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STATE OF NORTH DAKOTA

IN THE SUPREME COURT
STATE OF NORTH DAKOTA

Cynthia Feland,	)	
	)	
Petitioner/Appellee,	)	District Court No. 08-99-R-1194
	)	
vs.	)	
	)	Supreme Court No. 20100014
A.M.,	)	
	)	
Respondent/Appellant.	)	

BRIEF OF APPELLANT

Appeal from Findings of Fact and Order for Commitment dated December 14, 2009
Honorable Gail Hagerty, Presiding

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4 This is an appeal from the Finding of Fact and Order for Commitment continuing A.M.'s civil commitment as a sexually dangerous individual after his annual discharge hearing.

5 A.M. was found to be a sexually dangerous individual and was committed to the North Dakota State Hospital for treatment in July of 1999. App. p. 4. A.M. requested an annual review pursuant to N.D.C.C. § 25-03.3-18.

6 On December 8, 2008, an SDI Annual Re-evaluation report was completed at the North Dakota State Hospital by Dr. Lynne Sullivan, Ph.D., pursuant to N.D.C.C. § 25-3.3-17. App. p 4. An independent evaluation was done by Dr. Stacey Benson, PsyD, LP, who examined A.M. and completed her report on November 6, 2009. App. p.13.

7 A Discharge Hearing was held on December 10, 2009, before the Honorable Gail Hagerty. By Order dated December 14, 2009, Judge Hagerty found that A.M. continues to be a sexually dangerous individual and continued his commitment to the North Dakota State Hospital for treatment. App. p. 41. A.M. filed a timely Notice of Appeal. App. p. 43.

STATEMENT OF FACTS

9 A.M. was found to be a sexually dangerous person as defined by Chapter 25-03.3 of the North Dakota Century Code and he was committed to the North Dakota State Hospital in July of 1999. App. p. 4. For his annual review hearing, Lynn Sullivan, Ph.D., of the North Dakota State Hospital and an independent examiner, Stacey Benson, PsyD, LP, both filed reports regarding A.M. and testified at his release hearing.

10 A.M. had been placed in juvenile treatment facilities for sexual offenses committed while he was a juvenile, but he has no convictions as an adult. App. p. 13; Trans, p. 19. All of his offending took place when A.M. was between the ages of 13 and 15. App. p. 20; Trans. p. 19. A.M. was committed to the North Dakota State Hospital as a sexually dangerous individual directly from his release from the juvenile system. App. p. 13. When A.M. was initially found to be a sexually dangerous person in 1999, his diagnoses were Pedophilia, sexually attracted to both sexes, non-exclusive type; Fetishism; Antisocial Personality Disorder; and Impulse Control Disorder not otherwise specified. App. Pp. 23-24.

11 For the most part, A.M. has not had significant behavioral problems while at the North Dakota State Hospital and is respectful to staff, is not a management problem and interacts appropriately with most of his peers. App. p. 8; Transp. p. 20-21, 44-45. He did have an obsession with a social worker on his unit and in 2005 he kissed and groped her, but stopped when she told him to stop. Trans. Pp. 10-11, 24. In 2006, A.M. had another incident with this social worker that Dr. Sullivan characterized as an "verbal assault." Trans. p. 10. The Social Worker transferred to another unit in 2008, and since that time, A.M. has climbed on a chair to view her from a window as she walked past, but

otherwise has not attempted to have any contact, either directly or indirectly with her. Trans. Pp. 11, 24. Dr. Sullivan determined that since the social worker moved from the unit "some of his sexual preoccupation and energy for stalking may have been diminished." App. p. 8.

12 A.M. spends a considerable amount of his time living in fantasy as opposed to reality. Trans. p. 16. A.M. has admitted during his treatment that he has had sexual fantasies about the social worker and focused on body parts of other female staff on the unit. Trans. p. 15. He also has had rape fantasies approximately once or twice a year. Trans. p. 37. He described that fantasy as involving a woman saying no, and him continuing to be interested in sexual behavior with her. Trans. p. 38.

