



## DSM-5 proposed diagnostic criteria for sexual paraphilias: Tensions between diagnostic validity and forensic utility

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### ABSTRACT

In order to prevent sexual crimes, “sexual predator” laws now allow indefinite preventive civil commitment of criminals who have completed their prison sentences but are judged to have a paraphilic mental disorder that makes them likely to commit another crime. Such proceedings can bypass the usual protections of criminal law as long as the basis for incarceration is the attribution of a mental disorder. Thus, the difficult conceptual distinction between deviant sexual desires that are mental disorders versus those that are normal variations in sexual preference (even if they are eccentric, repugnant, or illegal if acted upon) has attained critical forensic significance. Yet, the concept of paraphilic disorders – called “perversions” in earlier times – is inherently fuzzy and controversial and thus open to conceptual abuse for social control purposes. Consequently, the criteria used in diagnosing paraphilic disorders deserve careful scrutiny. The DSM-5 sexual disorders work group is proposing substantial revisions to the paraphilia diagnostic criteria in the DSM-5 nosology. It is claimed that the new criteria provide a reconceptualization that clarifies the distinction between normal variation and paraphilic disorder in a way relevant to forensic settings. In this article, after considering the logic of the concept of a paraphilic disorder, I examine each of the proposed changes to the DSM-5 paraphilia criteria and assess their conceptual validity. I argue that the DSM-5 proposals, while containing a kernel of an advance in distinguishing paraphilias from paraphilic disorders, nonetheless would yield criteria for paraphilic disorders that are conceptually invalid in ways open to serious forensic abuse.

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The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 2000) – often called the “Bible of psychiatry” in virtue of its influence and authority – is undergoing a revision that will shortly lead to a fifth edition (DSM-5). Starting with the third edition in 1980 (DSM-III; American Psychiatric Association, 1980), the DSM has offered descriptive, symptom-based diagnostic criteria that define each of the mental disorders. The DSM’s necessary-and-sufficient diagnostic criteria are used by virtually all mental health professions, as well as attorneys, to determine what is and is not a mental disorder in clinical, research, and forensic settings in the United States and increasingly throughout much of the world.

On the DSM-5 website (American Psychiatric Association, 2010a), the Task Force working on the DSM-5 has posted many proposed changes to the diagnostic criteria for categories throughout the Manual, each of which could have a substantial impact on who is considered to be mentally disordered. In this paper, I evaluate the proposed changes to the section of disorders known as “sexual paraphilias,” that is, disorders of the objects of sexual impulses, desires, and arousal, as they currently appear on the website (as of November, 2010). These conditions used to

be known as “sexual perversions” or “sexual deviations.” The DSM-III introduced the more neutral term *paraphilia*, noting that this term’s Greek components correctly emphasize that there is a deviation (*para*) in that to which the person is attracted (*philia*).

Currently, the specific DSM paraphilia categories prominently include pedophilia, exhibitionism, voyeurism, sadism, masochism, frotteurism (rubbing against strangers), fetishism, and transvestic1 fetishism. Many other paraphilias, from asphyxophilia to zoophilia, can be diagnosed within a “wastebasket” category of “paraphilia not otherwise specified” (paraphilia NOS) that encompasses any condition judged by the clinician to be a paraphilia that does not fall under any of the specific categories provided by the DSM. However, the categories specifically named in the DSM along with the new categories proposed for the DSM-5 between them encompass the paraphilias most relevant to forensic evaluation, so I focus on these categories.

Because of strong feelings about what is normal versus disordered sexuality, as well as theoretical uncertainty about the nature of human sexuality, the definitions of the paraphilias remain among the most controversial in the DSM. Given the malleability of human sexuality and the creativity of human beings in pursuing and amplifying sexual pleasure, it remains a debated question as to what justifies the classification of a source of sexual pleasure or a type of sexual activity as a mental disorder. The malleability of normal sexuality and our current

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ignorance of the mechanisms underlying sexual desire are powerful reasons for being conservative in attributing paraphilic disorders.

The justification for paraphilic diagnoses has become even more puzzling since homosexuality was eliminated as a diagnostic category from DSM-III (Bayer, 1981; Spitzer, 1981), followed by the final elimination in the revised third edition (DSM-III-R; American Psychiatric Association, 1987) of a remaining more limited category of “ego-dystonic homosexuality” in which the patient is distressed about his or her homosexuality. During the nineteenth and early twentieth centuries, homosexuality was considered the prototypical sexual perversion. For quite powerful reasons, including changing social values regarding both homosexuality itself and the importance of the reproductive function of sexuality, and the fact that homosexuality is compatible with a full capacity for love and relationship happiness, homosexuality was reclassified as a non-disordered variant of human sexuality. One might have expected, based on parallel logic, that other supposed paraphilias would inevitably be depathologized as well as part of a broadened acceptance of human sexual pluralism. But that has not happened. This historical circumstance pointedly raises the question whether there is a defensible conceptual basis for the lines that are being drawn by the DSM between the normal and the disordered.

There are four changes in the paraphilia criteria proposed for DSM-5 that I consider here. The first is a proposal to clarify terminology by distinguishing paraphilias – which are to be considered non-disordered sexual variations – from paraphilic disorders, which are to be distinguished from the paraphilias themselves by the harm they cause (currently, “paraphilia” is used for both the deviant desire and the disorder). A second proposal is for diagnosis to rely more on the objectively ascertainable data of the number of an individual’s sexual victims, along with a continued emphasis on behavioral criteria as central to diagnosis. Two further proposed changes consist of new categories to be added to the paraphilic disorders. The first is *hebephilia* (sexual arousal to pubescent children), to be incorporated into an expanded category of pedophilia (arousal by prepubescent children) to be labeled *pedohebephilia*. The second proposed new category is *paraphilic coercive disorder*, which is basically arousal by the coerciveness of a sexual act, thus in effect a paraphilic rape disorder. After some introductory explanation of why the definition of the paraphilias has become of crucial importance to larger issues regarding the protection of civil liberties, I address the concept of disorder and its application to the paraphilias in some detail. I then offer a conceptual history of DSM criteria for the paraphilias, after which I consider each of the DSM-5 proposals in turn.

### 1. Why are the DSM-5 paraphilic disorder proposals so important?: The role of sexual diagnosis in preventive institutionalization under sexual predator laws

The behavior associated with the expression of some paraphilias – especially acts involving minors, or the involvement of nonconsenting victims, or various forms of bodily harm (e.g., during sadistic sexual acts) – is not only harmful but illegal. For reasons that were unanticipated just a few decades ago, the precise definitions of the paraphilias have become entwined with the attempt to prevent such harm to the public from individuals illegally acting out certain paraphilic desires. This is because the DSM definitions of the paraphilic disorders are now applied in civil commitment procedures allowed by “sexual predator” laws – also commonly known as Sexually Violent Predator (SVP) or Sexually Dangerous Person (SDP) provisions – that have been passed in various versions by about twenty states and the federal government (Frances, Sreenivasan, & Weinberger, 2008).

Sexual predator laws were to some extent prompted by public outrage at cases in which released sexual offenders committed horrific crimes soon after release. For example, in the case that led to the first such sexual predator law, in Oregon, an individual convicted of

kidnapping and sexually molesting two teenage girls was released after a ten-year prison term and two years later kidnapped, sodomized, and cut off the penis of a seven-year-old boy (Frances, Sreenivasan, & Weinberger, 2008). In response, rather than lengthening the prison terms of all such offenders, some legislatures chose to institute a form of selective preventive institutionalization upon release from prison of those offenders who are deemed likely to act illegally again due to a mental abnormality. The advent of such laws is attributable to several other factors as well. The general move towards fixed sentencing for a given crime was aimed at greater fairness, but it decreased the flexibility that judges and parole officers had under indeterminate sentencing to be sensitive to the details of an individual’s case and to provide lengthier sentences in more egregious cases. Legislatures resisted passing very long fixed prison terms for sexual crimes that would apply to everyone in a class of offenders, because that inevitably yielded some cases of gross injustice to less egregious offenders. Finally, perceived failure of rehabilitation and treatment programs for sex offenders to prevent recidivism led to a renewed belief that keeping individuals from society was a major goal in dealing with repeat offenders (Frances, Sreenivasan, & Weinberger, 2008).

It is unconstitutional to preventively detain normal individuals just because they are believed likely to commit heinous crimes. However, involuntary preventive institutionalization of the mentally ill is constitutional under circumstances in which the mentally ill individual poses an imminent danger to himself/herself or others due to the mental disorder. Such practices of involuntary commitment for the mentally disordered, traditionally applied primarily to the severely psychotic or suicidal, have found novel avenues of application within the American legal system to psychiatrically disordered sexual offenders whose impulses lead to illegal forms of sexual activity that they have trouble controlling. The Supreme Court has ruled that preventive institutionalization of potential sexual criminals is constitutionally acceptable and does not imply constitutionally barred “double jeopardy” even after such individuals have served full prison terms for their crimes, but only if it can be demonstrated that the threat of renewed harm upon their release is due to a mental disorder that renders the individual unable to exercise normal-range volitional control over sexual behavior.

In addressing the constitutionality of state laws providing for civil commitment of sexually dangerous persons, in the case of *Kansas v. Hendricks*, the Supreme Court ruled that individuals who are “unable to control their behavior and thereby pose a danger to the public health and safety” (521 U.S. 346, 357 (1997)) may be preventively institutionalized, as long as “a finding of future dangerousness” was linked “to the existence of a ‘mental abnormality’ or ‘personality disorder’ that makes it difficult, if not impossible, for the person to control his dangerous behavior” (*Id.* at 358). The Court emphasized that dangerousness in the form of inability to control one’s impulses must be due to a mental disorder to warrant preventive civil commitment:

A finding of dangerousness, standing alone, is ordinarily not a sufficient ground upon which to justify indefinite involuntary commitment. We have sustained civil commitment statutes when they have coupled proof of dangerousness with the proof of some additional factor, such as a ‘mental illness’ or ‘mental abnormality’. These added statutory requirements serve to limit involuntary civil confinement to those who suffer from a volitional impairment rendering them dangerous beyond their control.  
(*Id.*)

In the follow-up case of *Kansas v. Crane*, the Supreme Court reaffirmed that a psychiatric criterion was essential in distinguishing those subject to preventive civil detention from those other dangerous persons who should be addressed through criminal law. Otherwise, civil commitment could become a non-constitutional “mechanism

for retribution or general deterrence” (537 U.S. 407, 412 (2002)). The problem with the loss-of-control requirement from a diagnostic perspective is that, when actions are voluntary as in sexual acts, it is difficult to distinguish loss of control from willful decision to engage in a prohibited action despite the consequences. The Court recognized that loss of control is an inherently vague notion. The result was heavy reliance on the diagnosis of psychiatric disorder to justify civil commitment:

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

The notion of mental disorder as applied within the sexual predator civil commitment process has generally been interpreted as referring to disorders as formalized in the official diagnostic codes of the DSM. As in the passage above, in addition to “mental disorders,” the Supreme Court and some state laws refer to a vaguer class of “mental abnormality” to be used to justify civil commitment. However, this has generally been interpreted to imply disorder in the DSM sense, which covers not only “mental illness” in a narrow sense but all forms of mental pathology. Indeed, the sort of loss of control described by the Court would seem to suggest disorder, unless due to disqualifying causes, such as intoxication. In general, it is the paraphilic disorders that have been construed by courts as specific enough to justify preventive confinement under sexual predator laws, whereas other conditions – for example, personality disorders or substance dependence – that might be construed to more broadly lead to loss of control of certain kinds have tended to be resisted thus far as sufficient grounds (e.g., *U.S. v Carta, No. 07-12064-JLT, D. Mass June 4, 2009*).

