, PhD

Civil commitment under the sexually violent predator (SVP) statutes requires the presence of a statutorily defined diagnosed mental disorder linked to sexual offending. As a consequence of broad statutory definitions and ambiguously written court decisions, a bright line separating an SVP mental disorder from ordinary criminal behavior is difficult to draw. Some forensic evaluators reject whole categories of DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders: Text Revision) diagnoses as qualifying disorders (e.g., personality and substance abuse disorders), while others debate whether recurrent rape constitutes a paraphilic disorder. We argue that the ramifications of the SVP process, in representing both the balancing of public safety and the protection of an individual's right to liberty, demand that decisions about what is a legally defined mental disorder not be made in an arbitrary and idiosyncratic manner. Greater clarity and standardization must come from both sides: the legalists who interpret the law and the clinicians who apply and work under it.

J Am Acad Psychiatry Law 36:375–84, 2008

Perhaps one of the most controversial areas in forensic mental health is the civil commitment of sex offenders upon completion of their prison sentences. Several states have enacted either Sexually Violent Predator (SVP) or Sexually Dangerous Person (SDP) provisions.^{1,2} The SVP/SDP laws are meant to protect society from the relatively small group of sex offenders who have both a mental disorder and a high risk of recidivism. The criteria necessary for categorizing an individual as an SVP/SDP include findings that the person was convicted of offenses determined by the state to constitute a sexually violent crime; the person has a diagnosed mental disorder;

and as a result of that disorder, the person is likely to engage in sexually violent offenses. Individuals identified as an SVP/SDP are civilly committed for treatment in designated mental health facilities after serving their prison terms. The period for an SVP/SDP commitment is indefinite.

SVP/SDP statutes exist because of legislatures' concern about the release of known dangerous sex offenders from prison into the community. Notorious sex crimes committed by released offenders serve to reinforce society's acceptance of laws designed to identify extremely dangerous incarcerated sexual offenders who represent a threat to public safety. However, these laws have not been without controversy.

As civil commitment can only be initiated if the individual is determined to harbor a mental disorder, some in the psychiatric community view the SVP/SDP laws as an inappropriate use of psychiatry to promote preventive detention.³ Those who oppose the laws worry that in pursuing the worthwhile effort to reduce sexual crime, these laws violate individual civil rights and could provide a slippery slope toward

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psychiatric commitment for whatever behaviors society deems deviant at any given time.

On the other hand, the U.S. Supreme Court has considered these concerns and has held the SVP process to be constitutional, fulfilling the intent of civil commitment. Those who support the statutes view them as a necessary way of protecting potential victims from a small group of highly dangerous predators.

The conceptual debate between these camps is likely to continue as long as SVP/SDP laws exist, and cannot be settled easily. Even among those who do not oppose the SVP/SDP civil commitment statutes, there is much debate about what is meant by a diagnosed mental disorder and what disorders should qualify.^{1,4-6}

The rationale for SVP/SDP commitment is the presence of a statutorily defined "diagnosed mental disorder," which is linked to sexual offending. But what is meant by that term? The ramifications of the SVP/SDP process, in representing both the balancing of public safety and the protection of an individual's right to liberty, demand that decisions about what is a legally defined mental disorder should not be made in an arbitrary and idiosyncratic manner. The purposes of this article are to discuss the statutory and case law definitions of diagnosed mental disorder and what guidelines are offered as to who qualifies for an SVP/SDP civil commitment; to examine what the Diagnostic and Statistical Manual of Mental Disorders: Text Revision (DSM-IV TR)⁷ can and cannot offer to the process and what disorders may qualify; and to propose a conceptual template toward developing expert consensus in rendering SVP/SDP diagnoses.

Definition of SVP/SDP Mental Disorder by State Statutes

The current SVP/SDP statutory laws must not be confused with the earlier sexual psychopath laws (enacted in the 1930s and repealed by the 1980s). A brief historical overview serves to place the implementation of the current SVP/SDP statutes in context.

The intent of the sexual psychopath laws was to identify convicted sex offenders amenable to treatment who would then be placed in a psychiatric hospital in lieu of prison. These sexual psychopath laws were formulated during a period of optimism that mental health interventions could cure offenders³

and that hospitals were both more humane and more effective than prisons. The laws fell into disfavor in the 1980s in reaction to well-publicized cases of sex offenders who committed heinous acts after purportedly successful completion of their hospital treatment.

Another important contextual factor occurred at approximately the same time. There was a trend away from indeterminate prison sentences that gave judges and parole boards considerable discretion. Instead, courts applied fixed sentencing for similar crimes. Determinate sentencing reflected, in part, a shift in the criminal justice system from rehabilitation to incapacitation. The purpose of determinate sentences was to increase fairness and reduce possible bias. An unintended consequence was that some high-risk sex offenders served shorter sentences than they would have under an indeterminate scheme.

Despite the move to repeal sexual psychopath laws, civil commitment statutes emerged in the 1990s for a subpopulation of dangerous sex offenders. Earl K. Shriner was such an individual.³ Mr. Shriner served a 10-year term for the kidnap and assault of two teenaged girls. Two years after his release from custody, he sodomized a seven-year-old boy and cut off his penis. This case and the public outcry that ensued led the state of Washington to be the first to enact an SVP law. The purpose was to identify sex offenders who should be civilly committed because of their mental disorder, which predisposes them to dangerous sexual behavior.

Currently, most states with SVP/SDP laws define the qualifying mental disorders in very similar terms. The common definition of a diagnosed mental disorder is, "a congenital or acquired condition affecting the emotional or volitional capacity that predisposes the person to the commission of criminal sexual acts in a degree constituting the person a menace to the health and safety of others" (Ref. 1, p 473).

This legal definition is remarkably vague and difficult to apply in specific cases. For example, it is not clear why both congenital and acquired conditions are specified, as these together cover the territory of all conditions. The terms "emotional and volitional capacity" seem to form an important part of the definition but are not defined further. Nor do these terms have clear definitions within psychology or psychiatry. The term predisposes is never defined precisely, so it is not clear what degree is required before the statutory definition is met.

Perhaps absent most in the definition is any indication of which mental disorders might warrant an SVP/SDP civil commitment. Case law emerging in the various states has also been ambiguous on this question.¹ Moreover, the legal reasoning provided in the states' case decisions is not usually clear, specific, or clinically helpful. In summary, the statutory definitions across the states are so broad that they defy precise guidance as to what warrants a designation of an SVP/SDP mental disorder.

Definition of Mental Disorder: U.S. Supreme Court

The U.S. Supreme Court twice reviewed SVP matters, in *Kansas v. Hendricks*⁸ and *Kansas v. Crane*.⁹ On each occasion, the Court found the process to be constitutional. In both cases, the requirement of a mental abnormality coupled with dangerousness was cited as a predicate for civil commitment. Moreover, the Court recognized the historical view that restraining dangerous mentally ill persons for treatment via civil commitment has not been considered punishment (as articulated in *Jones v. U.S.*¹⁰).

In *Kansas v. Hendricks*, Mr. Hendricks had a long history of sexual molestation of children. He admitted to having sexual desires for children, urges that he could not control when he was under stress. Mr. Hendricks was given the diagnosis of pedophilia, a disorder that the Kansas trial court qualified as a mental abnormality under the Kansas SVP Act. However, the Kansas State Supreme Court invalidated the SVP Act on the grounds that mental abnormality did not satisfy due process, in that involuntary civil commitment must be predicated on a mental illness. The U.S. Supreme Court reversed the State Supreme Court's ruling, noting that states were left to define terms that were of a medical nature that have legal significance. The Court ruled that mental abnormality, as defined by the Kansas SVP statute, satisfied substantive due process requirements for civil commitment: "it couples proof of dangerousness with proof of some additional factor, such as 'mental illness' or 'mental abnormality'" (Ref. 8, p 346).

What was this mental abnormality according to the U.S. Supreme Court? The Court, in the majority opinion, stated that involuntary commitment statutes have been upheld consistently to detain people who are "unable to control their behavior and

thereby pose a danger to the public health and safety" (Ref. 8, p 346), provided that proper procedures and evidentiary standards were followed. The Court underscored that state legislatures were not required to use the term "mental illness," and that the states were free to use any similar term. In reviewing the Kansas statute, the Court noted that there must be "a finding of future dangerousness" that then "links that finding to the existence of a 'mental abnormality' or 'personality disorder' that makes it difficult, if not impossible, for the person to control his dangerous behavior" (Ref. 8, p 358).

How would this U.S. Supreme Court ruling fit with contemporary DSM-IV-TR⁷ nomenclature? In the *Hendricks* case, the DSM-IV¹¹ diagnosis at issue was pedophilia, and was one found to correspond with the legally defined mental disorder. But would other disorders qualify or comport within the broad meaning offered by the Court?

In *Kansas v. Crane*,⁹ the Court had an opportunity to rule on this issue. Mr. Crane, a previously convicted sex offender, was diagnosed as having exhibitionism and antisocial personality disorder. While the experts believed that exhibitionism alone would not support a classification as an SVP, they opined that the combination of the disorders would meet SVP criteria. Mr. Crane was declared an SVP, and the case was appealed.

The Kansas State Supreme Court reversed the lower court's finding and interpreted the *Hendricks* case as requiring, "a finding that the defendant cannot control his dangerous behavior"—even if (as provided by Kansas law) problems of 'emotional capacity' and not 'volitional capacity' prove the 'source of bad behavior' warranting commitment" (Ref. 9, p 411). The case was then appealed to the U.S. Supreme Court. Kansas argued that the State Supreme Court wrongly interpreted *Hendricks* as requiring that it must always be proved that a dangerous individual is "completely unable to control his behavior" (Ref. 9, p 411).

The U.S. Supreme Court held that there was no requirement for a total or complete lack of control. The Court wrote that lack of control was not absolute, and if such an approach were used it would, "risk barring the civil commitment of highly dangerous persons with severe mental abnormalities" (Ref. 9, p 407).

The Court recognized the important distinction between the civil commitment of dangerous sex of-

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fenders from other dangerous persons, for whom criminal proceedings would be more proper. The Court reasoned that such a distinction was necessary; otherwise, civil commitment would become a "mechanism for retribution or general deterrence" (Ref. 9, p 407). However, the Court never specified how to make this differentiation. Nor did the Court define its own conception of a qualifying "mental disorder."

In *Crane*, the Court acknowledged that no precise meaning was given to the phrase, "lack of control." The Court wrote:

[I]n cases where lack of control is at issue, "inability to control behavior" will not be demonstrable with mathematical precision. It is enough to say that there must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis, and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case [Ref. 9, p 413].

In both *Hendricks*⁸ and *Crane*,⁹ the Court avoided offering specific guidance as to what mental condition would support "proof of serious difficulty in controlling behavior." Rather, the Court acknowledged that states should have "considerable leeway in defining the mental abnormalities and personality disorders that make an individual eligible for commitment" (Ref. 9, p 413). While such allowance has been granted to the states, as mentioned, the states have remained equally nonspecific on this point.

In *Crane*, the Court considered whether an SVP mental abnormality could be justified solely on the basis of emotional as opposed to volitional impairment. Mr. Crane carried the dual diagnoses of exhibitionism and antisocial personality disorder (with the Court citing the DSM-IV¹¹ for reference); the experts believed that these diagnoses impacted his emotional capacity. The Court acknowledged that in *Hendricks*, the discussion was limited to volitional disabilities, such as pedophilia (referencing the DSM-IV criterion), which involved what the layperson might describe as a lack of control. The Court wrote that they had not drawn a clear distinction between a purely emotional versus volitional sexually related mental abnormality. They further noted that there might be considerable overlap between defective understanding and appreciation, and the inability to control behavior. The Court stated that they had no occasion to consider in either *Hendricks* or

Crane whether civil commitment on the basis of emotional abnormality would be constitutional.

Ultimately, the Court's commentary on the terms volitional and emotional impairment is not particularly useful to those who conduct SVP/SDP evaluations. Nonetheless, even in *Kansas v. Hendricks*, an egregiously clear case of sexual deviance, in which a man asserted that the only barrier that could keep him from sexually assaulting children was death, the U.S. Supreme Court filed a narrowly ruled decision. In the five-to-four decision, the swing voter, Justice Kennedy, wrote a separate opinion cautioning against overly broad interpretations of the boundaries of suitable mental disorders.

The U.S. Supreme Court holdings are largely silent and unhelpful in defining clearly what constitutes an SVP/SDP mental disorder. There is the instruction to consider the features of the case to determine the mental abnormality. Can a personality disorder qualify as an SVP/SDP mental disorder alone, or must it be coupled with a sexual deviancy disorder? Moreover, what mental abnormality is sufficient to distinguish between the cases of a dangerous sex offender and an ordinary criminal?

Definition of Diagnosed Mental Disorder: DSM-IV-TR

Given the vagueness of the Supreme Court's decisions coupled with the states' broad and ambiguous definitions encompassed in the SVP/SDP statutes, one might hope that the DSM-IV-TR⁷ would provide clearer guidelines on what constitutes a mental disorder. Unfortunately, the introduction of the DSM-IV-TR openly states that it is unable to provide a precise definition of a mental disorder:

Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies the precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions [Ref. 7, pp xxx-xxx].

Although the concept of mental disorder is crucial to both psychiatry and to the SVP/SDP laws, it is impossible to define well in the abstract. In practice, forensic clinicians use the DSM-IV-TR to describe mental disorders present in an individual. The courts, however, have not provided clear indications about which of these are applicable to the SVP/SDP statutes.

In the introduction, the DSM-IV-TR addresses its use in forensic settings:

In most situations, the clinical diagnosis of a DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability [Ref. 7, p xxxiii].

This caution in the introduction emphasizes the need for a case-by-case analysis of the elements present in the individual and its correspondence to the legal definition of an SVP/SDP diagnosed mental disorder. Moreover, the cautionary statement does not imply that the DSM-IV-TR cannot be used to justify SVP/SDP civil commitment, as may be concluded erroneously if no further review of the caution were undertaken. The DSM-IV-TR offers a widely accepted method of defining and diagnosing mental disorders and provides the means of conveying to the trier of fact the best information available on psychiatric disorders. In both *Hendricks*⁸ and *Crane*,⁹ the U.S. Supreme Court recognized the DSM-IV¹¹ classification system when referring to the diagnoses rendered.

Another potential misinterpretation of the DSM-IV-TR is that the mere presence of a specific disorder in an individual is equivalent to that person's having met the legally defined mental disorder. The introduction states explicitly:

Moreover, the fact that an individual's presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual's degree of control over the behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time [Ref. 7, p. xxxiii].

Bearing this caution in mind, a clinician conducting an SVP/SDP evaluation should not rely on the diagnosis alone to conclude that all persons with such a diagnosis are predisposed to reoffend sexually.

DSM-IV TR Mental Disorders: Which Qualify for an SVP/SDP Mental Disorder?