13 In her report, Dr. Sullivan diagnosed A.M. with the following: Paraphilia Not Otherwise Specified (nonconsent), Pedophilia, sexually attracted to both sexes, nonexclusive type, Fetishism and Antisocial Personality Disorder. App. p. 4. She further opined that A.M. would experience serious difficulty in controlling his behavior. App. p. 10. At the hearing held on December 10, 2009, Dr. Sullivan changed her diagnosis, finding that A.M. did not meet the criteria for Pedophilia or Antisocial Personality Disorder. Trans. Pp. 8-9. She continued with her diagnosis of Paraphilia Not Otherwise Specified (nonconsent) and Fetishism. Trans. p 9. Dr. Sullivan admitted that Paraphilia Not Otherwise Specified (nonconsent) is not a recognized diagnosis in the DSM- IV (Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition). Trans. p. 9.

14 Dr. Benson determined that A.M. did not meet the criteria for any diagnosis of a recognized condition that is manifested by a sexual disorder, a personality disorder, or other mental disorder or dysfunction that makes the respondent likely to engage in further

acts of sexual predatory conduct. App. Pp. 32-40; Trans. p. 34.

15 Dr. Benson specifically disagreed with the diagnosis of Paraphilia Not Otherwise Specified (nonconsent) because it is not a recognized diagnosis and also from the literature she found, A.M. did not meet any of the criteria specified by the professionals who advocate for this diagnosis. App. Pp. 36-38; Trans. Pp. 35-38. Dr. Benson outlines Paraphilia Not Otherwise Specified (nonconsent) in her report as follows:

> *In Regards to Paraphilia NOS Nonconsent:*
>
> This highly controversial diagnosis was added by Dr. Lynne Sullivan in 2006 and she lists his acknowledgment of rape fantasies as evidence of this.
>
> She states in her 2007 evaluation that he continues to obsess on the social worker despite knowing she is not interested and that he continues to have rape fantasies of other women. She finds this as evidence of Paraphilia NOS.
>
> She states in her 2008 evaluation that he has not discussed sexual contact with nonconsenting females during this review period and that some of his sexual preoccupation may have diminished when the social worker he was obsessed with left the unit. She states there is no evidence that this diagnosis would just go away without treatment, (perhaps ignoring the fact that he has been involved in treatment since he was 15 years old).
>
> Paraphilia NOS is a category included for coding paraphilias that do not meet the criteria for any of the specific paraphilias that are listed in the DSM4TR. The NOS categories are 'reserved for sexual disorders that are either so uncommon or have been so inadequately described in the literature that a separate category is not warranted" (Zander 2005).
>
> Paraphilia NOS Nonconsent is the name given by some examiners for individuals who seem to have a paraphiliac interest in rape. A similar construct, Paraphiliac Coercive Disorder, was considered (and rejected) by the DSM-III-R advisory committee for inclusion in the DSM-III-R back in the 1980's. At the time, there was strong objection to including such a diagnosis from the US Department of Justice, the American Psychiatric Association, the American Psychological Association, the American Orthopsychiatric Association, the National Association of Social Workers, and the National Organization of Woman (among others). In fact, the APA received hundreds of letters from mental health professionals who opposed the diagnosis. The only other diagnosis that has had this much controversy around it was homosexuality, which was considered a mental disorder until 1973.

In an article that was just published online today (11/6/09), which will soon be available in the printed version of the Archives of Sexual Behavior, Dr. Knight offers his review of this disorder and the possibility that it may be included in a future edition of the DSM, he concludes his article by saying "The present review indicates that the diagnosis has little empirical support, and it would be a travesty to grant it status that would perpetuate its misuse."

Because Paraphilia NOS Nonconsent is not listed in the DSM, there is no uniform and agreed upon criteria to diagnose it. In his book, Evaluating Sexual Offenders, Dr. Doren, who has been one of the strongest advocates for his disorder, identifies the 9 guidelines he uses to diagnose someone with Paraphilia NOS nonconsent. They are:

1. Ejaculation or other clear signs of sexual arousal during events that are clearly nonconsensual
2. Repetitive patterns of actions as if scripts
3. Virtually all of the person's criminal behavior is sexual
4. Raping when the victim had already been willing to have consensual sex
5. A short time period after consequences before raping again
6. Raping under circumstances with high likelihood of being caught
7. Having concomitant cooperative sexual partners
8. Various types of victims in "purely" sex offenders
9. Maintenance of a Rape Kit

While this is not a widely accepted list (and this is not a widely accepted diagnosis), it is one of the few, if only, published in a book. Assuming the diagnosis exists and assuming these are the criteria, I do not see how [A.M.] can be shown to meet this disorder, especially in light of the fact that he has not raped anyone. Doren states, on page 68 of his book that these criteria are used "beyond repetitive rapes" to help a clinician make a determination about whether or not the rapist also has Paraphilia NOS Nonconsent, suggesting that the first criteria is that the individual has committed repetitive rapes.