One may construe the use of paraphilic diagnosis in sexual-predator civil commitment procedures as a questionable form of “preventive detention” that is supposed to be constitutionally banned but has found a back-door route through the interpretations of courts regarding the special status of mental disorders. Alternatively, one can see such commitment procedures as a legitimate extension of the traditional “dangerous to oneself or others” standard for involuntary civil commitment previously applied primarily to psychoses. However one sees it, these legal developments have created a situation in which the way a sex offender is treated by the legal system may depend heavily on whether the individual is considered to have a paraphilic disorder.

There is obviously a potential for a dangerous slippery slope implicit in these legal developments. A pluralistic society is based on respect for human difference and acceptance of the enormous range of normal variation in tastes and desires. If sexual peculiarities that are labeled disorders and are offensive to others can be the grounds for civil commitment on the basis of the harm they do to the public, then it is not clear why other peculiarities that may be labeled disorders and may be out of control of the afflicted individual – such as, say, depression or anxiety that detracts from the efficiency of others and thus harms them – need remain constitutionally immune to such provisions in the future (Wakefield, 2010). The United Kingdom now has similar detention laws regarding those with antisocial personality disorder. Needless to say, prosecutors availing themselves of civil commitment processes and wishing to keep offenders from release find it in their interest to argue for the most expansive possible interpretation of the DSM criteria for paraphilic disorders – lending enormous weight to the details of the diagnostic criteria. Where to draw the line between disordered versus non-disordered undesirable

or harmful preferences has thus become a central issue to future protection of civil liberties.

In sum, these legal developments with respect to civil commitment of mentally disordered sexual predators pose an urgent challenge to mental health professionals to “get it right” when it comes to the distinction between disorder and non-disorder. However, the attempt to “get it right” has been tempered by the realities and needs of civil commitment procedures. In this round of DSM revision, the revision of the paraphilia criteria is being driven to some extent by the unique features and requirements of the forensic situation. Many of the DSM-5 paraphilia proposals – such as to add a coercive sexual disorder category, to retain the possibility of diagnosing disorder on the basis of behavior alone, to add a number-of-victims criterion to several disorders’ criteria sets, and to expand pedophilia to pedohebephilia – are responses to concerns about diagnosing individuals in forensic, and specifically civil commitment, situations. While responsiveness of diagnosis to forensic needs is in principle a good thing, it also holds the danger that broader conceptual issues regarding validity could be eclipsed. Close examination of the logic of the proposals is thus warranted.

## 2. Conceptual issues in the evaluation of criteria for paraphilic disorders

My primary purpose in this article is to review the DSM-5 proposals for changes in the paraphilia criteria and evaluate whether they take us in the direction of greater diagnostic validity, in the sense of identifying true pathologic entities. However, the evaluation of the DSM-5 proposals requires some preliminary consideration of the concept of a disorder in general and more specifically the concept of a paraphilic disorder.

### 2.1. The harmful dysfunction analysis of “disorder” as a framework for evaluating the proposed DSM-5 criteria for paraphilic disorders

As the previous discussion makes clear, in sexual predator civil commitment hearings, the distinction between disorder and non-disorder really matters, as others involved in the DSM have observed:

The rationale for SVP/SDP commitment is the presence of a statutorily defined “diagnosed mental disorder,” which is linked to sexual offending. But what is meant by that term? The ramifications of the SVP/SDP process, in representing both the balancing of public safety and the protection of an individual’s right to liberty, demand that decisions about what is a legally defined mental disorder should not be made in an arbitrary and idiosyncratic manner. (Frances, Sreenivasan, & Weinberger, 2008, p. 376).

Because of their central role as a proxy for the “mental abnormality” requirement in sexually violent predator commitment statutes (First & Halon, 2008), a false positive diagnosis of a paraphilia has a uniquely negative outcome, namely inappropriate and potentially indefinite civil commitment to a secure forensic psychiatric facility. (First, 2010, p. 1239).

In evaluating the paraphilia proposals, the usefulness of the evaluation depends wholly on the validity of the conceptual standard against which the proposed criteria are measured. The account of disorder that will provide the framework here for the evaluation of the paraphilia criteria will be the “harmful dysfunction” (HD) analysis (Wakefield, 1992a, 1992b, 1993, 1999a, 1999b, 2006).

An analysis of disorder attempts to explain widely shared consensual judgments about which problematic conditions are and which are not disorders. Even superficially similar conditions may be judged disorders in some instances and non-disorders in others. For example, illiteracy is not considered a disorder, yet reading disorders involve a very similar superficial phenomenon of lack of ability to read

that is considered a disorder. Routine delinquency is negative but not a disorder, whereas conduct disorder, which has many of the same manifestations, is considered a disorder (Wakefield, Pottick, & Kirk, 2002; Wakefield, Kirk, Pottick, Tian, & Hsieh, 2006). How do we make such distinctions?

The HD analysis is intended to apply to medical disorder in general, both mental and physical, in order to account for how – contrary to certain antipsychiatric arguments – there really literally are mental disorders in the medical sense of “disorder.” The HD analysis maintains that the concept of disorder has two components, a factual component of failure to perform a biologically designed function, and a value component of being harmful. To be a disorder, a condition must satisfy both components. The basic idea is simply that virtually any biologically shaped mental system (including the system generating sexual desire) can “go wrong” and malfunction relative to what it was biologically designed to do, just as can almost any physical process or system. However, even a malfunction is not a disorder when it is entirely harmless. When such a system malfunctions in way that has a negative or undesirable or harmful effect on the individual or on society at large as judged by social values, that constitutes a medical disorder.

In the context of considering paraphilias, it is important to emphasize that the value component by itself does not distinguish disorders from the great variety of other kinds of negative conditions in life, ranging from crime and ignorance to lack of skill, lack of talent, and undesirable personality traits. Even the DSM's definition of disorder points out that conflicts between the individual and society or sheer social deviance are not disorders, because symptoms must be caused by a dysfunction in the individual to constitute a disorder. Thus, for example, adultery, which is negatively socially valued, is not thereby considered a disorder because the desires underlying adultery, while disapproved, are conceded to be within the normal range of human biological design and not a dysfunction of sexual desire.

But what is a dysfunction? A dysfunction in the sense relevant to psychiatric diagnosis is a failure of a “natural” biologically designed function, which is best understood in evolutionary terms as the effects of the system that caused the system to be naturally selected (Wakefield, 1992a,b, 1999a, 1999b). This factual “dysfunction” requirement distinguishes those negative conditions that are disorders from all the rest of life's misfortunes. No matter how harmful a condition may be, it is not a disorder unless it is a failure of the way we are biologically designed. Most conditions appearing in the DSM involve harm in virtue of their symptoms, so it is the dysfunction component that tends to be overlooked when there are false positive diagnoses – that is, when negative conditions that are in fact problems in living or normal variation or eccentricity are mistakenly diagnosed as mental disorders.

## 2.2. Nagel on the concept of a paraphilia

What, then, characterizes a paraphilic dysfunction of sexual desire? (There are other kinds of sexual dysfunctions that do not have to do with the object of desire and so are not paraphilic and not considered here, such as the incapacity to get aroused even with preferred objects, or “sexual arousal disorder.”)

In a classic paper, the philosopher Thomas Nagel (1969) made four important and persuasive general points (these were preliminary to presenting his own Sartrean view of paraphilias, which seems to me indefensible and will not be reviewed here.) First, perversions are not merely sexual acts that a given society morally disapproves. As Nagel observes: “Anyone inclined to think that in each society the perversions are those sexual practices of which the community disapproves, should consider all the societies that have frowned upon adultery and fornication. These have not been regarded as unnatural practices...” (p. 6).

In this regard, allow me to share a personal anecdote that underscores the varying, socially shaped nature of judgments about the pathological status of sexual behavior. I was once engaged in a discussion of the DSM-III-R paraphilia diagnostic criteria with three

eminent psychiatrists, two of whom were of an older generation and the other of whom was a bit younger, of my generation. At one point in the discussion, I was critiquing the “sadism” criteria, which read: “A. Over a period of at least six months, recurrent intense sexual urges and sexually arousing fantasies involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person. B. The person has acted on these urges, or is markedly distressed by them.” I said triumphantly: “Look, if you take these criteria for sexual sadism seriously, then a man who enjoys spanking his wife before sex would have to be classified as having a sexual disorder.” The two older psychiatrists looked at me and said virtually in unison, “Well, someone like that would have a disorder.” The younger psychiatrist and I rolled our eyes. Such interchanges, which reveal the power of changing social mores to shape judgments of what is a disorder, make one realize that in this area one must be extremely careful to use stringent guidelines for diagnosis. With regard to the paraphilias in particular, which can not only involve illegality and harm but can also evoke powerful negative emotions such as disgust, one's judgment of the distinction between deviance and disorder can easily be contaminated.

Second, paraphilias are disorders of sexual arousal and desire, not matters of behavior and action undertaken for other reasons: “if there are perversions, they will be unnatural sexual *inclinations* rather than merely unnatural practices adopted not from inclination but for other reasons” (p. 5). So, for example, Nagel himself asserts that bestiality is a perversion if anything is. However, by his own standards he might have been more careful here. Likely most of the bestiality in the world is due to opportunistic use of animals for sexual purposes rather than an inherent desire for animal sex. Although habit formation may create such preferences, they are generally easily extinguishable if more standard sexual objects are available. There may be only few cases of genuine paraphilic bestiality with a fixed preference.

Third, Nagel observes that paraphilias are somehow linked to the concept of the “unnatural”: “if there are any sexual perversions, they will have to be sexual desires or practices that can be plausibly described as in some sense unnatural, though the explanation of this natural/unnatural distinction is of course the main problem” (p. 5). This is of course a highly suspect concept that requires careful elucidation because it can easily be confused with a moral judgment. Clearly, given Nagel's dismissal of social approval as a criterion for perversion, he accepts that the natural is not inherently a moral judgment. As noted above, I maintain that for disorder in general, the only persuasive and non-moralistic meaning that can be given to “the natural” is “the biologically designed/naturally selected.”

