

# Efforts to Reify Other Specified Paraphilic Disorder (Nonconsent) and Their Implications

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The concept of a paraphilic interest in rape was first described in the 1970s but became popular in the early 1990s with the advent of sexually violent predator laws. Today, the concept is described as other specified paraphilic disorder (nonconsent) (OSPD (nonconsent)) and is the second most common diagnosis of individuals committed to state facilities as sexually violent predators. This usage continues despite research indicating that OSPD (nonconsent) lacks scientific validity and has consistently poor interrater reliability. Furthermore, the concept of paraphilic rape has been repeatedly rejected from inclusion in the DSM over a span of decades. Despite obvious flaws in the construct, some experts continue to promote OSPD (nonconsent) and to present unresearched, unvalidated, and idiosyncratic criteria by which to assess individuals. This article reviews the history and development of the concept of a paraphilic interest in rape, describes its scientific flaws, reviews its proponents' efforts to reify it as a clinical entity, and considers the ethics, legal, and evaluative implications of experts' efforts to do so.

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Few diagnostic constructs have engendered as much controversy over so many years as the rape paraphilia, often referred to as paraphilic coercive disorder (PCD). Various iterations of PCD have been considered and excluded from five successive editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), making it “the most rejected disorder in DSM history” (Ref. 1, p 36) according to one of the leading researchers in the field of paraphilic arousal to violence and coercion. The reasons for its rejection include the failure of researchers to validate a paraphilic interest in rape as a definable diagnostic entity, accumulating evidence that it has poor interrater reliability, and continued, well-grounded concerns about the medicalization of rape.

Despite this history, PCD has not disappeared. In fact, now utilized under the DSM-5 nomenclature of “other specified paraphilic disorder (nonconsent)” or “OSPD (nonconsent),” it is one of the most utilized diagnoses in sexually violent predator (SVP) proceedings.<sup>2</sup>

With the growing body of evidence indicating that OSPD (nonconsent) is neither valid nor reliable, one might reasonably expect calls for caution and care in its application in SVP proceedings, especially since the diagnosis is not utilized in other contexts. Instead, experts in the field continue to present idiosyncratic criteria for the disorder, continuing a trend observed over many decades. While we argue that a paraphilic interest in rape cannot be identified or separated from related constructs and that experts rarely agree on its presence, one expert promotes the notion that evaluators can accurately and reliably diagnose paraphilic arousal to coercion if they utilize an unstudied methodology.<sup>3</sup> In this article, we review the history of the construct of OSPD (nonconsent) and summarize research relevant to its scientific validity and reliability. We describe the history of efforts to reify OSPD (nonconsent) despite conspicuous problems that arise from

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research on the construct. Finally, we highlight the ethics, legal, and evaluative implications of experts' continuing to promote a diagnostic construct that has failed to obtain acceptance in the fields of psychiatry, psychology, and sex offender risk assessment.

## History

In the 1980s, psychologist John Money hypothesized the existence of a paraphilia characterized by arousal to nonconsensual sexual activity or rape. This construct, which he labeled biastophilic rapism or rapitophilia, was grouped among the predatory paraphilias and described as sexual arousal from "the surprise attack and continued violent assault of a nonconsenting, terrified, and struggling stranger" (Ref. 4, p 259). Money reported that biastophilia was distinct from the disorder of sexual sadism, though he offered no empirical support for this claim. Money's early formulation of paraphilic rape received some limited research attention, for example from psychiatrist Gene Abel, who wrote that he could distinguish between seven rapists and seven nonrapists using penile plethysmography (PPG).<sup>5</sup>

Despite this incipient interest in paraphilic rape, diagnoses related to the construct were repeatedly rejected for inclusion in five editions of the DSM over the last four decades. In 1976, a diagnosis of sexual assault disorder was removed from the first draft of DSM-III, partly due to concerns that it would allow rapists to escape imprisonment.<sup>6</sup> In the 1980s, a similar diagnosis of paraphilic rapism was rejected from DSM-III-R.<sup>6</sup> In the 1990s, paraphilic rape was rejected from DSM-IV<sup>7</sup> and rebuffed in a 1999 Task Force Report of the American Psychiatric Association.<sup>8</sup> Most recently, PCD was proposed for inclusion in DSM-5 with the following criteria:

- 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 (Ref. 9, p 220).