Another article, by First and Halon, describe the "hotly contested debate" over the use of such a diagnosis in SVP (SDI) cases. They state that there *may* be a case for using this diagnosis, with extreme caution, with individuals who are incarcerated for raping adults, when it can be clear that it was specifically the nonconsensual nature of the event that was arousing. Once again, this would NOT apply to [A.M.].

It is extremely important for the court to understand that simply having non consensual sex, or having fantasies about non consensual sex, is NOT ENOUGH for this disorder. If it were, nearly every sexual offender could be diagnosed with this and it would lose its disciminatory ability. If it does exist, it must be rare enough that it occurs in less than 2% of the time (or it would presumably have been listed in the DSM in its own right and not as a residual category). The NOS

categories are all less frequently encountered than the larger categories.

> Continuing to fantasize about a woman who is not interested in him is NOT enough for this disorder. [A.M.] has been institutionalized since he was 15 years old. He has had no adult opportunity to date or form normal sexual relationships. He became attracted to an adult female who he saw nearly daily as part of his normal routine, and despite the fact that she is not interested in him, continued to think (obsess?) about her, culminating in his leaning in and kissing her. While this is inappropriate, it is surely not of the magnitude necessary for such a serious diagnosis as Paraphilia NOS Nonconsent, a disorder in which the individual is turned on sexually by the nonconsensual act of rape, uses highly scripted rape scenarios, has a rape kit (duct tape, rope, other torture objects etc) and prefers to force someone to have sex with them, even if that person were already willing to be a consensual partner.
>
> [A.M.] states how he stopped his assault on one of his victims because she yelled and tried to run away. This is highly contraindicated for a diagnosis of Paraphilia NOS, where this would only serve to heighten his arousal and sexual gratification. There was also no force in any of his offenses. Violence, beyond that which is needed to gain compliance, is a critical factor for those with this diagnosis.
>
> In sum, I see no evidence whatsoever to diagnose [A.M.] with this diagnosis, and apparently neither did Dr. Belanger, Dr. Roux, Dr. Coombs or Dr. Riedel as none of them listed it either.
>
> App. Pp. 36-38.

16 Judge Hagerty did not find that A.M. had the diagnosis of Paraphilia Not Otherwise Specified (nonconsent) as determined by Dr. Sullivan, but changed the diagnosis to Paraphilia NOS, without the nonconsent specifier. App. p. 41. Judge Hagerty found that A.M. "would be properly diagnosed with Paraphilia NOS. Whether or not there is a more distinct category, I think it's clear that he does fall under the NOS criteria." Trans. Pp. 59-60. She further found that he was properly diagnosed with Fetishism. Trans. p 60.

17 Judge Hagerty found that "while in treatment, A.M. spends approximately 60% of his time in fantasy focusing on a particular individual and on body parts. Given the fact that the respondent has been unable to control his behaviors in the most restrictive and

controlled setting." App. p. 41. She found that he was likely to engage in further acts of sexually predatory conduct and has serious difficulties controlling his behavior. App. p. 41.

18 LAW AND ARGUMENT

19 Did the Petitioner show by clear and convincing evidence that A.M. is a sexually dangerous individual?

20 The Court reviews appeals from commitments of sexually dangerous individuals under N.D.C.C. Ch. 25-03.3 using a modified clearly erroneous standard. In re L.D.M., 2005 ND 177, 704 N.W.2d 838, citing In re D.V.A., 2004 ND 57, 676 N.W.2d 776. The trial court's order of committal should be affirmed unless it is induced by an erroneous view of the law or the Court is firmly convinced that the decision was not supported by clear and convincing evidence. Matter of R.A.S., 2008 ND 185, ¶ 5, 756 N.W.2d 771, Matter of E.W.F., 2008 ND 130, ¶ 8, 751 N.W.2d 686.