Fourth, Nagel points out that “the connection between sex and reproduction has no bearing on sexual perversion. The latter is a concept of psychological, not physiological interest, and it is a concept that we do not apply to the lower animals, let alone to plants, all of which have reproductive functions that can go astray in various ways” (pp. 5–6). What Nagel is rejecting here is directly linking sexual perversion and reproduction, which clearly does not determine paraphilia. For example, sex with a partner who is known to be infertile is not a paraphilia – nor, the Catholic Church's view notwithstanding, is sex while using birth control. Paraphilias involve something going wrong with the naturally selected sexual psychology of arousal and desire, not reproduction. There is an indirect link with reproduction at the distal level because naturally selected sexual proclivities are selected because they lead to greater inclusive reproductive fitness. But the desires that are selected are not selected because their intentional object is reproduction, but because, whatever is their object, they in fact under typical environmental conditions at the time led to reproduction.

## 2.3. Freud on the concept of a paraphilia

Nagel identified some useful broad conceptual framework principles, but more substance is needed to evaluate specific DSM-5



proposals. What, then, does Freud have to say about how to define the paraphilias? Freud is the thinker who made us aware of how complex and malleable sexuality really is, and this poses a challenge to the definition of paraphilias that Freud attempted to address. It turns out that his view, as expressed in *Three Essays on Sexuality* (1905/1953), is quite developed and subtle and speaks directly to some of the conundrums affecting the DSM's criteria:

There is something else that I must add in order to complete our view of sexual perversions. However infamous they may be, however sharply they may be contrasted with normal sexual activity, quiet consideration will show that some perverse trait or other is seldom absent from the sexual life of normal people. Even a kiss can claim to be described as a perverse act, since it consists in the bringing together of two oral erotogenic zones instead of the two genitals. Yet no one rejects it as perverse; on the contrary, it is permitted in theatrical performances as a softened hint at the sexual act. But precisely kissing can easily turn into a complete sexual perversion – if, that is to say, it becomes so intense that a genital discharge and orgasm follow upon it directly, an event that is far from rare. We can learn, too, that for one person feeling and looking at the object are indispensable preconditions of sexual enjoyment, that another person will pinch or bite at the climax of sexual excitation, that the highest pitch of excitement in lovers is not always provoked by the genitals but by some other region of the object's body, and any number of similar things besides. There is no sense in excluding people with individual traits of this kind from the class of the normal and putting them among the perverts. On the contrary, we shall recognize more and more clearly that the essence of the perversions lies not in the extension of the sexual aim, not in the replacement of the genitals, not even always in the variant choice of the object, but solely in the exclusiveness with which these deviations are carried out and as a result of which the sexual act serving the purpose of reproduction is put on one side. In so far as the perverse actions are inserted in the performance of the normal sexual act as preparatory or intensifying contributions, they are in reality not perversions at all. The gulf between normal and perverse sexuality is of course very much narrowed by facts of this kind. (p. 322)

This passage reflects two of Freud's greatest contributions to human psychology. First, he grasped that sexuality has many “foreplay” components that are both gratifying in themselves and at the same time lead on to greater genital arousal and tension in preparation for sexual intercourse. Second, he realized that there is a relationship between perversions and these many aspects of normal courtship – a view reasserted more recently by Freund (Freund & Blanchard, 1986; Freund, Seto, & Kuban, 1997). The sexual courtship process normally involves many different desires and arousals due to various stimuli (e.g., seeing the sexual object, displaying oneself to the sexual object, touching the sexual object, yielding to the sexual object and getting the object to submit to one's desires). Paraphilic desires often involve excessive focus on such quite normal components of sexuality. So, for example, voyeurism and exhibitionism may be understood as pathological focus on the phases of courtship involving the arousing pleasure of seeing the sexual object and being seen by the sexual object, respectively.

The courtship theory of paraphilic desires has difficulty explaining all paraphilic desires, unless considerable interpretive work is added. Sexual desire and arousal can become fixated in some paraphilias on objects and aims that are not plausibly considered parts of the overall sexual courtship process, at least on first glance. Necrophilia and bestiality come to mind as two challenging examples in which sexual desire has shifted so far from its normative foreplay terrain as to constitute *prima facie* counterexamples to the courtship-gone-wrong approach.

The courtship theory aside, what makes a sexual desire pathological? Freud holds that it is not so much having the paraphilic desire itself or even acting on it that is the problem. After all, there is nothing inherently pathological about utilizing the body's capacity for sexual pleasure in whatever ways one can. Rather, it is the fact that there is a compulsiveness to the act so that the desire interferes with the capacity for normative functioning that makes it a dysfunction and disorder. It is the fixity of the desire (i.e., the activity is not merely opportunistically due to access or availability, and will not be abandoned when other routes to sexual gratification are available) and the desire's exclusivity (i.e., it replaces other normative acts and objects) that render the paraphilic desire pathological:

If a perversion, instead of appearing merely *alongside* the normal sexual aim and object, and only when circumstances are unfavorable to *them*, and favorable to *it* – if, instead of this, it ousts them completely and takes their place in all circumstances – if, in short, a perversion has the characteristics of exclusiveness and fixation – then we shall usually be justified in regarding it as a pathological symptom. (1905/1953 p. 161)

Freud is appropriately conservative in his attribution of pathology. He is aware that sexuality tends to flow through many pathways, even in those who are non-disordered, and that it is all too easy to attribute a disorder to behavior we find repellent or just strange. (One is reminded of Kinsey's remark that, when people are asked how much masturbation would constitute a disorder, they tend to set the threshold just a bit above what they themselves engage in.) Most people have their sexual idiosyncracies, and it seems normal to harbor and exploit such desires. Moreover, access makes a great difference; the practice in some cultures of using boys for sex is apparently fueled by the lack of access to available single women. Moreover, learned preferential tastes may gradually develop from experiences that occur initially due to accessibility. Bertrand Russell somewhere says that, although he hates football, he has to begrudgingly admit that, all else being equal, someone capable of loving football is better off than someone incapable, because it offers an additional source of pleasure. Similarly with paraphilias, one might imagine that when not interfering with the potential for other pleasures, an additional source of arousal can hardly be a bad thing let alone a disordered thing in itself.

Thus, Freud insists, to infer a disorder, the paraphilic desire must be acted on “in all circumstances” – with all lovers in all sexual acts – so as to show that it is a necessary, compulsive part of sexual gratification. In addition, it must be the exclusive method of gratification – it “ousts [the normal sexual aim and object] completely,” even when normative sexual relations are available, revealing a preference structure that places the paraphilic desire well ahead of and replacing normative desires.

The concept of exclusivity harbors some potential ambiguities. Within a given sexual act or a set of sexual acts, a paraphilic desire may be expressed exclusively without proceeding to intercourse. But must the exclusivity apply across partners and acts? For example, if one has a regular sadomasochistic relationship with one person and missionary sex regularly with another, or pedophilic relations with young boys and normative sexual relations with a spouse (as in the reported Afghani saying, “boys are for sex, women are for babies”), is that a paraphilia? Given that many sexual offenders have non-paraphilic sexual relationships in parallel to their seemingly disordered desires, this question is of more than theoretical interest.

Freud almost surely intended exclusivity to apply across relationships. He wrote of the way Victorian men respected their wives too much in the bedroom so that they engaged in normative sex at home and then went to the bordellos to obtain the perverse sex they desired (Freud, 1912/1957). He did not consider such men disordered – just frustrated. Freud considered it normal to desire some non-normative sex due to the special pleasures it can yield.

There is a subtlety that makes Freud's requirements a bit stronger than they may seem. The requirements concern not just what one actually does under the circumstances that in fact exist but, counterfactually, what one would do under various alternative circumstances. Freud says that the paraphilic desire must be fixed and exclusive even when conditions favor normative sex. Thus, as a thought experiment, suppose an individual, on the basis of sheer subjective pleasure, enjoyed oral sex more than genital intercourse. This preference in itself is not a disorder. In fact, a considerable number of quite normal people have this preference, according to some surveys, simply because of the intensity of pleasure it yields. Yet this preference might well become a seemingly fixed and exclusive preference, constituting the way the individual habitually seeks sexual gratification in his or her sexual relationships. This would still be a non-disordered preference, according to Freud's criteria, unless the individual would no longer be interested in or able to engage in normative sex even under conditions in which oral sex was impossible or rejected by a prospective partner who was happy to have normative sex.

Freud's account does not eliminate the possibility that sheer habituation to a preferred activity could yield a genuine paraphilic disorder, however. As Plato already pointed out in the *Republic*, perverse desires often demand more extreme actions for their gratification over time, as one becomes habituated to a given level of perversity. Although habituation generally yields only a strong preference that leaves some room for flexibility, in principle it is possible for dependence on one's habituated preferences to develop to such an extent that it renders the preferences a fixed paraphilic need.

Freud's account of paraphilic disorder in terms of exclusivity and fixity cleverly identifies the paraphilic dysfunction as interference with normative sexuality (exclusivity) as well as its peremptory, necessary or compulsive nature (fixity). Paraphilias are not merely optional preferences for maximizing pleasure when an activity is available or expressions of generally high and polymorphous sexual motivation. A paraphilia is a clear dysfunction for the same reasons that, say, impotence is a clear dysfunction, namely, there is an inability (not mere preference or circumstantial limitation) to have or enjoy normative sex.

Freud's demanding requirements offer a "gold standard" of evidence sufficient for inferring a paraphilic disorder. But are Freud's criteria necessary conditions for paraphilic disorder?

Surely there can be malfunctions of sexual desire that do not manifest in such absolute ways. Lesser evidence may make it more difficult to confidently infer the existence of a paraphilic disorder. But, however difficult the epistemological challenge may be, surely Freud's criteria are not strictly necessary in all cases of paraphilic disorder. Non-normative sexual desires that are clearly compulsive and go beyond any possible explanation as fragments of courtship can be clear cases of paraphilias, even if not exclusive or fixated. To take some extreme examples, the compulsive pedophile who cannot stop raping young children despite the dire consequences and a desire to stop, yet is also married with a satisfactory normative spousal sexual relationship, is still arguably disordered. The sadist who must torture and inflict bodily harm yet sometimes completes the normative sexual act at the end – and then goes home and has normative sex with a spouse – is still arguably disordered. In neither of these cases is there exclusivity or fixity. The problem in such instances lies in the difficult epistemological challenge of establishing the compulsive quality that makes the desire a disorder, when fixity and exclusivity are lacking.

