

Sexual Disorders: New and Expanded Proposals for the DSM-5—Do We Need Them?

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The sexual disorders in the current and proposed DSM contain a potpourri of categories that increasingly intersect with the criminal justice system. Caveats saying the DSM is designed for clinical and not legal purposes notwithstanding, our classification system has difficulty distinguishing what we consider criminal behavior from culturally unacceptable behavior and mental disorder. Several current proposals continue this trend and seem more responsive to criminal justice concerns than mental illness considerations. They also lack sufficient specificity to warrant being called a disorder.

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The Diagnostic and Statistical Manual, Fifth Edition (DSM-5) work group preparing for the next edition is proposing several changes to the American Psychiatric Association (APA) Classification of Mental Disorders in the Sexual and Gender Identity Disorders category. The proposals have been the subject of two well-attended presentations at the American Academy of Psychiatry and the Law at each of the annual meetings in 2009 and 2010. The sentiment of the forensic psychiatrists who attended was decidedly negative for many of the proposals discussed in this commentary.

Forensic psychiatrists have become increasingly involved with the group of sexual disorders over the past 20 years because of at least two trends. The first is related to the sexually violent predator (SVP) laws permitting civil commitment of convicted sex offenders at the end of their prison sentences, if they meet very low thresholds for having some mental condition that may make them a future risk for sexually violent and aggressive behavior. These statutes have been deemed constitutional by the U.S. Supreme Court and have been passed with small varia-

tions by 20 state legislatures. Mental health professionals (psychiatrists, psychologists, social workers, and nurses) are involved in preparing reports and testifying at the hearings at the end of an inmate's sentence to see if he meets the criteria for judicial consideration of his status as a SVP.

The second trend relates to the federal and state law enforcement that targets pedophiles and those who download child pornography from the Internet. Targeting is based on the idea that people who download these images have already, or soon will, become child abusers. Accompanying the arrest and prosecution of these offenders, longer prison sentences have been added to the federal sentencing guidelines and state statutes (e.g., the Arizona Supreme Court upheld a sentence of 200 years for the possession of 20 photographs of children deemed to be child pornography, 10 years for each picture, with the sentences to be served consecutively). Again, mental health professionals become involved either at the plea negotiating or presentencing phases of the criminal process.

Conceptual Difficulties

Before we get into the details of the proposals, a short detour into some of the underlying conceptualizations of mental disorders is useful in understanding the present conflicts. For the past 150 years, our society has developed institutions for those who have been classified as deviant: we have had asylums for

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the mentally ill and intellectually disabled, prisons for those who have broken our laws, and juvenile courts for younger people who misbehave. The boundaries are frequently overlapping so that the distinction between the mad and the bad remains a blur for many individuals and many are treated or confined in multiple institutions.

The DSM has not directly addressed the relationship between criminality, deviant behavior, and mental illness in the manual. This problem is exemplified by some disorders' being indistinguishable from the crime (e.g., pedophilic disorder), whereas some disorders like schizophrenia hardly mention any specific illegal or bad behavior, even though individuals with schizophrenia may be charged with crimes when they become too disruptive or violent. Aside from the sexual disorders, the few other categories that identify specific criminal or bad behaviors are conduct disorder, oppositional defiant disorder, kleptomania, intermittent explosive disorder, pathological gambling, and antisocial personality disorder.

The question then is, why are some criminal behaviors classified as mental disorders and others not? What is the conceptual difference? We do not define serial murder or stalking as a distinct disorder. The sexual disorders carry much additional moral and religious baggage (e.g., fornication and adultery are still codified as crimes in one third to one half of the states).

The DSM also remains unclear about the principle that distinguishes between symptoms, syndromes, and disorders. For example, what are the compelling data that transform hypersexuality as a symptom of many possible disorders into a proposed specific disorder? The DSM-5 Sexual and Gender Identity Disorders Work Group is proposing to address the problem by making a distinction between a paraphilia and a paraphilic disorder. The distinction is based on the presence of distress or impairment. This effort is worthwhile, but the boundaries remain fuzzy. Impairment can be defined by an arrest in the absence of subjective distress.

