

NOTES

BEYOND NO-MAN'S LAND: PSYCHIATRY'S IMPRECISION REVEALED BY ITS CRITIQUE OF SVP STATUTES AS APPLIED TO PEDOPHILIA

JENNIFER JASON*

I. INTRODUCTION

The field of psychiatry has identified a problem with the law, its source, and suggested a solution. The problem is “legislators . . . us[ing] psychiatric commitment [of sex offenders] to effect nonmedical societal ends.”¹ The source is U.S. Supreme Court decisions allowing legislatures to use definitions of mental illness that have no basis in psychiatry:

As a consequence of U.S. Supreme Court decisions that are written ambiguously and tentatively, the bright line separating . . . [the legal conception of] mental disorder [(for the purposes of civilly committing sex offenders under sexually violent predator statutes)] from ordinary criminal behavior is difficult to draw and tests a *no-man's land* between psychiatry and the law.²

* Class of 2010, University of Southern California Gould School of Law; B.A. Psychology and French 2007, Washington University in St. Louis. I am especially grateful to Professor Camille Gear Rich for instilling in me a passion for thorough legal analysis and for motivating me to push the boundaries. I would also like to thank the editors of the Southern California Law Review for their hard work and excellent feedback. Finally, I would like to thank my family and friends for their unwavering support.

1. AM. PSYCHIATRIC ASS'N, DANGEROUS SEX OFFENDERS: A TASK FORCE REPORT OF THE AMERICAN PSYCHIATRIC ASSOCIATION 174 (1999) [hereinafter TASK FORCE REPORT].

2. Allen Frances, Shoba Sreenivasan & Linda E. Weinberger, *Defining Mental Disorder When*

The solution is “[g]reater clarity and standardization . . . com[ing] from both sides: the legalists who interpret the law and the clinicians who apply and work under it.”³ A close analysis of the psychiatric critique of these statutes that allow for the civil commitment of sex offenders reveals psychiatry’s own imprecision within the bounds of psychiatry and in the domain of the overlap between psychiatry and the law.

Psychiatry believes that the determination of which sex offenders have mental disorders—and thus can constitutionally be placed in civil commitment after prison sentences under sexually violent predator (“SVP”) statutes—is the most “difficult call in all of mental health . . . with [the] greate[st] consequence to the individual and to society.”⁴ This Note considers the psychiatric arguments that critique two Supreme Court decisions in light of the disorder of pedophilia. Unlike other disorders found in the Diagnostic and Statistical Manual of Mental Disorders (“DSM”)⁵—such as “paraphilia not otherwise specified,” which is “the most controversial concept,” or “antisocial personality disorder,” which has “generated much debate”—pedophilia is “the most easily identified and supported mental disorder” leading to civil commitment under SVP statutes.⁶ Further, unlike the disorders mentioned above, pedophilia is not within the no-man’s land between psychiatry and the law; rather, it is clearly within psychiatry’s domain. This Note does not argue whether SVP statutes are constitutional or whether pedophilia is a valid mental disorder

It Really Counts: DSM-IV-TR and SVP/SDP Statutes, 36 J. AM. ACAD. PSYCHIATRY & L. 375, 383 (2008) (emphasis added).

3. *Id.*

4. Allen Frances & Shoba Sreenivasan, Commentary, *Sexually Violent Predator Statutes: The Clinical/Legal Interface*, 25 PSYCHIATRIC TIMES 49, 49 (2008). These assessments have high stakes from other perspectives as well. From a financial perspective, the costs of civil commitment are enormous. The average cost per year of civilly committing an offender is approximately \$144,000 (as opposed to the average yearly cost of imprisonment in a maximum security penal facility, which is approximately \$30,000). TERENCE W. CAMPBELL, ASSESSING SEX OFFENDERS: PROBLEMS AND PITFALLS 12 (Ralph Slovenko ed., 2d ed. 2007). These costs are anticipated to increase in the future—estimates for the Illinois SVP program for a ten-year period were more than \$1 billion. *Id.* at 13 (citing Fred Cohen, *The Law and Sexually Violent Predators: Through the Hendricks Looking Glass*, in CIVIC RESEARCH INST., THE SEXUAL PREDATOR: LAW, POLICY, EVALUATION, AND TREATMENT 1-1, 1-10 (Anita Schlink & Fred Cohen eds., 1999)). From a civil liberties perspective, it has been argued that civil commitment is merely a method to keep sex offenders locked up for a lifetime. Anita Schlink, *The Civil Commitment of Sexual Offenders: Lessons Learned*, in SEXUAL OFFENDER TREATMENT: CONTROVERSIAL ISSUES 45, 50–51 (William L. Marshall et al. eds., 2006).

5. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 571–72 (4th ed., text rev. 2000) [hereinafter DSM].

6. See Frances, Sreenivasan & Weinberger, *supra* note 2, at 379–81.

theoretically.⁷

Part II provides a brief history of SVP statutes, describes the commitment evaluation process, and identifies the psychiatric institutions that are involved in the debate. Part III argues that the psychiatric critique of SVP statutes with respect to pedophilia reveals that the difficulty in distinguishing between who is mentally ill and who is “normal”—for the purposes of these statutes—is not caused by Supreme Court decisions that allow for an overlap between psychiatric and legal conceptions of mental illness, but in fact is caused by psychiatry’s own theoretical and empirical imprecision. Part IV argues that within the “true” realm of no-man’s land, when deciding which individuals who have pedophilia can be constitutionally confined because they lack self-control (an element absent in the psychiatric definition), the psychiatric solutions of a more individualized approach do not assist the law to change because they fail to offer meaningful ways to evaluate pedophiles, both on a theoretical and practical basis. Part V concludes that psychiatry needs to admit its lack of superior knowledge about pedophiles and should concentrate its efforts on researching pedophilia to ensure that only the mentally ill are committed (if they should be committed at all), rather than criticizing legal definitions.

II. SVP STATUTES: THE DIVIDING LINE

States are currently in their second wave of statutes designed to isolate extremely dangerous sex offenders who pose a threat to the safety of society. These statutes were originally entitled “sexual psychopath statutes” and are discussed in Section A. Shortly after the demise of these statutes, a new generation of statutes arose in the 1990s called “sexually violent predator statutes,” which are examined in Section B. These laws are currently in effect. Psychiatric critiques of the civil commitment of pedophiles are based on the threshold standard that determines which

7. Some authors argue that attraction to children is not a disorder because it “is socially and culturally arbitrary, reflecting prevailing social values, attitudes, and biases.” MICHAEL C. SETO, PEDOPHILIA AND SEXUAL OFFENDING AGAINST CHILDREN: THEORY, ASSESSMENT, AND INTERVENTION 13 (2008). These arguments tend to discuss evidence of adult-minor sex in other times or cultures. *See id.* (citing Theo Sandfort, Edward Brongersma & Alex van Naerssen, *Man-Boy Relationships: Different Concepts for a Diversity of Phenomena*, 20 J. HOMOSEXUALITY 5 (1990)). Others argue that if one conceives of a disorder as a biological pathology, a “failing to adequately perform [a] biologically ‘designed’ (naturally selected) function,” then pedophilia qualifies because a preference for prepubescent children interferes with sexual behavior with adults, which would lead to offspring (at least in principle). Robert L. Spitzer & Jerome C. Wakefield, *Why Pedophilia Is a Disorder of Sexual Attraction—At Least Sometimes*, 31 ARCHIVES SEXUAL BEHAV. 499, 499–500 (2002).

individuals should be considered pedophiles and also the subsequent determination of which pedophiles should be committed because they lack self-control. These critiques are explored in Section C.

A. SEXUAL PSYCHOPATH STATUTES

Sexual psychopath statutes, the first version of sexually violent predator statutes, were enacted starting in the 1930s.⁸ The laws were designed in response to several brutal and highly publicized sex and nonsex crimes and the resulting mass hysteria.⁹ Newspapers contributed to the fear by publishing articles detailing how “[c]hildren in alarming numbers have been the victims of molesters, exhibitionists, perverts, and pedophiles. The sex hoodlum, hanging around schools with comic books and bubble gum to lure his victim, has imbued parents with a stark new fear.”¹⁰ These sex offenses were perceived as being violent, extreme, and linked by a common denominator: an offender who was a sexual psychopath.¹¹

The timing of the outbreak in the media about sex offenses coincided with a shift in legislation to medical explanations for criminal behavior.¹² The criminal justice system changed its focus from a punishment-based system to a rehabilitative-based system, best accomplished by indefinite confinement and treatment of certain criminals.¹³ Psychiatry and the law agreed that sexual psychopaths needed treatment for an overall condition rather than deserving punishment for a particular crime.¹⁴ The goal of sexual psychopath statutes was to identify sex offenders amenable to treatment and to place them in psychiatric hospitals rather than prisons.¹⁵

Although experts in psychiatry agreed on the existence of sexual psychopaths, they disagreed about how to characterize or identify this particular type of individual.¹⁶ One therapist characterized sexual

8. See, e.g., Frances, Sreenivasan & Weinberger, *supra* note 2, at 376.

9. PHILIP JENKINS, MORAL PANIC: CHANGING CONCEPTS OF THE CHILD MOLESTER IN MODERN AMERICA 52 (1998).

10. *Id.* at 53.

11. See *id.* at 60.

12. See Deborah W. Denno, *Life Before the Modern Sex Offender Statutes*, 92 NW. U. L. REV. 1317, 1343 (1998).

13. See Laura Barnickol, *Missouri's Sexually Violent Predator Law: Treatment or Punishment?*, 4 WASH. U. J.L. & POL'Y 321, 323–24 (2000); Samuel Jan Brakel & James L. Cavanaugh, Jr., *Of Psychopaths and Pendulums: Legal and Psychiatric Treatment of Sex Offenders in the United States*, 30 N.M.L. REV. 69, 70 (2000).

14. See JENKINS, *supra* note 9, at 76.

15. Frances, Sreenivasan & Weinberger, *supra* note 2, at 376.

16. JENKINS, *supra* note 9, at 59.

psychopaths as “anyone who is a queer guy, the fellow that does not fit, he is a psychopath.”¹⁷ An institutional psychiatrist commented, “I have lived with the criminal for 24 years, and I know there is the psychopathic individual, but I just cannot describe him.”¹⁸ Despite the uncertainty of experts, the *Saturday Evening Post* claimed to the public that the “psychopathic personality can easily be detected early in life by any psychiatrist” and legislation designed to capture these psychopaths would be easy to draft.¹⁹

The psychiatric profession grew immensely both in size and prestige during this time.²⁰ The American Psychological Association grew from 2739 members in 1940 to 30,839 members in 1970. During the same time, the American Psychiatric Association expanded from 2423 members to 18,407 members.²¹ Psychiatrists played a crucial role in disseminating their expertise regarding sexual psychopaths to lawyers, judges, police, clergy, parents, and teachers.²²

Optimism prevailed that there was an ability to identify and treat this amorphous group of sex offenders.²³ Between 1937 and 1957, thirty states and the District of Columbia enacted sexual psychopath statutes.²⁴ The terminology and procedures varied from state to state,²⁵ but usually the individual was not released until he or she was fully treated or no longer a menace to society.²⁶ Psychiatrists were the key contributors to the sexual psychopath legislation.²⁷ Overall, there was a substantial consensus between the law and psychiatry regarding the workings and objectives of

17. *Id.* at 60.

18. *Id.* This statement is akin to Justice Stewart’s definition of pornography in *Jacobellis v. Ohio*, “I know it when I see it.” *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964) (Stewart, J., concurring).

19. JENKINS, *supra* note 9, at 60.

20. *See id.* at 73. This growth was also due to the role psychiatrists played during wartime in screening and managing the millions of people mobilized for military service. *Id.*

21. *Id.*

22. *See id.*

23. Brakel & Cavanaugh, *supra* note 13, at 71. This group of sex offenders included homosexuals, peepers, exhibitionists, and fetishists. Denno, *supra* note 12, at 1353 (referring to OHIO REV. CODE ANN. §§ 2947.24–.29 (West 1958)).

24. Denno, *supra* note 12, at 1351 (citing GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, COMM. ON PSYCHIATRY & LAW, PSYCHIATRY AND SEX PSYCHOPATH LEGISLATION: THE 30S TO THE 80S 853 (1977)).