Although in principle one cannot hold all judgments of paraphilias to the standards set by Freud's account, one can at least say the following: To the extent that the requirements Freud sets out are not satisfied, making the case for the presence of disorder is more challenging and evidential thresholds should be recalibrated accordingly. In such instances, before a paraphilic disorder can be attributed, there must be some other kind of evidence of the desire's compulsive

quality that offers an alternative means of eliminating obvious rival explanations for the desire and its expression. The specific nature of the desire will also play a role. Perhaps necrophilia might be considered a dysfunction even in small doses if pursued as a specific goal with any compulsiveness, whereas sadism, being an extreme of a normal dimension of sexual interaction observed since antiquity, is not a dysfunction unless it interferes with normative sexual functioning or otherwise goes well beyond any conceivable normative limits.

Interestingly, DSM-III's original description of paraphilias was not far from the Freudian conception: "[T]he essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement" (American Psychiatric Association, 1980, p. 266). The requirement that the deviant desires "are necessary for sexual excitement" appears to imply exclusivity as Freud envisioned it. But, as noted, to account for the great variety of examples, we will have to allow some alternative route to dysfunction, other than exclusivity – as long as there is adequate alternative evidence of compulsion or other pathognomonic features.

Sometimes sheer intensity of deviant desire or arousal is used as a criterion for paraphilia, even where exclusivity does not exist. One problem with using intensity as a criterion is that one risks pathologizing intensely sexual individuals who have a generally higher level of libido. This is why it is important, especially if exclusivity is lacking, to demand some evidence that a deviant desire is fixedly peremptory or compulsive in a way that demands expression. I now apply these considerations to the evaluation of the various proposals for changes in the paraphilia criteria in DSM-5.

### 3. Conceptual evolution of paraphilia criteria: the example of exhibitionism

The diagnostic criteria sets for the various paraphilias within any given edition of the DSM tend to all have roughly the same structure. However, that structure has varied across editions. These different attempts across the various editions of the DSM to capture the notion of a paraphilic disorder are a repository of ideas, some good and some problematic, and many abandoned in subsequent editions. To place the DSM-5 proposals in context, I review these successive attempts to capture the notion of a paraphilic disorder, especially focusing on whether or how they manage to satisfy the HD analysis's requirements of dysfunction and harm.

Specifically, I consider the evolution of the diagnostic criteria for exhibitionism over the course of the revisions in the DSM since DSM-III. Exhibitionism is fairly representative in these respects of the paraphilias in general, and especially of those paraphilias with forensic implications. My commentary follows each criteria set.

#### 3.1. DSM-III diagnostic criteria for exhibitionism

*Repetitive acts of exposing the genitals to an unsuspecting stranger for the purpose of achieving sexual excitement, with no attempt at further sexual activity with the stranger.*

Comment: Generally speaking, in DSM-III the focus of the paraphilia criteria was simply on describing a dysfunction – something that has gone wrong with sexual arousal. It was not yet fully recognized that harm is essential to disorder and that deviant desire is not sufficient.

The DSM-III exhibitionism criteria focus entirely on the deviant sexually arousing event, exposure to an unsuspecting stranger. Harm is specified at best only implicitly, in that there are repetitive acts with unsuspecting, thus non-consenting, individuals (I assume throughout that non-consent is a form of harm). The indicator of dysfunction is neither exclusivity nor peremptory intensity but simply that the actions issuing from the desire are repetitive. It is, however, recognized that the behavior of exposing oneself is not

sufficient; one could expose oneself in the course of public urination, for example. Rather, it is the fact that the exposure is undertaken “for the purpose of achieving sexual excitement” that makes it potentially a paraphilia. However, a degree of exclusivity is implied by the fact that the purpose of sexual excitement must be accomplished by the exposure itself, and not by some further seduction of the stranger. That is, the exhibitionism cannot be a form of seduction or foreplay, where the display is intended to excite the victim into submission. It must be a sexual end in itself, not a means to intercourse, and this must be due to the structure of the individual’s desire and not, say, because of fear of the consequences of going further. But, there is no consideration of whether the individual has other, normal sexual relationships, so exclusivity in that across-relationship sense is not required. Moreover, virtually every form of sexual foreplay and interaction are sometimes normally engaged in under circumstances where intercourse does not follow (even aside from teenage “petting”), starting with the traditional “standing on the corner, watching all the girls go by.” This insight – that activities that increase sexual tension are also exciting and gratifying in their own right – is why Freud set a high bar for diagnosis of sexual perversion.

It is questionable whether these criteria are adequate to imply dysfunction. Paraphilic desires are widespread as part of overall normal sexuality. Often these desires are not acted on due to fear of being caught or other inhibitions. But they may represent neither exclusive nor peremptory desires, and nothing in this definition requires that the exhibitionistic impulse be exclusive or replace normative relations. Preferential arousal patterns for this and other paraphilias may not emerge in response to stimuli:

[P]araphilic sexual interest may be the underlying explanation in only a minority of cases of sexual offenses. For example, [Marshall and Fernandez \(2003\)](#) reviewed 10 studies of exhibitionists using penile plethysmography and found that 9 out of the 10 studies suggested that exhibitionists in clinical settings did not have a preference for exposing themselves. Similarly, a study by [Seto and Lalumiere \(2001\)](#) of over 1000 child molesters using phallometric testing as a validator demonstrated that less than one-third had an underlying pedophilic arousal pattern. ([First, 2010](#), p. 1240)

To examine whether non-clinical subjects would engage in voyeurism, [Rye and Meaney \(2007\)](#) asked university students about the likelihood (0–100%) that they would secretly watch an attractive person undress or two attractive people having sex. When the risk of being caught was manipulated from 0 to 25%, the mean likelihood fell from 84 to 61% among men and from 74 to 36% in women. ([Langstrom, 2010](#), p. 320)

One wonders about the role of “unsuspecting stranger” in this and subsequent definitions. (Similar issues to the ones I mention here arise in other disorders in which non-consent is stated or implied in the Criterion A specifying dysfunction as well as Criterion B specifying harm, as in voyeurism and frotteurism.) It does eliminate obvious counterexamples such as sexual game-playing by consent, and it does imply a typically illegal act. But is this a confusion of criminal or moral violation with dysfunction, which would, as Freud argued, require substitution of genital exposure for the fuller sexual relationship across situations? Or does the fact that the exposure occurs before an unsuspecting stranger make it a dysfunction? Conceptually it seems clear that the same behavior in an ongoing relationship, if including exclusivity, could be a paraphilia (“Repetitive acts of exposing the genitals to one’s partner for the purpose of achieving sexual excitement, with no attempt at further sexual activity with the partner”), but only if there is exclusivity in Freud’s sense that the exposure is generally substituted for genital intercourse. I will return to the puzzling issue of the role of non-consent

in the definition of paraphilias below, in a discussion of non-consent in the proposal for a new coercive paraphilic disorder.

### 3.2. DSM-III-R diagnostic criteria for exhibitionism

- A. *Over a period of at least 6 months, recurrent intense sexual urges and sexually arousing fantasies involving the exposure of one’s genitals to an unsuspecting stranger.*
- B. *The person has acted on these urges, or is markedly distressed by them.*

Comment: The evidence of dysfunction and of harm is separated into Criterion A and B, respectively. Dysfunction is given a somewhat higher threshold, not only “recurrent” but also lasting at least 6 months. Importantly, whereas DSM-III specified that there were certain behaviors aimed at sexual excitement, DSM-III-R provides a clarification that the dysfunction consists of the facts about desires (urges), fantasies, and arousal and not about the resulting behaviors. Even if there are no acts, the desire and arousal pattern can reveal a paraphilia. The required harm is that either the individual has acted on the urges or is markedly distressed. Unfortunately, the useful clarification that the urges and exciting fantasies cannot concern using exposure as a prelude to seduction is dropped. There is no requirement of exclusivity, fixation, or compulsion.

This two-component structure is consistent with the HD analysis’s two-component approach. Michael First, the Text Editor of DSM-IV ([American Psychiatric Association, 1994](#)) and Editor of DSM-IV-TR ([American Psychiatric Association, 2000](#)), has characterized the structure of the paraphilia diagnostic criteria sets as follows:

The definitions of the various paraphilias in DSM-IV-TR reflect the same overall diagnostic construct. The first component of the definition lays out the core psychopathology of a paraphilia, namely the fact that the person is intensely aroused by deviant sexual stimuli. The second part requires that the deviant pattern carries negative consequences for the individual or society: for those paraphilias which involve the participation of an unwilling victim (i.e., exhibitionism, voyeurism, frotteurism, pedophilia and sexual sadism), the diagnosis is made if the person has acted on his urges or else if the urges or fantasies cause marked distress or interpersonal difficulty; for the remaining paraphilias (e.g., fetishism, sexual masochism, and transvestic fetishism), the diagnosis is made if the urges, fantasies, or behaviors cause clinically significant distress or impairment in functioning. ([First, 2010](#), p. 1239)

This seems to me to be about the right way of looking at these criteria sets, when translated into HD terms. They set out the evidence for a dysfunction (i.e., deviant sexual desire) in Criterion A, and the evidence that the dysfunction is causing harm in Criterion B.

### 3.3. DSM-IV diagnostic criteria for exhibitionism

- A. *Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one’s genitals to an unsuspecting stranger.*
- B. *The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.*

Comment: The evidence of dysfunction and of harm is again separated into Criterion A and B. In DSM-IV, a standard “clinical significance criterion” requiring that symptoms “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” was added to many diagnostic criterion sets throughout the Manual to establish at least a minimal level of harm and thus limit false positive diagnoses of conditions that



were not clinically meaningful. To be consistent, this clause was substituted in the paraphilia criteria for the former harm specification that “The person has acted on these urges, or is markedly distressed by them.” The distress criterion obviously is thus retained, but the behavioral criterion of having acted on the urges is eliminated. The editors of DSM-IV have subsequently explained that, to compensate for this change, they consequently moved mention of behavior to Criterion A, intending that it too, like the urges and fantasies, would be evidence of a deviant arousal pattern – and an especially important source of such evidence in forensic cases. However, the simple disjunctive phrase, “or behaviors,” did not in fact say anything about the motives behind the behavior, allowing for the first time for behaviors in their own right to be taken as evidence of a paraphilic dysfunction. This risked false positives – especially confusing crime and disorder – because behavior is often a very weak indicator of an internal paraphilic dysfunction of sexual desire.

A different kind of problem – and one that caused great controversy with regard to certain categories such as pedophilia – resulted from the removal of the “acted on these urges” clause in Criterion B and the introduction of the standard clinical significance distress or role impairment criteria. The criteria now required that someone with a paraphilic dysfunction of sexual desire, even if the individual acted out the paraphilic desire illegally or with harm to others, could not be classified as disordered unless the individual experienced distress about or role impairment from the dysfunction. (“Impairment of functioning” here refers to negative impact on social role functioning, such as family or school or job functioning; if as is sometimes suggested it referred to sexual functioning, obviously it would be a tautology and redundant to say that an individual with a paraphilia is impaired, and it could not offer an independent criterion for deciding whether a condition is a disorder.) Yet many paraphilically driven perpetrators feel little remorse or distress, and they may be unimpaired in their role functioning in the family or at work. Some constituencies were outraged that these criteria seemed to give the ego-syntonic well-functioning paraphilic a free pass as far as disorder goes, even in such cases as the compulsive repetitive pedophile.