As indicated earlier, the statutes and the U.S. Supreme Court have not delineated what specific mental disorders do or do not qualify for an SVP/SDP commitment. Therefore, it may follow that any DSM-IV-TR diagnosis could render a person eligible for commitment as long as it can be demonstrated that such a condition predisposes the person to committing dangerous sexual acts. But which ones should count for an SVP/SDP commitment?

Pedophilia

This disorder is probably the most easily identified and supported mental disorder in SVP/SDP cases. Pedophilia is widely recognized as sexual deviance, and the DSM-IV-TR criterion sets for this disorder are well defined. Those who meet the diagnosis of pedophilia engage in deviant urges, fantasies, and behaviors over an extended period. Such individuals are distinguished from those who engage in sexual activity with children that may be short-term and situational (e.g., incestual context during divorce or other stress, influenced by intoxication).

One area of debate is whether diagnosed pedophilia can ever be in remission. Some evaluators believe that a prior remote pattern of pedophilic behavior does not mean that the disorder is current. Such evaluators may argue that the remoteness of the acts and the individual's lack of endorsement of current pedophilic urges and fantasies justify an in-remission categorization. However, DSM-IV-TR describes pedophilia as tending to be chronic and lifelong, with the expression of sexual deviancy waxing and waning in response to opportunity, stressors, or interaction with comorbid disorders. In addition, those who are in custody do not have the opportunity to engage in deviant sexual behavior with children, nor are they very likely to endorse pedophilic urges and sexual fantasies in an adversarial context. Thus, a conclusion that the disorder is in remission would be weak in such circumstances. Careful consideration of the case facts and other data (e.g., treatment variables, physical debilitation) is necessary before a conclusion that the pedophilia is in remission can be justified for

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those who have been in custody with the lack of opportunity to reoffend.

Paraphilia NOS

The disorder, paraphilia not otherwise specified (NOS), nonconsenting person, has been used most frequently to diagnose the presence of sexual deviancy in the form of coercive sexual contact, primarily for the crime of rape. This diagnosis is given to distinguish the criminally inclined individual who rapes as a part of a broad repertoire of illegal activities from the rapist driven by deviant sexual urges—namely, arousal to coercion.

This is probably the most controversial concept in SVP/SDP evaluations and one that has a long and much misunderstood history. During construction of the DSM-III-R¹² in 1985, the suggestion was made to add paraphilic coercive disorder as a separate category in the paraphilia section. Researchers in the area supported this suggestion; however, there had been little systematic research on the usefulness, reliability, validity, or definition of the proposed disorder. Moreover, significant debate ensued in a 1985 DSM conference about categorizing rape behavior as a mental disorder. There was considerable concern that such a disorder could be used in forensic settings to exculpate rapists. Consequently, the disorder was not included in the DSM-III-R. In the DSM-IV,¹¹ new disorders for inclusion had to demonstrate a high degree of empirical support. There was no suggestion for including a category for coercive sexual disorder in the DSM-IV, nor in the Text Revision.⁷ Paraphilic coercive disorder is not mentioned in the examples of paraphilia NOS, and it is not included in an appendix of suggested diagnoses for further study. The basis for the exclusion of a separate coercive sexual disorder in the DSM-IV was that there were insufficient data to support this disorder.

Unfortunately, the DSM IV wording of paraphilia was not thought out carefully, which has led to much misinterpretation, nor was it corrected in the Text Revision. In DSM-III-R, Criterion B included distress or acts. In DSM-IV, the acts element was referred to as behaviors under Criterion A and remained so in DSM-IV-TR. The DSM-IV-TR describes the essential features of a paraphilia as, "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors . . ." (Ref. 7, p 566). The use of "or behaviors" was an inadvertent placement and in no way meant to signify that a paraphilia could be

diagnosed based on acts alone. Rather, the behaviors were meant to signify the culmination of urges and fantasies. This distinction is necessary to separate paraphilia from opportunistic criminality. The other misleading aspect was the narrative in the introduction of the paraphilias that one type was nonconsent. The term nonconsenting persons was meant to apply only to exhibitionism, voyeurism, and sadism. It was not meant to signify rapism specifically; rape was not included as a coded diagnosis nor as an example of NOS. While there may be cases where the diagnosis is justified purely on the basis of rape behavior, it was never intended to convey that the acts alone would be paraphilic. Some rapes may be triggered by opportunity, others may occur in the context of intoxication-related disinhibition, and some may reflect character disorder or other nonparaphilic pathology.

The discussion regarding paraphilic coercive disorder was not widely promulgated to the general clinical community, and the confusion regarding paraphilia NOS is understandable. However, now that this information is disclosed in a public forum, SVP/SDP evaluators should take notice of the current clarification and of the meaning of "or behaviors" in the narrative descriptor of this set of disorders. The use of paraphilia NOS to describe repetitive rape cannot be justified on the basis of the term "or behaviors" alone.

This distinction does not mean that paraphilia NOS cannot or should not be used to describe some individuals who commit coercive sexual acts. However, such diagnosis would require considerable evidence documenting that the rapes reflected paraphilic urges and fantasies linking the coercion to arousal. One acceptable standard for using it may be to demonstrate clear substantiation of urges and fantasies, either as inferred by the acts perpetrated on the victim or by the interview information, so as to distinguish it from criminal behavior that is not rooted in sexual psychopathology.

The term rape does appear within the DSM-IV-TR⁷ in the context of sexual sadism. It is possible that the repetitive expression of sadistic behaviors (e.g., domination, strangulation, beatings) in a particular case of a serial rapist may well warrant the diagnosis of paraphilia NOS, with sadistic traits, when there is insufficient evidence to support the criteria for sexual sadism. The DSM-IV-TR Casebook¹³ provides an illustration of paraphilia NOS, for a serial rapist (Jim) without antisocial traits. The narrative in the

Casebook states, "During the development of DSM-III-R, the term *Paraphilic Coercive Disorder* was suggested for this particular kind of Paraphilia, but the category has never been officially recognized. Therefore, Jim's disorder would be coded as Paraphilia Not Otherwise Specified (DSM-IV-TR, p.579)" (Ref. 13, p 173). However, reliance on the Casebook to buttress an argument for using paraphilia NOS to signify paraphilic coercive disorder may be a weak avenue; particularly, in a forensic context. The Casebook, unlike the DSM-IV, does not reflect the work or endorsement of the DSM-IV Task Force; therefore, it is not authoritative.

The sexual disorder section does include an NOS category. Throughout the DSM-IV, the NOS diagnosis reflected the Task Force's intent to include generic residual categories for patients with clinical problems that did not fit into one of the more specific definitions of disorders. As with the specific criteria sets, the intent for NOS was to allow clinicians to use their judgment for each individual as to whether the symptom cluster caused enough distress and/or impairment to be a mental disorder. There were no guidelines as to how such judgments should be made and no hard and fast rules; it was left to the clinician to make the determination on a case-by-case basis. This vagueness in guidelines was intentional so as to permit the clinician flexibility in using the Manual.

Nonetheless, paraphilia NOS, nonconsenting partners, is an inherently weak construct, given the lack of a set of defined criteria. There is a danger of misusing DSM-IV TR⁷ mental disorders by applying an idiosyncratic interpretation of case facts to shoe-horn individuals, so as to justify an SVP/SDP commitment. Paraphilia, NOS has the potential to be a catch-all diagnosis for persons accused of sexual offenses and for whom the clinician cannot identify criteria for a specific clinical diagnostic category.

Attempts to describe rape-related paraphilia is a difficult diagnostic endeavor.^{6,14,15} Identifying the behavior as paraphilic as opposed to criminal is complicated by the often comorbid disorder of antisocial personality disorder. The line between personality disorder and sexual disorder may not be drawn easily in certain instances, nor may one disorder exclude the other. In some instances, the behaviors demonstrated can be articulated to reflect paraphilic urges and fantasies; in other instances, it may be more accurate diagnostically to render only the antisocial personality disorder.

Antisocial Personality Disorder

The position that antisocial personality disorder (ASPD) is a qualifying mental disorder has generated much debate in recent articles.^{1,4-6} It has been argued that ASPD should be excluded on the grounds that SVP/SDP commitment should require the presence of a sexual deviancy disorder. ASPD has been viewed as triggering rape or other deviant sexual behaviors because of criminal rather than sexual motives. Further, it is argued, that most prisoners in custody would qualify for ASPD, and no one is suggesting that they be transferred from a prison to a psychiatric hospital. In this view, the use of ASPD to trigger SVP/SDP commitment is not justified and would represent preventive detention.

The other view argues that there has been no prescription on the use of ASPD in the SVP/SDP statutes or the U.S. Supreme Court rulings.^{8,9} This position maintains that the application of ASPD or any other diagnosis as a qualifying mental disorder should be formulated on a case-by-case basis, rather than excluding *pro forma* entire categories of diagnoses. The core distinction between these views is that those who oppose the use of ASPD base their position on group analysis. Those who support the use of ASPD base their position on conducting an analysis of a specific individual's predisposition to engage specifically in repetitive sexual criminal behavior.

The U.S. Supreme Court has not drawn the bright line of what is a diagnosed mental disorder; instead, the Court has noted that there should be a distinction between the repetitive criminal and those whose behaviors are driven by a mental disorder.⁹ The Court discussed the need to consider the features of the case to determine if the individual has a mental abnormality, and if so, whether that condition renders the person distinguishable from an individual who is an ordinary criminal offender. The case characteristics of a particular offender should be the guideposts for the clinician. For example, the clinician's rationale should articulate how the failure to conform to social norms with respect to lawful behaviors relates to this person's proclivity toward dangerous sexual behavior toward others.

Clinicians who categorically exclude ASPD as a qualifying diagnosis may be criticized for ignoring the statutory language and Supreme Court guidance. Unless there is legal instruction to the contrary, either through statutory or case law, ASPD should be a

viable SVP/SDP mental disorder if it can be demonstrated that it leads specifically to a pattern of sexual offenses.

Other Disorders: Psychosis, Mood, Substance Abuse, and Cognitive Conditions

Generally, the SVP/SDP process has been based predominantly on a showing that the individual has a sexual deviancy disorder. There is no premise in the law to include only sexual deviancy disorders. Therefore, examiners should not be reluctant to use diagnoses other than the paraphilias as a qualifying SVP/SDP mental disorder if it can be demonstrated that such disorders are causally linked to the individual engaging in sexual crimes.

There may be cases of persons who have schizophrenia, in which an aspect of their disorder is recurrent sexual impulsiveness and aggression. While the general population of those who have schizophrenia may not be predisposed to committing criminal sexual offenses, a particular individual's psychosis may manifest repeatedly in a sexually aggressive manner. For example, a person's delusion may be that he is a deity who must impregnate all available females to save the world and produce perfect beings. Consequently, he rapes adult women. His psychosis predisposes him to engage repeatedly in sexual behavior with nonconsenting partners to fulfill the requirements of the delusion.

In addition, there may be cases of individuals with intellectual disabilities who commit sexual offenses. On a case-by-case basis, the clinician can examine how that specific person's limited cognitive capacity (e.g., impaired judgment, limited coping resources, poor frustration tolerance) impairs the person's ability to understand what is appropriate sexual behavior and what is not. Such impairment may, in some persons, result in repetitive pedophilic or rape behavior.

Mania and attendant hypersexuality may be a driving element in repetitive sexually assaultive behavior. An individual in a manic state may consistently become sexually disinhibited and force others into sexual activity or choose children as sexual targets. In such instances, bipolar disorder could be argued as representing a qualifying mental disorder for an SVP/SDP commitment.

Substance abuse and intoxication represent another class of disorders that may warrant a designation as an SVP/SDP mental disorder diagnosis. For example, an individual who rapes repetitively under

the influence of stimulants may warrant an SVP/SDP civil commitment. Intoxication may be uncovering an underlying sexual deviancy disorder or may represent an aberrant reaction to the stimulant. As with ASPD, it is important to emphasize that while substance abuse as an SVP/SDP designated mental disorder may represent an unusual case, the presence of a clear pattern connecting substance abuse to sexual offending in that individual should be the basis of determining whether it is a qualifying mental disorder.

Comorbid Conditions

Comorbid conditions are both common and important for evaluators to consider in their interviews. Coexisting disorders may be associated with a worse outcome than if the individual presents with only one disorder. The cumulative impact of comorbid mental conditions such as sexual deviancy, personality disorder, and substance abuse may be the underlying mechanism for driving the individual to have a predisposition to commit deviant sexual acts. Therefore, we strongly encourage examiners to explore disorders present in the individual, in addition to paraphilias, that may drive repetitive sexual deviant behavior.

Developing an Expert Consensus

Forensic applications of DSM diagnoses are left largely to the individual clinician. As the SVP/SDP process demonstrates, there is no good fit between criteria sets in the DSM-IV-TR and the legal standards of mental disorder. However, clinicians have to apply these psychiatric and legal concepts to the individual being examined and then explain them to the trier of fact. If experts disagree as to what constitutes a diagnosed mental disorder, how will the lay trier of fact make this legal determination? Therefore, it would be of value if clinical examiners in the SVP/SDP field attempted to establish a consensus in several different areas of their work. Such a consensus would increase the reliability and credibility of the evaluations and facilitate communication across the psychiatric/legal interface. We suggest the following areas that need review and consideration.

First, there should be a consensus regarding which diagnoses qualify for an SVP/SDP commitment, and under what circumstances. The two areas of controversy, paraphilia NOS and antisocial personality disorder, may be appropriate in some circumstances and

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inappropriate in others. These should be clarified and detailed to avoid idiosyncratic determinations.

For Paraphilia NOS, one approach may be to demonstrate that there are sufficient case data regarding the individual's underlying deviant fantasies and urges upon which he has acted, so as to conclude that he is predisposed to commit dangerous sexual offenses. These may include identifying the presence of ritualistic behaviors (e.g., always uses duct tape to bind victims), statements, or behaviors that demean the victim (e.g., forces her to say she enjoys being raped), and behaviors that demonstrate arousal in controlling the victim (e.g., sustains an erection while victim is pleading for his or her life, crying, or making statements that he or she is being hurt).

For antisocial personality disorder, this would involve demonstrating how the disorder, based on the case facts, leads to repetitive sexual offenses as opposed to illegal acts of a general nature. This method of reporting the data and how they relate to the SVP/SDP criteria enhances the thoroughness and rigor of the reasoning, which ultimately makes the opinions easier to understand and defend in court.

Second, there should be agreement on the use of semistructured interviews for diagnostic evaluations in SVP/SDP cases. One of the more difficult, consequential, and scrutinized settings for psychiatric diagnosis is the SVP/SDP evaluation. The interviews afford no confidentiality. In addition, the findings pose risks for both the inmate and society, and will be challenged before a jury. Under these circumstances, it would be highly desirable to have the interviews be as standardized as possible on questions meant to tap the most common disorders likely to be present (viz., antisocial personality disorder, paraphilia, and substance abuse or dependence). Other possible but much less frequently encountered diagnoses (e.g., bipolar disorder, schizophrenia) would not routinely be the subject of semistructured interviewing, unless they seemed pertinent to the particular case. Semistructured interviewing will increase the reliability, transparency, and credibility of diagnosis with little or no increased interview time or effort.