25. *See* JENKINS, *supra* note 9, at 83. Sex offenses other than child molestation were also included, such as a nonaggressive homosexual convicted of passing bad checks and engaging in homosexual sex. *Id.* at 86.

26. *See* Denno, *supra* note 12, at 1352.

27. *Id.* at 1350 (citing Edwin H. Sutherland, *The Diffusion of Sexual Psychopath Laws*, 56 AM. J. SOC. 142, 145 (1952)).

these statutes.²⁸

The demise of the sexual psychopath laws began with the loss of the intradisciplinary approach of the laws.²⁹ On the psychiatry side, some psychiatrists complained that the legislation ignored the psychiatric knowledge; others protested that individuals were being sacrificed to therapeutic fads.³⁰ Psychiatrists reported that children were not even necessarily harmed by the behavior—that molested children who showed symptoms of being disturbed were disturbed before the sexual behavior took place and that this disturbed behavior perhaps even contributed to their being molested.³¹ Further, several cases arose in which it was determined that children had lied about being molested.³² The problem suddenly became the public hysteria surrounding the behaviors and the false accusations, rather than the behaviors themselves.³³ On the legal side, the law shifted to a more punitive approach and less of a compassionate, rehabilitation-oriented approach.³⁴ This punitive, incapacitation approach included a trend away from indeterminate prison sentences, which was thought to increase fairness.³⁵

Several Supreme Court decisions contributed to the demise of sexual psychopath statutes, though the message was somewhat indirect.³⁶ In 1967, the Court decided *Specht v. Patterson*, which involved a man who was convicted of taking “indecent liberties” with a child.³⁷ The Court refused to agree with the State’s contention that commitment under the statute was akin to a sentencing decision that required little formal process, but rather required most, if not all, of the procedural safeguards of a criminal trial.³⁸ In 1973, the district court in *Davy v. Sullivan*, following *Specht*, struck down Alabama’s statute on the grounds that its standard for release was impossibly high, given that it required a “full and permanent recovery”

28. Brakel & Cavanaugh, *supra* note 13, at 72 (citing Edwin H. Sutherland, *The Sexual Psychopath Laws*, 40 J. CRIM. L. & CRIMINOLOGY 547 (1950)).

29. *See id.* at 73 (citing SAMUEL J. BRAKEL & RONALD S. ROCK, *THE MENTALLY DISABLED AND THE LAW* 348–57 (ABA rev. ed. 1971)).

30. JENKINS, *supra* note 9, at 91–92.

31. *See id.* at 104. Some researchers commented that seductive children should not be viewed as victims because the children themselves were responsible for tempting the offender. *See id.* at 105.

32. *See id.* at 94–97.

33. *See id.*

34. Brakel & Cavanaugh, *supra* note 13, at 73.

35. *See* Frances, Sreenivasan & Weinberger, *supra* note 2, at 376.

36. Brakel & Cavanaugh, *supra* note 13, at 73.

37. *See Specht v. Patterson*, 386 U.S. 605, 607 (1967).

38. *Id.* at 609–10.

from psychopathy.³⁹ By the 1980s, most sexual psychopath laws were repealed⁴⁰ because the legislation regarding sex offenders became the problem rather than the offenders themselves.⁴¹

B. SEXUALLY VIOLENT PREDATOR STATUTES

Statutes designed to address the same problem were revived in the 1990s, again in response to highly publicized crimes against children by sex offenders who had been released from prison.⁴² In 1990, Washington was the first state to enact a sexually violent predator statute. It did so in response to the actions of a man named Earl Shriener who, after being released from ten years in prison for kidnapping and sexually assaulting two teenage girls, raped a seven-year-old boy and cut off his penis.⁴³ Legislators in other states, outraged that a man this dangerous (and others like him) could be on the loose, passed their own versions of SVP statutes.⁴⁴ Currently, twenty states and the District of Columbia have enacted SVP statutes.⁴⁵ SVP statutes target individuals who pose a threat to society because of an illness that makes them likely to commit a sexual act again in the future.⁴⁶ Under these statutes, an SVP is typically defined as “any person who has been convicted of or charged with a sexually violent offense and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence.”⁴⁷ Unlike their predecessors, this wave of sex offender statutes places offenders in civil commitment *after* incarceration, rather than as a replacement to incarceration. Offenders are kept in treatment until they no longer meet the SVP criteria; that is, until they no longer pose a threat to

39. *Davy v. Sullivan*, 354 F. Supp. 1320, 1329 (M.D. Ala. 1973).

40. *See* Frances, Sreenivasan & Weinberger, *supra* note 2, at 376.

41. JENKINS, *supra* note 9, at 117.

42. *See* Brakel & Cavanaugh, *supra* note 13, at 75.

43. *See id.*

44. *See id.*

45. These states include Arizona, California, Florida, Illinois, Iowa, Kansas, Massachusetts, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Dakota, Pennsylvania, South Carolina, Texas, Virginia, Washington, and Wisconsin. CAMPBELL, *supra* note 4, at 4. Texas's statute is the only one that places sex offenders in supervised community settings. *Id.*

46. *See* William D. Murphy, *Management and Treatment of the Adult Sexual Offender*, in *SEXUALIZED VIOLENCE AGAINST WOMEN AND CHILDREN: A PSYCHOLOGY AND LAW PERSPECTIVE* 217, 232 (B.J. Cling ed., 2004).

47. Aman Ahluwalia, *Civil Commitment of Sexually Violent Predators: The Search for a Limiting Principle*, 4 CARDOZO PUB. L. POL'Y & ETHICS J. 489, 507 (2006) (citing KAN. STAT. ANN. § 59-29a02(a) (2005)).

society.⁴⁸

The civil commitment procedure is similar in most states.⁴⁹ Specifically, the state's department of corrections notifies prosecutors of the impending prison releases of all sex offenders who are potentially eligible for civil commitment.⁵⁰ Typically the decision to pursue commitment is made by the prosecutors, not by evaluators or other agencies,⁵¹ and the commitment process is initiated approximately ninety days prior to the offender's anticipated discharge.⁵² Prison officials or other authorities prescreen the offenders based solely on a review of the offenders' records and submit lists of potential SVPs to the applicable court.⁵³ If the court determines that there is a probable cause that a particular offender is an SVP, the offender is then examined for a mental illness.⁵⁴

Ultimately, it is the judge or the jury who decides whether an offender is an SVP based on the expert evidence provided by the forensic examiners.⁵⁵ Clinicians may serve as consultants to the court but are typically dissuaded from addressing the final question of whether the offender qualifies as an SVP.⁵⁶ Once offenders are civilly committed, they are entitled to reexaminations, typically administered annually, in order to determine whether they are eligible for release.⁵⁷

The entire SVP evaluation normally involves four steps.⁵⁸ In the first step, the State must prove that the offender has been convicted of a sexually violent offense.⁵⁹ "Violent" sexual acts include physically violent sexual acts, such as rape, and coercive acts, such as engaging in a sexual

48. See Brakel & Cavanaugh, *supra* note 13, at 83.

49. See John Matthew Fabian, *The Risky Business of Conducting Risk Assessments for Those Already Civilly Committed as Sexually Violent Predators*, 32 WM. MITCHELL L. REV. 81, 96-97 (2005).

50. *Id.* at 96.

51. *Id.* (citing DENNIS M. DOREN, *EVALUATING SEX OFFENDERS: A MANUAL FOR CIVIL COMMITMENTS AND BEYOND* 5 (2002)).

52. Brakel & Cavanaugh, *supra* note 13, at 78.

53. A small percentage get interviews. See *id.* at 79.

54. See Fabian, *supra* note 49, at 96.

55. Cynthia Calkins Mercado, Robert F. Schopp & Brian H. Bornstein, *Evaluating Sex Offenders Under Sexually Violent Predator Laws: How Might Mental Health Professionals Conceptualize the Notion of Volitional Impairment?*, 10 AGGRESSION & VIOLENT BEHAV. 289, 295 (2005).

56. See *id.*

57. Fabian, *supra* note 49, at 97. The trend for reexaminations is a separation of the treatment team and the examiners. See *id.* at 100.

58. See CAMPBELL, *supra* note 4, at 5.

59. *Id.*

act with a child.⁶⁰ This requirement is already met by the time the offender is at the hearing.⁶¹

In the second step, the State must prove that the offender has a mental illness (a mental abnormality or personality disorder) that predisposes him or her to committing violent sexual acts.⁶² The Supreme Court held in *Kansas v. Hendricks* that state legislatures may create their own definitions of mental illness rather than relying on psychiatric terminology.⁶³ Despite having a legislative-based definition of mental illness (“mental abnormality”), the states rely on psychologists or psychiatrists (who refer to mental illness as a “mental disorder”) for the actual substantiation of the mental illness.⁶⁴ Offenders may be examined by an evaluator of their choice in addition to the evaluator assigned to the case by the State.⁶⁵ Several different diagnoses, such as antisocial personality disorder, are used to justify civil commitment, but pedophilia is one of the most common diagnoses in SVP civil commitment cases.⁶⁶ For example, approximately 76 of 120 men (63 percent) who were civilly committed in Arizona in 2003 were diagnosed with pedophilia, and 143 of 242 men (more than 59 percent) who were civilly committed in Wisconsin in 2005 were diagnosed

60. Some argue that not all relationships between children and adults are problematic or coercive. See, e.g., Gerald P. Jones, *The Study of Intergenerational Intimacy in North America: Beyond Politics and Pedophilia*, in MALE INTERGENERATIONAL INTIMACY: HISTORICAL, SOCIO-PSYCHOLOGICAL, AND LEGAL PERSPECTIVES 275, 277 (Theo Sandfort, Edward Brongersma & Alex van Naerssen eds., 1991) (using the terminology “intergenerational intimacy” to describe close relationships between adults and children that do not necessarily result in harm to the child).

61. Brakel & Cavanaugh, *supra* note 13, at 79.

62. CAMPBELL, *supra* note 4, at 5. Note that “[t]reatability is not a requirement of the statutes.” Frances & Sreenivasan, *supra* note 4, at 49.

63. *Kansas v. Hendricks*, 521 U.S. 346, 356 (1997).

64. See Richard Wollert, *Poor Diagnostic Reliability, the Null-Bayes Logic Model, and Their Implications for Sexually Violent Predator Evaluations*, 13 PSYCHOL. PUB. POL’Y & L. 167, 176 (2007). The evaluator must also establish that the mental abnormality, mental disorder, or both is the cause of the sexual offense. The first part of the causality analysis is to make sure that the sex offenses are in harmony with the diagnosis—child molestations accompanied by a diagnosis of pedophilia satisfies this element. The second part of the causality analysis is to rule out all other possible explanations for the behavior, such as other mental disorders or nondisorder conditions. The issue with the pedophilia diagnosis for psychiatry seems to be the necessity of establishing that it is the pedophilic arousal pattern that has caused the behavior, rather than stress or some other nonmental illness related cause. The causality issue is addressed throughout this Note, and a separate analysis is relevant for other psychiatric disorders, such as antisocial personality disorder. Michael B. First & Robert L. Halon, *Use of DSM Paraphilia Diagnoses in Sexually Violent Predator Commitment Cases*, 36 J. AM. ACAD. PSYCHIATRY L. 443, 446–48 (2008).