21 At a discharge hearing, the burden is on the State to prove by clear and convincing evidence that the committed individual remains a sexually dangerous individual. N.D.C.C. § 25-03.3-18(4), Matter of R.A.S., 2008 ND 185, ¶ 6, 756 N.W.2d 771. To meet this burden, the State must show the committed individual has:

> [1] engaged in sexually predatory conduct and . . . [2] has a congenital or acquired condition that is manifested by a sexual disorder, a personality disorder, or other mental disorder or dysfunction that [3] makes that individual likely to engage in further acts of sexually predatory conduct which constitute a danger to the physical or mental health or safety of others.

N.D.C.C. § 25-03.3-01(8).

22 **Engaged in Sexually Predatory Conduct**

23 The first prong of the three part test under N.D.C.C. § 25-03.3-01(8) is whether the person engaged in sexually predatory conduct. A.M. was found to have engaged in sexually predatory conduct as a juvenile, with all of his offenses taking place when A.M. was between the ages of 13 and 15. He has not offended as an adult. All evaluators have determined that he meets this criteria based on his juvenile offenses.

24 **Congenital or Acquired Condition That Is Manifested by a Sexual Disorder, a Personality Disorder, or Other Mental Disorder or Dysfunction**

25 The second prong of the three part test under N.D.C.C. § 25-03.3-01(8) is whether the person has a congenital or acquired condition that is manifested by a sexual disorder, a personality disorder, or other mental disorder or dysfunction. Matter of Anderson, 2007 ND 50, 730 N.W.2d 570, In re G.R.H., 2006 ND 56, ¶6, 711 N.W.2d 587.

26 When Dr. Sullivan completed her re-evaluation of A.M. in December of 2008, she diagnosed him with Paraphilia Not Otherwise Specified (nonconsent), Pedophilia, sexually attracted to both sexes, nonexclusive type, Fetishism and Antisocial Personality Disorder. By the time of the hearing, she changed her diagnosis and testified that at the current time she did not believe A.M. met the criteria for Pedophilia or Antisocial Personality Disorder. Transcript P. 8-9. She maintained her diagnosis of Paraphilia Not Otherwise Specified (nonconsent) and Fetishism. Dr. Sullivan admitted that there have been no indications of Fetishism since A.M. was 15 years. old. Trans. p. 22.

27 Dr. Benson clearly outlines in her report why Paraphilia Not Otherwise Specified (nonconsent) should not be used as a diagnosis. First of all, it is not recognized by the

mental health community as a valid diagnosis and is not included in the DSM-IV, therefore, there are no set criteria to use to determine if a person falls into the category. Using the criteria that are published by proponents of using the diagnosis, A.M. does not meet a single one of the guidelines listed. The crux of the diagnosis in the literature is the offender is a violent, repeat rapist, which A.M. is not.

28 Dr. Sullivan admitted that her diagnosis of Paraphilia Not Otherwise Specified (nonconsent) is not in the DSM-IV and there were no specific criteria to determine if a person would fall into that category, but the general construct that she used was an interest in forcing unwanted sexual contact on persons that don't want it. Trans. Pp. 9-10, 13, 23-24.

29 Using Dr. Sullivan's criteria, the diagnosis could be used for anyone who has rape fantasies or who has been involved in nonconsensual sexual acts. Every person charged with a sexual crime could then be diagnosed with Paraphilia Not Otherwise Specified (nonconsent), because every crime, by definition, has a nonconsenting victim. Trans. p 36. The various recognized categories of Paraphilia NOS are reserved for disorders that are so rare they occur less than other paraphilic disorders that are included in the DSM-IV. Trans. p. 36.

30 Dr. Sullivan based her diagnosis of Paraphilia Not Otherwise Specified (nonconsent) on A.M.'s conduct including his forcing a kiss on a social worker, then groping her (but stopping when she requested he stop), what she characterized as his "verbally attacking" the social worker, A.M. standing on a chair to get a glimpse of her out of the window, A.M.'s continuing to fantasize about the social worker, and his occasional rape fantasies. Trans. P. 24. Even using Dr. Sullivan's stated criteria for a

diagnosis of Paraphilia Not Otherwise Specified (nonconsent) of an interest in forcing unwanted sexual contact on persons that don't want it, A.M. would not fall into that category. Fantasizing and looking out a window at someone can hardly be considered sexual contact. There is nothing in the record to indicate if A.M. knew or believed the kiss and groping were unwanted at the time he initiated the contact. It can be assumed that it was unwanted on the part of the social worker because she told A.M. to stop, but he could have incorrectly believed it was contact that she wanted. The important factor is that he stopped as soon as she told him to. If he was truly interested in forcing unwanted sexual contact, he would have continued at the point he determined that the contact was unwanted. His actions were certainly inappropriate, but did not rise to the level needed to diagnose any sort of Paraphilia.