The three disorders that were debated at the meetings were hypersexual disorder, paraphilic coercive disorder, and pedohebephilic disorder. Without biological markers for most psychiatric disorders, normative distributions can be established. The distribution of most behaviors follows a bell curve. It is possible to select a line, for example, two standard deviations from the mean and say that those above or

below represent possible disorders. We do that with IQ and call two standard deviations below the mean indicative of a disability. On the other hand, we do not call those above by the same amount disordered; we value them as having special abilities. Such normative choices have an intuitive appeal, but may become contaminated by cultural values or arbitrary norms. Normative scales are also more likely to generate false-positive cases.

There are differences, however, between a normative measure of intelligence and a normative measure of sexuality. The norm for IQ was based on an unlimited sample of the population, not one defined as impaired, distressed, or deviant. The psychiatric measure of sexual arousal or behavior is one derived from a measure of patients or (as in the Kinsey report) of those willing to answer questions about their sexuality, truthfully or not. Therefore, hyposexuality or hypersexuality in the absence of distress or deviant behavior is less meaningful. A second relevant difference between norming intelligence and norms of sexual practice is the predictive value of each. Levels of intelligence correlate with the ability to learn, success in academics, and educational needs. Will sexual norms in the absence of behaviors or emotional correlates have the same connection to outcomes?

Hypersexual Disorder

The new proposal is to add a hypersexual disorder.¹ The criteria are

- A. Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:
 1. Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior.
 2. Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g. anxiety, depression, boredom, irritability).
 3. Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events.
 4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior.

5. Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others.
- B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.
- C. These sexual fantasies, urges, and behavior are not due to direct physiological effects of exogenous substances (e.g., drugs of abuse or medications) or to Manic Episodes.
- D. The person is at least 18 years of age.
Specify if:
Masturbation
Pornography
Sexual Behavior With Consenting Adults
Cybersex
Telephone Sex
Strip Clubs

Hyposexuality was designated as a disorder in DSM-IV, but hypersexuality had been regarded as a symptom, not as a separate disorder. The amount of time a person spends thinking about and engaging in sexual behavior varies enormously across the life cycle, with a sharp peak in adolescence and early adulthood. The most striking feature of the current criteria for hypersexuality is that, in my experience, it will be especially hard to find a young adult of college age who does not meet all of the criteria. The same will be true of many adults. The amount of time adolescents spend fantasizing and engaging in sex-related behavior is enormous. The distress over real or perceived vicissitudes of relationships is also high and normative. To call this a mental disorder will include far too many false positives.

Pedohebephilic Disorder

Of the several proposed changes to the definition of pedophilia, one is to raise the age qualification of the children (now 13) to include 14-year-olds. A second is to change the DSM IV-TR Criterion A from:

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 aged 13 years or younger) [Ref. 2, p 572].

The proposed change is to add “or pubescent children” as follows³:

1. Recurrent and intense sexual arousal from prepubescent or pubescent children.
2. Equal or greater arousal from such children than from physically mature individuals.
Specify type:

Pedophilic Type—Sexually Attracted to Prepubescent Children (Generally Younger than 11)

Hebephilic Type—Sexually Attracted to Pubescent Children (Generally Age 11 through 14)

Pedohebephilic Type—Sexually Attracted to Both

In Criterion B, a third sign or symptom has been added³:

3. Repeated use of, and greater arousal from, pornography depicting prepubescent or pubescent children than from pornography depicting physically mature persons, for a period of six months or longer.

The justification offered by the work group is that it will make it easier to diagnose or catch more pedophiles, since many individuals lie about their interests:

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.⁴

What is the great need to expand the definition to make more diagnoses? Their rationale seems to conflate law enforcement with mental illness even more. There certainly are no new good treatments to justify a need to identify more cases. The evidence linking watching child pornography to future molesting is only marginally suggestive and does not take into account the rapid growth of the Internet and its increasing use.

In addition, children's sexual development and activity begin over a wide range of years, and, in our culture, the onset of menses seems to have dropped

over the past quarter century so that it is not unusual for 7- to 9-year-olds to show the beginnings of breast development. In a study by Biro and colleagues,⁵ the baseline cohort included 1,239 girls. The proportion of girls who had attained breast stage 2 varied by age, race/ethnicity, body mass index (BMI) percentile, and site. At 7 years, 10.4 percent of white, 23.4 percent of black non-Hispanic, and 14.9 percent of Hispanic girls had attained breast stage ≥ 2 ; at 8 years, 18.3, 42.9, and 30.9 percent, respectively, had attained breast stage ≥ 2 . The prime determinant of height velocity was pubertal status. In this multi-site study, there was substantial agreement regarding pubertal staging between examiners across sites. The proportion of girls who had breast development at ages 7 and 8 years, particularly among white girls, was greater than that reported in studies of girls who were born 10 to 30 years earlier.