65. Fabian, *supra* note 49, at 96.

66. Thomas K. Zander, *Civil Commitment Without Psychosis: The Law’s Reliance on the Weakest Links in Psychodiagnosis*, 1 J. SEXUAL OFFENDER CIV. COMMITMENT: SCI. & L. 17, 36 (2005).

with pedophilia.⁶⁷

In the third step, the State must prove that the mental abnormality or personality disorder impairs the offender's volitional control, known as "volitional impairment."⁶⁸ The exact level of difficulty in controlling impulses to commit future sex crimes was not defined precisely⁶⁹ in the Supreme Court case that added this step, *Kansas v. Crane*.⁷⁰ Although the volitional impairment notion is technically a separate step, in practice it is usually combined with the next step, the dangerousness analysis.⁷¹

The fourth step, the dangerousness analysis, asks whether the offender (if not committed and treated) is *likely* to reoffend as a result of the mental abnormality.⁷² The exact way to translate the term "likely" into a practical assessment has never been made clear.⁷³ In practice, the civil commitment of pedophiles is highly reliant on the dangerousness assessment; establishing some sort of likelihood of recidivism in the pedophile is extremely important.⁷⁴ Risk assessment has been referred to as "the mother of all uncertainties" because humans have a limited ability to assess future risk of harmful behavior and the future is inherently unknowable.⁷⁵ The likelihood to commit another violent sexual act in the future is demonstrated by a risk assessment provided by both a forensic examination unit and the defendant's retained expert.⁷⁶

There are two basic approaches to risk assessment: clinical and

67. *See id.*

68. CAMPBELL, *supra* note 4, at 5.

69. *See* First & Halon, *supra* note 64, at 450.

70. *Kansas v. Crane*, 534 U.S. 407 (2002).

71. *See* First & Halon, *supra* note 64, at 450.

72. CAMPBELL, *supra* note 4, at 5. The language of the risk threshold in state statutes is typically "likely" (for example, Arizona, California, Florida, Kansas), but some states use other language such as "more likely than not" (Iowa) or "substantially probable" (Wisconsin). *See* Shoba Sreenivasan, Linda E. Weinberger & Thomas Garrick, *Expert Testimony in Sexually Violent Predator Commitments: Conceptualizing Legal Standards of "Mental Disorder" and "Likely to Reoffend,"* 31 J. AM. ACAD. PSYCHIATRY L. 471, 478 (2003).

73. *See* Sreenivasan, Weinberger & Garrick, *supra* note 72, at 478.

74. *See* Ahluwalia, *supra* note 47, at 524.

75. Robert A. Prentky et al., *Sexually Violent Predators in the Courtroom: Science on Trial*, 12 PSYCHOL. PUB. POL'Y & L. 357, 371 (2006) (citing John C. Bailer III & A. John Bailer, *Risk Assessment—The Mother of All Uncertainties: Disciplinary Perspectives on Uncertainty in Risk Assessment*, 895 ANNALS N.Y. ACAD. SCIS. 273, 273 (1999)).

76. *See* Fabian, *supra* note 49, at 100; Daniel C. Murrie et al., *Does Interrater (Dis)agreement on Psychopathy Checklist Scores in Sexually Violent Predator Trials Suggest Partisan Allegiance in Forensic Evaluations?*, 32 LAW & HUM. BEHAV. 352, 353 (2008) (discussing evaluators' use of Hare's Psychopathy Checklist-Revised for risk assessment).

actuarial.⁷⁷ Clinical prediction “relies on the subjective judgment of experienced decisionmakers—typically . . . psychologists and psychiatrists.”⁷⁸ Actuarial risk assessment relies on rules specifying which risk factors are to be measured, how they are to be scored, and how the scores are to be combined mathematically to yield an objective estimate of risk.⁷⁹ Although clinical risk predictions have been held valid repeatedly by courts,⁸⁰ actuarial risk assessment is overwhelmingly recognized as superior⁸¹ and is becoming more prevalent in courts despite various shortcomings that have been identified.⁸² Actuarial scales are developed by analyzing statistics of groups of sex offenders and their rates of arrest or conviction for a new sex offense or other offense during a defined follow-up period.⁸³

C. PSYCHIATRIC STATEMENTS

Psychiatry's critiques of the two seminal Supreme Court SVP cases are the mental abnormality definition as applied to pedophilia, which distinguishes between those who can and cannot meet the first threshold for civil commitment, and the definition and measurement of volitional impairment (lack of self-control), which determines which of the

77. John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm Among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 405 (2006).

78. *See id.*

79. *See id.* at 405–06 (citing Barbara D. Underwood, *Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment*, 88 YALE L.J. 1408, 1420–22 (1979)). Since experts for both sides have access to the same materials (the case file of correctional and law enforcement materials), it would be assumed that the evaluators, despite the adversarial nature of the process, would present very similar results. *See* Murrie et al., *supra* note 76, at 355. Researchers have started to analyze the statistical relationships of risk assessment scores between adversarial evaluators. *See id.* at 358 (discussing the first published study addressing interrater agreement for a particular type of psychopathy risk assessment).

80. *See* Monahan, *supra* note 77, at 407.

81. *See id.* at 408 (citing PAUL E. MEEHL, *CLINICAL VERSUS STATISTICAL PREDICTION: A THEORETICAL ANALYSIS AND A REVIEW OF THE EVIDENCE* (1954)).

82. *See* Prentky et al., *supra* note 75, at 370–72; Fabian, *supra* note 49, at 116 (citing TERENCE W. CAMPBELL, *ASSESSING SEX OFFENDERS: PROBLEMS AND PITFALLS* 80–109 (2004)).

83. *See* Prentky et al., *supra* note 75, at 373. The three most commonly used tests are the Static-99, the Rapid Risk Assessment for Sex Offender Recidivism, and the Minnesota Sex Offender Screening Tool-Revised. Fabian, *supra* note 49, at 115. With the Static-99, a forensic examiner gives the offender points for individual items and compiles the points for a total score ranging from zero (least likely to reoffend) to greater than six (most likely to reoffend). A score of four, for example, places the offender in a category of “moderate-high” likelihood to reoffend. One item on the ten-item test is age. An eighteen- to twenty-five-year-old is given one point for the item and a twenty-five-year-old or older is given zero points because, based on studies by the test's creator, Karl Hanson, sexual recidivism is more likely in an offender's early years than in his or her later years. *See id.* at 152–53.

individuals diagnosed with pedophilia are eligible for civil commitment.

Organized criticism of the distinction between mental illness and ordinary criminality began with an American Psychiatric Association (“APA”)⁸⁴ Task Force report that “present[ed] a blistering critique of SVP statutes” out of concern “that psychiatric commitment is being misused to cover a sentencing loophole created by the legal system,”⁸⁵ a loophole that allows for the commitment of individuals without legitimate psychiatric diagnoses. The APA and state psychiatric associations have commented as to the problem in their amicus briefs in *Hendricks*, the case regarding this distinction.⁸⁶ More recently, the editors of the DSM have published several statements with more specific concerns as to which DSM diagnoses can be used for commitment.⁸⁷

With respect to the issue of volitional impairment, there have been very limited “official” statements. The APA argued in an amicus brief in *Crane* that the volitional impairment notion is conceptually vague and difficult to apply and recommended instead that a more extreme conception of a complete lack of self-control should be used.⁸⁸ The editors of the DSM have also made statements regarding the problem of assuming lack of volitional impairment because of a diagnosis of pedophilia (or any DSM disorder for that matter).⁸⁹

In general, psychiatry believes the problem of reconciling the different purposes of psychiatry and the law must be solved by standardization.⁹⁰ In terms of its own community, psychiatry recommends “a careful examination and articulation of the fit between DSM . . . diagnoses and qualifying SVP[] mental disorders.”⁹¹ Most of its arguments, however,

84. The APA is a national group that advocates on behalf of patients, psychiatrists, and the psychiatry profession.

85. Frances & Sreenivasan, *supra* note 4, at 49.

86. See, e.g., Brief for The APA as Amicus Curiae in Support of Leroy Hendricks, *Kansas v. Hendricks*, 521 U.S. 346 (1997) (Nos. 95-1649, 95-9075), 1995 U.S. Briefs 1649; Brief of Amicus Curiae State of Wisconsin in Support of Petitioner and Cross-Respondent, *Hendricks*, 521 U.S. 346 (Nos. 95-1649, 95-9075), 1995 U.S. Briefs 1649; Brief of Amicus Curiae Washington State Psychiatric Association in Support of Respondent, *Hendricks*, 521 U.S. 346 (Nos. 95-1649, 95-9075), 1995 U.S. Briefs 1649.

87. See, e.g., Frances & Sreenivasan, *supra* note 4, at 49.

88. Brief for the Am. Psychiatric Ass’n & Am. Acad. of Psychiatry & the Law as Amici Curiae in Support of Respondent at 1, *Kansas v. Crane*, 534 U.S. 407 (2002) (No. 00-957), 2001 U.S. Ct. Briefs LEXIS 763 [hereinafter Brief for the APA in Support of Respondent].

89. See First & Halon, *supra* note 64, at 450.

90. See Frances, Sreenivasan & Weinberger, *supra* note 2, at 383.

91. *Id.*

focus on the shortcomings of the law. It hopes “that a variety of cases make it to the state and federal courts to determine the constitutionality of civil commitment for various diagnoses currently under consideration”⁹² because “[l]egislative 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 . . . support the need for public safety.”⁹³ In waiting for these court decisions, it suggests that “[i]n the meantime, it is crucial for the forensic professions to achieve a national consensus on how best to determine what qualifies as an SVP . . . mental disorder.”⁹⁴ Its arguments regarding how to solve the problem on a more practical level tend to focus on a more global approach to measuring the requisite steps of the SVP analysis (in terms of breadth of measurement tools) and a more individualized approach by using direct assessment (meaning conducting interviews with the particular pedophile instead of using statistical analysis).⁹⁵

Because pedophilia is not in the no-man’s land between psychiatry and the law, and because there is no reason to wait for clarifying court decisions, analysis of the psychiatric criticism of the legislative conception of mental illness reveals that psychiatry does not have a precise definition of pedophilia for its own purposes, nor has it provided the law with any sort of adequate substitution for its current practices. Moreover, in the domain of no-man’s land, psychiatric suggestions do not provide the law with concrete, valuable ways to improve.

III. MENTAL ILLNESS: PSYCHIATRY’S DOMAIN

Psychiatry’s first problem with the law comes from *Hendricks*, in which the Supreme Court held that state legislatures’ definitions of mental illness for the purposes of SVP statutes do not have to correspond to psychiatric definitions.⁹⁶ Psychiatry argues that these legal definitions lead to the commitment of individuals who, despite having been convicted of having sex with children, do not have a valid diagnosis of pedophilia.⁹⁷ It

92. Frances & Sreenivasan, *supra* note 4, at 49.

93. Frances, Sreenivasan & Weinberger, *supra* note 2, at 383.

94. Frances & Sreenivasan, *supra* note 4, at 49.

95. First & Halon, *supra* note 64, at 450. Also, psychiatry would like more transparency from forensic examiners—specifically, information regarding why a particular individual was given a diagnosis. *Id.*

96. *Kansas v. Hendricks*, 521 U.S. 346, 360 & n.3 (1997).

97. Michael B. First & Allen Frances, *Issues for DSM-V: Unintended Consequences of Small Changes: The Case of Paraphilias*, 165 AM. J. PSYCHIATRY 1240, 1240 (2008).

asserts that there is a difference between those with pedophilia and those who are “ordinary criminal[s],” and that the latter are being committed because the State is not required to prove the indispensable component of pedophilia: a pattern of arousal to children.⁹⁸ A closer look at psychiatry’s alternative definition and measurement suggestions, however, reveals that the true problem for the diagnosis of pedophilia is the imprecision of psychiatry as to its own definition from both a theoretical and practical standpoint.

A. *KANSAS V. HENDRICKS*⁹⁹

The seminal Supreme Court case *Kansas v. Hendricks* held that state legislatures may define mental illness without strict adherence to psychiatric terminology and denied that the purpose of SVP statutes is punishment.¹⁰⁰ In *Hendricks*, the Court upheld Kansas’s Sexually Violent Predator Act—which provided for the civil commitment of individuals who had been convicted of or charged with a “sexually violent offense” and who suffered from a “mental abnormality” or “personality disorder” that made them “likely to engage in . . . predatory acts of sexual violence”—against constitutional challenges under the Fourteenth Amendment’s substantive due process and the Fifth Amendment’s Ex Post Facto and Double Jeopardy Clauses.¹⁰¹

Leroy Hendricks pled guilty to taking “indecent liberties” with two thirteen-year-old boys and admitted that he could not control his urges to engage in sexual behavior with children when he got “stressed out.”¹⁰² At trial, the state psychologist testified that although Hendricks did not suffer from a personality disorder and was not mentally ill, he suffered from pedophilia (a “mental abnormality”).¹⁰³ He stated that Hendricks was likely to engage in future sexual acts with children if permitted to do so because “behavior is a good predictor of future behavior.”¹⁰⁴ Although a forensic psychiatrist testified on Hendricks’s behalf that “a psychiatrist or

98. *See id.*

99. The discussion that appears in Part III.A, is adapted from the author’s seminar paper written for Camille Gear Rich’s class in fall 2008. *See generally* Jennifer Jason, “Us” Versus “Them”: A Foucaultian Analysis of Pedophiles, Psychiatry, and the Law (Dec. 19, 2008) (on file with author).