Third, there should be consensus on the appropriate rationales that demonstrate convincingly that the diagnosed mental disorder qualifies for an SVP/SDP civil commitment. It is recommended that forensic clinicians attempt to achieve greater transparency by reporting the rationale they used to justify the presence of an SVP/SDP diagnosed mental disorder or

the reasons why such a disorder is not present. It is not enough to base a conclusion that an individual does or does not have a qualifying SVP/SDP mental disorder solely on the presence or absence of a listed DSM-IV-TR disorder. By demanding the rationale for the clinician's opinion, there is less risk that the trier of fact will accept unknowingly idiosyncratic and/or ill-defined conclusions about whether a diagnosed mental disorder is or is not present. This assurance would provide additional quality control, reliability, and credibility to controversial diagnoses. The more detailed the documentation regarding an evaluator's opinion on whether a diagnosis does or does not represent an SVP/SDP mental disorder, the more clarity is provided for the trier of fact to consider fully the expert's opinion. Clear articulation of the reasoning on how a particular DSM-IV-TR disorder or set of disorders qualifies could serve to reduce an inclination toward overinclusiveness as well as underinclusiveness.

Conclusion

As a consequence of U.S. Supreme Court decisions that are written ambiguously and tentatively, the bright line separating an SVP/SDP mental disorder from ordinary criminal behavior is difficult to draw and tests a no-man's land between psychiatry and the law. One way to resolve this dilemma is to discuss the existing definitions of the legally qualifying mental disorder and call for more specificity. Legislative and/or judicial review may force the legal system to be more explicit as to the kind and degree of mental disorder that is constitutionally sufficient to deprive individuals of their right to freedom as well as support the need for public safety. As for forensic clinicians, their role demands a careful examination and articulation of the fit between DSM-IV-TR diagnoses and qualifying SVP/SDP mental disorders. Greater clarity and standardization must come from both sides: the legalists who interpret the law and the clinicians who apply and work under it.

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APPENDIX B

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May 7, 2013

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Psychological Evaluation of Mr. Roy Stout
Skagit County Superior Court Case Number 01-2-01307-9

Dear Ms. Armstrong-Smith:

As you know, your office recently retained me to undertake a psychological assessment/evaluation of Mr. Roy Stout's current status on the sexually violent predator (SVP) criteria adopted by the Washington State Legislature. I understand that Mr. Stout, who is now 53 years old (date of birth: June 14, 1959), was adjudged to meet the sexually violent criteria and committed to Washington's Sex Offender Special Commitment Center (SCC) in October of 2003 and that the reason for evaluating him now is to determine whether he has so changed that he no longer meets the criteria.

Before the present evaluation I evaluated Mr. Stout in 2008, 2009, 2011, and 2012. I concluded that he no longer met Washington's SVP criteria in each evaluation.

After implementing the procedures below I have concluded in the present evaluation that Mr. Stout no longer meets the SVP criteria. My evaluation is set forth in the following sections.

I. Expert's Assignment and Procedures Regarding Mr. Stout's Case

To carry out my first two evaluations I examined many documents your office sent me, including Findings of Legal Fact made by Judge Susan Cook in October of 2003, a deposition by psychologist Dr. Richard Packard, Ph.D. (dated March 11, 2003), copies of evaluations of Mr. Stout by psychologists Dr. Betty Richardson, Ph.D. (dated February 22, 2001) and Dr. Carla van Dam, Ph.D. (one dated July 9, 2001 and a revision dated July 28, 2001), handwritten notes describing an interview Dr. Packard had with Mr. Stout on September 12, 2002, and Annual SCC Reviews completed by Dr. Jason Dunham, Ph.D. (October 10, 2004), Dr. Mark McClung, M.D. (January 25, 2006), Dr. Daniel Yanisch, Psy.D. (August 29, 2006), Dr. Paul Spizman, Psy.D. (October 10, 2007;

September 2, 2009; October 2, 2010; and November 8, 2011), Dr. Christopher North, Ph.D. (October 15, 2008), and Dr. Henry Richards, Ph.D. (September 12, 2011). I also reviewed SVP evaluations of Mr. Stout I completed in September of 2008, December of 2009, January of 2011, and February 2011 (an addendum to my January 2011 evaluation), interviews I completed with Mr. Stout in August of 2008 (in person), December of 2009 (in person), and January of 2011 (by telephone), and an interview I completed with his fiancé Ms. Monica Wolfe in January of 2011. I also completed a new interview of Mr. Stout by telephone on March 17, 2012 and a new telephone interview of Monica, who married Mr. Stout in June of 2012, on March 14, 2012. Then I scored Mr. Stout on the MATS-1 actuarial instrument and answered your referral questions.

To carry out my present assignment I reviewed some of the foregoing documents, my 2012 evaluation of Mr. Stout, and about 2550 pages of file materials your office sent me on a CD. The CD contained Bates-stamped documents 0001-1959 and SCC-stamped documents 1950-2564. These documents included Mr. Stout's most recent Annual Review, dated January 31, 2013, by Dr. Daniel Yanisch, Psy.D. I also completed a new in-person interview with Mr. Stout on April 10, 2013, and he called me a couple of times to give me the numbers of some possible collateral informants. After carrying out these procedures and summarizing Mr. Stout's case history, I answered your referral questions. I have emphasized some observations and facts in the following sections by putting them in bold typeface.

II. A Chronological History of Mr. Stout's Case Based on File and Interview Data

From my examination of the file materials pertaining to Mr. Stout and my interviews with him I compiled the following case history. The sources of the events in this history are included in parentheses so that, for example, "CVD" means an event that was reported in Dr. Van Dam's evaluation, "RP" refers to Dr. Packard's evaluation, "FOF" refers to Judge Cook's Finding of Legal Facts, "PS07" and "PS09" refer to Dr. Spizman's Annual Reviews for 2007 and 2009, respectively, and DY13 refers to Dr. Daniel Yanisch's 2013 evaluation. The page or pages on which an event is reported in a reference has been cited after the reference's abbreviation.

Mr. Stout was born in 1959, and grew up with two brothers and three sisters. His father was in the military and his family moved frequently. Although he denied ever being sexually abused he has told one investigator that "when dad was drunk he was violent." (PS09-15).

He took some beer from his family's refrigerator and drank it when he was 6 years old, but "was severely punished and did not try beer again until about age 16" (PS10-14).

He completed the eleventh grade but was assigned to Special Education classes and was expelled because of truancy problems (PS10-13). During our interviews he told me that "I was put in a Special Education class because I wouldn't do the homework. I was 7 or 8. I went back to the regular class room about 6 months later."

The following bullet points summarize his juvenile criminal history:

- His first legal difficulties occurred in June of 1974, when he was 15 years old, after he took his uncle's car without permission and had an accident: He was cited for Operating a Vehicle Without a Valid Driver's License (PS10-14).
- In July of 1974 he was arrested for Possession of Marijuana.
- In September of 1974 he was declared a Delinquent Ward of the State and assigned special supervision after he assaulted two individuals who did not pay him for drugs he had sold them (PS10-14).
- In September of 1974 he was convicted of Truancy and ordered to see a psychiatrist.
- In February of 1975 he was convicted of Arson and given 12 days of detention after he threw a lighted book of matches into a mail slot at a Post Office.
- In February of 1976 he was given two days of detention after he was convicted of Burglary and Incurability.
- In July of 1976 he was given three days of detention after he violated his probation by running away from home.

During our interviews Mr. Stout also told me that he was placed in juvenile detention for three months when he was 13 or 14 years old after "I threw a book of matches into the Post Office mail slot ... my parents were getting a divorce and I was angry."

He was involved in 3 or 4 heterosexual relationships that involved kissing girls his own age when he was in high school. He did not have sexual intercourse until he married his first wife Patricia in 1978. They separated in 1981 after having two daughters. When I asked about the circumstances under which they separated he told me that

Patricia and I separated because of my drinking. We never had any arguments and I didn't do anything physically harmful. But she was afraid that something might happen. She gave me an ultimatum and I chose the alcohol over my family.

He married his second wife Tanya in June of 1989 and separated from her in December of 1989. During our interviews he told me that he did so because he found her cheating on him. He has also lived with two other adult women for several months. He has denied ever sexually assaulting any of his wives or girlfriends, and there does not appear to be any evidence to the contrary (RP notes – 2189 to 2194; RP notes – 2152 to 2154). He also indicated that this was the case during our interviews.

During our interviews Mr. Stout consistently denied being compulsively aroused to fantasies of nonconsensual sexual interactions or ever collecting any pornography that depicted nonconsensual sexual interactions. He also indicated that he has never behaved

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During our interviews Mr. Stout consistently denied being compulsively aroused to fantasies of nonconsensual sexual interactions or ever collecting any pornography that depicted nonconsensual sexual interactions. He also indicated that he has never behaved

in a sexually inappropriate manner towards female staff members during any of his several incarcerations or while he has been committed at the SCC.

Between 1982 and 1992 Mr. Stout was charged with or convicted of 3 contact sex offenses. The following bullet points summarize these events:

- In January of 1982 he was arrested for rape, but he was acquitted of the charge.
- In August of 1990 he was convicted of Third Degree Assault after he was initially charged with rape. During our interviews he told me that "I think I was released in late 1990 or early 1991."
- In August of 1992 a jury convicted him of Indecent Liberties by Forcible Compulsion. During our interviews he told me that "they gave me five years ... my prison release date was in late 1996."

In November of 1996 he was charged with Telephone Harassment after a woman complained that he called her in an attempt to solicit sexual favors for money. Although he was referred to the End of Sentence Review Board for evaluation as a SVP after this, he was not found guilty of harassment and further action on the referral was not taken.

In December of 1997 he was convicted of First Degree Burglary after he was initially charged with First Degree Burglary and Indecent Liberties. (PS09-17 to 19). During our interviews he told me that "I was sentenced to 75 months in prison ... I was transported to the SCC sometime around November of 2001."

In 2001 Mr. Stout's status on the SVP criteria was evaluated by Dr. Richardson (BR-1202-1210) and Dr. Van Dam (CVD - 1211 to 1239 and CVD - 1227 to 1239). In September of 2002 a third SVP evaluation was completed by Dr. Packard (RP - 2135). In October of 2002 the Washington State Attorney General's Office filed a civil commitment petition alleging that Mr. Stout met the criteria for being classified as a SVP.

Mr. Stout subsequently elected to have his case tried by the bench rather than a jury. (FOF - 1).

In his pre-commitment trial evaluation of Mr. Stout Dr. Packard opined that Mr. Stout met the criteria for a diagnosis he referred to as "Paraphilia Not Otherwise Specified Nonconsent" (PNOSN). He acknowledged, however, that "there's been controversy about whether or not certain syndromes or diagnoses should or should not be considered in the DSM" and, with respect to a particularly controversial issue, Dr. Packard stated that "there's been considerable discussion regarding paraphilic rape or coercive sexual disorder," and that Paraphilia NOS Nonconsent "would be very similar" to paraphiliccoercive sexual disorder in its conceptualization (RP Deposition - 15). Dr. Packard also testified that Mr. Stout met the criteria for a diagnosis known as "Antisocial Personality Disorder" (ASPD) (RP Deposition - 11).As far as

psychological testing was concerned, he scored Mr. Stout on the revised version of the **Psychopathy Checklist (PCL-R)** and obtained an overall score of 26, a Factor 1 score of 7, and a Factor 2 score of 13. Actuarially, he scored Mr. Stout on three actuarial instruments - the **Static-99** (total score = 6), the revised version of the **Minnesota Sex Offender Screening Tool (MnSOST-R)**; total = 8); the **Sex Offender Risk Appraisal Guide (SORAG)**; total =13). On the basis of his procedures, Dr. Packard opined that Mr. Stout “would be more likely to commit future acts of predatory sexual violence if not confined to a secure facility” (RP Deposition - 126).

After hearing the evidence the Court provided a detailed and individualized description as to how Mr. Stout met Washington’s SVP criteria. It stated that:

Mr. Stout suffers from a mental disorder. That disorder is paraphilia not otherwise specified nonconsent ... A paraphilia of this kind is a mental disorder that causes recurrent intense sexually arousing fantasies, urges, and behaviors involving non-consenting adults, that lasts for more than six months, and results in negative consequences to the individual ... Mr. Stout's paraphilia is a congenital or acquired condition that affects his volitional capacity and predisposes him to the commission of criminal sexual acts such that he is a menace to the health and safety of others ... Mr. Stout also suffers from anti-social personality disorder ... Mr. Stout's anti-social personality disorder is manifested by a disregard for the rights of others and the rules of society ... Dr. Packard utilized three assessment tools to evaluate Mr. Stout's risk of reoffense: the Static 99, the MnSOST-R, and the SORAG...all three tools used by Dr. Packard provide support for his opinion that Mr. Stout is more likely than not to reoffend sexually if not confined ... In Mr. Stout, the combination of paraphilia (NOS) non-consent with antisocial personality disorder makes him more likely than not to reoffend ... In Mr. Stout the combination of paraphilia (NOS) non-consent with anti-social personality disorder causes him serious difficulty in controlling his behavior of engaging in sex with non-consenting others ... Based on the testing and Mr. Stout's history of offending ... Mr. Stout is more likely than not to engage in acts of sexual violence against those same kinds of people if not confined in a secure facility. (FOF – 8 to 10).

To be rational Dr. Packard’s diagnostic opinions must have been premised on at least two assumptions. The first is that Dr. Packard must have assumed that members of the relevant professional community had the ability to reliably classify Mr. Stout with the combination of PNOSN and ASPD using whatever diagnostic criteria they associated with these concepts. The second is that at the time of his evaluation Dr. Packard must have assumed the relevant professional community accepted both Paraphilia Not Otherwise Specified Nonconsent/“Paraphilic Coercive Disorder” and Antisocial Personality Disorder (ASPD) as reliable mental disorders.

The pattern of diagnoses assigned to Mr. Stout by many different state evaluators indicates that Dr. Packard’s first assumption was wrong. Table 1, below, reports the agreement rate for the presence or absence of both PNOSN and ASPD among state-employed or state-retained doctoral level professionals who evaluated Mr. Stout after his

last conviction. Only the most recent set of diagnostic opinions has been included for each evaluator, but the earliest set precedes Mr. Stout's commitment trial. From the data in this table it is apparent that **there is only a 3% agreement rate between evaluators that Mr. Stout met whatever criteria they were using to identify PNOSN and ASPD.** This agreement rate is far below a reasonable degree of certainty, which must surely be greater than 3%. **Mental health professionals have therefore been unable to reliably identify diagnoses in Mr. Stout's case.**

Table 1. Thirty-six pairs of diagnostic ratings about Mr. Stout were made by state-employed or state-retained evaluators whose identities have been abbreviated in the left column and the top row. The 36 boxes above the diagonal marked by blank cells shows the agreement rate for the presence (3%) and absence (47%) of PNOSN (50% of the raters did not agree on whether PNOSN was present or absent). The 36 boxes below the diagonal shows the agreement rate for the presence (75%) and absence (0%) of ASPD (25% of the raters did not agree on whether ASPD was present or absent). Only 1 pair of raters (footnoted as JD and RP) agreed Mr. Stout met whatever criteria they were using to identify both PNOSN and ASPD. Only 3% of all raters have therefore agreed on Mr. Stout's commitment diagnoses. Entries after "DY" refer to Dr. Yanisch's 2011 report.