The DSM-5's paraphilia sub-workgroup ultimately rejected the PCD diagnosis because of its lack of empirical support and concerns over creating large numbers of false-positive diagnoses.<sup>10</sup> Not only was PCD rejected from DSM-5, it was also not included

as an example of one of the "other specified paraphilic disorder" diagnoses, nor was it included in the appendix on Conditions for Further Study. Notably, PCD is also not included in the most recent edition of the International Classification of Diseases, though the name of its catch-all category "other specified paraphilic disorder involving nonconsenting individuals" might confuse one to think otherwise.<sup>11</sup> The text for this ICD-11 diagnosis indicates that it can be applied to atypical sexual arousal involving those who are unable or unwilling to consent, for example animals or dead bodies, similar to the OSPD category in the DSM-5.

## Validity and Reliability Studies

Studies have consistently demonstrated that the various iterations of PCD, including paraphilia Not Otherwise Specified nonconsent (PNOS (nonconsent)) and OSPD (nonconsent), are unreliable diagnoses, meaning that evaluators are unlikely to arrive at the same diagnostic conclusion regarding its presence or absence in the same individual. Researchers have evaluated the kappa statistic of interrater reliability and consistently found it to be poor ( $\kappa = .35-.36$ )<sup>12,13</sup> and, in some cases, the least reliable diagnosis in SVP evaluations (prevalence-adjusted biased-adjusted kappa = .36).<sup>14</sup> In a recent study, 190 male sexual offenders underwent two SVP evaluations, receiving a total of 68 OSPD (nonconsent) or similar nonconsent diagnoses (17.9%).<sup>15</sup> In that study, the kappa coefficient for the diagnosis was only .17 compared with .78 for pedophilic disorder. The reliability of PCD is so poor that one expert identified the likelihood of two evaluators agreeing on the presence of PNOS (nonconsent) in an individual facing SVP commitment to be no better than chance.<sup>16</sup> The only researcher to report a moderate kappa coefficient of .50 for PCD from DSM-5 field trials, psychologist David Thornton, has not published this work in peer-reviewed journals.<sup>3</sup> Clinicians struggle to reliably distinguish hypothesized paraphilic rapists from the larger pool of nonparaphilic rapists. It remains unclear how reliably clinicians might diagnose PCD outside the context of SVP evaluations, since the diagnosis is not made in other contexts.

One might argue that if PCD were formalized in the next version of the DSM with specified criteria, its diagnostic reliability would improve. To do so would be inappropriate, however, since researchers have failed to validate the concept of a preferential sexual arousal

to coercive sex. Most research on this concern has involved the use of PPG, a procedure that itself has significant limitations in terms of its reliability and validity.<sup>17</sup> Though an exhaustive review of PPG studies on arousal to coercive sex is beyond the scope of this article, some problems with utilizing PPG to identify a paraphilic interest in rape are readily apparent. Studies have failed to consistently demonstrate a difference in arousal to coercive stimuli between rapists and nonoffenders<sup>18</sup> or rapists and other types of sexual offenders.<sup>19</sup> In fact, both coercive and noncoercive subjects tend to demonstrate an arousal to coercive stimuli and a diminished response when coercive elements are introduced into sexual scenarios, though coercive subjects' responses may reduce less.<sup>20</sup> One meta-analysis concluding that rapists can be identified by PPG noted that there tends to be better discrimination between rapists and nonoffenders using "stimulus sets that employ graphic and brutal rape stimuli" (Ref. 21, p 169); however, such stimulus sets may be identifying sadistic sexual arousal, rather than arousal to lesser forms of coercion.

