Forensic and Diagnostic Concerns Arising From the Proposed DSM-5 Criteria for Sexual Paraphilic Disorder

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This article reviews proposed revisions to the DSM-5 diagnostic criteria for the paraphilic disorders. It is argued that the proposed revisions will decrease the diagnostic accuracy of the diagnoses. A more effective diagnostic scheme is suggested.

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The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), criteria for the paraphilias are still under review, but in this essay, the proposed DSM-5 criteria are referred to simply as the DSM-5 criteria. Comments in this article are intended to be instructive, constructive, and respectful of the difficult task facing the DSM-5 Sexual and Gender Identity Disorders Work Group of drafting valid and reliable evidence-based diagnostic criteria. The Workgroup has proposed criteria for the Gender Disorders, Sexual Dysfunctions, and Paraphilic Sexual Disorders. This article will discuss only the Paraphilia Diagnostic Criteria, since these are the ones of most interest to forensic psychiatrists.

Category B Criteria

Until DSM-5, Paraphilic Sexual Disorders have been universally defined on the basis of specific sexual fantasies.[1] The defining fantasies can involve legal activities (e.g., wearing lingerie to facilitate sexual arousal) or illegal acts (e.g., nonconsensual torture). The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)[2] used two different Category B criteria for the two types of paraphilias.

For paraphilias involving legal interests:

> The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning [Ref. 2, p 570].

For paraphilias involving interest in illegal scenarios:

> The person has acted on these sexual urges, or the urges or fantasies cause marked distress or interpersonal difficulty [Ref. 2, p 569].

While it is known that not all people with paraphilias commit sex crimes and that not all sex crimes are committed by people with paraphilias,[3] the diagnoses of these disorders are more likely than others to be tested or challenged in court. To date, the APA has elected not to field test the paraphilia diagnoses, almost ensuring that they will invite *Daubert*-based challenges.[4]

For sexual disorders, the concept of DSM-5 diagnosis will be subject to further challenge because of the introduction of the novel DSM-5 concept of ascertainment. This distinction is described by the Sexual and Gender Identity Disorders Work Group as follows:

> 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 (emphasis in original).[5]

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In English, ascertain means to find out definitely.[6] However, in the DSM-5 it will mean the opposite, referring to situations in which the person being evaluated does not meet Category B criteria for the disorder. For example, an elderly woman who fantasizes about exposing herself to a young orderly in her nursing home would presumably be ascertained as having exhibitionism (assuming the fantasies persisted for six months). The invention of ascertainment may be an attempt by the DSM-5 work group to acknowledge that it is possible to have unconventional sexual interests that do not cause problems. If so, why list them in DSM-5? The problem is that the coined term ascertainment opens the door to permit the labeling of anyone with a sexual interest different from the examiner, including homosexuality. This concern is particularly troubling because of the recent tendency to refer to paraphilic disorders as orientations.[7]

Further, once a person is ascertained, it is hard to imagine that he will not be regarded as having been diagnosed. People ascertained with pedophilia will be grouped with people diagnosed with pedophilia. If Category B criteria can be discarded, why not ascertain Category A criteria as well? Does a person really have to have sexual fantasies about dead people for a full six months to have necrophilia? It is also disappointing that the six-month duration criteria are not deleted, since early treatment is more likely to be effective.[8]

Category B has always been a proxy for degree of dependence on the paraphilic scenario in question. A better solution would be to change Criterion B for all paraphilias to: "The person is distressed or made less sexually functional by the *absence* of the paraphilic thought or act." For example, most people with transvestic fetishism are not distressed by cross-dressing. In fact, by definition, they find the act sexually arousing. What is distressing for a transvestite is not cross-dressing but the opposite, not being able to cross-dress in sexual situations.

DSM-5 Category A criteria repeat the phraseology of DSM-IV-TR "for at least six months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviors involving. . . ."[5] However, there is no evidence that people with paraphilias have higher sex drives or more intense fantasies than anyone else.[9]

Specific Diagnoses: Proposed New Disorders

Hypersexual Disorder

A proposed new DSM-5 disorder is hypersexual disorder. This diagnosis will pathologize consensual sexual thoughts or acts (including masturbation) by linking them to psychiatric vulnerabilities such as addictions, anxiety, depression, or compulsions. Together with the ability to ascertain hypersexual disorder, it is hard to imagine how any person who is sexually active (even if just with himself) could avoid being labeled. This designation will be good for the business of sex addictionologists, but will it be good for patients? The concern is that people with treatable disorders (e.g., mood disorders or addictions) will be ascertained or diagnosed with hypersexual disorder and therefore will not receive appropriate treatment. It remains to be seen whether hypersexual disorder will become a legal defense, at least as a mitigating factor.

Paraphilic Coercive Disorder

Another newly defined diagnosis is paraphilic coercive disorder (PCD). These criteria break the DSM convention that encourages assigning multiple diagnoses because Criterion C requires that the diagnosis of PCD not be made if the person has sexual sadism. Why? Of particular concern in the United States is the possibility that people facing SVP sentencing will be ascertained PCD without evidence of sadism or in-person assessment.

Pedohebephilia

A third new diagnosis is pedohebephilic disorder. The criteria for this condition loosen those used to diagnose pedophilia under DSM-IV. With the broadening of the age range of interest that will satisfy the diagnosis, more people will be labeled. By definition, expansion of the range of diagnostic criteria reduces sensitivity (true positives). Is this a good idea? A woman who has looked at pubescent females on the Internet on three occasions may be different from a man who has had repeated sexual intercourse with an infant. Both would meet the proposed criteria for pedohebephilia but may be quite different phenomenologically. If a person is diagnosed with pedophilia on the basis of persistent use of child pornography (Criterion B(3)) and he is kept from accessing child pornography, does the diagnosis disap-

pear? Is a person who is prevented from using child pornography different from one who voluntarily desists from its use or one who no longer has any interest in child pornography?