Top Triangle: Agreement Rate for the Presence or Absence of PNOSN

	JD	MM	CN	RP	BR	PS11	CVD	DY	HR
JD		+-	+-	(++) ¹	+-	+-	+-	+-	+-
MM	++		--	--+	--	--	--	--	--
CN	++	++		--+	--	--	--	--	--
RP	(++) ¹	++	++		+-	+-	+-	+-	+-
BR	++	++	++	++		--	--	--	--
PS11	-+	-+	-+	-+	-+		+-	+-	+-
CVD	++	++	++	++	++	+-		--	--
DY	++	++	++	++	++	+-	++		+-
HR	++	++	++	++	++	+-	++	+-	

Bottom Triangle: Agreement Rate for the Presence or Absence of ASPD

Note. A "+" stands for an endorsement of a diagnosis. A "-" stands for a non-endorsement. "++" stands for rater agreement on the presence of a disorder while "--" stands for rater agreement on its absence. "+-" means the rater in the row concluded the disorder was present and the rater in the column concluded it was absent. "-+" means the rater in the row concluded the disorder was absent and the rater in the column concluded it was present.

Recent events in the realm of psychiatric science indicates that Dr. Packard's second assumption must now be regarded as wrong. In about 2011 Paraphilic Coercive Disorder (PCD) was proposed for inclusion in the upcoming fifth edition of the

Diagnostic and Statistical Manual of the American Psychiatric Association. The DSM is invariably relied upon by psychologists and psychologists for diagnostic classification when they undertake SVP evaluations. Starting in 2007, a groundswell of opposition arose in the psychological and psychiatric communities to the use of PNOSN or PCD for the purposes of diagnostic classification for use in SVP cases. Opposition increased during the pendency of the proposal to adopt PCD as a DSM diagnosis and included a petition against PCD that was submitted to the President of the American Psychiatric Association by almost 125 mental health professionals from around the world. In December of 2012 the Trustees of the American Psychiatric Association rejected the proposal to include PCD – and by extension a PNOS diagnosis qualified by “nonconsent” – as an authorized DSM diagnosis. The rejection was so complete that PCD was not even included in the section of the DSM that includes criteria that have not been adopted as authorized diagnoses but have been deemed worthy of further study.

Paraphilia Not Otherwise Specified Nonconsent is therefore not considered a reliable mental disorder by the relevant community. This is not the appropriate place to describe the extensive body of literature published in scientific journals that bears on this result, but I would easily be able to submit a substantial compendium of articles on this issue if asked to do so. I am also confident that a fair review of these articles and the APA’s ultimate decision would confirm the foregoing assertion. For probable cause purposes I have attached to the present document the petition submitted to the APA’s President and a very brief article (Wollert, 2012) that summarizes many of the major objections against treating PCD as a mental disorder.

Regarding Mr. Stout’s level of functioning at the SCC from 2008 to 2009 Dr. Spizman indicated that

In 12/08 and 5/09 Mr. Stout received feedback for his work as a custodian. He received moderate to positive ratings, with comments including he never missed work and did an excellent job (PS09-2) ... While frequently pleasant with staff, documentation reflected ongoing complaints and verbal aggression from Mr. Stout. Several of these focused on his dietary restrictions, such as being a vegan, and he would be served a meal with an aspect he could not eat (PS09-2) ... Documentation reviewed did not indicate that Mr. Stout had participated in any sex offender specific treatment activities during the period under review (PS09-5) ... Mr. Stout typically is able to relate well with others. He also demonstrated considerable strength in his employment efforts. Finally, he is often able to comply with the rules of the institution (PS09-5) ... He will go out of his way to assist (others) (PS09-6) ... He does not discuss any sexual thoughts, feeling, behavior, or attitudes (PS09-6) ... He is co-operative for the most part (PS09-6) ... he holds grudges for an extended period of time (PS09-7).

Mr. Stout’s third to most recent SCC Annual Review was completed by Dr. Spizman on October 10, 2010. Regarding Mr. Stout’s SCC functioning, Dr. Spizman’s description of Mr. Stout’s behavior was similar to his 2009 description. No incidents of sexual misconduct were noted. Although Dr. Spizman did not indicate that Mr. Stout

received any Behavior Management Reports in his review, Mr. Stout told me during our 2011 interviews that

I received a Category 2 BMR after I complained about how the food was being handled in the kitchen. I didn't throw anything at them or swear at them, but I was insistent about the problems of contamination that their food handling procedures created for vegans like myself.

The following bullet points allude to other important portions of Dr. Spizman's report:

- Regarding Mr. Stout's health status, Dr. Spizman reported that Mr. Stout was diagnosed with prostate cancer and had decided to proceed with radiation treatment.

When I asked him about this issue during our 2011 interviews Mr. Stout told me that

I don't know how the radiation treatments I've just completed have worked out, and I won't know for another five years. I think the treatments have affected my sexual functioning. I get a shot once a month. It causes impotency. The doctors will re-evaluate my status in September of this year. They might give me the shots for another year, but they don't like to administer them for more than two years. There are other drugs they can use if they take me off the medication I'm currently on.

- Regarding Mr. Stout's diagnostic status, Dr. Spizman opined that Mr. Stout met the criteria for Paraphilia Not Otherwise Specified (Nonconsent), Polysubstance Abuse (In a Controlled Environment), Antisocial Personality Disorder, and Borderline Intellectual Functioning.
- Regarding Mr. Stout's risk status, Dr. Spizman did not score Mr. Stout on any of the risk assessments that were used by Dr. Packard. Instead, he used a new actuarial risk assessment instrument known as Static-99R and several dynamic risk factors from an "instrument designed for use in the community" that he thought could "still provide some useful information about someone in full confinement." Referring to Static-99R, Dr. Spizman observed that "Mr. Stout did not score in a particularly high level on a commonly used actuarial measure (after accounting for his advancing age)" ... thus there is some uncertainty regarding whether or not he would be more likely than not to reoffend sexually if released unconditionally" (PS10-11). Nonetheless, he stated that the "dynamic risk factors intermingle with aspects" of the first three of Mr. Stout's diagnoses to produce "an elevated risk of sexual offending" (PS10-10) and that "it is assumed that this combination of mental abnormalities and personality disorder still impair Mr. Stout's ability to control his behavior" (PS10-11). Dr. Spizman did not articulate how the intermingling process worked or what aspects of Mr. Stout's diagnoses were specifically involved in the process.

Regarding Mr. Stout's status on Washington's SVP risk criteria, Dr. Spizman opined that

"Mr. Stout appears to continue to meet the definition of a sexually violent predator" (PS10-12).

When I asked Mr. Stout about whether he intended to use alcohol if he were released during our 2011 interviews he told me that

If I'm released I'm not going to be doing any drinking at all. I have no use for it. I've done a lot of urinalyses since I quit drinking in 1983. All of them have come up clean. I did get a write-up on one occasion when I was unable to urinate after I was asked for a urine sample.

He also told me that

My fiancé and I are going to get married at some point, depending in part on how things work out regarding my release petition. I met Monica last December. One of the guys here was dating her and introduced her to me. Then things didn't work out between them, and we hit it off. She was able to shatter the wall of isolation I had around me. I get along with people OK, but I wouldn't let anybody in because I didn't want to make a commitment because of my being on the inside and the problems that others have to deal with when that is the case.

I don't like it here at the SCC but I wouldn't have met Monica otherwise, and being with her makes my whole stay worthwhile. I've also completed a lot of Christian training and have nine certificates on issues like metaphysics and soul therapy.

After my last 2011 interview with Mr. Stout I interviewed his then fiancé Ms. Monica Wolfe. Ms. Wolfe told me that

I was dating his adopted son but we didn't get along. I started talking with Roy after Halloween of 2009 ("Halloween of 2009" is a typo; it should have read "Halloween of 2010"). We discussed marriage over the holidays. If he is released we'll get married in February. Otherwise we'll get married in April. He told me about his offenses in 1990, 1992, and 1997. I'm OK with that because the past is the past. He's trying to start a fresh life and so am I. He treats me good. He treats me with respect. He doesn't yell at me and he's been there for me when I've had my ups and downs. He calls me and he listens to me when I tell him what's going on.

Mr. Stout's second to most recent SCC Annual Review was completed by Dr. Spizman on November 8, 2011. Regarding Mr. Stout's SCC functioning, Dr. Spizman stated that

While Mr. Stout was often able to maintain appropriate behavior on the living unit, he had some verbal outbursts (PS11-3) ... (he) often is able to relate well with others. He also has demonstrated strength in his employment efforts (PS11-5).

Mr. Stout was also apparently married to his fiancé' Monica about midway through the

year. No incidents of sexual misconduct were noted and during our 2012 interview Mr. Stout denied receiving any Behavior Management Reports during this review period. He also indicated that he has maintained a Privilege Level of a "4," which is the highest level attainable by a resident who is not participating in the sex offender counseling program that is offered at the SCC. When I talked with him about his relationship with his wife Mr. Stout told me that

Monica and I are doing very good, really good. She comes out here about once a month. I wish it were more often but she has to take a bus if she wants to visit. She's living with JoAnne. This is a whole lot better than where she was living the last time you talked with me. At that time she was living in Bremerton. This is 110% better.

Mrs. Stout's interview comments were consistent with this view. She told me that

We were married on June 22nd, 2011. We are doing just great. We're succeeding in our relationship. Roy's on phone restriction but we talk with each other 5 times a day. We talk for up to 30 minutes a call.

The following bullet points allude to other important portions of Dr. Spizman's report:

- Regarding Mr. Stout's health status, Dr. Spizman's report included the following passages.

He went through radiation treatment for the (prostate) cancer and currently does not show any signs of progression of the cancer. He is also using hormone therapy, to slow down the progression of the cancer (this could potentially effect libido and erectile functioning ... Regarding erectile functioning, at his age there would be some expected dysfunction, which could be further impaired by the smoking and hormone therapy, but there are no complaints at this time.

When I asked him about this issue during our interview Mr. Stout told me that

As far as my prostate radiation treatment is concerned, there's no evidence of cancer. The PSL test is as low as you can go. I got the treatments in November of 2010. I am taking Lupron as part of my post-radiation plan. Some side effects of this are minimal libido, hot and cold flashes, and mood swings. The mood swings come on after the administration of the Lupron. I anticipate this reaction so I monitor myself closely during this period. I attribute my mood changes in large part during this time to the effects of the Lupron.

- Regarding Mr. Stout's diagnostic status, **the only entries included in this Review were Paraphilia Not Otherwise Specified (Nonconsent) Rule Out, Antisocial Personality Disorder - Provisional, Polysubstance Abuse (In a Controlled Environment), and Borderline Intellectual Functioning (PSI I-7).** Therefore, **unlike**

previous reviews, Dr. Spizman did not conclude that Mr. Stout suffered from a Mental Abnormality to a reasonable degree of certainty.

Explaining the first entry (PS11-7), Dr. Spizman stated that

Mr. Stout has been arrested or convicted of sexual offenses against adult women with whom he had no prior meaningful relationship. The incidents were nonconsensual, and he did not stop his action in the presence of clear signals of fear or signals to stop from the victims. However, the assaults did not clearly indicate a desire for non-consensual sexual activity. Rather, it appears he often sought consent, but when it was not obtained, this did not prevent him from pursuing the woman. However, one documented assault did not involve any apparent interaction prior to the assault and the attempted forced sex. Overall, there was some uncertainty of his exact desire/drive, with one assault I believed to clearly indicate a drive for nonconsensual sex. I previously opined that Mr. Stout met the criteria for this disorder.

At this time, Mr. Stout is over age 50, a point that I now consider him to be an older sexual offender. Research demonstrates that as a man enters his older years, his sexual interest and behavior typically decline. While I have very limited information about Mr. Stout, if he is following this typical course, it would logically follow that any sexual drive toward rape has also decreased. In the sex offender population, rape of an adult female by a man past the age of 50 is quite uncommon. Thus, there is some uncertainty as to how strong a desire he initially had for nonconsensual sex, with even greater uncertainty now caused by his advanced age. Therefore, at this time, I am providing this diagnosis as a rule out, to indicate the significant uncertainty as to whether or not Mr. Stout continues to meet the criteria for this disorder. The rule out specifier indicates that further information (e.g., obtained through interview or physiological testing) could provide information that would indicate this is an appropriate diagnosis, or if it is ruled out.

Explaining his characterization of Antisocial Personality Disorder as "provisional," (PS11-8), Dr. Spizman stated

Research demonstrates that as a man reaches his fifties, many of the antisocial traits will "burn out." With Mr. Stout, while we still see some evidence of difficulties (e.g., his apparent indifference to other residents regarding phone use), there is limited demonstration of antisocial behavior. Therefore, I have rendered this diagnosis as provisional to indicate that at this time Mr. Stout appears to still have some antisocial traits, however, further information may indicate this diagnosis is no longer warranted.

- **Regarding Mr. Stout's risk status, Dr. Spizman did not score Mr. Stout on any of the risk assessment instruments used by Dr. Packard. Instead he used the Static-99R and several dynamic risk factors from an "instrument designed for use in the**

community” that he thought could “still provide some useful information about someone in full confinement.” Referring to Static-99R, Dr. Spizman observed that “Mr. Stout scored a 5 ... this yields a risk estimate of 25.2% in five years and 35.5% in ten years” (PS11-9).

- Regarding Mr. Stout’s status on Washington’s SVP risk criteria Dr. Spizman stated (PS11-12) that “there is a degree of uncertainty whether or not Mr. Stout has an underlying mental abnormality or personality disorder that meets the criteria for civil commitment.” He also stated that “there is some uncertainty regarding whether or not he would be more likely than not to reoffend sexually if released unconditionally.” Yet, after these assertions he concluded that “I believe Mr. Stout has a continuing abnormality that meets the criteria for civil commitment and that his risk level continues to remain more likely than not to reoffend if released unconditionally.”

Dr. Spizman therefore asserted that he was both certain and uncertain regarding Mr. Stout’s status, which is equivalent to saying that he is and he isn’t a sexually violent predator. This is illogical and indicates that Dr. Spizman is too uncertain to take a position on the SVP issue. Mr. Stout should not be considered to meet the SVP criteria under such a high level of uncertainty.