These PPG studies raise some basic questions regarding the plausibility of a rape paraphilia and the ability of PPG to detect it. First, if nonoffenders demonstrate some arousal to coercive stimuli, it is difficult to know what aspects of coercion, if any, represent an atypical sexual interest. One survey of the sexual fantasies of over 1500 people from the general public found that over 20 percent of men report having fantasized about "forcing someone to have sex" or "sexually abusing a person who is drunk, asleep, or unconscious," and that over 50 percent of men and 40 percent of women report having fantasized about "dominating someone sexually."<sup>22</sup> If fantasies about rape and dominating others are so common, then arousal to relevant stimuli is also likely common. Perhaps sexual interest to coercive forms of sex is normative to some extent. Second, it is unclear if men's arousal to coercive sexual scenarios is caused by genuine excitement from the coercive elements or failure of inhibition from them. Though physiological mechanisms do not define the paraphilias, presumably a positive interest in coercive sex would be needed before diagnosing PCD. One researcher has proposed using a "rape index" value (a comparison of penile response to coercive versus consensual stimuli) of one as a cutoff for defining a paraphilic arousal to rape.<sup>23</sup> Such a division is arbitrary and fails to address the potential mechanisms for arousal to rape and the other elements of sexual scenarios that might influence one's arousal.<sup>24,25</sup>

Another concern related to the validity of paraphilic rape is whether such a construct could be distinguished from the existing paraphilic disorder of sexual sadism disorder. Longpré and colleagues assessed a mixed sample of 680 sex offenders using the Multidimensional Inventory of Development, Sex, and Aggression, a self-report instrument measuring aspects of coercive sexual behavior.<sup>26</sup> Similar to PPG findings, the respondents with a higher titer of sadism reported significantly more arousal from coercive sex than those with a lower titer, which did not support treating PCD and sexual sadism as two distinct conditions.<sup>27</sup> Instead, Longpré suggested that PCD and sexual sadism may be better conceptualized as existing on an "agonistic continuum" with no natural boundary between them. PPG studies have similarly demonstrated overlap and an inability to distinguish between sadistic rapists and nonsadistic rapists, as sadistic rapists consistently demonstrate the highest rape indices.<sup>25</sup> On the basis of diagnostic quandaries posed by the agonistic continuum, Longpré has recommended against the use of OSPD (nonconsent) in SVP civil commitment proceedings.<sup>27</sup>

## Efforts to Codify PCD

With the advent of SVP legislation, states sought to restrict high-risk, convicted sexual offenders to state psychiatric facilities following the completion of their prison terms. After the establishment of this legal procedure, the concept of PCD gained fresh importance, as evaluators began to confront rapists with a high risk for re-offense. Within ten years of the passage of his own state's SVP law, Wisconsin state hospital psychologist Dennis Doren published a book on the evaluation of sexual offenders for civil commitment in which he openly endorsed the use of the DSM-IV-TR to diagnose rapists with PNOS (nonconsent).<sup>28</sup> He advocated disregarding diagnostic criteria and using DSM-IV-TR definitions as guidelines to be applied to specific cases and stated that the use of Not Otherwise Specified (NOS) diagnoses is "considered just as meaningful by the writers of the DSM-IV as using any of the individually listed diagnoses" (Ref. 28, p 67). After dismissing the methodology by which the DSM-IV-TR was meant to be used, he then co-opted the terminology from the very same text and stated:

If the offender has repetitively and knowingly enacted sexual contact with nonconsenting persons over a period of at least 6 months (specifically for sexual arousal to the non-consensual interaction), and that behavior has caused him significant impairment in social, occupational, or other

areas of functioning, then criteria for a paraphilia are met (Ref. 28, p 67).

Doren stated that criteria for a diagnosis would be met shortly after dismissing the utility of diagnostic criteria. He also failed to realize that the definition he provided would, by necessity, apply to half of the DSM-IV-TR paraphilia diagnoses, including pedophilia, voyeurism, exhibitionism, and frotteurism, all of which involve nonconsensual sexual acts as sources of sexual arousal.

Doren not only utilized DSM-IV-TR definitions and terminology to promote a diagnostic entity that was explicitly rejected from the same text, but he also provided his own idiosyncratic behavioral indicators of PNOS (nonconsent). These included the following: ejaculation; repetitive patterns of scripted actions; all of the individual's criminal behavior is sexual; raping when the victim was willing to have consensual sex; repeated rape shortly after experiencing consequences; raping when there is a high likelihood of being caught; having cooperative sex partners available; various victim types; and maintenance of a "rape kit" (items for serial assault, like ligatures, condoms, etc.). His indicators foreshadowed the most recent list of indicators used to reify OSPD (nonconsent).