100. *See Hendricks*, 521 U.S. at 371.

101. *See id.* at 350–52, 371 (quoting KAN. STAT. ANN. § 59-29a02(a) (1994)).

102. *See In re Hendricks*, 912 P.2d 129, 131 (Kan. 1996), *rev’d*, *Hendricks*, 521 U.S. at 396. He stated that the only way he could keep from sexually abusing children in the future was “to die.” *Id.* at 143.

103. *Id.* at 131.

104. *Id.*

psychologist cannot predict whether an individual is more likely than not to engage in a future act of sexual predation,” the jury nevertheless found that Hendricks was an SVP.¹⁰⁵

Hendricks then appealed to the Kansas Supreme Court, claiming the statute violated the Fourteenth Amendment, based on substantive due process, and the Fifth Amendment, based on the Ex Post Facto and Double Jeopardy Clauses. The Kansas Supreme Court reversed the decision, finding that the SVP statute violated Hendricks's substantive due process rights by committing him for having a mere mental “abnormality” rather than a mental “illness,” the requirement for civil commitment of individuals other than SVPs.¹⁰⁶

The U.S. Supreme Court reversed the Kansas Supreme Court's decision, holding that Hendricks's substantive due process rights were not violated and that the criminal charges, violation of the Ex Post Facto and Double Jeopardy Clauses of the Fifth Amendment, did not apply because the statute was civil rather than criminal or punitive in nature.¹⁰⁷

The Court's first major holding was to approve a more expansive category of those who could qualify as SVPs—from those with “mental illnesses” to those with a “mental abnormality” or “personality disorder.”¹⁰⁸ Sexual disorders, such as pedophilia, were not included in the mentally ill category at the time but were included in the mentally abnormal category. In addressing the substantive due process claim, Justice Thomas, writing for the majority, stated that Kansas's SVP civil commitment statute was not inconsistent with the other civil commitment statutes (of non-SVPs), which required a finding that the person was mentally ill and posed a danger to himself or herself or to others.¹⁰⁹ The SVP civil commitment statute defined “mentally abnormal” as a “congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such person a menace to the health and safety of others.”¹¹⁰ According to the Court, the “mentally abnormal” aspect of the SVP statute was appropriate because the states are able to define the level of mental illness however they choose for

105. *Id.*

106. *See id.* at 137. The court did not address the criminal charges.

107. *See Hendricks*, 521 U.S. at 370–71.

108. *See id.* at 358.

109. *See id.*

110. *Id.* at 352 (quoting KAN. STAT. ANN. § 59-29a02(b) (1994)). The term “personality disorder” is not defined by the statutes and is not relevant for the purposes of this Note.

the purposes of civil commitment so long as the definition is sufficiently limiting.¹¹¹ The Court held that the State's characterization of Hendricks as an SVP was constitutional because there was proof of a mental abnormality (pedophilia) coupled with proof of dangerousness¹¹² (his admitted lack of volitional control when "stressed out" that made him likely to engage in a violent sexual offense in the future).¹¹³

Despite the fact that the Court technically expanded the category of individuals who could qualify for civil commitment from those who are "mentally ill" to those who have a "mental abnormality," it claimed the distinction was merely semantics because "the term 'mental illness' is devoid of any talismanic significance."¹¹⁴ The Court reinforced the concept that the precise terminology of mental abnormality or mental illness does not matter: "Not only do 'psychiatrists disagree widely and frequently on what constitutes mental illness,' but the Court itself has used a variety of expressions to describe the mental condition of those properly subject to civil confinement."¹¹⁵ In reality, this supposed semantic change had the effect of distinguishing the law's category of mental illness from psychiatry's category because the term "mental abnormality" is not a psychiatric term. Even though the Court emphasized that the legislature was not required to define its statute in terms of psychiatric definitions, it ultimately showed the inextricable connection between psychiatry and the law in concluding its substantive due process analysis by justifying Hendricks's commitment because mental health professionals had diagnosed him with pedophilia, "a condition the psychiatric profession itself classifies as a serious mental disorder."¹¹⁶

The second major holding was to announce that the purpose of the statute was not punitive (thus not criminal), but merely to "hold the person until his mental abnormality no longer causes him to be a threat to

111. *See id.* at 359 ("Indeed, we have never required state legislatures to adopt any particular nomenclature in drafting civil commitment statutes. Rather, we have traditionally left to legislators the task of defining terms of a medical nature that have legal significance.").

112. *See id.* at 357–58 (citing *Heller v. Doe*, 509 U.S. 312, 314–15 (1993)).

113. *See id.* at 360. Hendricks, now seventy-five, is currently still in civil commitment in Kansas. Monica Davey & Abby Goodnough, *Doubts Rise as States Hold Sex Offenders After Prison*, N.Y. TIMES, Mar. 4, 2007, § 1, at 1. As of 2007, it costs Kansas \$185,000 per year to commit him and he spends most days in a wheelchair because of diabetes, circulation ailments, and the effects of a stroke.

Id.

114. *Hendricks*, 521 U.S. at 359.

115. *Id.* (quoting *Ake v. Oklahoma*, 470 U.S. 68, 81 (1985)).

116. *Id.* at 360.

others.”¹¹⁷ The SVP statute was not retributive, according to the Court, because culpability under the statute is not dependent on prior criminal conduct.¹¹⁸ Such conduct is used only to demonstrate a mental abnormality or to support a finding of future dangerousness, and the conduct does not necessarily have to be criminal. Furthermore, the commitment process hinges on a mental abnormality or personality disorder, which means there is no scienter requirement, unlike most criminal statutes. The intent of the SVP statute was not deterrence either, because by definition the people being committed are not able to control themselves due to their mental abnormalities or personality disorders.¹¹⁹ Thus, it does not serve the purpose of stopping these people in the future. The conditions of the commitment centers are more akin to mental institutions than to prisons, the Court reasoned.¹²⁰ This decision had the result of facially barring the criminal claims of ex post facto and double jeopardy.¹²¹ It also implies that similar SVP statutes are similarly not criminal.

B. PSYCHIATRIC CRITIQUE AND SUGGESTIONS

Psychiatry opposes the principles of *Hendricks*, arguing that legislative-based definitions of mental illness lead to the civil commitment of individuals who are not mentally ill. Psychiatry asserts that not only is the legislative definition of mental illness as any “mental abnormality” circular on its face, but also that it is overinclusive as applied to pedophilia because it treats individuals who do not fantasize about children as mentally ill.

1. All Individuals with Pedophilia Have Fantasies

Psychiatric associations vehemently oppose the legislatures’ “mental abnormality” conception of mental illness, protesting that it leads to the nonmedical use of civil commitment.¹²² These psychiatric arguments come in the form of amicus briefs in *Hendricks*¹²³ and position statements to

117. *See id.* at 363.

118. *Id.* at 362.

119. *See id.*

120. *See id.* at 363.

121. *See id.* at 370–71.

122. TASK FORCE REPORT, *supra* note 1, at 173.

123. *See* Brief for the Am. Psychiatric Ass’n as Amicus Curiae in Support of Leroy Hendricks, *Kansas v. Hendricks*, 521 U.S. 346 (1997) (No. 95-1649), 1996 U.S. S. Ct. Briefs LEXIS 510 [hereinafter Brief for the APA in Support of Hendricks]; Brief of Amicus Curiae Washington State Psychiatric Ass’n in Support of Respondent, *Hendricks*, 521 U.S. 346 (No. 95-1649), 1996 U.S. S. Ct. Briefs LEXIS 526 [hereinafter Brief of WSPA in Support of Respondent].

legislatures. A task force of the APA released a statement two years after the decision in *Hendricks* announcing its opposition to SVP statutes.¹²⁴ This statement was followed by the support of several district branches of the Association in the form of position statements,¹²⁵ with the exception of the New Jersey Psychiatric Association, which chose to support the SVP statute because “it was better . . . to provide [psychiatric] input and have a role because [psychiatrists] are the most qualified to diagnose and treat this population.”¹²⁶

Psychiatric associations oppose using legislative-based definitions of mental illness in the first step of the SVP evaluation, explaining that “although the terms ‘mental abnormality’ and ‘mental illness’ appear synonymous, ‘mental abnormality’ . . . has no scientific or clinical basis” and consequently “most SVPs do not have a legitimate psychiatric diagnosis.”¹²⁷ In its amicus brief for *Hendricks*, the APA argued that “[i]f ‘mental illness’ were freely subject to legislative definition (through new terms like ‘mental abnormality’ or otherwise),” then “anyone ‘crazy’ or ‘sick’ enough to engage in repeated serious offenses could be civilly confined for that reason.”¹²⁸ Since the definition of “abnormal” has no basis in psychiatry’s manual of mental disorders (the DSM, described as “the leading authoritative text on the diagnosis of mental disorders”),¹²⁹ an individual whose pedophilia diagnosis does not comport exactly with the psychiatric definition may still be committed.

Not only do psychiatric associations theoretically dispute the use of a legislative-based definition for mental illness, but they also dispute the substance of the definition, calling it a “vague and circular determination”¹³⁰ of mental illness. Psychiatric associations argue that the term “abnormality” and its definition “connotes sufficient vagueness that

124. See TASK FORCE REPORT, *supra* note 1.

125. See, e.g., Rich Daly, *New Mexico Declines to Board Outpatient Commitment Bandwagon*, PSYCHIATRIC NEWS, Mar. 17, 2006, at 7.

126. *New Jersey DB Decides to Back State Law on Sex Offenders*, PSYCHIATRIC NEWS, Aug. 21, 1998, available at <http://www.psychiatricnews.org/pnews/98-08-21/nj.html>.

127. New York State Psychiatric Association, Position Statement on Sexually Violent Predators Civil Confinement Legislation, available at <http://image.iarchives.nysed.gov/images/images/92563.pdf>.

128. Brief for the APA in Support of *Hendricks*, *supra* note 123, at *40. In fact, the refusal to abide by psychiatric guidance has enabled a task force of the Washington State Legislature to create its own disorder defined as a “sexually violent predator,” absent any research. See James D. Reardon, *Sexual Predators: Mental Illness or Abnormality? A Psychiatrist’s Perspective*, 15 U. PUGET SOUND L. REV. 849, 849 (1992).

129. Brief of WSPA in Support of Respondent, *supra* note 123, at *1.

130. TASK FORCE REPORT, *supra* note 1, at 174.

nearly any symptom, deficit, or historical detail might be included” because “something that is ‘abnormal’ could be desirable or undesirable, or could involve underlying mental processes or merely observable behavior, depending on the intended meaning of the user.”¹³¹ Psychiatry has said that the legal definition of mental abnormality, “a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses,”¹³² is “remarkably vague and difficult to apply in specific cases.”¹³³ It comments that “it is not clear why both congenital and acquired conditions are specified, as these together cover the territory of all conditions.”¹³⁴

Psychiatry is critical of the effects of this definition as applied to pedophilia because it results in individuals being diagnosed with pedophilia based merely on the evidence of a couple of sexual acts (or even a single sexual act), which is not in and of itself indicative of mental illness.¹³⁵ Justifying a diagnosis of pedophilia “based entirely on criminal sexual behavior goes against . . . the spirit of the DSM,”¹³⁶ according to psychiatry. “Sexually violent behavior, such as molesting a child . . . is not in and of itself indicative that a [pedophilic] arousal pattern is the cause of the behavior (i.e., not every sex offender’s sexually deviant behavior is driven by a [pedophilic] sexual arousal pattern),” and this attraction is indispensable to the psychiatric definition of pedophilia.¹³⁷ It follows that in order to commit civilly only those with mental illnesses, psychiatry believes that its empirically based definition should be used and that pedophilia should be diagnosed only when there is evidence of a pedophilic arousal pattern.¹³⁸ Psychiatry comments that if the sexual behavior itself were sufficient for making the diagnosis of pedophilia, then there would be no need for input from psychiatrists at all in the civil commitment process.¹³⁹

131. Brief of WSPA in Support of Respondent, *supra* note 123, at *12.

132. KAN. STAT. ANN. § 59-29a02(b) (2005).

133. Frances, Sreenivasan & Weinberger, *supra* note 2, at 376.

134. *Id.* Scholars have argued about the imprecision of this definition. *See, e.g.*, Stephen J. Morse, *Fear of Danger, Flight from Culpability*, 4 PSYCHOL. PUB. POL’Y & L. 250, 260–61 (1998). For the purposes of this Note, the circularity of its definition is not as relevant as the psychiatric discourse itself.