31 Assuming that Paraphilia Not Otherwise Specified (nonconsent) is a valid condition, the evidence does not indicate that A.M. meets either the criteria proposed in the literature, or the criteria Dr. Sullivan testified she uses.

32 Judge Hagerty found that A.M. should be diagnosed with something that none of the evaluators has ever proposed: Paraphilia NOS, with no other qualifier. Both Dr. Sullivan and Dr. Benson testified that Paraphilia Not Otherwise Specified is an umbrella term for some rare types of paraphilia, but each gave specific qualifiers for the categories, such as an interest in enemas, or klismaphilia; telephone scatologia, or obscene phone calls; interest in urine; interest in animals; sexual sadism. Trans. Pp. 9-10; 36. To take away part of the diagnosis changes it and there is no evidence the change made by Judge Hagerty is valid or supported by acceptable criteria.

33 Judge Hagerty found A.M. "would be properly diagnosed with paraphilia NOS.

Whether or not there is a more distinct category, I think it's clear that he does fall under the NOS criteria. There's an indication he spends 60 percent of his time in fantasy. There have been ongoing fantasies concerning a particular individual. There have been inappropriate fantasies concerning body parts." Trans. Pp. 59-60. This indicates that if someone prefers fantasy, including sexual fantasies, to real life, they can be diagnosed with a sexual disorder. It's quite a stretch to commit someone as sexually dangerous because of what they think verses their actions.

34 A.M. is also in a bit of a Catch-22 regarding any sexual fantasies he reports. He has been in institutions since his teens and does not have opportunity to develop any real life sexual relationships at this time. He is not allowed to have sexual contact with any of the staff or other patients. When he reports his fantasies about a real person, they are used as one of the primary components of his diagnosis of Paraphilia Not Otherwise Specified (nonconsent) as he is not supposed to fantasize about someone if they do not consent. When he reports that he has focused on the body parts of some female staff members, it is considered problematic because he is supposed to view them as a whole or in a relationship aspect (although he his not allowed to have a relationship with them). Trans. Pp. 27-28. It appears that any sexual outlet that A.M. may have would be considered inappropriate. Dr. Sullivan also considers that A.M. is not adequately participating in his treatment, yet the only way that his fantasies can be known is if he reports them during treatment. If A.M. had not voluntarily participated in his treatment, Dr. Sullivan would have virtually nothing in the past two or three years to use as the basis for her diagnosis of Paraphilia Not Otherwise Specified (nonconsent).

35 **Likely to Engage in Further Acts of Sexually Predatory Conduct**

36 The third prong of the test under N.D.C.C. § 25-03.3-01(8) is whether the person is likely to engage in further acts of sexually predatory conduct. The term "likely to engage in further acts of sexually predatory conduct" means the individual's propensity towards sexual violence is of such a degree as to pose a threat to others. In re M.B.K., 2002 ND 25, ¶ 18, 639 N.W.2d 473; Matter of G.R.H., 2006 ND 56, ¶ 16, 711 N.W.2d 587. This definition prevents a contest over percentage points and the results of other actuarial tools, and allows experts to use the fullness of their education, experience and resources available to them in order to determine if an individual poses a threat to society." In re M.B.K., 2002 ND 25, 639 N.W.2d 473, 477.

37 In addition to the three requirements contained in the plain language of the statute and this Court's definition of "likely to engage in further acts of sexually predatory conduct," the United States Supreme Court held that in order to satisfy substantive due process requirements, the individual must be shown to have serious difficulty controlling his behavior. Matter of Hehn, 2008 ND 36, ¶ 19, 745 N.W.2d 631, quoting Kansas v. Crane, 534 U.S. 407, 413 (2002). This additional consideration is necessary to distinguish a sexually dangerous individual from the "dangerous but typical recidivist convicted in an ordinary criminal case." Id.