Mr. Stout was also evaluated by Dr. Richards after he was evaluated by Dr. Spizman. Dr. Richards claimed that he suffered from a Mental Abnormality after he listed the following entries as “listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)”: Alcohol Abuse in a Controlled Environment, Polysubstance Dependence in a Controlled Environment, Antisocial Personality Disorder (Severe Psychopathy) with Paranoid Personality Traits, and Borderline Intellectual Functioning. On the Static-99R he assigned Mr. Stout a total of 6 points. This is one point too many because Mr. Stout’s “first marriage lasted two and a half years” (HR11-6). On both the Static-2002R and the MnSOST-R he scored Mr. Stout as in the third highest risk category. He also assessed his status on various risk factors.

Dr. Richards concluded that “it is my opinion that Mr. Donald Roy Stout, Jr., does meet the criteria as a Sexually Violent Predator.” Although he stated that he believed that Mr. Stout “is more likely than not to commit a new crime of sexual violence” Dr. Richards did not agree that Mr. Stout continued to suffer from this original commitment diagnoses of Paraphilia NOS Nonconsent and Antisocial Personality Disorder. Furthermore, the diagnosis that he discussed at greatest length – Antisocial Personality Disorder/Psychopathy – is not accepted as a legitimate diagnosis in DSM-IV-TR.

Mr. Stout’s most recent SCC Annual Review was completed by Dr. Daniel Yanisch on January 31, 2013. Regarding that range of treatment activities that Mr. Stout might have accessed at the SCC during the current review period, Dr. Yanisch at one point reported that

An inspection of all SCC records generated about Mr. Stout for the current review

period reveals that **(Mr. Stout) has not taken part in any of the sex offender specific treatment groups.** He has not requested or participated in any individual therapy or treatment planning sessions, despite being regularly asked via letter or memo about his interest to discuss case management issues (DY13-2).

At a later point, however, Dr. Yanisch indicated that **"Mr. Stout requested contact with his assigned Psychology Associate, Joe Coleman ... as he wanted to discuss his treatment plan, and some of the listed dynamic risk factors ...** Mr. Stout argued that he had been sober a long time and that (Substance Abuse) was not a factor for him anymore" (DY13-3).

Regarding Mr. Stout's current medical status Dr. Yanisch reported that "In 2010 ... following a biopsy, he was diagnosed with prostate cancer. He was treated with radiation and hormone therapy in the Fall of 2011" (DY13-3).

Dr. Yanisch did not indicate that Mr. Stout is still being treated with Depo-Lupron (2544, 2553). When I asked Mr. Stout about his current sex drive he indicated that he did not have any. He also told me he has not had an erection for over 3 years, that he does not masturbate, and that he has not had any nocturnal emissions.

Regarding Mr. Stout's residential functioning Dr. Yanisch reported that

As noted in the 2011 SCC Annual Review by Dr. Spizman, Mr. Stout became involved with a woman ... and eventually was married to her. Because of the extent of his telephone contacts with her, and the fact that other residents were upset (by this) ... Mr. Stout was moved to a different living unit ... By the end of January 2012 (these issues) resulted in treatment staff implementing a revision of his treatment plan ... Mr. Stout was directed not to answer the phone when it rang ... By the middle of June it was noted that Mr. Stout was monitoring his phone use much more effectively ... However, by 08.05.12 he appeared to be reverting to some earlier behaviors ... Residential progress notes and room inspection reports indicate that Mr. Stout ... keeps his room up to standards ... (DY13-4).

Regarding behavioral management issues Dr. Yanisch reported that

When staff escorting another resident requested the pill line nurse deal with that resident before Mr. Stout ... Mr. Stout protested ... He continued to escalate and was informed that "he was blowing this whole thing out of proportion." He finally just walked away from staff ... The above situation was later determined to be a Category 2 BMR incident and was brought to Mr. Stout's treatment team. He was cited for "Delaying Staff and Disruptive Behavior" (DY13-5).

(Residential Rehabilitation Counselor Shauna Anderson) noted that Mr. Stout is no longer working because "he has to be available for telephone calls from his wife" ... When questioned if she had observed any sexual preoccupation or

sexualized content coming from Mr. Stout, Ms. Anderson stated, "I have never observed anything like that from him." (DY13-6 to 7).

Mr. Stout also received a Category I BMR for Computer Violations after Dr. Yanisch's report. According to the "Treatment Plan Addendum" describing this incident "Mr. Stout possessed on his computer a lewd story describing an ultimate sexual act ... he was also in possession of 17 software/computer related items which is a violation of SCC Policy 212" (2502). A February 26, 2013 memorandum by Investigator Joseph Henderson indicated that Mr. Stout told him that "He had allowed another resident ... to complete legal work on his computer in the past. Mr. Stout stated that this resident must have written the story. Mr. Stout did admit that his computer was ultimately his responsibility" (2510).

When I asked Mr. Stout about the content of the story he told me that "it was a graphic story about Batman ... I didn't put it on there."

Regarding Mr. Stout's diagnostic status, **the entries included in Dr. Yanisch's Review were Paraphilia Not Otherwise Specified (Nonconsent) Rule Out, Antisocial Personality Disorder, Polysubstance Abuse, In a Controlled Environment (by history), and Borderline Intellectual Functioning (DY13-7).**

Regarding Mr. Stout's risk status, Dr. Yanisch did not score Mr. Stout on any of the risk assessments used by Dr. Packard. Instead he used the **Static-99R**. Like Dr. Spizman in his 2011 Review, **Dr. Yanisch observed in his 2012 Review that "Mr. Stout scored a 5 ... this yields a risk estimate of 25.2% in five years and 35.5% in ten years"** (DY13-7 to 8). Like Dr. Spizman he also assessed Mr. Stout on risk factors from the Stable "and a few others that are considered pertinent to treatment progress at the SCC" (DY13-8).

Overall, Dr. Yanisch concluded that

Mr. Stout has a Rule Out Diagnosis of Paraphilia NOS (Nonconsent), coupled with Antisocial Personality Disorder and Borderline Intellectual Functioning. The above noted dynamic risk factors intermingle with aspects of these diagnoses, leading to Mr. Stout's elevated risk of sexual offending ... The combination of mental disorders and personality disorder impairs Mr. Stout's ability to control his behavior and places him at high risk for sexually violent offenses in the absence of any therapeutic or other intervention ... It is my professional opinion that Mr. Stout appears to continue to meet the definition of a sexually violent predator. Mr. Stout's present mental condition seriously impairs his ability to control his sexually violent behavior.

In his deposition as part of his trial testimony Dr. Packard indicated that he was reasonably certain that the diagnoses of Paraphilia NOS (Nonconsent) and Antisocial Personality were applicable to Mr. Stout. The trial court subsequently concluded that "***In Mr. Stout the combination of paraphilia (NOS) non-consent with anti-social***

personality disorder causes him serious difficulty in controlling his behavior of engaging in sex with non-consenting others.” Mr. Stout’s Mental Abnormality was therefore regarded as the product of a compound diagnosis. Diagnosticians indicate that they are uncertain about the applicability of a diagnosis by stating that it should be “Ruled Out.” Dr. Yanisch, like Dr. Spizman, indicated in his most recent Annual Review that “Mr. Stout has a Rule Out Diagnosis of Paraphilia (Nonconsent).” Both Dr. Yanisch and Dr. Spizman are therefore uncertain that this alleged disorder, even if assumed to be accepted by the relevant community, is currently active in Mr. Stout’s case. Since they are both doubtful about the applicability of one of the two diagnoses that make up Mr. Stout’s compound diagnosis they must also be uncertain as to whether the full combination of diagnoses necessary to Mr. Stout’s Mental Abnormality are currently active. The reports by Dr. Spizman and Dr. Yanisch therefore indicate that Mr. Stout’s diagnostic status has so changed that he no longer meets Washington’s SVP criteria.

In his deposition before Mr. Stout’s commitment trial Dr. Packard also testified that the risk assessment methodologies he used left him with the opinion that Mr. Stout “would be more likely to commit predatory acts of sexual violence.” Both Dr. Yanisch and Dr. Spizman reported that their scoring of Mr. Stout “yields a risk estimate of 25.2% in five years and 35.5% in ten years.” The top end of the range of these estimates does not exceed Washington’s “more likely than not” SVP criterion. Dr. Spizman explicitly acknowledged this, pointing out that “there is some uncertainty regarding whether or not (Mr. Stout) would be more likely than not to reoffend sexually if released unconditionally.” Dr. Yanisch referred to Mr. Stout’s risk as being “elevated” and “high” but did not specifically opine that Mr. Stout met Washington’s SVP criterion of being “more likely than not” to commit new predatory crimes of sexual violence. The reports by both Dr. Spizman and Dr. Yanisch therefore indicate that Mr. Stout’s risk status has so changed that he no longer meets Washington’s SVP criteria.

At the end of their Reviews both Dr. Spizman and Dr. Yanisch concluded that it was their opinion that Mr. Stout continued to meet the criteria for civil commitment. The foregoing paragraphs indicate that, prior to these statements, neither Dr. Spizman nor Dr. Yanisch laid out any foundation for coming to this conclusion. Because of this I believe their “ultimate opinions” are simply dispositive and thus do not make a “prima facie case” that Mr. Stout continues to meet Washington’s SVP criteria.

III. Expert's Training, Clinical Experience, Academic Experience, and Research Experience

I was awarded a Ph.D. in clinical psychology by Indiana University in 1978. While I was in residence there I was mentored at the Kinsey Institute for Sex Research by its director, Dr. Paul Gebhard. From 1977 to 1993 I was a professor at four universities (Florida State University, Portland State University, University of Saskatchewan, and Lewis & Clark College) and received \$563,000 in research grants from the U.S. and Canadian governments for various projects that related to studying sex offenders, self-help groups, and aspects of the third edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. I am currently a nonsalaried adjunct/research professor at Washington State University Vancouver. A copy of my vita has been attached.

Over the last 30 years I have personally evaluated about 1,000 sex offenders and personally treated about 3,000. Clinical staff under my supervision treated another 5,000. I have provided extensive clinical services to sex offenders in both Oregon and Canada. In Oregon, from 1990 to 2002, I initiated a sex offender program, Wollert and Associates, based on relapse prevention principles. In the course of developing it I generated many descriptive materials, wrote my own treatment manual (now in its third edition), implemented an array of computerized client-tracking systems, and developed a systematic, thorough, and cost-effective approach to intake evaluations. At one point this program served a census of over 300 clients and provided services under separate contracts with the federal government and Community Justice Departments from Multnomah, Marion, Clackamas, and Washington Counties. I have worked with dozens of parole and probation officers who supervised my clients while they were living in their own residences or in work release centers. The annual contact sexual recidivism rate for supervisees adhering to the rules of my program was found to be ½ of 1%.

In June of 2002 I transferred the ownership of my clinic serving Multnomah County to my colleague Casey Weber, MS, LPC. I thereafter continued in practice as a sole practitioner, providing evaluation and treatment services pursuant to a contract I held with the federal government from 1999 until November of 2009. During that time I treated about 50 child pornography offenders and about 25 other federal offenders who either physically contacted or attempted to physically contact minors they had met via the internet. Other federal offenders I have treated include men who have committed rape or molested children on either a Native American reservation or while they were serving in the United States military.

I moved my office to its present Vancouver location and discontinued providing treatment services in November of 2009. My practice now revolves around consultations related to sex offender litigation and sex offender evaluations.

I have been qualified to testify and provide expert testimony about sexual offending and/or sex offender risk assessment in federal courts in the United States (North Carolina and Oregon) and Canada (Saskatchewan) and in superior courts in various states (Oregon, Washington, California, Massachusetts, Iowa, and Wisconsin). I have also provided reports or evaluations in other states (Alaska, Illinois, and New Jersey) where I was not retained to testify. Overall, I have testified in about 100 adult sex offender sentencing proceedings for

contact offenses, about 25 adult child pornography offender sentencing proceedings, 25 adult probation or parole revocation proceedings, and 10 child placement proceedings. I submitted reports but did not testify in about 40 adult sentencing proceedings for contact sex offenses, 25 juvenile sentencing proceedings for contact sex offenses, and 25 sexually violent predator (SVP) cases. I have been retained in 200 sexually violent predator cases in seven states (Washington, California, Iowa, Wisconsin, Illinois, New Jersey, and Massachusetts), *testifying in about 100 cases where respondents committed index offenses as adults and in about 25 cases where respondents committed index offenses as minors.*

Since 2001 I have published 11 peer-reviewed articles, 1 book chapter, and 1 other manuscript on sex offenders. About half of these documents focused on diagnostic issues such as the reliability of authorized paraphilic diagnoses in the Diagnostic and Statistical Manual of the American Psychiatric Association (e.g., Pedophilia, Sexual Sadism; see Wollert, 2006, and Frances & Wollert, 2012) and proposed diagnoses that the APA rejected in 2012 (Hebephilia and Paraphilia Not Otherwise Specified, Rape; see Wollert, 2007; Wollert & Cramer, 2011; Wollert, 2011). My other articles focused on describing a new instrument – the “MATS-1” – that my colleagues and I developed for the purpose of sex offender risk assessment (e.g., Wollert, Cramer, Waggoner, Skelton, & Vess, 2010).

During this same period I provided 20 trainings and conference presentations on sex offender diagnosis, risk assessment, and treatment. In October of 2012 I participated as an invited expert witness in a mock SVP trial on the diagnostic adequacy of Hebephilia at the Annual Meeting of the American Academy of Psychiatry and the Law in Montreal. A description of the trial may be accessed at <http://forensicpsychologist.blogspot.com>. The United States Sentencing Commission also invited me to provide testimony at a two-day hearing on child pornography offenders that the Commission held at the Washington, D.C., Thurgood Marshall Justice Building in February of 2012. My testimony is summarized as part of a 468-page report which the Commission submitted to Congress on February 27, 2013. Several sections of the Commission’s Report also cited to research I have published on federal child pornography offenders.

IV. Washington Statutes and Court Decisions About SVP Proceedings

A. I have read sections of RCW Chapter 71.09 and Court Decisions that set forth (1) legislative findings regarding the prevalence of sexually violent predators (SVPs) and their resistance to change; (2) those characteristics that define SVPs; (3) the conditions that must be satisfied to determine whether a respondent to a civil commitment petition is a SVP; and (4) the conditions that must be met to set a hearing to determine whether a person once classified as a SVP continues to merit this classification.

1. Regarding issue (1) under section III.A., RCW 71.09.010 states that the legislature for the State of Washington "*finds that a small but extremely dangerous group of sexually violent predators exist*" and that they "*are unamenable to existing mental illness treatment modalities.*"
2. Regarding issue (2) under section III.A., RCW 71.09.020 (16) states that a "*'sexually violent predator' means any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence if not confined in a secure setting.*"

RCW 71.09.020 (8) provides some elaboration on this definition by stating that "*'mental abnormality' means a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others.*"

Although RCW 71.09.020 (8) links the term "Mental Abnormality" to a condition that presumably impairs emotional or volitional capacity it does not further clarify the meaning of an emotional or volitional impairment.