Thus, many girls aged 14 may not be truly prepubescent. The Tanner scale⁶ for puberty, using clinical landmarks of breast and pubic hair development, remains the standard data collected to assess the initiation and staging of puberty in many clinical settings.⁷ The Tanner scale, which involves the use of pictures of the breast reflecting developmental stages from the absence of development (stage 1) to adult breast development (stage 5), is based mainly on external morphology. Current norms are based on this visual scaling. It is highly unlikely that these examinations will be performed in a psychiatric context.

Children are maturing physically at younger ages. Physical development does not necessarily correlate with emotional and psychological maturity. For defining pedophilic attraction in adults, the earlier maturation is relevant. An adult male attracted to a 14-year-old girl with physical development of mid to advanced adolescence is not the same as an adult male attracted to a prepubescent girl of 10. Raising the age of the victim to 14 (even calling the object of the attraction a victim) detracts from the scientific base of psychiatry. Society and the law may choose to criminalize behavior; psychiatry, to be credible, must base its definitions, categories, and diagnoses on scientific approaches.

This change also seems very culture based. For many centuries, 14-year-olds have been deemed of sufficient age to be betrothed and married. Our culture has initiated a "war on sex offenders" and the legal system has geared up to wage it. Since we have made the diagnosis almost completely overlap with the crime, we have become overly enmeshed with legal goals.

The work group's proposal to add pornography viewing and greater arousal in response to prepubescent or pubescent children than to adults as diagnostic criteria is also fraught with major difficulties for professionals. Of the few tests that measure arousal, some are proprietary with no published methodology and others are not available in this country because photographs are used that are illegal in the United States. The tests are far from foolproof and have substantial margins of error. The data are not compelling that viewers of such photos are likely to be molesters or will be future molesters. Adding pubescent children to the mix adds a criterion without supporting data and totally changes the meaning of pedophilia.

Paraphilic Coercive Disorder

The proposed criteria for this new disorder include⁸:

- A. Over a period of at least six months, recurrent, and intense sexual arousal from sexual coercion, as manifested by fantasies, urges, or behaviors.
- B. The person has clinically significant distress or impairment in important areas of functioning, or has sought sexual stimulation from forcing sex on three or more nonconsenting persons on separate occasions.

The rationale offered by the work group was:

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.⁹

The work group explains that the intent of the proposed revisions to the paraphilias is to distinguish between paraphilias and paraphilic disorders so that not all those with paraphilias will necessarily meet criteria for having the disorder, unless they evidence

distress or impairment. It also seems debatable that an arrest or imprisonment is equivalent to impairment. The group, however, does not clarify what the label of paraphilia now means. Is it a diagnosis, a syndrome, a symptom, or merely a description of certain feelings or fantasies? Can it be used as a mental condition for Sexually Violent Predator (SVP) statutes? Is it a mental illness? Is it a V Code? What happens if you meet Criterion A only by virtue of finding consenting partners who are willing to be coerced. Under the criteria, you have a paraphilia but not a disorder. What would it be called: coercive or rape-fantasy paraphilia?

This disorder was proposed for DSM-IV and ultimately was rejected. It is a diagnosis that can be based on criminal behavior alone, as both Criteria A and B are satisfied by behavior alone (e.g., the commission of three rapes is sufficient for a diagnosis). Even the most ardent supporters of this diagnosis feel that a very small percentage of rapists should meet the criteria. They are trying to capture a small group of people whom they feel suffer, such as exhibitionists who seem unable to control their behavior despite immediate and direct consequences. The criteria, however, would not permit a narrowing to this highly specific group, if it exists. It transforms the crime of repeated rape into a mental disorder like pedophilia. I do not think that there is consensus in the field that the commission of three rapes constitutes a mental disorder, unless we are adopting the thesis that all sexually deviant behavior should be classified as a mental disorder. (Editor's Note: As this article was going to press, the DSM-5 committee rejected this diagnosis, although the sexual disorders work group is discussing placing it in an Appendix.^{10,11})

Conclusions

The work group has a difficult set of disorders to contend with. The category lacks a principled basis for considering inclusions and exclusions, which

makes it vulnerable to societal pressures rather than advances in science. The proposals discussed should not be accepted in their current form, as they create more problems than they solve.

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