These concerns led to a change in the next edition, DSM-IV-TR. “TR” stands for “text revision,” because only the textual descriptions in the Manual were supposed to be changed and the diagnostic criteria were not supposed to be revised. However, the paraphilias were seen as a special case that needed to be immediately adjusted due to controversy and the implications for the forensic and victim communities in the aftermath of DSM-IV.

#### 3.4. DSM-IV-TR diagnostic criteria for exhibitionism

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger.
- B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

Comment: Regarding Criterion A, criteria for identifying dysfunction stay the same as in DSM-IV. Regarding Criterion B, acting on the sexual urges, formerly only in Criterion A, has been added to distress and interpersonal difficulties as one possible way to fulfill the harm requirement.

There are two major problems. First it is clear that Criterion A is invalid as an indicator of dysfunction. Depending on how one parses the words, it appears to allow the diagnosis of a paraphilic dysfunction based on recurrent genital-exposing behavior, yet this can occur for all sorts of reasons other than a paraphilia – from intoxication-related disinhibition to other disorders such as mania, and can even be a side effect of normal behaviors such as public urination. Moreover, whatever caused the behavior, the individual may feel distress about it, so the criteria are easily satisfied by non-paraphilic individuals.

Second, a serious problem arises due to addition of the behavioral clause to Criterion B. As a result of that addition, neither distress nor role impairment is necessary any longer for diagnosis, which is of debatable merit. More importantly, for the first time, as an inadvertent result of the juggling around of the criteria for various purposes, behavior alone can now fulfill both the A and B criteria (First & Frances, 2008). Behavior is in one instance evidence of a paraphilic dysfunction and in the other evidence of harm from the paraphilia. Consequently, on a not implausible interpretation of these criteria, simply repeatedly exposing one's genitals to an unsuspecting stranger for whatever reason and with no further harm other than the potential harm of exposure to a stranger (making it illegal) is sufficient for diagnosis. Basically, the legal criteria for a crime and the psychiatric criteria for mental disorder tend to converge, so that anyone who engages in repeated genital exposure to non-intimates is considered to have a disorder. On its face, this seems like a potential violation of DSM's definitional caution that social deviance or conflict with others is not in and of itself a mental disorder.

The problem cannot be solved by simply trying to parse the wording to ensure that the behavior is sexually motivated. Rather than seeing “sexually arousing” as modifying only “fantasies” thus leaving the “behaviors” clause purely defined by exposure, one might see the phrase “sexually arousing” as applying across the three following subjects of fantasies, sexual urges, and behavior – so that to fulfill the criterion, the behavior must be sexually arousing. This would bring sex into the behavior, but the problem remains that the behavior of exposing one's genitals may be sexually arousing to many people. Moreover, sexual motivation is insufficient to demonstrate a paraphilia, if the behavior is undertaken as part of broader sexual activity.

And so we finally come to the current proposal.:

#### 3.5. DSM-5 proposed diagnostic criteria for exhibitionistic disorder

- A. Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors involving the exposure of one's genitals to an unsuspecting stranger.
- B. The person is distressed or impaired by these attractions, or has sought sexual stimulation from exposing the genitals to three or more unsuspecting strangers on separate occasions.

Comment: The DSM-5 proposal preserves all of the weaknesses of the DSM-IV-TR criteria. The behavioral clause in Criterion A, which was originally a questionable afterthought, is retained, no doubt partly because it is useful in forensic contexts where patients are prone not to share their fantasies and urges due to the negative results that could occur for them. When the behavioral criterion is applied, the motivation behind the exposure of genitals is not specified, and its relation to the individual's broader sexual motivation or behavior is not explained in a way that ensures dysfunction.

First (2010) has correctly argued that at the least these criteria should be changed to (1) rule out alternative explanations if the behavioral criterion is used. He suggests the following exclusion clause: “The behavioral manifestations are not due to the direct physiological effects of a substance (e.g., alcohol intoxication), a general medical condition (e.g., Alzheimer's disease) and not better accounted for another mental disorder (e.g., manic episode, antisocial personality disorder) or by instances of public urination”; and (2) more clearly specify that the behavior is due to sexual arousal from the exposure. So, with respect to Criterion A, he suggests: “Over a period of at least 6 months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting stranger, as manifested by fantasies, urges, or behaviors,” which places arousal squarely at the center of the evaluation, whether from fantasies, urges, or behavior. These would be improvements. Yet this criterion lacks any reference to the stricter requirements of exclusivity or fixation or even prepotency (i.e., an overwhelming desire that overrides other desires and makes rational



deliberation impossible) – unless the notion of “intense” is intended to cover peremptoriness. The difference between a paraphilia versus opportunistic behavior or defiant or provocative breaking of taboos due to generally high sexual drive is lost in these criteria. While it may be sufficient for harm to satisfy the criterion of illegal behavior or distress or role impairment, use of behavior and one qualifier for dysfunction – especially without any system for ruling out alternative hypotheses – poses a continued threat of false positives, and thus of potential indefinite detention beyond prison time of a criminal due to diagnosis of a paraphilia that an individual does not in fact have. The convenience of these criteria in forensic evaluations seems more than offset by the potential for prosecutorial abuse and the long-term undermining of the credibility of the distinction – sanctioned by the Supreme Court as a constitutionally crucial one – between mental disorder-driven behavior and other motives for criminal behavior.

#### 4. Evaluation of DSM-5 proposals for changes in paraphilic disorders

##### 4.1. Paraphilias versus paraphilic disorders: DSM paraphilia criteria and the HD analysis

A DSM-5 proposal that is welcome but more a terminological revision rather than an actual change in criteria is the proposal that paraphilias should be distinguished from paraphilic disorders. I quote at length from the stated rationale for this distinction:

The Paraphilias subworkgroup is proposing two broad changes that affect all or several of the paraphilia diagnoses.... The first broad change follows from our consensus that paraphilias are not *ipso facto* psychiatric disorders. We are proposing that the DSM-V make a distinction between *paraphilias* and *paraphilic disorders*. A paraphilia by itself would not automatically justify or require psychiatric intervention. A *paraphilic disorder* is a paraphilia that causes distress or impairment to the individual or harm to others. One would *ascertain* a paraphilia (according to the nature of the urges, fantasies, or behaviors) but *diagnose* a paraphilic disorder (on the basis of distress and impairment). In this conception, having a paraphilia would be a necessary but not a sufficient condition for having a paraphilic disorder.

This approach leaves intact the distinction between normative and non-normative sexual behavior, which could be important to researchers, but without automatically labeling non-normative sexual behavior as psychopathological. It also eliminates certain logical absurdities in the DSM-IV-TR. In that version, for example, a man cannot be classified as a transvestite – however much he cross-dresses and however sexually exciting that is to him – unless he is unhappy about this activity or impaired by it. This change in viewpoint would be reflected in the diagnostic criteria sets by the addition of the word “Disorder” to all the paraphilias. Thus, Sexual Sadism would become Sexual Sadism Disorder; Sexual Masochism would become Sexual Masochism Disorder, and so on.

In general, the distinction between paraphilias and paraphilic disorders is reflected in the format of the diagnostic criteria for specific paraphilias. Paraphilias are ascertained according to the “A” criteria, and paraphilic disorders are diagnosed according to the “A” and “B” criteria. (American Psychiatric Association, 2010b).

Although the DSM-5 website suggests that it is a substantial change to distinguish paraphilias in themselves from paraphilic disorders, this is essentially a terminological shift. Essentially, the idea is that the deviant preferred desire is a paraphilia, but it is only a paraphilic disorder if there are certain harmful consequences, such as non-consenting victims or distress. But in fact this distinction has been implicitly recognized since the DSM-III-R, in the breakdown of

the criteria into Criterion A (the deviant desire) and Criterion B (the harm that is caused by the way the desire is acted out).

The problem being addressed by this proposal is that, for example, the DSM paraphilia criteria for sexual sadism are labeled “sexual sadism,” but the desires and practices described in the Criterion A are not necessarily a disorder if they occur by themselves and do not bring about certain harmful consequences described in Criterion B. It would be natural to refer to those desires and practices without the Criterion B harm as “sexual sadism,” but terminologically that would confuse the desires and practices with the harmful disorder which has the same name. The solution is to label the deviant desires described in Criterion A to be “sexual sadism,” and then if Criterion B harm requirements are also satisfied, the condition would be “sexual sadism disorder.” An analogous distinction would be made for each paraphilia (e.g., exhibitionism versus exhibitionistic disorder).

##### 4.2. The DSM-5 proposal to add a “Number of Victims” criterion

The DSM-5 Workgroup members are aware of the dangers in reliance on illegal behavior as a sufficient indicator of paraphilic disorder. To address the threat of false positives, it is proposed that Criterion B’s behavioral criterion for the first time specify some threshold of number of victims needed for diagnosis of a paraphilic disorder. Thus, across the paraphilias that involve non-consent sexual acts, the behavioral criterion would be satisfied only if there are a certain number of victims – generally two or three. For example, we saw above that for exhibitionistic disorder there must be three victims for the behavioral harm clause to be satisfied. The requirements for pedohebephilia vary depending on whether the victims are prepubescent children (at least two victims) or pubescent (at least three, to allow for the greater fuzziness in the boundary with normality). For diagnosis of frotteurism disorder, an individual must have “sought sexual stimulation from touching and rubbing against three or more nonconsenting persons on separate occasions”; for sexual sadism disorder, the individual must have “sought sexual stimulation from behaviors involving the physical or psychological suffering of two or more nonconsenting persons on separate occasions.”

It seems intuitive that requiring multiple victims might serve to reduce false positives. Nonetheless, this proposal has been rightly criticized for being arbitrary (there is next to no research foundation for the particular cutoff points that were selected). It is also ambiguous what this feature is supposed to do – whether it is aimed at revealing that there must be a paraphilia underlying behavior because of the number of offenses, or establishing sufficient harm, or (most likely) both. Here is the rationale offered for this new feature of the diagnoses:

The second broad change applies to paraphilias that involve nonconsenting persons (e.g., Voyeuristic Disorder, Exhibitionistic Disorder, and Sexual Sadism Disorder). We propose that the B criteria suggest a minimum number of separate victims for diagnosing the paraphilia in uncooperative patients. This was done to reflect the fact that a substantial proportion – perhaps a majority – of patients referred for assessment of paraphilias is referred after committing a criminal sexual offense. Such patients are not reliable historians, and they are typically not candid about their sexual urges and fantasies. The criteria have therefore been modified to lessen the dependence of diagnosis on patients’ self-reports regarding urges and fantasies. This change also addresses the past criticism that the word “recurrent” in the DSM-IV-TR A criteria says nothing beyond “more than once” and is too vague to be clinically useful. The reason for diagnosing specific paraphilic disorders from multiple, similar offenses in uncooperative patients is to achieve a level of diagnostic certitude closer to the certitude in diagnosing these disorders from self-reports in cooperative patients. It is not derived from legal theory or practice.