3. Regarding issue (3) under section III.A., RCW 71.09.060 (1) states that "*the court or jury shall determine whether, beyond a reasonable doubt, the person is a sexually violent predator.*"
4. Regarding issue (4) under section III.A., RCW 71.09.090 (2) (c) states that if "*probable cause exists to believe that the person's condition has so changed that: (A) the person no longer meets the definition of a sexually violent predator; or (B) release to a less restrictive alternative would be in the best interest of the person and conditions can be imposed that would adequately protect the community, then the court shall set a hearing on either or both issues.*"

Further clarification of the procedures referenced under RCW 71.09.090 (2) have been provided in various decisions. In *State of Washington v. David McCuiston* (2012), in particular, the Washington Supreme Court stated that:

At the show cause hearing, the State bears the burden to present prima facie

evidence that the individual continues to meet the definition of a SVP and that conditional release to a less restrictive alternative would be inappropriate. The court must order an evidentiary hearing if the State fails to meet its burden or, alternatively, the individual establishes probable cause to believe his "condition has so changed" that he no longer meets the definition of a SVP or that conditional release to a less restrictive placement would be appropriate ... "there are two possible statutory ways for a court to determine there is probable cause to proceed to an evidentiary hearing ... (1) by deficiency in the proof submitted by the State, or (2) by sufficiency of proof by the prisoner."

5. Also regarding issue (4) under section III.A., RCW 71.09.090 (4) states

(4) (a) Probable cause exists to believe a person's condition has 'so changed' under subsection (2) of this section, only when evidence exists, since the person's last commitment trial, or less restrictive alternative revocation proceeding, of a substantial change in the person's physical or mental condition such that the person either no longer meets the definition of a sexually violent predator or that a condition ...

(b) A new trial under subsection (3) of this section may be ordered, or a trial proceeding may be held, only when there is current evidence from a licensed professional of one of the following and the evidence presents a change in condition since the person's last commitment trial proceeding:

- i. An identified physiological change to the person, such as paralysis, stroke, or dementia, that renders the committed person unable to commit a sexually violent act and this change is permanent; or*
- ii. A change in the person's mental condition brought about through positive response to continuing participation in treatment which indicates that the person meets the standard for conditional release to a less restrictive alternative such that the person would be safe at large if unconditionally released from commitment.*

(c) For purposes of this section, a change in a single demographic factor, without more, does not establish probable cause for a new trial proceeding under subsection (3) of this section. As used in this section, a single demographic factor includes, but is not limited to, a change in chronological age, marital status, or gender of the committed person.

Although RCW 71.09.090 (4) refers to the concept of "change" as necessary to a new trial it does not specify the conditions under which the requisite change must be entirely produced by processes or factors that are internal to a person, the conditions under which change may be a product of an interaction between internal and external factors, and the conditions under which it may be due entirely to external factors. It also does not define three terms in the phrase "brought about through positive

response to continuing participation in treatment" (underlined terms remain undefined).

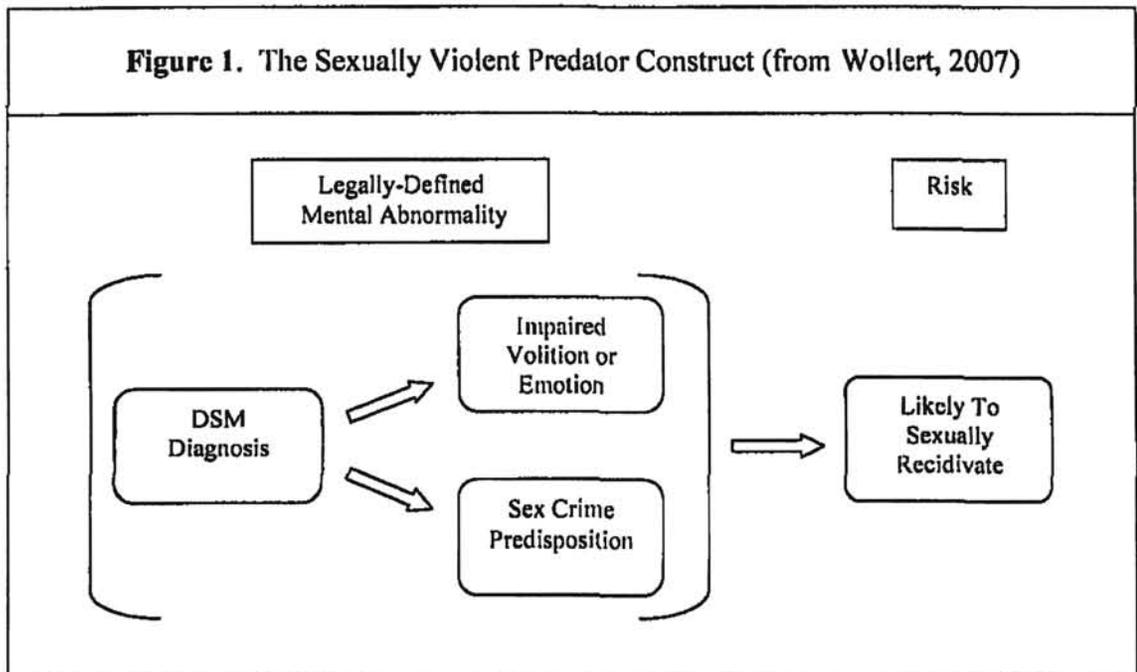
V. Definitions of Vague Terms in Washington's SVP Laws That Were Applied in the Present Review

A. Many of the terms cited in section IV. have not been clearly defined. Further definition is useful, however, for the completion of a meaningful sexually violent predator evaluation. I believe that various potentially important sources of information sources should be consulted to provide useful guidance to SVP evaluators on the questions that need to be addressed to formulate an adequate evaluation. The following items enumerate the questions that are currently most important to me.

1. Which disorders are typically considered "congenital or acquired conditions"?
2. Should experts assume that diagnoses from the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-TR) constitute congenital or acquired conditions?
3. What is the best way to identify emotional or volitional impairments which predispose individuals to the commission of criminal sexual acts?
4. What is the appropriate timeframe for applying the Mental Abnormality criterion?
5. What is the appropriate scope of application of the SVP criteria to Washington's sex offender population?
6. What standard of consistency should be followed in determining whether a person who has been found to be an SVP remains an SVP?
7. What standard should be used to determine whether a person who was found to be a SVP has "changed" so that he no longer meets the criteria that define a SVP?
8. What is the definition of "change ... brought about through ... continuing participation in treatment"?

B. The following items enumerate my views on the foregoing questions based on my publications, reading of relevant materials, discussions with colleagues, and experience.

B1. Acquired or Congenital Conditions. Figure 1 is a schematic that was published in two different peer-reviewed journals that depicts how I believe that experts (see, for example, Doren, 2002, and First & Halon, 2008) typically conceptualize SVPs. It shows that experts usually equate a DSM diagnosis with an "acquired or congenital condition." Most of these diagnoses fall in the categories referred to as "Paraphilias."



A comparison of the content of the DSMs since the first “modern” DSM (DSM-III) was published in 1980 strongly implies that stringent levels of evidence must be met before any of the Paraphilias may be assigned to a respondent (Frances & Wollert, 2012). The following passages describing the Paraphilias, for example, were included in DSM-III.

The essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement. Such imagery or acts tend to be insistently and involuntarily repetitive and generally involve either (1) preference for use of a nonhuman object sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation, or (3) repetitive sexual activity with nonconsenting partners.

The imagery in a Paraphilia, such as simulated bondage, may be playful and harmless and acted out with a mutually consenting partner. More likely it is not reciprocated by the partner, who consequently feels erotically excluded or superfluous to some degree. In more extreme form, paraphiliac imagery is acted out with a nonconsenting partner, and is noxious and injurious to the partner (as in severe Sexual Sadism) or to the self (as in Sexual Masochism).

Since paraphiliac imagery is necessary for erotic arousal, it must be included in masturbatory fantasies if not actually acted out alone or with a partner and supporting cast or paraphernalia. In the absence of paraphilic imagery there is no relief from nonerotic tension, and sexual excitement or orgasm is not attained.

Frequently these individuals assert that the behavior causes them no distress and that

their only problem is the reaction of others to their behavior. Others admit to guilt, shame, and depression at having to engage in an unusual sexual activity is socially unacceptable. There is often impairment in the capacity for reciprocal affectionate sexual activity, and psychosexual dysfunction are common.

Social and sexual relationships may suffer if others, such as a spouse (many of these individuals are married), become aware of the unusual sexual behavior. In addition, if the individual engages in sexual activity with a partner who refuses to cooperate in the unusual behavior, such as fetishistic or sadistic behavior, sexual excitement may be inhibited and the relationship may suffer.

Complications(may occur, including) physical harm ... serious damage (to oneself) ... (and) incarceration.

The current version of the DSM (DSM-IV-TR) describes the Paraphilias in the following terms.

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 that occur over a period of at least 6 months (Criterion A). For some individuals, paraphilic fantasies are obligatory for erotic arousal and are always included in sexual activity. In other cases, the paraphilic preferences occur only episodically (e.g., perhaps during periods of stress), whereas other times the person is able to function without paraphilic fantasies or stimuli. For Pedophilia, Voyeurism, Exhibitionism, the diagnosis is made if the person has acted on these urges or the urges or sexual fantasies cause marked distress or interpersonal difficulty. For Sexual Sadism, the diagnosis is made if the person has acted on these urges with a nonconsenting person or the urges, sexual fantasies, or behaviors cause marked distress or interpersonal difficulty. For the remaining Paraphilias, the diagnosis is made if the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Paraphilic imagery may be acted out ... in a way that may be injurious to the partner (as in Sexual Sadism) ... the individual may be subject to arrest or incarceration (Exhibitionism, Pedophilia, and Voyeurism make up the majority of apprehended sex offenders) ... self-injury (as in Sexual Masochism) ... social and sexual relationships may suffer if others find the unusual sexual behavior shameful or repugnant, or if the individual's sexual partner refuses to cooperate.

Many individuals with these disorders assert that the behavior causes them no distress and that their only problem is social dysfunction as a result of the reaction of others to their behavior. Others report extreme guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable or that they regard as immoral. There is often impairment in the capacity for reciprocal, affectionate sexual activity, and Sexual Dysfunctions may be present.

Considering the description of the Paraphilias presented in the current DSM within the historical context of previous definitions, and giving heavy weight to the passages I have put in bold type, I believe the following elements must be satisfied to conclude that a mature adult meets the criteria for a Paraphilia.

- a) There must be a six-month period during which the person experiences paraphilic imagery that is so recurrent and intense that it is necessary for sexual excitement (this is the meaning of the A, or essential, criterion).
- b) The person must be severely distressed during this six month period by his paraphilic urges, or experience serious interpersonal difficulties or an impairment in his daily routine due to these urges, or act on them in way that is harmful (this is the meaning of the B, or threshold, criterion).
- c) The paraphilias do not apply to acts of rape that are perpetrated by those who do not meet the criteria for Pedophilia or Sexual Sadism (there is no mention of a diagnosis that is reserved for rape in general).

The DSM also requires a high level of evidence stringency in order to assign a Personality Disorder to a respondent. In the case of Antisocial Personality Disorder, which is the specific Personality Disorder most commonly assigned in SVP cases, a person must be found to show evidence of a Conduct Disorder before his fifteenth birthday.

- B2. DSM Diagnoses and Acquired or Congenital Conditions. Three facts point to the conclusion that experts should not assume that any diagnosis from the DSM constitutes an acquired or congenital condition.

First, no research has ever confirmed that any DSM diagnosis affects "the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others."

Furthermore, the DSM diagnoses that are invoked in SVP cases are widely regarded as error-ridden (First & Frances, 2008; First & Halon, 2008; Frances, Sreenivasan & Weinberger, 2008), invalid or unreliable (Brody & Green, 1994; Green, 2002; Kingston, Firestone, Moulden, & Bradford, 2007; Levenson, 2004; Marshall, 1997; Marshall & Kennedy, 2003; Marshall, Kennedy, & Yates, 2002; Marshall, Kennedy, Yates, & Serran, 2002; O'Donohue, Regev, & Hagstrom, 2000; Prentky, Coward, & Gabriel, 2008; Wilson, Abracen, Looman, Picheca, & Ferguson, 2010), associated with high rates of misdiagnoses (Wollert, 2007; Wollert & Waggoner, 2009), or dubious labels that may facilitate "shoe-horning" respondents into the SVP criteria (Frances, Sreenivasan, & Weinberger, 2008; Frances, September 1, 2010; Franklin, 2010; Green, 2010; Knight, 2010; Wollert & Cramer, 2011; Zander, 2005; Zander, 2008).

Finally, the American Psychiatric Association and those who authored the most recent manual of DSM diagnoses insist that no diagnosis is sufficient to determine that a person

has a mental illness which warrants civil commitment (American Psychiatric Association, 1994, 1996, 2000, 2001; First & Halon, 2008). As I have also mentioned, the APA has rejected the inclusion of Paraphilia Not Otherwise Specified (Nonconsent) in the 2013 edition of DSM-5 when the criteria for PNOSN were referred to as Paraphilic Coercive Disorder.

- B3. Impairment. The validity of the concept of volitional impairment has been widely criticized and there is no agreement among evaluators as to what the best method is for identifying emotional or volitional impairments which predispose individuals to the commission of criminal sexual acts (American Bar Association, 1986; American Psychiatric Association, 1983; LaFond, 2000; Jackson, Rogers, & Shuman, 2004; First & Halon, 2008; Prentky, Janus, Barbaree, Schwartz, & Kafka, 2006; Prentky et al., 2008; Wollert & Waggoner, 2009).

From the information in V.B.2. we know that DSM diagnoses are inadequate for identifying volitional impairments. Common-sense also tells us that examples are usually inadequate for this purpose because examples almost never differentiate SVP recidivists from typical sex offender recidivists.

It is therefore most likely impossible for experts to accurately assess the impairment requirement of the SVP construct without intentionally and carefully defining what it means.

I believe there are two approaches that might be adopted to address this problem.

One would be to assess whether respondents meet the criteria for insanity, which involves answering the following questions: (1) Is the respondent aware of the nature and quality of his actions? and (2) Does the respondent know right from wrong with respect to his actions? This approach has the advantage of clarity in that the "notion of volitional impairment generally collapses into the more operationally useful notion of *rationality defects*" (APA, 2001, p. 28, footnote 11; Morse, 1994).