135. *See* First & Frances, *supra* note 97, at 1240.

136. First & Halon, *supra* note 64, at 447.

137. *Id.* at 446.

138. *See id.*

139. *Id.* at 447.

2. The Solution

In its criticism of the legislative construction of pedophilia, psychiatry recognized the importance of changing its own definition of pedophilia to clarify to its own community and to the law the qualifications for mental illness. The editors of the DSM, Michael First and Allen Frances, recently announced plans to modify the DSM to require a pattern of fantasies for a diagnosis of pedophilia; its current definition, like the legislative-based definition of mental abnormality as applied to pedophilia, does not include this requirement.¹⁴⁰ Recognizing the theoretical and practical implications of its definition for its own community and the legal community, the editors emphasized that “[d]efining [pedophilia] based on acts alone blurs the distinction between mental disorder and ordinary criminality.”¹⁴¹ Under the current manual of the DSM (DSM-IV-TR), a diagnosis of pedophilia necessitates that an individual of at least sixteen years of age (and at least five years older than the child involved) meet two requirements.¹⁴² The first criterion is “recurrent, intense sexually arousing fantasies, sexual urges, *or behaviors* involving sexual activity with a prepubescent child or children (generally age 13 years or younger)” that takes place for “a period of at least 6 months.”¹⁴³ The second criterion requires that “[t]he person has *acted* on these sexual urges” or is markedly distressed by them.¹⁴⁴ Pedophilia includes any combination of the two. The diagnosis is further delineated into the specifications of (1) whether the individual is sexually attracted to male children, female children, or both; (2) whether the individual’s behavior is limited to incest; and (3) whether the individual is sexually attracted exclusively to children, or to both children and adults.¹⁴⁵ When the “or behaviors” component of the first criterion is combined with the “acted” component of the second criterion, an individual can be diagnosed with pedophilia based simply on a sexual act with a child, absent a particular mental state.¹⁴⁶

Thus, the next edition of the DSM will remove the phrase “or behaviors” to clarify that a pedophilia diagnosis used as the basis for civil commitment cannot rely solely on a history of repeated sexual acts with

140. See First & Frances, *supra* note 97, at 1240.

141. See *id.*

142. DSM, *supra* note 5, at 571–72.

143. *Id.* (emphasis added).

144. *Id.* (emphasis added).

145. *Id.*

146. See First & Frances, *supra* note 97, at 1240. Note that this is the exact problem psychiatry found with the legal definition.

children. This revised definition of pedophilia will include two types of people. The first is someone who fantasizes about children and engages in at least one sexual act with a child. The second is someone who fantasizes about children and is distressed or ashamed about the fantasies, despite never acting on the fantasies. The fantasies component, indicative of some sort of pedophilia arousal pattern, is what differentiates a mental disorder from "ordinary criminality."¹⁴⁷ According to psychiatry, "recurrent, intense, sexually arousing fantasies (i.e., mental imagery [involving children] that the individual considers to be erotic) and urges (i.e., to act on the fantasies) . . . are the *sine qua non* in [pedophilic] diagnosis."¹⁴⁸ Psychiatry reinforces its objection to the legislative mental abnormality definition, clarifying once again that an individual who engages in a sexual act with a child does not necessarily have a mental disorder (pedophilia), and an individual who has a mental disorder (pedophilia) will not necessarily ever engage in a sexual act with a child.¹⁴⁹ Rather, it is a more prolonged period of fantasies that causes a person to have pedophilia.¹⁵⁰ According to psychiatry, this definition must be employed in order to commit civilly only those individuals who truly have a mental illness.¹⁵¹ Because it is usually psychiatrists (or psychologists) who are responsible for the mental abnormality diagnosis, psychiatry has recognized the importance of clarifying its own definition for use by its own community.¹⁵²

C. INADEQUACY OF PSYCHIATRIC SOLUTIONS

The changes that psychiatry proposes are inadequate themselves because the requisite fantasies component is too vague, and psychiatry has not provided an empirically validated way to measure fantasies besides

147. *See id.*

148. First & Halon, *supra* note 64, at 445.

149. *See* First & Frances, *supra* note 97, at 1240.

150. Psychiatry does not refer to these individuals as "pedophiles," but rather as individuals with pedophilia because the DSM classifies disorders that people have, not the people themselves. *See* DSM, *supra* note 5, at xxxi (noting that "the [psychiatry] text . . . avoids the use of such expressions as . . . 'an alcoholic' and instead uses the more accurate, but admittedly more cumbersome, . . . 'an individual with Alcohol Dependence'" because of the "common misconception . . . that . . . mental disorders classif[y] people").

151. *See* First & Frances, *supra* note 97, at 1240.

152. It has been argued that the DSM diagnosis of pedophilia is "virtually ignored" by practitioners and researchers. *See* William O'Donohue, Lisa G. Regev & Anne Hagstrom, *Problems with the DSM-IV Diagnosis of Pedophilia*, 12 *SEXUAL ABUSE: J. RES. & TREATMENT* 95, 96 (2000) (citing William L. Marshall, *Pedophilia: Psychopathology and Theory*, in *SEXUAL DEVIANCE: THEORY, ASSESSMENT, AND TREATMENT* 152 (D. Richard Laws & William T. O'Donohue eds., 1997)).

inferring them on the basis of a pattern of sexual behavior with children.

1. Vagueness of Psychiatry's Definition

The vagueness in the proposed psychiatric definition of pedophilia for the mental illness element of civil commitment under SVP statutes (six months of recurrent fantasies combined with at least one sexual act with a child) has been exposed by the law's use of these definitions for substantiation of civil commitment. Since the behavior part of the definition is already defined by statute (whatever behavior resulted in a criminal conviction), the relevant consideration is the vagueness of the "intense" and "recurrent" fantasies criteria.¹⁵³ In terms of the "intense" aspect, what does it mean to have an intense fantasy—"is it more vivid, more arousing, or more real"?¹⁵⁴ Where do persistent but moderate- or low-intensity fantasies fit into this definition?¹⁵⁵ In terms of the "recurrent" aspect, how many fantasies must occur in order to qualify as "recurrent"?¹⁵⁶ Recurrent clearly implies more than one fantasy, but how many fantasies are necessary within the six-month time frame?¹⁵⁷ Two fantasies over the course of a lifetime? Twice a week? Twice a day? Twice an hour? Also, the six-month period appears arbitrary.¹⁵⁸ A rationale is needed to conclude that individuals experiencing six months of fantasies are pedophiles while those who experience only five months' worth are not.¹⁵⁹ In terms of longevity, the DSM does not specify whether an individual who has qualified for pedophilia under its definition at a given point in time necessarily still has the disorder years or even decades later.¹⁶⁰

Seeking such precise symptoms for a diagnosis may seem peculiar, especially given that the DSM itself states "the specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by

153. *See id.* at 99. It has also been argued that the behavioral criterion is overly vague. *See id.* at 100 (questioning whether choosing "to work as a school bus driver because it fulfills a sexual desire to be around children is . . . considered a behavior that is sufficient to fulfill the criterion" assuming "the driver has not actually touched a child in an inappropriate manner").

154. *Id.* at 100.

155. William L. Marshall, *Diagnostic Problems with Sexual Offenders*, in *SEXUAL OFFENDER TREATMENT: CONTROVERSIAL ISSUES*, *supra* note 4, at 33, 37.

156. O'Donohue, Regev & Hagstrom, *supra* note 152, at 99.

157. *Id.*

158. *Id.* at 101.

159. *Id.*

160. *See* Frances & Sreenivasan, *supra* note 4, at 49. This lack of specificity is relevant because the SVP evaluations are conducted after years in jail.

clinical judgment and are not meant to be used in a cookbook fashion.”¹⁶¹ But it should be noted that far more specific qualifications and guidelines are given for other DSM disorders, such as major depressive disorder.¹⁶² A diagnosis of major depressive disorder has several other features that can be included, such as (1) mild, moderate, severe without psychotic features, severe with psychotic features, (2) chronic, (3) with catatonic features, (4) with melancholic features, (5) with atypical features, and (6) with postpartum onset.¹⁶³ All of these various features modify the diagnosis of depression in order to research and treat patients with depression effectively.¹⁶⁴ The specificity ranges from particular times of onset (after pregnancy) to frequency (recurrent versus single episode).¹⁶⁵ The current pedophilia diagnostic criteria do not allow for anywhere near this degree of specificity.¹⁶⁶

One possible explanation for why the psychiatric definition is so vague is that in the development of the definition, psychiatry has very limited and controlled access to the individuals with pedophilia that it observes.¹⁶⁷ Pedophilia is usually observed and researched in forensic settings, such as during civil commitment and, based on recidivism rates, after civil commitment.¹⁶⁸ The DSM indicates that pedophilia is “rarely diagnosed [and thus observed] in general clinical facilities” because “[t]hese individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with . . . society.”¹⁶⁹ Unlike with major depressive disorder, in which individuals who feel depressed tend to seek the help of psychiatrists voluntarily and thus are more likely to be forthcoming about their relevant symptoms, individuals with pedophilia are observed and treated in forensic settings, in which they are less motivated to be honest because of the design of the legal system.

161. First & Halon, *supra* note 64, at 447 (quoting DSM, *supra* note 5, at xxxii).

162. See O’Donohue, Regev & Hagstrom, *supra* note 152, at 101.

163. DSM, *supra* note 5, at 369–70.

164. *See id.*

165. *See id.*; O’Donohue, Regev & Hagstrom, *supra* note 152, at 101.

166. See O’Donohue, Regev & Hagstrom, *supra* note 152, at 99–102.

167. DSM, *supra* note 5, at 566.

168. *See id.* Much of what is known about pedophilia is based on statistical studies that use arrests for sexual offenses as a proxy for sex offenses. See, e.g., Jeffrey C. Sandler, Naomi J. Freeman & Kelly M. Socia, *Does A Watched Pot Boil?: A Time-Series Analysis of New York State’s Sex Offender Registration and Notification Law*, 14 PSYCHOL. PUB. POL’Y & L. 284, 284 (2008). These studies do not include other possible acts, such as sexual offenses before and after prison that did not catch the attention of law enforcement.