The suggested minimum number of separate victims varies for different paraphilias. This represents an attempt to obtain similar rates of false positive and false negative diagnoses for all the paraphilias. The logic runs as follows: Paraphilias differ in the extent to which they resemble behaviors in the typical adult's sexual repertoire. For example, sexual arousal from seeing unsuspecting people in the nude seems more probable, in a typical adult, than sexual arousal from hurting or maiming struggling, terrified strangers. It follows that the more closely a potentially paraphilic behavior resembles a potentially normophilic behavior, the more evidence should be required to conclude that the behavior is paraphilically motivated. We have therefore suggested, for example, three different victims for Voyeuristic Disorder but only two different victims for Sexual Sadism Disorder. We felt that fewer than three victims for Voyeuristic Disorder would result in too many false positives and more than two victims for Sexual Sadism Disorder would result in too many false negatives. (*American Psychiatric Association, 2010b*).

Leaving the arbitrariness of the thresholds aside, the proposal attempts to compensate for the lack of necessary non-behavioral indicators of dysfunction by introducing a requirement for a minimal number of victims as an indirect indicator of likely internal arousal patterns, a strategy that has appeared occasionally in earlier editions, as noted above. The validity problem with the number-of-victims proposal is easy to see. The motives due to causes other than having a paraphilia that give rise to pseudo-paraphilic behavior can be repetitive, just like paraphilic motives. So, multiple behaviors – especially when certain environmental contextual considerations remain constant – are a spurious demonstration of validity of a paraphilia diagnosis. For example, normal exploitative individuals confronted with repeated opportunity due to their situation (e.g., a teacher; a man who is in several relationships with women who have children of whom he ends up in charge) may have multiple victims for reasons other than paraphilia, whereas truly disordered individuals may select one vulnerable individual as a chronic victim (e.g., a family member). Like the old joke about checking the accuracy of a report in the newspaper by buying a second copy of the newspaper, one cannot deduce from a repeat of a non-paraphilia-motivated act that somehow now there is a paraphilia. The diagnostic question is what is motivating the acts, whether one or many.

This said, perhaps a threshold as a partial protection against false positives is a good idea and would protect against some of the most egregious diagnostic excesses in cases of only one or two instances of paraphilia-like behavior. Yet this would hardly provide a constraint on sexual predator commitment proceedings, because mostly individuals are subjected to such proceedings only if they have been repeat offenders.

None of this is to underestimate the challenge to forensic clinicians. Ascertaining patterns of internal states such as sexual fantasies, urges, and arousal require the individual's cooperation and honesty, which often is lacking in forensic settings. Behavioral approaches to diagnosis provide a solution to this conundrum. However, to allow such special difficulties within specific settings to drive the proposed revision to the diagnostic criteria is ill-advised. Perhaps in forensic evaluations where patients are not sharing information, this sort of guideline might sometimes be useful in lieu of any other pathway to evaluation, but such diagnostic inferential strategies suitable to a specific situation should not determine the general criteria for the disorder. To do so is to confuse epistemological with ontological/definitional problems that in principle determine diagnostic validity and apply to all contexts. The answer to the epistemological problem – how can we tell if the patient has these desires if the patient won't reveal his inner experiences to us? – must

not be confused with the definitional issue of what comprises such a disorder in the first place.

#### 4.3. *The DSM-5's proposal to expand pedophilia to pedohebephilia to include sexual desire for pubescent adolescents as a paraphilia*

Hebephilia is paraphilic sexual desire for pubescent children. Rather than proposing an additional separate category for hebephilia, the DSM-5 proposal is to extend the pedophilia criteria, which now encompass sexual desire only for prepubescent children, to create a combined category of pedohebephilia that also includes desire for pubescent children.

This proposal is driven primarily by forensic issues in the sexual predator commitment arena. An offender who has illegally had sex with multiple pubescent teens – even if there was consent – may be seen as a threat to the community, and upon the end of the prison term, an attempt may be made to civilly commit the individual on the basis of mental disorder consisting of paraphilic attraction to pubescent teens. However, hebephilia does not currently appear in the DSM as a disorder – and has never before been taken seriously as a mental disorder by the DSM. Rather, prosecutors who use hebephilia as the qualifying mental disorder in sexual predator civil commitment proceedings generally use the “paraphilia not otherwise specified (paraphilia NOS)” diagnosis, adding the qualifier, “hebephilia” – thus, “paraphilia NOS, hebephilia.”

The current pedophilia criteria, and the proposed criteria for DSM-5 pedohebephilia, are as follows:

##### DSM-IV-TR diagnostic criteria for pedophilia

- A. *Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age thirteen years or younger).*
- B. *The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.*
- C. *The person is at least age sixteen years and at least 5 years older than the child or children in Criterion A.*

*Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a twelve or thirteen-year-old.*

##### DSM-5 proposed diagnostic criteria for pedohebephilia

- A. *Over a period of at least 6 months, one or both of the following, as manifested by fantasies, urges, or behaviors:*
  - (1) *recurrent and intense sexual arousal from prepubescent or pubescent children;*
  - (2) *equal or greater arousal from such children than from physically mature individuals.*
- B. *One or more of the following signs or symptoms:*
  - (1) *the person is distressed or impaired by sexual attraction to children;*
  - (2) *the person has sought sexual stimulation, on separate occasions, from either of the following:*
    - (a) *two or more different children, if both are prepubescent;*
    - (b) *three or more different children, if one or more are pubescent.*
  - (3) *use of child pornography in preference to adult pornography, for a period of six months or longer.*
- C. *The person is at least age eighteen years and at least five years older than the children in Criterion A.*

It should be kept in mind that most sex with pubescent teenagers – and much with children as well (“the prevalence of pedophilic sexual interests among adult sex offenders with child victims appears to be approximately 40 to 50%” [First & Halon, 2008, p. 6]) is probably not driven by any systematic preference but is simply opportunistic or, in the case of young teens, romantic involvement. These criteria allow a 6-month relationship with a teen that causes distress to be classified as a paraphilic disorder, a likely pathway to many false positives.

The rationale offered for this addition to the pedophilia category contains several arguments (American Psychiatric Association, 2010b):

There are four reasons for replacing Pedophilia with Pedohebephilic Disorder. These reasons are: (a) Hebephilia (the erotic preference for pubescents) is similar to pedophilia in that both involve sexual attractions to persons who are physically quite immature (Blanchard, 2009a; Blanchard et al., 2009b), (b) Many men do not differentiate much or at all between prepubescent and pubescent children and offend against both (Blanchard et al., 2009b), (c) Many hebephilic patients are getting DSM diagnoses anyway – they are diagnosed as pedophilic under a very liberal definition of “prepubertal child,” or they are diagnosed with “Paraphilia NOS (Hebephilia)” (Levenson, 2004), and (d) This would harmonize with an ICD definition of Pedophilia: “A sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age” (ICD-10 F65; emphasis added). (American Psychiatric Association, 2010b)

These arguments are remarkably weak. The first argument for the expanded category is that hebephilia is similar to pedophilia in that both involve attraction to physically immature individuals. This is about as valid an argument as saying that both dyslexia and illiteracy involve difficulties reading, thus illiteracy should be considered a disorder. The kind of immaturity involved in pubescence is vastly different from the kind in prepubescence from the specific perspective of its ability to trigger normal sexual interest, so in fact the dissimilarity is more important than the similarity when it comes to judging the presence of a paraphilic disorder. Correlatively, it is absurd to argue that people tend not to discriminate prepubescent's from pubescents when it comes to potential for arousing normal sexual interest. The other two arguments – that some prosecutors are currently using the diagnosis “Paraphilia NOS (Hebephilia)” and that the ICD allows sexual preference for early pubescence as a disorder – ignores the critical question of whether these uses are valid.

Another part of the rationale for the pedohebephilia proposal addresses the revised threshold for attributing dysfunction that allows either intense desire or desire stronger than that for adult partners:

According to DSM-III, a patient is pedophilic if his sexual interest in children is greater than his interest in adults. According to DSM-III-R, a patient is pedophilic if his sexual interest in children is intense. There is no obvious clinical reason to regard the DSM-III-R approach as an advance over the DSM-III approach (Blanchard, 2009b; Blanchard et al., 2009a). There might, for example, be men who could honestly say that, due to age, ill health, current medications, or natural constitution, they have no intense sexual urges or fantasies at all, but such feelings as they have are directed solely toward children. It would be absurd then to exclude them from ascertainment as pedophiles. We have therefore proposed to incorporate both approaches to ascertainment in the A criterion for Pedohebephilic Disorder.

Our reasons for recommending the use of both approaches also relate to the clinical realities of ascertaining pedophilia or hebephilia in patients charged for sexual offenses against children. Many or most such patients are unreliable when it comes to reporting their erotic interests. Even those who are well aware that they have a pedophilic or hebephilic orientation may deny this. The examining clinician is forced to make an inference about the patient's sexual interests, whether the clinician is looking for evidence that the patient's interest in children is intense or evidence that the patient's interest in children is greater than his interest in adults. Which type of inference is possible depends on the type of evidence available. Depending on the data, it is sometimes possible only to infer that the patient's interest in children is intense, and sometimes possible only

to infer that the patient's interest in children is greater than his interest in adults. (Blanchard et al., 2009a) (American Psychiatric Association, 2010b).

Whereas formerly only intense desire would do, the proposed threshold is either intense desire or, if the desire is not intense, then it must be stronger than the desire for an adult. The basic problem is that neither of these in and of themselves implies a paraphilic disorder when it comes to desire for pubescent individuals. As the last paragraph makes clear, the proposal to incorporate the heretofore obscure, scientifically questionable, and conceptually controversial condition of hebephilia within pedophilia, one of the DSM's main and most accepted paraphilia pathological categories, is largely driven by the desire to respond to prosecutorial needs in sexual offender civil commitment procedures. Unfortunately, conceptual requirements for validity have not adequately been addressed in the attempt to facilitate forensic judgments.

The rationale also explains the introduction of Criterion B3, in which pornography is used as an indicator of sexual preference. The placement seems confused; the pornography criterion is placed with the “harm” indicators of distress, impairment, or multiple victims when in fact if anything this would be a dysfunction indicator. Introduced as an alternative to the harms, this criterion weakens the criteria set by allowing that certain kinds of fantasies combined with pornography that caters to them is a paraphilic disorder, when it may be that no harm is present. Moreover, the link between what turns people on in pornography versus what they would actually prefer in real life is a complex one. The Workgroup's rationale (American Psychiatric Association, 2010b) is based on a rather shaky evidential base that is supposed to suggest that pornography indicates primary erotic interest: “Some research indicates that child pornography use may be at least as good an indicator of erotic interest in children as “hands-on” offenses (Seto, Cantor, & Blanchard, 2006)” (American Psychiatric Association, 2010b). However, fantasy interest is not necessarily a paraphilia.