A broader approach would be to evaluate respondents in terms of the severity to which they are sexually impaired. Abel and Rouleau (1990), for example, have suggested that *a severe cycle of deviant sexual compulsivity* exists among a specific class of sex offenders who

Report having recurrent, repetitive, and compulsive urges and fantasies to commit rapes. These offenders attempt to control their urges, but the urges eventually become so strong that they act upon them, commit rapes, and then feel guilty afterwards with a temporary reduction of urges, only to have the cycle repeat again. This cycle of ongoing urges, attempts to control them, breakdown of those attempts, and recurrence of the sex crime is similar to the clinical picture presented by exhibitionists, voyeurs, pedophiles, and other traditionally recognized categories of paraphiliacs.

Although rejection of Paraphilic Coercive Disorder by the APA means that the foregoing conceptualization does not apply to rapists, a number of considerations recommend it as an

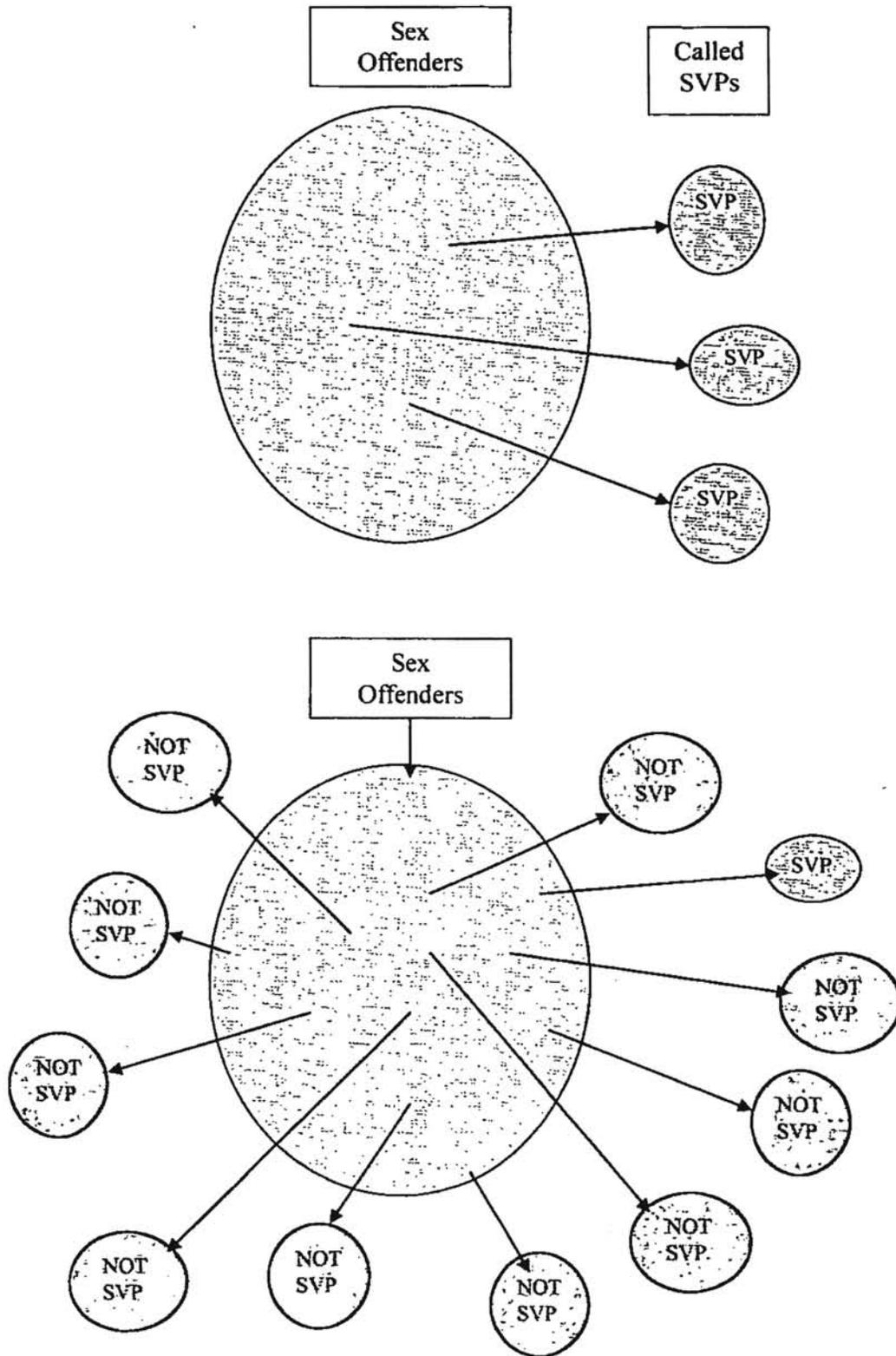
approach to conceptualizing Mental Abnormality among those with authorized paraphilias – particularly Pedophilia and Sexual Sadism – that are most relevant to Washington’s SVP statutes. One is that it covers all of the elements of a Mental Abnormality by combining the Paraphilic criteria from the DSM with predispositional, emotional, and volitional concepts. Another is that the Washington State Supreme Court has referred to the Abel and Rouleau article that includes the foregoing passage as being of “seminal” importance in a SVP case [In re Young, 857 P. 2d 989, 1002 (Wash. 1993)]. Still another advantage is that a multifaceted and extensive program of research (Carnes & Delmonico, 1996; Coleman, Minor, Ohlerking, & Raymond; Coleman-Kennedy & Pendley, 2002; Galbreath, Berlin, & Sawyer, 2002; Goodman, 2004; Goodman, May 26, 2009; Kafka, 2009; Kalichman & Rompa, 1995, 2001; Wines, 1997) and testing (e.g., the Sexual Addictions Screening Scale, the Sexual Compulsivity Scale, the Compulsive Sexual Behavior Inventory) has applied a somewhat less stringent conception of this view to various clinical and nonclinical populations.

- B4. **Timeframe.** The timeframe for applying the Mental Abnormality criterion to a person being evaluated on the SVP criterion must reflect his “current” status on the criterion (APA, 2000; *State of Washington vs. David McCuiston*). Extrapolating from past observations is therefore insufficient to render a meaningful opinion.
- B5. **Scope.** The appropriate scope for the application of Washington’s SVP criteria is one that is narrow [*Kansas v. Hendricks*, 521 U.S. 346 (1997); *Kansas v. Crane*, 534 U.S. 407 (2002); Jackson & Richards, 2007, p. 191]. The criteria, in other words, should apply to a very small percentage of sex offenders: Stern (2010), for example, has estimated that only 1.5% of all incarcerated sex offenders in Washington are thought to meet the SVP criteria.

It is hoped, as illustrated in the top circles of **Figure 2** (modeled after Figure 2 from Wollert & Waggoner, 2009), that some methods of evaluation processes will be reliable enough to identify offenders who fall in this group to a reasonable degree of certainty. But it is also almost certain, as illustrated in the bottom circles of **Figure 2** (after Figure 3 from Wollert & Waggoner, 2009), that this will not be the case for all methods of SVP evaluation and that caution must be exercised to avoid “false positives.”

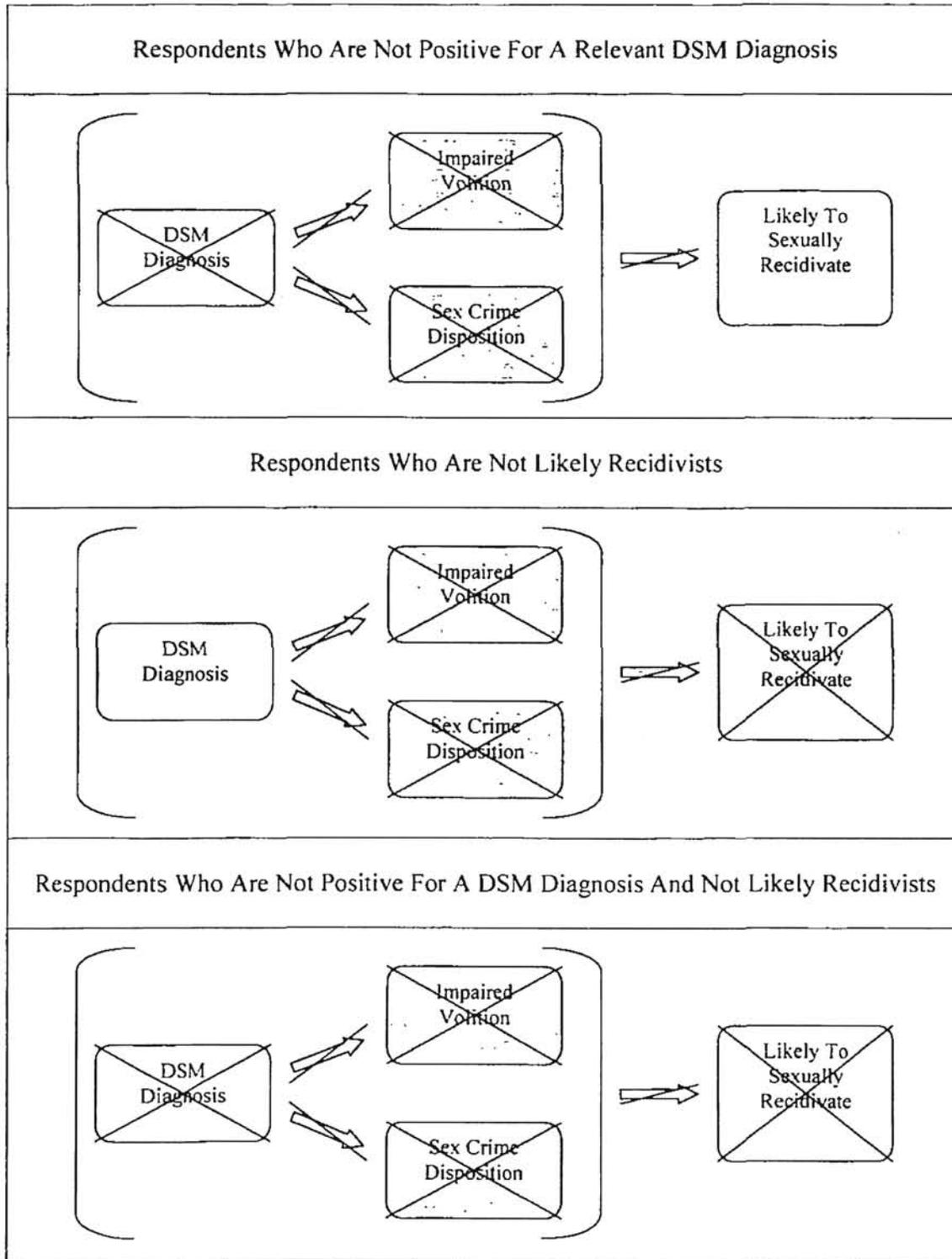
Regarding the issue of scope, it is also the case that a respondent must be positive for all of the elements that define a SVP to be classified as one. Adopting an electrical metaphor for descriptive purposes, I believe that all of the “switches” depicted in **Figure 1** must be in the “on” position. This is denoted in **Figure 3** by a lack of shading. Someone who is a typical criminal or typical criminal recidivist but not an SVP will therefore be negative for one or more of the components. Using shading to represent switches that are in the “off” position, and then crossing out these elements, **Figure 3** presents a conceptual illustration of a non-SVP. As **Figure 3** indicates, an offender does not have to be negative for each and every feature to be a non-SVP.

Figure 2. The Problem With SVPs Is Differentiating Them From Non-SVPs
(The Top Panel Works Well; The Bottom Panel Does Not)



OK

Figure 3. Three Classes of Respondents Who Would Not Qualify as SVPs



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- B6. Consistency of standard of proof. The SVP criteria should be consistently applied so that evaluators apply the same standard of proof in both pre-commitment evaluations and annual review evaluations. [see *State of Washington v. David McCuiston* (2012) for a more general discussion of this issue]. Evaluators should not, in other words, apply a stricter set of standards in making a release recommendation than they would apply if they were making a commitment recommendation.
- B7. Definitions of change. The most widely-accepted philosophical perspective on the nature of science and how this perspective defines the meaning of "change" revolves around a cumulative and ever-evolving process of conceptualization and hypothesis testing. Pursuing the first objective, the scientific enterprise conceptualizes objects and processes that have a bearing on human existence, properties associated with these constructs, the mechanisms by which they operate, and the results of these operations. Pursuing the second, it tests the validity of these conceptualizations by attempting to show that they are false.

Another fundamental tenet is that common sense indicates that a physical universe exists, but the sciences of biology and sensory psychology indicate that direct knowledge of that universe is beyond human capability. Scientists therefore construct and test their conceptualizations of the physical universe by collecting indirect observations and using logic to interpret the meaning of these observations.

This "constructivist" perspective on the nature of science holds a number of implications. One is that the properties of the physical universe do not precisely correspond to the universe of scientific constructs. Another is that the world that scientists "see" at any given point in time is determined by the scientific conceptualizations through which they are viewing it. Still another is that **scientists will see an object as having "changed" if their conceptualizations about the object change as a result developing new conceptualizations or combining previous conceptualizations that advance understanding, means-ends operations, or predictive power.** This is logical and coherent in that any other reaction on their part would involve the continued application of inferior conceptions.

Conclusions that were considered "facts" at one time are therefore often revised as a scientific discipline evolves. This is particularly the case for psychiatric and psychological constructs that are relevant for SVP evaluations, which the Supreme Court alluded to as "ever-advancing" rather than unchanging in *Kansas v. Crane* (2002). Regarding the diagnosis of mental disorders, for example, homosexuality was considered a mental disorder in an early version of the Diagnostic and Statistical Manual of the American Psychiatric Association but was removed from later versions (Zander, 2005). This change, in turn, necessitated a change in the mental health status of many who had previously been thought of as mentally disordered. Regarding the prediction of violent behavior, a professor of forensic psychiatry named Caesar Lombroso promoted the theory in the late 1800s that criminality was often inherited and

that evaluatees who were affected by this congenital disorder could be identified by measuring their skull and other features of their *physiognomy*. A corollary of this theory was that people of color were physiognomically predisposed to criminality because "only we white people have reached ... the ultimate bodily form" (Herman, 1997). Following the discreditation of the theory of physiognomy, it was incumbent on professionals who had once adhered to it to change their opinions about the criminological predispositions they had previously "seen" in persons who came from ethnic backgrounds that differed from their own. Any other response would simply have amounted to argumentation for the sake of argumentation, which runs counter to scientific tradition.