The proposed criteria delete the subcategory of incest. The reasoning for this change is unclear. There is published evidence that men who have committed incest offenses have a higher likelihood of having pedophilia, but they also have a lower likelihood of reoffense.[10] This distinction seems to be an important one. At a time when evidenced-based practice is emphasized, why eliminate it? As a final comment, to be grammatically appropriate and to be crystal clear that children do not cause pedophilia, Criterion A, which refers to "recurrent and intense sexual arousal *from* prepubescent or pubescent children" should be written as ". . . sexual arousal in response to. . . ."

Specific Diagnoses: Revised Disorders

The revised disorders are listed numerically.

302.3 Transvestic Disorder

The new criteria for "transvestic disorder" (finally) eliminate the requirement that the person be heterosexual and male. This change is helpful, although the reasons given for it (i.e., that bisexual men may cross-dress) are incomplete. There is no evidence that men or women with homosexual interests cannot be sexually aroused by cross-dressing. However, the contrary proposition has been published.[11]

As a final comment on DSM-5 criteria for transvestic fetishism, the subcriteria for this condition imply that a person is either fetishistic or autogynephilic (or autoandrophilic). Clearly, a person could also be both and possibly neither. At a time when psychiatry is moving toward increased levels of diagnostic specificity, does it make sense to list autogynephilia and autoandrophilia within transvestic disorder rather than as separate paraphilias?

302.4 Exhibitionism

The proposed criteria for exhibitionism are based on exposure to an "unsuspecting" person. Shouldn't the criteria read "nonconsenting person"? This would eliminate the potential for diagnosing a woman who has surprised three consenting and perhaps appreciative sexual partners by undressing herself without prior informed consent.

302.81 Fetishism

Can a cross-dresser have a clothing fetish? The work group says it strives to have similar rates of false positives and false negatives for all the paraphilias. Why? Shouldn't more harmful paraphilias have lower false negatives? The number of victims in the criteria should be based on potential harm not on the work group's opinion about how deviant the interest is from "normophilic behavior."

302.82 Voyeurism

The work group's criteria include observing an "unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity." However, many Internet sites that cater to voyeuristic interests feature pictures of women who are not "naked, disrobing (nor) engaged in sexual activity." The criteria should be rewritten: "nonconsensual observation of a person for sexual purposes." The victim's behavior is not the issue. What makes the act voyeuristic is the fact that the victim has not given consent and is being observed for a sexual purpose.

302.83 Masochism

The proposed specifier "asphyxiophilia" is inadequate, because it fails to distinguish between people who are aroused by being asphyxiated, those who are aroused by asphyxiating others, or those who are aroused by both. The same can be said for humiliation and suffering. Sadism and masochism should be combined as in the ICD-10. The work group's distinction between "oxygen deprivation" and "the subjective experience of oxygen deprivation" makes little sense. Perhaps they are attempting to point out that there is more than one way to be asphyxiated. It should simply say so.

302.84 Sadism

It is proposed that the phrase "real not simulated" be dropped from the criteria as a modifier defining "acts." This is a fundamental change in what is meant by sexual sadism since it means that people who are aroused by "safe, sane, and consensual"[12] prenegotiated sexual scenarios will be ascertained to have Criterion A sexual sadism under the same designation as people aroused only by the infliction of nonconsensual harm on another person. How is this different from proposing that the definition of alcohol dependence be changed to include people who overconsume alcohol-free beer?

The effect of the change will be to increase the number of people with sadism, especially since the difference between ascertained and diagnosed is unlikely to be understood once a person is said to have sadism. More important, under the new criteria, it will mean that no one will know what sort of problem a person with sadism has, since he could be aroused either by consensual or nonconsensual thoughts or acts. The importance of this distinction has been described elsewhere.[13]

302.89 Frotteurism

The proposed criteria appear to include toucherism (sexual arousal from touching nonconsenting people). Will there be an exclusion for Tourette's syndrome, intellectual disability, other disorder? This is a disorder in which it is easy to mistake behavior for motivation. People with intellectual disabilities are often misdiagnosed with counterfeit deviancies.[12] The proposed criteria may make the problem worse.

302.9 Paraphilia Not Otherwise Specified

The criterion for 302.9 is simply that it is not listed elsewhere in the DSM-5. There is no explanation for why the six listed examples were chosen. A recent published list included over 100 paraphilias.[8] Why not list the most frequent, or most dangerous paraphilic disorders? An alternative option is described in the next section.

How to Fix the Problems

Paraphilias are remarkably consistent in their phenomenology, but highly variable in their expression. Why not define the criteria and capture variability in the specifiers? By analogy, broken bones are defined by type of break and specified by the bone involved.

Recommended Diagnostic Criteria for the Paraphilic Disorders

A persistent or recurrent sexual interest that involves nonconsent or interferes with sexual function.

Specify

1. Type of paraphilic activity
2. Target of paraphilic activity
3. Age range of target(s)
4. Degree of dependence on the paraphilia for normal sexual function

Subspecify

a. Has acted on the paraphilic interest
b. Intermittent, continuous, in remission (no evidence of disease)

Conclusions

The work group criteria reviewed in this article raise more questions than answers. The proposed revisions to current DSM-IV-TR criteria will decrease the specificity of ascertained and diagnosed conditions by dramatically loosening the diagnostic categories. While the proposed changes may increase diagnostic reliability, they will certainly decrease diagnostic accuracy. Given the consequences of mistaken diagnosis, the proposed revisions are both unhelpful and dangerous. In contrast, the alternative revisions suggested in this article are more likely to increase reliability, specificity, sensitivity, accuracy, and therefore validity.

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