The rationale also contains an argument that the proposed addition of hebephilia would not really change things all that much because children up to thirteen years of age are already allowed as pedophilic targets:

There is another important point to be noted. A change from Pedophilia to Pedohebephilic Disorder in DSM-V would primarily affect the precision of diagnosis, not the number of people being diagnosed. In DSM-IV-TR, the definition of “child,” as an erotic object, is someone “generally age 13 years or younger.” In the definition proposed for DSM-V, this guideline would be moved only one year, to age 14 years or younger. (American Psychiatric Association, 2010b)

This argument misrepresents what the DSM says. In the DSM-IV-TR criteria for pedophilia (see above), it is specified that the target must be “a prepubescent child,” and then a parenthetical comment is added that prepubescent children are “generally age 13 years or younger.” This is supposed to set a rough upper limit on pubescence, not define the target children as any child up to thirteen years old. In fact, today many children are pubescent well before thirteen years of age and thus would no longer be allowed as pedophilic targets by DSM-IV-TR. The magnitude of the proposed change is thus larger than the rationale suggests.

There are many missteps in the hebephilia proposal. The evidence is not in favor of hebephilia and pedophilia being part of the same overall condition (Frances & First, 2011), so there is a question as to why this addition is not being proposed as an independent category to be evaluated on its own merits rather than being presented as a revision to the existing category of pedophilia. The more basic problem is that there is simply no reason to think that those who are preferentially or markedly sexually interested in pubescent adolescents are mentally disordered, as opposed to having a normal-range



preference. Surely experiencing some such attraction is within normal range. Study after study shows sizable percentages of males experiencing sexual arousal in response to images of pubescent females, often at levels approaching the response to adult females – and these levels of attraction differ from attraction to children and to males of all ages (Frances & First, 2011). Many prostitutes around the world are drawn from this age group.

As Frances and First (2011) have remarked, anybody who has any doubt about the capacity for normal men to be aroused by pubescent girls – predictably enough so as to be exploitable in ad campaigns – should take a look at the frankly sexual 1980 Calvin Klein ads featuring a 15-year-old Brooke Shields in jeans with her legs spread wide straight into the camera saying provocatively, “You want to know what comes between me and my Calvins? Nothing.” Her roles in the movies *Pretty Baby* and *Blue Lagoon* traded further on the pubescent girl's natural sexuality. Surely Freud would have raised his eyebrows in disbelief at the idea that the desire for sexual intercourse with the sorts of very young women that were often found in the brothels frequented by Victorian gentlemen in search of the sexual activities they were not permitted in the marital bed constituted some sort of perversion.

So, the issue is not whether sexual attraction to pubescents is within normal range. It clearly is, irrespective of the moral and legal censure directed at it in our society. Rather, the question on which hebephilia's disorder status turns is whether, if in some people this normal-range desire happens to be particularly intense or what most turns them on, then that constitutes a disorder. However, the intensity and preference level of a desire are shaped by many normal circumstances. Individuals who harbor unrealistic Romeo-and-Juliet visions of young love, individuals who routinely have access to and may find themselves sexually stimulated by young females or males (e.g., junior high school teachers, priests), individuals attracted to “forbidden fruit” or preoccupied with sexual purity, individuals who are predatory and see young girls and boys as easily seduced and thus a target of opportunity hard to resist, and many others may be inclined in their fantasies and possibly their actions to prefer pubescent targets for their desires. In all of this there is much of which to strongly disapprove, criminally prosecute, and attempt to prevent, but nothing that is necessarily indicative of a mental disorder by any conceptually legitimate test.

Thus far, the courts have tended to agree with the doubts expressed above. Several courts have found the “paraphilia NOS, hebephilia” diagnosis used in civil commitment proceedings to be either not demonstrably a mental disorder at all or not a serious enough mental disorder to meet the threshold for application to the sexual predator civil hearings (e.g., *U.S. v Carta*, No. 07-12064-JLT, D. Mass June 4, 2009; *U.S. v. Shields*, No. 07-12056-PBS, 2008 WL 544940, at \*2, D. Mass. Feb. 26, 2008; *U.S. v. Abregana*, 574 F. Supp. 2d 1123, August 22, 2008, No. 07-00385 HG-BMK). The attempt to place this disorder in the DSM is partly an attempt to legitimize this diagnosis and thus offer a stronger argument to the courts, which have cited the lack of such a diagnosis in the DSM as one basis for overturning civil commitment decisions based on it. However, hebephilia as formulated just does not pass muster as a validly diagnosable genuine disorder. Perhaps a small number of individuals exist who actually have such an extreme, exclusive, and fixed hebephilic condition that they can be considered disordered. But, the burden of proof is very high for any diagnosis of sexual desire for normal-range sexual objects, even if those objects are preferred. Using similar logic, do we really want to start diagnosing those who are fixated on partners with one hair color or one ethnic type or a particularly large body part of one kind or another (penis, breasts, derriere) as paraphilic?

In sum, the hebephilia proposal is probably the Workgroup's most flawed and blatantly overpathologizing paraphilia proposal. Hebephilia as a diagnosis violates the basic constraint that disorder judgments should not be determined by social disapproval. This is a case where crime and disorder are being hopelessly confused.

#### 4.4. DSM-5 proposal for paraphilic coercive disorder

Sexual activities with non-consenting victims play a role in several of the paraphilia criteria sets (e.g., frotteurism, voyeurism, sadism, exhibitionism). For several of them, however, the mention of non-consent occurs only in Criterion B, the criterion specifying harm. Nonconsent is certainly a harm, so this makes sense. However, we saw earlier that reference to nonconsent (or to the “unsuspecting stranger” in exhibitionism) in Criterion A that specifies the sexual dysfunction – the nature of the deviant sexual desire – is much more puzzling. Does a desire become paraphilic just because it is pursued or fantasized in nonconsent situations? Is it the nonconsent itself or the content of the desire that is directed at the nonconsenting individual or the combination of the two that yields a paraphilic desire? I will not try to solve this problem in general here, but attend only to the proposed category of paraphilic coercive disorder – of which one form is paraphilic rape.

Paraphilic coercive disorder does not presently appear in the DSM. Again, like hebephilia, it has been diagnosed under the wastebasket category of “paraphilia NOS” and used in civil commitment procedures aimed at institutionalizing those who have sexually assaulted – raped – multiple individuals. What makes this proposed category different from all the others mentioning nonconsent is that in this case there is no bizarre or unusual desire involved in the act or the related urges and fantasies. The desire is for sexual intercourse with an adult. Thus, paraphilic coercive disorder squarely targets desired nonconsent itself as a paraphilia. The proposed criteria are as follows:

##### Paraphilic Coercive Disorder

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

The immediate problem with these criteria is that it will be tempting to diagnose paraphilic coercive disorder on the basis of behavior alone. If an individual commits several rapes in a limited period, Criterion B will be met. It is possible to argue, in the absence of information to decide the issue, that if several rapes occurred in a fixed period, then the individual must have been entertaining fantasies of coercion or must be excited by coercion. This is in fact exactly how the argument has gone in some sexual predator civil commitment proceedings. Here are two examples of such fallacious inferences that move from behavior alone to the conclusion that there exists a mental disorder, both by experts consulted in sexual predator cases, and both citing the “paraphilia NOS” category (for conditions that would easily fit under the proposed paraphilic coercive disorder category):

[The respondent] clearly meets the diagnostic criteria for a paraphilia for nonconsenting sexual aggression because he has committed four rapes over a seven year period. [The respondent] began raping at age 17, and sexually reoffends almost immediately upon release from custody. He seems incapable of controlling his aggressive sexual impulses. (Peo V. G. Thomas, Case No. 12607 C, San Joaquin County, Cal. 1997. SVP Evaluation report of G. Zinik, Ph.D., dated 11/24/1997, admitted as Exhibit A at SVP commitment trial; cited in *First & Halon, 2008*, p. 4).

[The respondent] appears to suffer from a mental abnormality, Paraphilia NOS: Rape, which predisposes him to engage in sexual acts with nonconsenting persons. Central to [the respondent's] disorder is a pattern of sexual assault extending over a period from 1979 to 1992, during which he was convicted of three

sexually violent crimes and was implicated in three additional sexual assaults. (State of Washington v. W. Davenport, Case No. 96-2-01119-0, County of Franklin. Report of J. R. Wheeler, Ph.D., dated 2/10/96; cited in [First & Halon, 2008](#), p. 2).

Of course, this is not what is intended in formulating this category. The idea is rather that certain individuals are “turned on” by the very coerciveness of a sexual act. The DSM website rationale for this category primarily argues that research shows that there are some men who are aroused by the coercive nature of sex, and that rapists are disproportionately subject to this condition ([American Psychiatric Association, 2010c](#)). As [Thornton \(2009\)](#) states the claim: “Salient cues indicating that their partner is feeling coerced normally at least partially inhibit male sexual arousal while cues indicating mutual interest heighten arousal. However, for a minority of males, this pattern reverses with salient coercion cues leading to heightened arousal.”

Arousal by coerciveness is not clearly distinguished here from arousal despite coerciveness, or arousal enhanced by coerciveness. In fact, it is not clear to what extent the capacity for arousal under coercive conditions is a normal part of sexuality that is usually suppressed by most individuals but can emerge under some circumstances, just as “rape fantasies” can be exciting to women when the fantasized act is placed in a certain context. For example, in surveys of college students, about two-thirds of college women report some experience of coercive sex, over a third of male undergraduates say they can imagine possibly raping someone, and over a third agree with the item “I fantasize about raping a woman.” Questions more indirectly measuring coercive fantasy garner high percentages of positive responses from undergraduate males. For example, “I get excited when a woman struggles over sex,” “It would be exciting to use force to subdue a woman,” and “I fantasize about having a woman tied up, spread-eagled to a bed” are agreed to by about two-thirds, and “I fantasize about forcing a woman to have sex” by about half ([Greendlinger & Byrne, 1987](#)).

Unfortunately, in judging whether coerciveness is a paraphilic symptom, [Thornton \(2009\)](#) confusingly equates abnormality with a cultural judgment rather than identifying it with a failure of what is biologically designed, thus ensuring that coercive sex must be considered an abnormality:

[T]his article takes the core of the paraphilia construct to be an abnormal sexual interest. What counts as “abnormal” is culturally relative. To be significant in a mental health context, this abnormal sexual interest needs to be sufficiently sustained and intense that it causes “clinically significant distress or impairment in social, occupational, or other important areas of functioning.” Included under impairment of functioning are cases where the behavioral expression of a paraphilic sexual interest causes significant harm to others ([Thornton, 2009](#)).