169. DSM, *supra* note 5, at 566.

Because the patient's state of mind is at issue in civil commitment evaluations, almost any information is admissible at hearings for initial commitment and evaluation for release, including statements to therapists and psychiatrists.¹⁷⁰ This fact severely limits psychiatric access to honest and open communication with pedophiles who have been civilly committed;¹⁷¹ even though patients are encouraged to disclose information about their sexual fantasies, they have no incentive to do so because disclosing fantasies about children may prevent them from ever being released—it would be seen as a sign that they still pose a danger to society.¹⁷² As a result, patients sometimes deceive their therapists by failing to admit to fantasies.¹⁷³ One released sex offender from Florida recounted: “Most of those guys, they are just faking it to make it They're just waiting to get released so they can go right back to what they were doing.”¹⁷⁴

In fact, many sex offenders do not even attend therapy at the advice of their lawyers, who inform them that admission of past misdeeds during therapy could make getting out impossible, or even worse, could lead to new criminal charges.¹⁷⁵ In California, for instance, 75 percent of civilly committed sex offenders do not attend therapy.¹⁷⁶ Some patients even resort to hiring private therapists so that their admissions are not used against them in court when they petition for release.¹⁷⁷ Refusal to participate is seen as indicative of their illness¹⁷⁸ and “[t]he state often cites patients' denials—or playing down—of offenses as evidence that further treatment is needed.”¹⁷⁹

2. Lack of Measurement Alternative

Besides the vagueness problem in the definition of pedophilia, another

170. Laura Mansnerus, *Unfinished Sentences: Keeping Prisoners as Patients*, N.Y. TIMES, Nov. 17, 2003, at A1.

171. *Id.*

172. See Fabian, *supra* note 49, at 146.

173. Abby Goodnough & Monica Davey, *For Sex Offenders, Dispute on Therapy's Benefits*, N.Y. TIMES, Mar. 6, 2007, at A1.

174. *Id.*

175. See Davey & Goodnough, *supra* note 113, at 1.

176. *Id.*

177. Laura Crimaldi, *Sex Offender Rehab Center Draws Scrutiny*, BOSTON HERALD, Mar. 2, 2008, at 4.

178. Scott Gold & Lee Romney, *Treatment Replaced by Turmoil*, L.A. TIMES, Nov. 15, 2007, at A1.

179. Mansnerus, *supra* note 170. Most forensic studies have found no link between denial or hostility to treatment and future crimes. *Id.*

problem is that psychiatry has failed to justify or clarify why repeated sexual acts with children are not together a sufficient indicator of arousal to children or fantasies about children and has not presented an adequate alternative measurement tool. It must explain why else someone would have sex repeatedly with children¹⁸⁰ or, in the case of only a couple of sexual acts, why the momentary attraction that takes place during the sexual act itself is not sufficient to constitute pedophilia.¹⁸¹ If the primary purpose of the fantasies criterion is merely to establish a pattern within the individual for the sake of showing that the sexual act was not an isolated event but rather one instance indicative of a “chronic and lifelong” condition (since typically mental disorders are conceived of as some sort of pattern over a prolonged period),¹⁸² then psychiatry should clarify that this is the reason for requiring fantasies for several months rather than the attraction during the sexual act.¹⁸³ On the other hand, regardless of their effect of demonstrating a lifelong condition, perhaps fantasies themselves are indicative of the attraction necessary for the purposes of pedophilia because, for whatever reason, attraction to children at times other than while engaged in the sexual act is indicative of mental illness.

In fact, psychiatry has contradicted itself in its argument that a pattern of behavior is not sufficient to indicate the fantasies criterion in its discussion of evaluating rapists for SVP statutes. It has commented that for a rapist to meet the fantasies criterion, “a pattern of behavior in which the rapist makes repeated demands of his victims to act in an overtly submissive way suggests that the nonconsensual nature of the acts may be a primary stimulus for sexual arousal” can be used as evidence to infer that the rapist is aroused specifically by the nonconsensual nature of the sexual act.¹⁸⁴ Psychiatry must clarify why a pattern of behavior in which a person has sex with children does not suggest that the prepubescent nature of the

180. Some suggestions psychiatry has made in passing are “situational” reasons, such as “incestual context during divorce or other stress, influenced by intoxication.” Frances, Sreenivasan & Weinberger, *supra* note 2, at 379.

181. See generally Marshall, *supra* note 155, at 36–37 (pointing out that “[i]t seems very unlikely that a man could commit a sexual offense against a child in the absence of at least transitory urges or thoughts about the act”).

182. See Frances, Sreenivasan & Weinberger, *supra* note 2, at 379.

183. After gaining the confidence of clients who had engaged in a sexual act with a child, William Marshall found that “60% of nonfamilial offenders . . . admitted having recurrent fantasies and urges.” Marshall, *supra* note 155, at 36 (citing William L. Marshall, *Pedophilia: Psychopathology and Theory*, in *SEXUAL DEVIANCE: THEORY, ASSESSMENT, AND TREATMENT*, *supra* note 152, at 152).

184. See First & Halon, *supra* note 64, at 452. Another way is by admissions of the offender to fantasies involving nonconsensual sex, and that it was the nonconsenting aspect of the act that the offender found sexually gratifying. *Id.*

child is the primary stimulus for sexual arousal. Based on the DSM and other psychiatric statements, an individual who has sex ten times with a child but does not exhibit attraction to children in the form of fantasies or otherwise would not meet the fantasies criterion, whereas a rapist who rapes ten times but does not exhibit attraction to nonconsensual sex in the form of fantasies or otherwise does meet the fantasies criterion for the relevant mental disorder.¹⁸⁵ Perhaps a certain type of pattern of sexual behavior with children would be indicative of this necessary arousal.

Psychiatry has not proposed an adequate measurement alternative because its suggested measurement tools have not been empirically validated and would not work on a practical level due to the ability of the offender to “deceive” the tests. Psychiatry suggests conducting a more global (in terms of the number of instruments used) and individualized (in terms of directly asking the individual questions) approach. This approach would combine a diagnostic interview (which would ask about the individual’s sexual thoughts, fantasies, and urges), an inquiry into whether there is possession of child pornography, and phallometric measurements in response to child pornography.¹⁸⁶ As a practical matter, psychiatry has admitted that none of these methods is sufficiently fool proof.¹⁸⁷ As discussed earlier, a diagnostic interview, which would include self-report questionnaires, probably would not produce accurate information because self-report questionnaires are unlikely to be answered truthfully in a civil commitment proceeding.¹⁸⁸ Possession of child pornography has rarely been studied in connection with sex offenses so its capabilities are unknown for the time being.¹⁸⁹ Phallometric measures in response to child pornography have never rendered results that meet reasonable statistical standards of reliability and validity.¹⁹⁰ The DSM itself states that “[t]he reliability and validity of [phallometric assessment] in clinical assessment have not been well established, and clinical experience suggests that

185. The common mental disorders for rapists, paraphilia not otherwise specified and antisocial personality disorder, are hotly debated. *See id.* at 449–52.

186. *See id.* at 447–48. Phallometric assessment measures penile responses to sexual stimuli in a laboratory. *See* SETO, *supra* note 7, at 23.

187. First & Halon, *supra* note 64, at 448.

188. *See id.* (explaining that “one must always be skeptical” about information obtained from interviews and questionnaires “because of the legal and social sanctions offenders may face”).

189. Michael C. Seto & Angela W. Eke, *The Criminal Histories and Later Offending of Child Pornography Offenders*, 17 *SEXUAL ABUSE: J. RES. & TREATMENT* 201, 208 (2005).

190. Marshall, *supra* note 155, at 36 (citing WILLIAM L. MARSHALL & YOLANDA M. FERNANDEZ, *PHALLOMETRIC TESTING WITH SEXUAL OFFENDERS: THEORY, RESEARCH AND PRACTICE* (2003)).

subjects can simulate response by manipulating mental images.”¹⁹¹ One released sex offender reported stifling his arousal to cheat the test by “star[ing] at a shelf of cleaning products and read[ing] the labels.”¹⁹² Suppressing deviant sexual arousal and increasing normal arousal can result in sampling bias.¹⁹³ All in all, psychiatry has not made a single concrete, empirically validated substitution for assuming an arousal pattern based on repeated sexual acts.

D. PSYCHIATRY'S IMPRECISION WITHIN PSYCHIATRY

Psychiatry's insistence on the inclusion of fantasies in a diagnosis of pedophilia raises several questions about the precise distinction between pedophiles and the non-mentally ill, regardless of whether the law is involved. Even if there were a method to measure fantasies or attraction in a way that psychiatry endorses, psychiatry has not provided guidance on how to interpret the results as compared to the rest of the population. The research coordinator for the DSM-IV Task Force, Thomas Widiger, has discussed the problems encountered in the current DSM in differentiating between abnormality and normality and the importance of solving this problem in the next edition of the DSM, stating that “[a] difficult task facing the authors of DSM-V will be establishing meaningful boundaries or points of demarcation between abnormal and normal psychological functioning, if any such distinctions can in fact be made.”¹⁹⁴ He admits that the “DSM-IV routinely fails in the goal of guiding the clinician to the presence of one specific disorder, despite the best efforts of the leading clinicians and researchers who have authored the manual.”¹⁹⁵

The DSM does not clarify how the arousal of pedophiles is different from that of the rest of the population. The manual does not articulate the relevant control group—whether fantasies should be measured relative to the general population or only to individuals who have had sex with children. For example, if an individual is more aroused by child pornography than the average person, is he or she definitely a pedophile? Or, does the individual need to be more aroused by child pornography than

191. DSM, *supra* note 5, at 567.

192. Goodnough & Davey, *supra* note 173.

193. See Fabian, *supra* note 49, at 137.

194. Thomas A. Widiger & Lee Anna Clark, *Toward DSM-V and the Classification of Psychopathology*, 126 PSYCHOL. BULL. 946, 949 (2000).

195. Thomas A. Widiger & Douglas B. Samuel, *Diagnostic Categories or Dimensions? A Question for the Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition*, 114 J. ABNORMAL PSYCHOL. 494, 494 (2005).

the average individual who has had sex with children? This line of argument begs the question, if attraction could be measured accurately with the various instruments psychiatry identified, which of these various assessments would take precedence when the results contradict one another? For example, would individuals who verbally report sexual attraction to children but are phallometrically aroused only by adult pornography be considered pedophiles?¹⁹⁶ Or, is the ultimate defining method of assessment whether a particular individual is more aroused by child pornography than by adult pornography?¹⁹⁷

The lack of clarity in the psychiatric distinction between pedophilia and “ordinary criminality”¹⁹⁸ is exposed by a close look at psychiatry’s critiques of and solutions to its problems with the legal definition of mental abnormality as applied to pedophilia. Psychiatry repeatedly emphasizes the difficulty of the no-man’s land between the DSM diagnoses and the SVP mental abnormalities, but in the case of pedophilia, its definition is problematic independent of its relationship to the law. Psychiatry must not only reexamine the relationship between its definition’s purposes and the law’s purposes, but also the purpose of its definition for its own community’s purposes. Although “the DSM was [not] designed to provide taxonomic differentiation among sex offenders,”¹⁹⁹ it is being used for that purpose and thus, psychiatry must make these clarifications or else it will risk having a far more limited role in the SVP commitment process. Perhaps its distinction between the mentally ill and the non-mentally ill with respect to pedophilia should focus on differentiating between pedophiles (especially those who actually do engage in sexual acts with children) and criminals who engage in sexual acts with children, rather than using a broad definition that focuses on the differences between pedophiles and people who do not have sex with children.

196. In the First Amendment child pornography context, Congress has warned that child pornography “‘whet[s] [the] sexual appetites’ of pedophiles, creating their fantasies and stimulating them to victimize . . . children.” Amy Adler, *The Perverse Law of Child Pornography*, 101 COLUM. L. REV. 209, 216 (2001) (citing Child Pornography Prevention Act of 1996, Pub. L. No. 104-208, 110 Stat. 3009).

197. Kurt Freund, a famous psychiatric researcher, used the criterion of arousal to child stimuli greater than arousal to adult stimuli based on phallometric evaluations to diagnose pedophilia. Marshall, *supra* note 155, at 35. Freund’s ground-breaking research in the 1950s led to the development of phallometric testing.

198. See First & Frances, *supra* note 97, at 1240.

199. Robert A. Prentky, Anna I. Coward & Adeena M. Gabriel, *Commentary: Muddy Waters in the SVP Courtroom*, 36 J. AM. ACAD. PSYCHIATRY L. 455, 456 (2008).

IV. VOLITIONAL IMPAIRMENT: NO-MAN'S LAND

The decision of which pedophiles can constitutionally be civilly committed *is* in no-man's land because the law inserts a new element into a psychiatric definition and refers to a concept that does not have a precise meaning in psychiatry. Psychiatry argues that a pedophilia diagnosis does not necessarily mean that an individual has a volitional impairment because the DSM's definition of pedophilia includes individuals with self-control and without self-control. Psychiatry argues further that because the volitional impairment concept is too difficult to operationalize, the requisite lack of self-control should be limited to an extreme lack of self-control. Its disputes regarding the way in which volitional impairment is typically measured in practice, however, focus on the problems of risk assessment measures—in measuring what they purport to measure (risk of reoffense)—and do not focus on psychiatry's argument that, conceptually, risk assessment procedures fail to measure volitional impairment. Psychiatry has an opportunity to give the law suggestions in the confusing domain of overlap between psychiatry and the law but it fails to do so because of the same failings that contribute to the vagueness of its own definition of pedophilia: conceptual imprecision and practical inapplicability.