38 A.M. unfortunately falls into the small category of offenders that cannot use the normal risk assessment tools to help determine their risk of re-offending. His offenses were committed as a juvenile and he had no adult offenses, therefore the tests normally given to adult sexual offenders, such as the MnSOST-R, RRASOR and Static 99, cannot be used on him. App. p. 39. While there are tests that can be used on juvenile offenders, they are of such a nature that they are only accurate while the person is a juvenile and

cannot be given once the person is an adult. App. p. 39; Trans. Pp. 40-42. This means that it is necessary to look at other tests, statistics and behaviors to determine if the person is likely to offend in the future.

39 A very important factor is that the rate of recidivism for juvenile sexual offenders is 4 to 10 percent. Trans. p. 43. Juveniles who commit crimes are not just younger versions of adult sexual offenders. Trans. p. 40. Some of the reasons juvenile offenders must be viewed differently than adult offenders is because the adolescent's prefrontal cortex, the part of the brain that looks at risks and rewards, deeper thinking, thrill-seeking and impulse control, isn't mature in adolescents. Trans. p. 44. The individuals who engage in risky, impulsive behavior in adolescence are believed to self-correct as an adult. Trans. p. 44. The low recidivism rate for juveniles and the maturation of the adolescent brain both are very strong indicators that A.M. has a low risk of re-offending at this time.

40 In prior evaluations and in Dr. Sullivan's written evaluation in this case, a lot of emphasis was given to the fact that either the diagnosis of Pedophilia or Antisocial Personality Disorder create reason to believe A.M. would be likely to engage in further acts of predatory conduct. It has now been determined that A.M. does not have either of these diagnosis at this time. In fact, by not meeting the criteria for antisocial personality disorder, it indicates that A.M. is able to control is behavior.

41 Even considering A.M.'s unwanted kiss of the social working in 2005 and his "verbal assault" against this same social worker in 2006, he has had no further overt unwanted acts reported in several years. He has tried to see this social worker by looking out a window, but she was unaware of his action and he has been appropriate and polite

with staff for the past two or more years and he interacts appropriately with his peers.

42 Dr. Sullivan reached a conclusion in her report that "until recently (i.e., within the last two years), he demonstrated difficulty with controlling his urges to rape women." App. p. 10. This conclusion is puzzling as there is nothing in any evaluations or testimony to show that A.M. has ever attempted to rape a women. Even if he has fantasized about rape, he has never acted on those fantasies. His lack of action on a fantasy indicates control of his actions, not a lack of control. A.M. has admitted during his treatment to having rape fantasies, approximately once or twice a year. He indicated that these include using force only to the point of obtaining compliance. Repeated studies have shown that rape fantasies are very common in the normal male population, with between 13 and 54 percent of adult men reporting having rape fantasies. Trans. Pp. 37; 25. Studies have found that of the top five most common sexual fantasies reported by men, sexually dominating or overpowering someone was number five and engaging in sexual behavior that the person would never do in real life was number four. Trans. p. 37. A.M. having occasional rape fantasies does not indicate that he will ever act on those fantasies as this is a common fantasy for men. The only time A.M. has ever used any sort of force was several years ago when he kissed and groped the social worker he was obsessed with. It is important to note that when she told him to stop, he immediately stopped.

43 The Petitioner failed to prove by clear and convincing evidence that A.M.'s propensity towards sexual violence is of such a degree as to pose a threat to others and further the Petitioner failed to show that A.M. would have serious difficulty controlling his behavior.

44 **CONCLUSION**

45 A.M. does not have a recognized congenital or acquired condition that is manifested by a sexual disorder, a personality disorder, or other mental disorder or dysfunction that makes him likely to engage in further acts of sexually predatory conduct or that he would have serious difficulty controlling his behavior.

46 A.M. respectfully requests the order of commitment be vacated and that he be released from treatment at the North Dakota State Hospital.

47 Dated April 5, 2010.

48 Susan Schmidt

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49 CERTIFICATE OF SERVICE VIA E-MAIL

50 True and correct copies of the *Brief of Appellant* and *Appendix to Brief of Appellant* were on April 5, 2010, sent via e-mail to the following:

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