Evidence for the hypothesis that an individual is excited specifically by coerciveness is difficult to obtain, especially with a noncooperative offender who knows what is at stake. As [Knight \(2009\)](#) points out, the empirical evidence is ambiguous. Some individuals may be less prone to be turned off by coerciveness, but that is different from saying they are turned on by coerciveness. Unless one argues that human beings are biologically designed to be incapable of sex when a partner protests (a position that is difficult defend given the evidence), the failure to be turned off by a partner's nonconsent does not appear to be a paraphilia. At most, it would seem that some individuals are less affected than others by a victim's protests and may lack the empathy and moral sense that overrides sexual assertion in most individuals. They may be terrible, unempathic, immoral people, but that is not a paraphilic disorder.

Allen Frances, the Editor of the DSM-IV, has argued that it was never intended for the category “Paraphilia NOS” to be used in the way it has

come to be used in sexual predator proceedings, and specifically that it was not intended to cover the often used diagnosis of “Paraphilia NOS (nonconsent)” ([Frances, 2010](#)). It is not very clear how one decides whether something was intended by a DSM category, if it is not mentioned explicitly. In any event, one of the points of NOS categories is to cover unanticipated instances of disorder that do not fall under the specific categories in the DSM, as the definition of “Paraphilia NOS” notes: “This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).” The mentioned examples, such as zoophilia and coprophilia, are surely genuine paraphilic disorders. The issue is not what was intended by this category, but whether “Paraphilia NOS (nonconsent)” identifies a genuine disorder that should be diagnosable under paraphilia NOS. Granted that Frances wrote the criteria, authorial authority has its limits when there are real conceptual and empirical issues at stake that are not settled by the author's opinion alone.

Frances has also suggested that the idea of using nonconsensuality as a sufficient criterion for a paraphilic disorder in paraphilic coercive disorder may have come about due to a misconstrual of DSM's text ([Frances, Sreenivasan, & Weinberger, 2008](#); [Frances & First, 2011](#)). In its general description of the paraphilias, DSM-III's text said that “the essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement” (1980, p. 266) and by way of example went on to state that paraphilias “generally involve either: (1) preference for use of a nonhuman object for sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation or (3) repetitive sexual activity with non-consenting partners” (1980, p. 266). The “nonconsent” clause was simply meant to refer to the examples of voyeurism, exhibitionism, and frotteurism. However, there was concern during the revision leading to DSM-III-R (1987) that the description “unusual or bizarre” was too subjective and unreliably applied ([Frances & First, 2011](#), cite a personal communication from Robert Spitzer on this historical point), so that description was dropped, leaving the examples (with “children” added to “other nonconsenting persons”) that misleadingly appeared to be an attempt at a definition. Thus, activity with nonconsenting partners could easily be seen as a fundamental category of paraphilia, although according to Frances and First it was never conceived or intended that way.

Frances's ([Frances & First, 2011](#); [Frances, Sreenivasan, & Weinberger, 2008](#)) account of a misimpression caused by a change in text seems to avoid the major issue. It does appear from the list that it is being claimed that sex with nonconsenting partners is in and of itself a form of paraphilia – that is, a form of bizarre or unusual sexual arousal. The other two listed categories clearly are aimed at illustrating that idea, so why not the third? If nonconsent is not a sufficient criterion for paraphilia (and clearly Frances is correct that it is not), then its role requires clarification.

There seem to be several possible answers to the question of the role nonconsensuality plays in judgments of paraphilic disorder. One is that nonconsensuality is a form of harm that fulfills the “harm” criterion for disorder, but is independent of whether there is a dysfunction in the desires aimed at the nonconsenting victim. Non-consent would then be seen as a moral and legal concern, but not by itself a determinant of whether a psychiatric disorder exists.

If this approach is taken, then rape, however terribly harmful it may be, cannot represent a paraphilic activity because the act is not paraphilic considered independently of the harm of nonconsent. As we saw, according to the harmful dysfunction analysis of disorder, harm to self or others is not sufficient to warrant attribution of disorder – and many harmful but nondisordered conditions, from birth pain to body odor, confirm this view. The question that must be asked is whether the condition in question is a dysfunction. If a paraphilia is attributed when

the dysfunction requirement is not satisfied, then that constitutes the pathologization of the individual's deviance and conflict with society, grounds for diagnosis that are specifically rejected by the DSM's definition of mental disorder.

One problem with the "harm" interpretation of nonconsent is that, although in some criteria sets nonconsent appears only in the harm criterion, in several criteria sets nonconsent appears as well in Criterion A's description of the dysfunctional sexual arousal pattern. So, nonconsent seems to be more than harm. It is necessary to look further for ways in which nonconsent might indicate dysfunction.

Another hypothesis is that nonconsensuality inevitably indicates an extreme intensity of desire or a lack of inhibitory control that reveals disorder. However, the number of nonconsensual sexual acts among psychiatrically normal people suggests that this hypothesis is simply social control dressed up as pop psychology. There are too many known reasons for engaging in nonconsensual sex and too much normal variation in human inhibitory functioning to make this plausible. It is like saying that someone who engages in adultery with another individual's spouse must have a disorder because the lack of inhibition in violating social rules or in hurting another individual reveals a disorder of inhibitory and empathic mechanisms. Admittedly at our current stage of knowledge there are judgment calls required here, but surely this line of reasoning, in the face of actual human nature and its manifestations in behavior, has little meaningful support.

A third and somewhat more plausible answer is that what makes such activity indicative of dysfunction is that it reveals that nonconsensuality is part of the intentional content of the desire – that is, that the nonconsensuality of the act is not just a means to the end of obtaining the act in the face of resistance but rather is part of what "turns on" the individual. And, this desire, common as it is among sexually normal people, becomes paraphilic when it becomes exclusive or peremptory so that the individual is either no longer capable of or interested in opportunities for consensual sex or driven to coercive sex in a compulsive way that leaves no room for deliberation.

The problem is how to distinguish such a paraphilic desire for coercive sex from repeated nonconsensual sexual acts. One would expect individuals with such a disorder to be preferential nonconsensualists – that is, they would prefer or even exclusively limit themselves to nonconsensual sex. This must be the essential idea of a paraphilic coercive desire category that has conceptual integrity. Whether such a disorder can be successfully discriminated from nonparaphilic multiple rape, which likely forms the vast majority of rapes, is a challenging question. In exchange for the remote possibility of catching a few paraphilics, surely it is not worth creating enormous numbers of misdiagnoses. As Quinsey (2009) argues, "It is doubtful, however, that rape represents a malfunction of the male sexual preference system."

The proposed criteria thus seem to invite abuse in the form of large numbers of false positive diagnoses. One precaution against this outcome is taken in the DSM-5 proposal: behavior is left out as a criterion for dysfunction (Criterion A is limited to fantasies and urges). If behavior appeared as one way of satisfying Criterion A and indicating a dysfunction, this would be too obvious an attempt to pathologize rape itself. As it is, given that the harm criterion is satisfied by three rapes, the integrity of the distinction between paraphilic coercive disorder and the criminal acts of multiple rapes pivots entirely on the integrity and specificity of Criterion A in identifying a sexual-desire paraphilic dysfunction. To satisfy Criterion A, we saw, an individual must experience "intense sexually arousing fantasies or sexual urges focused on sexual coercion." This is hardly an airtight case for the presence of a paraphilia. No exclusivity, peremptoriness, or fixity is required, only that one has had some intense sexually arousing fantasies about coercion. Fantasies about coercion are not uncommon, and especially among individuals who have raped or are contemplating rape, coercion may be part of a fantasized potential sexual act, even if it is not coercion itself that is the sexually satisfying element. This Criterion seems too weak by far to preserve the distinction between crime and disorder.

## 5. Conclusion

I have wrestled in this paper with the conceptual underpinnings of diagnosis of paraphilic disorders, and examined the validity of the proposed changes to the paraphilic diagnostic criteria in DSM-5. The DSM-5 proposals are driven to an extent by challenges posed by the need for diagnosis in the forensic context of sexual predator civil commitment proceedings. The most valid indicators of true paraphilic disorder – such as exclusiveness, fixation, and compulsiveness – which are difficult to establish in a forensic context, are not adequately taken into account either in the paraphilia criteria of the past or the proposals for DSM-5. Weaker criteria are used that open the door to false positive diagnoses.

The proposals offered by the DSM-5 Workgroup dealing with sexual and gender identity disorders incorporate an enormous effort of thought and scholarship. They have some potentially useful features, but also some troubling limitations. If combined with other requirements, it may be that a "multiple victims" requirement could be helpful in protecting against false positive diagnoses under some circumstances, even though a history of multiple victims is neither necessary nor sufficient for disorder by itself. Terminological clarification of the distinction between a paraphilia, which may be a harmless sexual inclination even if a dysfunction, versus paraphilic disorders that are sexual dysfunctions that cause substantial harm to oneself or others, is useful, although it is already implicit in the "Criterion A/Criterion B" structure of the diagnostic criteria sets. On the other hand, the proposals for the new categories of "hebephilia" (incorporated into an omnibus "pedohebephilia" category) and "paraphilic coercive disorder" fail to satisfy rigorous standards for diagnostic validity, and open up major new avenues for false positive diagnoses. The proposed new categories as well as the multiple-victims proposal are open to abuse by confusing the performance of criminal sexual acts with having a paraphilic disorder.

The paraphilic disorders present a continuing challenge to our conceptualization of mental disorder. Oddly enough, with the passing of laws allowing civil commitment of sexual offenders whose behavior is the outcome of a mental disorder and the declaring of such laws as constitutional by the Supreme Court, the valid diagnosis of paraphilic disorders has also become tactically central to the future of civil liberties in our country. At this important juncture, one would hope that the DSM-5 Workgroup might focus on basics and build on the long intellectual tradition of grappling with the nature of paraphilic disorders independent of the issue of forensic facilitation, so as to clarify the kinds of evidence that distinguish genuine sexual paraphilias from deviant sexual behavior not due to a sexual paraphilia.

Unfortunately, it appears instead that the Workgroup's deliberations may have overly emphasized the facilitation of forensic evaluations with noncooperative respondents in sexual predator proceedings, rather than the core issue of diagnostic validity. The importance of protecting the public means that one cannot blithely adopt anti-psychiatric attitudes in this arena. The Workgroup's attempt to be both practical and respecting of the public and victims as well as the rights of the offender is to be admired. However, the first task should be to "get it right" with respect to diagnostic validity, and then to explore the practical needs in the forensic context within the framework set by validity considerations. Otherwise, the forensic tail is wagging the validity dog, and we are likely to get criteria that possess a misdirected pseudo-validity that will not serve us in the long run and set a dangerous precedent for future tensions between civil liberties and civil commitment for mental disorder.

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