A. *KANSAS V. CRANE*

Kansas v. Crane, another important U.S. Supreme Court SVP case, clarified an unresolved issue from *Kansas v. Hendricks*—what degree of lack of self-control is required for the SVP analysis once the diagnosis of the mental abnormality has been made.²⁰⁰ In *Hendricks*, the defendant's dangerousness was proved by his diagnosis of pedophilia and his own statement that he could not control his urges when stressed out.²⁰¹ *Crane* held that *Hendricks* requires volitional impairment as a separate step in the SVP evaluation and asserted that the State does not need to prove that the offenders have a complete inability to control themselves, but rather some sort of volitional impairment.²⁰²

Michael Crane pleaded guilty to aggravated sexual battery for exposing himself twice in one day—first to a tanning salon attendant and approximately thirty minutes later to a video store clerk.²⁰³ The State filed

200. *Kansas v. Crane*, 534 U.S. 407, 411 (2002).

201. *Kansas v. Hendricks*, 521 U.S. 346, 360 (1997).

202. *Crane*, 534 U.S. at 412–13.

203. *In re Crane*, 7 P.3d 285, 286 (Kan. 2000), *vacated sub nom.*, *Crane*, 534 U.S. at 407.

a petition to have him evaluated as an SVP.²⁰⁴ At trial, the State's psychiatrist diagnosed Crane with exhibitionism and antisocial personality disorder.²⁰⁵ The psychiatrist gave the opinion "that Crane's behavior was a combination of willful and uncontrollable behavior."²⁰⁶ The district court held that Crane was an SVP and Crane appealed, arguing among other issues that his Fourteenth Amendment substantive due process rights were violated because, although he was diagnosed with a mental abnormality, the State did not prove that he was unable to control his behavior.²⁰⁷

The Kansas Supreme Court reversed and remanded the district court decision, holding that civil commitment under its SVP statute is unconstitutional unless the State limits commitment "to those who 'suffer from a volitional impairment rendering them dangerous beyond their control.'"²⁰⁸ The court distinguished the facts of its case from those of *Hendricks*.²⁰⁹ Unlike Leroy Hendricks, who himself admitted that he was unable to control his urges to molest children when he was "stressed out,"²¹⁰ Michael Crane did not make any such statement.²¹¹ Further, the court held, the implications regarding lack of control for the respective diagnoses of the individuals differed.²¹² Unlike Hendricks, whose pedophilia diagnosis automatically meant he met the criteria for volitional impairment, Crane's exhibitionism and antisocial personality disorder diagnoses did not have any implications as to volitional impairment.²¹³ The court concluded that the volitional impairment standard was not met because the State failed to prove additional evidence that Crane had volitional impairment.²¹⁴

The U.S. Supreme Court vacated and remanded the Kansas Supreme Court's judgment, holding that *Hendricks* did not imply that a *complete* lack of control was required, but rather *some* sort of lack of control.²¹⁵ Similar to the Kansas Supreme Court's discussion, the Court distinguished *Hendricks* because Hendricks not only said that he could not control his

204. *Id.*

205. *Id.* at 286–87.

206. *Id.* at 290.

207. *See id.* at 286–87.

208. *Id.* at 290 (quoting *Kansas v. Hendricks*, 521 U.S. 346, 358 (1997)).

209. *See id.*

210. *Hendricks*, 521 U.S. at 360.

211. *See In re Crane*, 7 P.3d at 290.

212. *See id.* at 289–90.

213. *See id.* at 290.

214. *See id.*

215. *Kansas v. Crane*, 534 U.S. 407, 412–13 (2002).

urge to molest children, but he also had pedophilia, which “critically involves what a lay person might describe as a lack of control.”²¹⁶ Justice Breyer, writing for the majority, stated that “our cases suggest that civil commitment of dangerous sexual offenders will normally involve individuals who find it particularly difficult to control their behavior” and “it is often appropriate to say of such individuals, in ordinary English, that they are ‘unable to control their dangerousness.’”²¹⁷

The Court discussed the importance of the offender’s ability to control his or her urges in “distinguishing a dangerous sexual offender subject to civil confinement ‘from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings.’”²¹⁸ Only those offenders who cannot control themselves to some degree must be placed in civil commitment to be treated until they can control themselves.²¹⁹

The Court did not give guidance as to a specific definition of “lack of control,” stating that “‘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.”²²⁰ After *Crane*, it is now unclear what the notion of volitional impairment means.²²¹ Lower court cases since *Crane* have articulated contradictory standards relating to volitional impairment, and there is no clear standard for what qualifies as inability to control.²²²

Although *Crane* suggests that the SVP evaluations for offenders convicted of having sex with a child consist of three distinct requirements: (1) mental abnormality (pedophilia), (2) volitional impairment, and (3) dangerousness, in practice the volitional impairment component has been collapsed into either the mental abnormality requirement or the dangerousness requirement. The assumption of volitional impairment based on a diagnosis of pedophilia appears to be rarely used. More often, the volitional impairment step is collapsed with the dangerousness step and

216. *See id.* at 414. Ironically, the Court cited the DSM to justify this notion: “[L]isting as a diagnostic criterion for pedophilia that an individual have acted on, or been affected by, ‘sexual urges’ toward children.” *Id.*

217. *Id.* at 414–15 (citation omitted).

218. *Id.* at 412 (quoting *Kansas v. Hendricks*, 521 U.S. 346, 360 (1997)).

219. *See id.* at 413.

220. *Id.* Some sort of “proof” of volitional impairment is necessary but no indication was given as to what type of proof would suffice.

221. *See Mercado, Schopp & Bornstein, supra* note 55, at 299.

222. *See id.*

thus a statistical risk assessment analysis is used.²²³

B. PSYCHIATRIC CRITIQUE AND SUGGESTIONS

Psychiatry argues that it is difficult to operationalize the concept of volitional impairment and, thus, it is perhaps better to conceive of it as a complete lack of control, rather than some nebulous concept of inability to control oneself. Psychiatry argues that as applied to pedophilia, volitional impairment cannot be inferred merely on the basis of the presence of the disorder in an individual because individuals with pedophilia have varying levels of self-control. Moreover, it argues that volitional impairment cannot be measured on the basis of likelihood to commit a sexual act with a child again in the future because likelihood to commit an act in the future is not necessarily caused by lack of control in the individual.

1. Not All Individuals with Pedophilia Have Volitional Impairment

With respect to the volitional impairment standard as applied to pedophilia, psychiatry argues that a DSM diagnosis of pedophilia does not necessarily reflect volitional impairment—a sex offender does not necessarily have difficulty controlling his or her behavior as a result of the pedophilia.²²⁴ The DSM states that “the fact that an individual’s presentation meets the criteria for a [pedophilia] diagnosis does not carry any necessary implication regarding the individual’s degree of control over the behaviors that may be associated with [pedophilia],”²²⁵ and that a “diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.”²²⁶ Volitional impairment is not included in its definition of pedophilia and is not meant to be implied by its definition.²²⁷ Psychiatry indicates that the group of individuals diagnosed with pedophilia are not necessarily more or less likely to have difficulty controlling their impulses in the future.²²⁸

According to psychiatry, the assumption that a diagnosis of pedophilia indicates volitional impairment inaccurately homogenizes a heterogeneous group because many individuals with pedophilia have no trouble controlling their behavior.²²⁹ In this argument, psychiatry emphasizes the

223. *See id.*

224. *See* First & Halon, *supra* note 64, at 450.

225. DSM, *supra* note 5, at xxxiii.

226. *Id.*

227. *See id.*

228. *See* First & Halon, *supra* note 64, at 450.

229. *See id.* This is true of all DSM mental disorders. The DSM states that “[i]t is precisely

variety of individuals it would diagnose with pedophilia.²³⁰ Some individuals with pedophilia are ashamed of being attracted to children. Some individuals with pedophilia collect child pornography but never engage in a sexual act with a child. Some individuals with pedophilia cross the line from fantasy to behavior but only in situations in which they have easy access to potential victims, such as with family members. Even though all of these individuals would be diagnosed with pedophilia, psychiatry asserts, not all of them would be considered to have difficulty controlling his or her behavior due to pedophilia.²³¹ Risk assessment measures, such as the mental abnormality definition as applied to pedophilia, essentially are a measurement of sexual acts. Psychiatry would prefer a more individualized approach, requiring “positive evidence” that “the particular individual . . . has serious difficulty controlling . . . behavior” based on “direct assessment.”²³²

2. The Solution

As a more general matter, psychiatry responded to *Crane*, in the form of an APA amicus brief, by arguing that volitional impairment is difficult to operationalize and, thus, it is best to conceive of it in terms of extreme lack of control.²³³ The brief notes that in the past, the APA has argued in the context of volitional impairment within the insanity defense that the gray area between complete lack of control and complete self-control is a complex construct that is hard to measure and apply: “[T]he line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk.”²³⁴ In its position on *Crane*, the APA retreats somewhat, noting that “[a]s a simple logical matter . . . the inability to make the notion operationally precise across the full range of human behavior does not mean that the idea of volitional control lacks a coherent ordinary meaning,” nor does it mean “that there are not clear cases at the

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.” DSM, *supra* note 5, at xxxiii.

230. See First & Halon, *supra* note 64, at 450.

231. See *id.*

232. *Id.*

233. See Brief for the APA in Support of Respondent, *supra* note 88, at *10.

234. See First & Halon, *supra* note 64, at 450 (citing Am. Psychiatric Ass’n, *American Psychiatric Association Statement on the Insanity Defense*, 140 AM. J. PSYCHIATRY 681, 685 (1983)). The APA also points out that the American Bar Association has argued successfully in some jurisdictions for the elimination of volitional impairment as the basis for the insanity defense because of these difficulties. See Brief for the APA in Support of Respondent, *supra* note 88, at *27–28.

ends of the spectrum, any more than that ‘day’ and ‘night’ are meaningless or useless or indistinguishable concepts simply because light fades gradually at twilight and dusk.”²³⁵ Even though it is logically possible to carry out the standard set out by *Crane*, the APA believes that “substantial problems of consistent, workable, objective application” would be caused by “the wide middle range of nonextreme cases [of] volitional ‘impairment.’”²³⁶ Thus, it recommends instead that “the standard [be] set near the far end of the spectrum.”²³⁷ It notes that in *Hendricks*, the fact that Hendricks himself spoke about his inability to control himself was a crucial part of the Court’s assessment of his dangerousness. Based on the problems of applying this conception of volitional impairment consistently and the Court’s emphasis in *Hendricks* regarding his self-professed inability to control his behavior,²³⁸ the APA argues that the volitional impairment concept should be limited to “such severe impairment as to avoid the large gray area: inability to control the conduct, as proved with a high degree of certainty.”²³⁹

The DSM editors have recently issued statements disputing the risk assessment methods used as a proxy for volitional impairment by forensic examiners because the editors believe that a high risk of reoffense does not necessarily imply that the individual lacks self-control and that a direct assessment of the individual is necessary.²⁴⁰ Even if pedophilia did cause a high risk of reoffending, psychiatry argues that a likelihood of reoffense is not necessarily caused by the requisite lack of control.²⁴¹ This argument is clarified as follows. Assume that a test could predict likelihood to reoffend perfectly. If a test demonstrated that 95 percent of twenty-one-year-old men who have had sex once with a child and live in Anaheim, California will have sex with a child again in the future, then an individual fitting this description would be rated as a “high risk.” The individual’s high risk,

235. Brief for the APA in Support of Respondent, *supra* note 88, at *27.

236. *Id.* at *28. Recently, scholars have also argued that “[i]n discussing the components of lack of control, lawmakers, theorists, researchers, or professionals seem to consistently confuse the notion of impulsive conduct with the notion of uncontrollable behavior.” Mercado, Schopp & Bornstein, *supra* note 55, at 306.