The foregoing position and examples indicated to me that **there are two pathways by which a civilly committed person's "condition" may be found to have "changed"** so that the person no longer meets the definition of a sexually violent predator. **One is that he has changed with respect to scientific conceptualizations that have withstood the test of time and attempts at scientific falsification. The other is that scientific conceptualizations that were once thought to identify him as a sexually violent predator have either been discredited or re-interpreted in such a way that his continued classification as a sexually violent predator would be inconsistent with the status of science.**

- B8. **Change Brought About Through Continuing Participation in Treatment.** Regarding the definition of "treatment," it is self-evident that (1) the *raison d'être* for Washington's Special Commitment Center is to provide continuous care and treatment to all who are placed there. Treatment therefore includes, but is not limited to, such different interventions as psychotherapy, skills training, pharmacotherapy, social support, inspirational modeling, maturation, response inhibition, rest, recreation, reflection, adequate health care, and scientific advances that inform the processes by which SVPs and non-SVPs are identified. This position is supported by court testimony from former SCC Superintendent Henry Richards indicating in one hearing (In re the Detention of Gale West) held on January 31, 2007 that

all of the offenders who are at ... the SCC are in treatment (p. 182),

and then elaborating on this position in a later hearing (In re the Detention of Toney Bates, January 18, 2008) by stating that

the SCC is responsible for ... a milieu therapy where the entire environment is in the treatment process through structure, through ongoing interaction with the staff, vocational training, education, and also through more specialized interventions (p. 14) ... once a detainee has been committed, we see the whole process as a treatment process (p. 71).

Since those who have been committed to the SCC are not released until they are eligible for release it also follows that all SVPs are continuously in treatment while they are in residence at the SCC.

The counter to the foregoing line of reasoning is that what the legislature meant by "treatment" when it amended RCW 71.09.090 was "sex offender-specific counseling." This, of course, would be useful to know. However, if this was the legislature's intent it would have been a simple matter for it to qualify the term "treatment" in RCW 71.09.090 (4) by inserting the term "sex offender-specific counseling treatment" in its place. It did not do this, so my assumption is that it meant to refer to "treatment" in a very broad sense. A narrower release specification may also have exposed RCW 71.09.090 (4) to more scrutiny by higher courts [see the majority decision in *State of Washington v. David McCuiston* (2011) and the dissent in *State of Washington v. David McCuiston* (2012) for a discussion of this issue]. Whatever the legislature's intent, the current language in RCW 71.09.090 (4) increases evaluator uncertainty because it creates a situation where the term "treatment" may be represented as sex offender-specific counseling in lower courts and as a broader process in higher courts.

Regarding the definition of "change through treatment," the ultimate goal of placing an individual at the SCC is to transform him from being a SVP into being a non-SVP. Considering this purpose within the context of the broad definition of treatment, and also considering that the legislature has apparently found that SVPs are very unlikely to change unless they are exposed to the unique treatment offered at the SCC, it follows that any person who was committed to the SCC in the past but does not meet the SVP criteria at the present time must have undergone a "change" in his "mental condition brought about through positive response to continuing participation" in the unique type of treatment offered at the SCC.

VI. Statement of Questions That Bear on Determining Whether Mr. Stout is an SVP

- A. The following questions are of paramount relevance for determining Mr. Stout's status on the SVP criteria:
1. Does the current SCC Annual Review for Mr. Stout provide prima facie evidence that he continues to meet Washington's SVP criteria?
 2. Can Mr. Stout present evidence that, if believed, would be sufficient to plausibly argue that he does not have a "Mental Abnormality"?
 3. Can Mr. Stout present evidence that, if believed, would be sufficient to plausibly argue that he is unlikely to commit sexually violent offenses of a predatory nature because of a current Mental Abnormality if he were released?
 4. Can Mr. Stout present evidence that, if believed, would be sufficient to plausibly argue that he has "so changed" as a result of continuous participation in treatment that he would be safe to be at large if unconditionally released?
 5. Has Mr. Stout undergone an identified and permanent physiological change that renders him unable to commit a sexually violent act?

VII. Procedures That Were Followed to Address the Questions at Issue

- A. To address the questions raised under sections VI.A.1. through VI.A.5., I first carried out the procedures described under section I.
- B. After completing these preliminary steps I addressed each of the five preceding questions by considering the relevant data. My conclusions are presented in the following sections.

VIII. Testing Question VI.A.1. Indicates That The Current SCC Annual Review Does Not Provide Prima Facie Evidence That Mr. Stout Currently Continues to Meet Washington's SVP Criteria.

My reasons for reaching this conclusion are presented in Section II. The last three paragraphs, in particular, indicate that recent State evaluations advance opinions that are dispositive rather than substantive. The State has therefore not made a prima facie case that Mr. Stout currently meets the SVP criteria for having a Mental Abnormality. A prima facie case has also not been made that he is more likely than not to sexually recidivate.

IX. Testing Question VI.A.2. Indicates That Mr. Stout Can Present Evidence In Support of a Plausible Argument that He Does Not Currently Have a Mental Abnormality.

- A. The following reasons, grounded in the content of Mr. Stout's chronological case history, point to this conclusion.
 - 1. There is no indication in his Annual Review that he suffers from a rationality defect. He also did not show a rationality defect in any of my interviews with him.
 - 2. There is no indication in his Annual Review or in my present evaluation that he suffers from a severe cycle of sexual compulsivity.
 - 3. The assumption that Mr. Stout has a Mental Abnormality has been predicated on the underlying assumption that he meets the criteria for an alleged disorder referred to as Paraphilia Not Otherwise Specified Nonconsent (PNOSN). The criteria for this disorder are the same as the criteria for another alleged disorder referred to as Paraphilic Coercive Disorder. Paraphilic Coercive Disorder is not accepted by the relevant professional community because it was proposed for inclusion in DSM-5 but was rejected in 2012 by the Board of Trustees of the American Psychiatric Association. PNOSN is therefore also not accepted by the relevant professional community.
 - 4. Mr. Stout would not currently meet the criteria for PNOSN even if it were believed that PNOSN is accepted by the relevant professional community. The reason for this is that his current Annual Review indicates that PNOSN may well not apply to him

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because its "Rule-Out" status signifies diagnostic uncertainty. This conclusion is consistent with evaluator results presented in Table 1 of Section II, where only 3% of 36 pairs of ratings indicated that state evaluators agreed on his compound commitment diagnoses of PNOSN and ASPD.

X. A Framework For Testing Question VII.A.3.

- A. **The goal of sex offender risk assessment in SVP cases is to evaluate the probability that the State's theory that an evaluatee is a future recidivist is true.** A respondent meets the SVP risk criterion if the likelihood that this theory is true exceeds 50%. A respondent does not meet the risk criterion if the likelihood does not exceed 50%.
- B. The most accurate approach to evaluating the state's "recidivism theory", according to empirical research, is based on actuarial procedures (Dix, 1976; Hall, 1988; Hanson & Thornton, 2000; Hanson, 2006; Kahn & Chambers, 1991; Skelton & Vess, 2008; Smith & Monastersky, 1986; Sturgeon & Taylor, 1980; Waggoner, Wollert, & Cramer, 2008; Wollert, 2006). An actuarial system includes 1) a battery of risk items (e.g., whether or not an evaluatee has been married, whether or not he has ever been convicted of a violent offense, how many times he has been convicted of a sex offense); 2) a manual for assigning numerical ratings to risk items (e.g., an evaluatee who has committed a violent crime may be given a "1" on this risk item whereas an evaluatee who has not may be given a "0") and combining the ratings into a total score; and 3) an experience table that lists the percentage of offenders with each score who have recidivated in the past.
- C. A number of different risk item batteries have been disseminated. The most well-known are referred to as Static-99, Static-99R("R" means "Revised" in this case), Static 2002R, the RRASOR, the MnSOST-R, and the SORAG. At least one experience table has been formulated for each of these batteries and more than one experience table has been formulated for Static-99.
- D. It has been found that the percentage of sex offenders who commit new sex offenses, known as the base recidivism rate, has gone down over the last several decades (Wollert & Waggoner, 2009; Harris, Helmus, Hanson, & Thornton, October 2008). It has also been found that the base recidivism rate is most elevated for the youngest offenders and steadily decreases with age (Barbaree & Blanchard, 2008; Barbaree, Blanchard, & Langton, 2003; Hanson, 2002; Skelton & Vess, 2008; Wollert, 2006; Waggoner et al., 2008). Evaluators therefore need to use actuarial systems that take these factors into account as fully as possible in order to estimate the risk of sexual recidivism. This criterion rules out the use of the MnSOST-R and the SORAG. It also rules out the use of miscellaneous risk factors that are not corrected for age or recidivism reduction.
- E. Two actuarial systems have been developed, however, that take both recidivism decline and the effects of age on recidivism into account. One is the "MATS-I", which is based on the Static-99 risk item battery and an age-stratified experience table disseminated by Hanson (2006) that was corrected by Waggoner, Wollert, and Cramer (2008) in one peer-reviewed article and expanded in a second article (Wollert, Cramer, Waggoner, Skelton,

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& Vess, 2010). The other is based on the Static-99 and Static-2002 risk item batteries and nonstratified tables disseminated by the Static-99 research team (Helmus, Thornton, and Hanson, October 2009; Hanson, Helmus, & Thornton, 2010; Helmus, Thornton, Hanson, & Babchshin, 2011). Both systems have been shown to be reasonably reliable (Helmus, Thornton, & Hanson, October 2009; Hanson, Helmus, & Thornton, 2010; Wollert, August 2007; Wollert et al., 2010). They also overlap one another because they are based on recidivism data collected on some of the same offenders.

F. I scored Mr. Stout on both the MATS-1 and the Static-99R because both have now been published and either one or the other was used by all of the experts who evaluated Mr. Stout most recently. This is redundant in most cases because the published actuarial tables generally point to similar findings.

XI. Testing Question VI.A.3. Indicates That Mr. Stout Can Present Evidence In Support of a Plausible Argument that He Is Unlikely To Sexually Recidivate.

A. The following observations point to this conclusion:

1. I gave Mr. Stout a high range score of "4" on the "ASRS version" of the MATS-1 battery. This score is based on the fact that he has been convicted of 2 sex offenses prior to his index sex offense, has been sentenced on five occasions, and was convicted of a violent nonsexual crime prior to his index offense. The highest score in the high range is an 8. The eight-year sexual recidivism rate for those with scores of 4 more on the MATS-1 who are 50 to 60 years old is 23%.
2. Like Drs. Spizman and Yanisch I gave Mr. Stout a moderately high score of "5" on Static-99R. This score is based on the fact that he has been convicted of 2 sex offenses prior to his index sex offense, has been sentenced on five occasions, was convicted of a violent nonsexual crime prior to his index offense, has committed a sex offense against a nonrelative, and has committed a sex offense against a stranger. One point is subtracted from the total of these scores because Mr. Stout is over 40 years old. The highest score in the high range is a 12. The only published actuarial table for the Static-99R indicates that the five-year sexual recidivism rate for those with scores of 5 is 13.5%.
3. The foregoing results are inconsistent with the state's theory that Mr. Stout is a likely recidivist.

One objection that is sometimes raised in response to this type of negative finding is that it is possible to generate higher recidivism estimates by scoring a respondent on multiple actuarials or attempting to add the effects of "dynamic risk factors" other than age to the scores from multiple actuarials. Studies that have assessed the merits of this hypothesis for evaluating SVPs (Seto, 2005; Vrieze & Grove, 2010; Nunes et al., 2006), however, have consistently rejected it on the grounds that it does not satisfy the "total relevant evidence requirement," which is a fundamental principle of inductive logic (Vrieze & Grove, 2010). As applied to SVP risk

evaluations it requires evaluators who claim that multiple actuarials and dynamic factors can be combined to derive valid risk estimates to produce mathematical evidence in the form of likelihood ratios that supports their practice.

I am unaware of any evidence for an approach that combines multiple actuarials with dynamic risk factors, or for an approach that combines a single actuarial with dynamic risk factors, that meets the total relevant evidence requirement. In contrast, the age stratification approach used in the MATS-1 does meet this requirement (Wollert et al., 2010).

I therefore believe the risk estimate I have advanced for Mr. Stout includes all total relevant evidence. The consideration of other factors would therefore amount to nothing more than clinical judgment, which is notoriously speculative and unreliable.

XII. Testing Question VI.A.4. Indicates That Mr. Stout Can Present Evidence In Support of a Plausible Argument that He Has "So Changed" As A Result of Continuous Participation in Treatment That He Would Be Safe To Be At Large If Unconditionally Released

Mr. Stout has been continuously confined at the SCC since 2001. He was committed in 2003 after it was determined that he had a Mental Abnormality that caused him to be sexually dangerous. He no longer has a Mental Abnormality and is no longer sexually dangerous. Conceptualizing treatment in the least restrictive sense, it is most reasonable to conclude that his current changed condition is attributable to continuously participating in treatment as a result of being in treatment on an ongoing basis. Any other interpretation would make the conditions for being released from civil confinement more restrictive than the conditions for being placed in civil confinement.

XIII. Testing Question VI.A.5. Indicates That Mr. Stout Can Present Evidence In Support of a Plausible Argument that He Has Undergone an Identified and Permanent Physiological Change that Renders Him Unable to Commit a Sexually Violent Act?

Mr. Stout underwent radiation treatments after being diagnosed with prostate cancer in 2010. He has been treated with Depo-Lupron injections for over two years. His self-reported capacity for sexual arousal is minimal. Very few sex offenders over the age of 50 commit new rape offenses. Mr. Stout's physiological changes as a result of cancer, pharmacological treatment, and advancing age have greatly disabled his capacity for sexual arousal. These developments make it very unlikely that he has the libido to commit sexually violent acts in the future.

XIV. Conclusions Regarding the Questions at Issue

- A. Mr. Stout does not currently suffer from a Mental Abnormality.
- B. It is unlikely that he will sexually recidivate as a result of a Mental Abnormality if he is released from confinement.
- C. He has experienced physiological changes as a result of cancer, pharmacological treatment, and advancing age that have greatly disabled his capacity for sexual arousal. It is unlikely that he has the libido to commit sexually violent acts in the future.

I certify and declare under penalty of perjury of the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

Executed at Vancouver, Washington, this 7th day of May, 2013.

Richard Wollert, Ph.D.

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

IN RE THE DETENTION OF)	
)	
)	
ROY STOUT,)	NO. 71343-4-I
)	
)	
APPELLANT.)	

DECLARATION OF DOCUMENT FILING AND SERVICE

I, MARIA ARRANZA RILEY, DECLARE THAT ON THE 26TH DAY OF AUGUST, 2014, I CAUSED THE ORIGINAL **CORRECTED OPENING BRIEF OF APPELLANT** TO BE FILED IN THE **COURT OF APPEALS - DIVISION ONE** AND A TRUE COPY OF THE SAME TO BE SERVED ON THE FOLLOWING IN THE MANNER INDICATED BELOW:

<p>[X] FRED WIST II, AAG [fredw@atg.wa.gov] OFFICE OF THE ATTORNEY GENERAL 800 FIFTH AVENUE, SUITE 2000 SEATTLE, WA 98104-3188</p>	<p>(X) () ()</p>	<p>U.S. MAIL HAND DELIVERY _____</p>
<p>[X] ROY STOUT SPECIAL COMMITMENT CENTER PO BOX 88600 STEILACOOM, WA 98388</p>	<p>(X) () ()</p>	<p>U.S. MAIL HAND DELIVERY _____</p>

SIGNED IN SEATTLE, WASHINGTON THIS 26TH DAY OF AUGUST, 2014.

X _____ 

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