237. See Brief for the APA in Support of Respondent, *supra* note 88, at *28.

238. See *id.* The APA discusses how *Hendricks* was based on *Minnesota ex rel. Pearson v. Probate Court*, 309 U.S. 270 (1940), in which the U.S. Supreme Court upheld the Minnesota Supreme Court’s construction of a law committing psychopaths who had shown “an utter lack of power to control their sexual impulses” and “uncontrolled and uncontrollable desire.” *Id.* (emphasis omitted) (citations omitted).

239. Brief for the APA in Support of Respondent, *supra* note 88, at *29.

240. See *id.*

241. See *id.*

however, might be caused by the external circumstances (the fact that he lives near Disneyland, where children are accessible), rather than something internal to him (volitional impairment). He may have perfect self-control despite his high risk score. On the contrary, an individual who is deemed a “low risk” could have a high level of volitional impairment.²⁴² Most psychiatric arguments regarding risk assessment, however, are based on the problems of the risk assessment method as a way to predict risk of future sex crimes against children, rather than the connection between risk assessment and volitional impairment.²⁴³

C. INADEQUACY OF PSYCHIATRIC SOLUTIONS

The changes that psychiatry proposes, asserting that its definition of pedophilia includes a wide range of levels of self-control and directly assesses individuals, are inadequate because psychiatry gives no information as to which pedophiles have higher or lower amounts of self-control. Moreover, it has not justified why the risk of future acts is an insufficient tool of measurement, and it has not provided an adequate alternative.

1. Vagueness of Psychiatry's Definition

In its assertion about the wide variation within the group of individuals with pedophilia, psychiatry does not provide any meaningful information about how volitional impairment (in the “gray area” or in an extreme form) relates to all of these different individuals. It lists all of the

242. The test might predict that only 10 percent of twenty-one-year-old men who live in a city filled with retirement communities will offend again in the future, so an individual with no self-control would be rated a “low risk” because of the fact that he lives in an area that is predominately composed of the elderly, not because of something internal to him.

243. Criticisms of the actuarial risk assessments “include the generalizability of findings from the development group to the individual being assessed (e.g., ethnic differences), the inability to include case-specific factors that may reduce risk (e.g., health changes) or aggravate (e.g., sadism) risk, and the accuracy of the risk percentage estimates.” Sreenivasan, Weinberger & Garrick, *supra* note 72, at 479. For example, the samples of sex offenders used in the development of the risk assessment instruments have a preponderance of younger offenders; therefore, these risk assessments likely substantially overestimate risk for older sex offenders. See Prentky et al., *supra* note 75, at 376–77. The creator of the Static-99 acknowledged that the test overestimates expected risk, especially in the forty-to-sixty age range, but failed to offer specific advice on how to adjust the score. *Id.* at 377. But see Dennis M. Doren, *Recidivism Risk Assessments: Making Sense of Controversies*, in *SEXUAL OFFENDER TREATMENT: CONTROVERSIAL ISSUES*, *supra* note 4, at 3, 13 (arguing that focusing on the samples used in the development of the tools misses the ultimate points: “It really does not matter how an instrument was developed if it consistently works with a variety of samples and users”).

different types of individuals who would qualify but does not explain which of these individuals has a lack of volitional impairment. Does the individual who collects child pornography but does not engage in sexual acts with children have self-control? Or, in comparing two individuals who have never had sex with a child, would an individual who is aroused solely by child pornography be considered to have less self-control than an individual who is aroused by both child pornography and adult pornography (and thus presumably enjoys sex with adults)? Does resistance to watching child pornography constitute self-control? Although psychiatry has commented that a better conception of volitional impairment is to consider the extremes, it does not clarify the relationship between the extreme lack of self-control or how it would be exhibited in an individual.

2. Lack of Measurement Alternative

Psychiatry has not justified why the number of acts is not a sufficient way to measure lack of volitional impairment. If the law were to adopt psychiatry's suggestion on limiting the volitional impairment concept to pedophiles with an extreme lack of self-control, then would a prediction of future acts (assuming a perfect prediction) be adequate? Psychiatry's position is somewhat unclear because there is so little commentary on the matter.

Furthermore, psychiatry has not presented an adequate measurement alternative. In measuring this volitional impairment that varies from pedophile to pedophile, psychiatry asserts that "[o]ne needs to provide positive evidence that [this particular pedophile] has difficulty controlling his sexually assaultive behavior as a result of the [pedophilia]."²⁴⁴ This affirmative evidence should come from some sort of direct assessment. This evidence would include the pedophile's acknowledging the inability to control his or her behavior, as Hendricks did. Psychiatry has not stated what sorts of questions would be asked, even in a situation in which an individual is telling the truth. It has not given the law any specific instructions besides asking individuals whether they feel that they lack self-control, and it has indicated that this method is unlikely to prove successful because individuals being evaluated are not motivated to be honest. Because psychiatry has not given a single other method besides the one the Court already approved (confessions by the individual), the law has no direction in modifying its current definition and practice in this area of

244. First & Halon, *supra* note 64, at 450.

overlap between psychiatry and the law.

Psychiatry itself has acknowledged that there are no established, validated scientific methods for measuring volitional impairment in an individual.²⁴⁵ There is very little scientific evidence on how volition operates in general, and no research on how volitional impairment operates in sexual predators.²⁴⁶ Psychiatry recommends that “mental health professionals testifying as ‘experts’ in SVP commitment trials must caution triers of fact” that “there is no professional consensus in the field of mental health concerning what constitutes volitional impairment nor even what constitutes adequate psychiatric or psychological evidence of it.”²⁴⁷ Psychiatry has cautioned that “[t]he testifying expert should be aware that such scores may give the appearance of a greater degree of accuracy and precision than in fact exists.”²⁴⁸ This criticism, combined with a lack of a replacement method, is virtually useless. Advising the trier of fact that a method is not precise does not clarify what information the trier of fact should use to make the decision.

D. PSYCHIATRY'S IMPRECISION IN ITS RELATIONSHIP TO THE LAW

Psychiatry has not clarified whether its main problem is the use of risk assessment measures to assess volitional impairment or the lack of individualization created by the process. There has been very little psychiatric commentary on the connection between volitional impairment and the risk assessment methods currently in use.²⁴⁹ Perhaps this is due in part to the overwhelming futility of both conceptualizing and finding an adequate measure of volitional impairment.²⁵⁰ The overlap between the legal conception of volitional impairment and psychiatry's definition of pedophilia *is* in no-man's land, in which perhaps psychiatry can wait for

245. *See id.*

246. *See* Mercado, Schopp & Bornstein, *supra* note 55, at 305.

247. First & Halon, *supra* note 64, at 451.

248. Sreenivasan, Weinberger & Garrick, *supra* note 72, at 479 (citing William Gardner et al., *Clinical Versus Actuarial Predictions of Violence in Patients with Mental Illness*, 64 J. CONSULTING & CLINICAL PSYCHOL. 602, 602–09 (1996); Richard Rogers, *The Uncritical Acceptance of Risk Assessment in Forensic Practice*, 24 LAW & HUM. BEHAV. 595, 595–605 (2000)).

249. Most of the analysis in this Note with respect to this issue was conducted based on a few pages of psychiatric commentary.

250. Robert Prentky, Anna Coward, and Adeena Gabriel have commented that “we are saddled with an 800-lb. diagnostic gorilla, an essential defining characteristic of an indispensable statutory element that the weight of scholarly opinion regards in the same vein as divination.” Prentky, Coward & Gabriel, *supra* note 199, at 457. They assert that “[t]here is no answer to this insoluble problem, other than to excise ‘volitional impairment’ from statutory language (unlikely) or to provide strict operational guidelines for what constitutes incapacity (equally unlikely).” *Id.*

more case decisions. In the meantime, though, psychiatry should provide concrete suggestions. The DSM itself warns about the “significant risks that diagnostic information will be misused or misunderstood” if employed for forensic purposes “because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis.”²⁵¹ Creating meaningful differentiations (in terms of both conceptual and empirical differences) within its pedophilia diagnosis for the purposes of the law would avoid what it sees as somewhat arbitrary means of differentiating within pedophiles.

In terms of its complaint about risk assessment used as a proxy, psychiatry should either find a better way to measure volitional impairment than risk assessment, or devise a way to measure it based on psychiatry’s preferred construction as an extreme lack of self-control. It is possible that psychiatry would be satisfied with having high risk of reoffending as a simplification for extreme amounts of volitional impairment, but this conclusion is not clear based on its statements. Perhaps a way to reconcile these notions would be to require an extremely high prediction of risk. On the other hand, if psychiatry does not agree at all with the notion of volitional impairment, then it should propose a new construct along with suggestions of ways to detect the construct in a given individual based on direct assessment. Overall, psychiatry is not clear on how the law should decide which pedophiles should be civilly committed. Perhaps its caution in making such a statement is that its language apparently does carry heavy weight in SVP commitment decisions, despite the formal distinctions of definitions that suggest otherwise, and further, that language has the potential to be misconstrued.

In terms of variation among pedophiles, psychiatrists need to clarify the nature of the relationship between some sort of conception of self-control and pedophilia, which, besides clarifying psychiatry’s relationship to the law, would provide information for its own community. Currently, volitional impairment plays no role in its definition of pedophilia; perhaps it should. Thomas Widiger, Research Coordinator for the DSM-IV Task Force, has commented that “[w]ell-meaning clinicians, theorists, and researchers could find some basis for fault in virtually every sentence due in part to the absence of adequate research to guide its construction.”²⁵² Clarification of self-control based on empirical observation would help the

251. DSM, *supra* note 5, at xxxii–xxxiii.

252. CAMPBELL, *supra* note 4, at 237 (citing Widiger & Clark, *supra* note 194, at 946).

psychiatric community and the legal community in standardization and adequate justification for their decisions.

V. CONCLUSION

Psychiatry supposedly has a “unique understanding of human behavior,”²⁵³ but it must prove why it is more equipped than the average person, or the law for that matter, to diagnose mental illness. In order to continue to have relevance and influence in the realm of the no-man’s land of SVP statutes, it must first look within its own definitions and add clarity and precision. As many psychiatrists probably tell their patients, the first step in solving a problem is admitting to having a problem in the first place. Although it may seem like the main source of problems between psychiatry and the law is based on the psychiatric insistence on looking at each individual on a case-by-case basis rather than reducing them to statistics,²⁵⁴ the imprecision revealed in this Note shows that the problem is not merely one of measurement but of substantial conceptual vagueness in psychiatry’s own definition. Part of this problem may be due to lack of information. Psychiatrists themselves must admit that they do not have enough information in what they have called the most “difficult call in all of mental health.”²⁵⁵ Psychiatry should push for more funding since there is a lack of funding for the research of pedophiles in the United States (“many American researchers have been loath to have anything to do with pedophiles”) and most research is conducted in Canada.²⁵⁶ Psychiatry emphasizes repeatedly that there is a difference between having sex with children because of pedophilia, and having sex with children absent a mental illness. Psychiatry must gain the knowledge to explain *why* the two situations are different and *how* they are different. Once it can explain these

253. See Mercado, Schopp & Bornstein, *supra* note 55, at 296.

254. One man convicted of sex offenses against a child wrote a letter to the *Archives of Sexual Behavior* after being released from six years in jail and years of treatment, detailing his experience of pedophilia, which began at the age of twelve. The letter describes with great specificity his attraction to children from a young age, his lack of knowledge as to the problematic nature of this attraction, and his subsequent conquering of the attraction. It describes what treatment methods worked and suggests ways in which adolescents who fantasize about young children can be taught that these fantasies and acting on these fantasies can be dangerous to the victims. The thoughtful, gentle letter tells a far different story from that of Washington’s Earl Shriner, who cut off a child’s penis. The type of frankness found in the letter is unlikely to appear during the course of civil commitment because of the design of the legal system. Brian E. Oliver, *Thoughts on Combating Pedophilia in Non-Offending Adolescents*, 34 *ARCHIVES SEXUAL BEHAV.* 3, 3–5 (2005).

255. See Frances & Sreenivasan, *supra* note 4, at 49.

256. See Joan Arehart-Treichel, *Pedophilia Often in Headlines, but Not in Research Labs*, 41 *PSYCHIATRIC NEWS* 37, 37 (2006).

differences and provide concrete ways of measuring them, the problems of no-man's land will be greatly reduced.