Within a few years of Doren's publication, psychologists Gary Zinik and Jesus Padilla proposed criteria for PNOS (nonconsent) in a chapter in the book *Sexual Offending: Predisposing Antecedents, Assessments and Management*.<sup>29</sup> They modeled their diagnostic criteria on DSM-IV-TR paraphilia criteria despite the fact that PNOS (nonconsent) was rejected from the text:

- A. Over a period of at least six months, recurrent sexually arousing fantasies, urges, or behaviors involving coercive sexual acts with nonconsenting persons, typically including genital contact.
- B. The experience of power, dominance, and control are sexually arousing because the sexual behavior is forced upon a person who is deprived the liberty of consent and would otherwise refuse the sex if given a free choice.
- C. The individual has acted on these sexual urges (committed sexual assault), or the sexual urges or fantasies caused marked distress or interpersonal difficulty.
- D. The disorder is distinguished from sexual sadism in which the physical suffering and/or psychological humiliation of the nonconsenting person is the source of sexual arousal (Ref. 29, p 46).

The authors essentially transcribed criteria A and C from other paraphilic diagnoses in DSM-IV-TR and added a criterion B that generates confusion. According to criterion B, for the paraphilic rapist it is the "experience of power, dominance, and control"

(Ref. 29, p 46) that is sexually arousing, but only because the experience occurs in the context of rape. Being sexually aroused by the act of rape itself or the victim's associated behavior (e.g., struggling, crying, pleading), then, would not be considered evidence of a paraphilic interest in rape. How to identify a rapist's subjective "experience of power, dominance, and control" (Ref. 29, p 46) is an even thornier research and evaluative question than those previously discussed, which is perhaps why Zinik and Padilla's proposed criteria are not widely known. Furthermore, the authors state in criterion D that the diagnosis is "distinguished from sexual sadism," but provide no guidance or recommendation for how to do so. As already discussed, current evidence suggests significant overlap between sadistic and nonsadistic rapists' responses to self-report measures and PPG analysis.<sup>25-27</sup>

Psychologist David Thornton has spearheaded the most recent effort to reify PCD. In a 2010 paper,<sup>23</sup> he proposed criteria for PCD for the then-forthcoming DSM-5:

- A. Over a period of at least six months, recurrent, intense sexually arousing fantasies or sexual urges focused on sexual coercion, as indicated by self-report, laboratory testing, or behavior.
- B. The person is distressed or impaired by these attractions, or has sought sexual stimulation from forcing sex on three or more non-consenting 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 (Ref. 23, p 417).

Thornton's criteria pose numerous problems. Criterion A suggests that the science of laboratory testing of sexual arousal has advanced to the point of accurately identifying a paraphilic interest in rape, which it has not. In addition, coercive sexual behavior is not evidence of a paraphilic interest in rape, given the multitude of more plausible reasons for which individuals engage in rape.<sup>25</sup> Finally, fantasies of sexual coercion are relatively common in the general population, which calls into question if such a sexual interest is atypical.<sup>22</sup> Criterion B, like Thornton's concept of the "rape index," provides an arbitrary cut-off value for the number of rape victims one must have for a diagnosis. As with Zinik and Padilla's criteria, criterion C recommends distinguishing between a paraphilic interest in rape and sexual sadism disorder, something that researchers have failed to do.

Even after the DSM-5 paraphilias sub-workgroup (on which Thornton served) rejected the proposed



criteria for PCD, he continued to promulgate the concept of paraphilic rape. In a presentation titled “Diagnosing Paraphilic Coercion” in 2019,<sup>3</sup> he described 14 “indicators” of paraphilic rape divided into five categories: strong propensity to rape, arousal despite coercion, rape motivated by more than seeking sex, sustained intention to rape, and fantasy reenactment. Thornton copied seven of Doren’s original indicators and added seven of his own. He then suggested that evaluators assess sexual offenders for a strong propensity to rape, which indicates that rape “is not merely situational” and then look for evidence of indicators in the last three groups “indicating that it is not simply antisocial.”<sup>3</sup>

Apart from the lack of research to validate any of Thornton’s proposed indicators as evidence of OSPD (nonconsent), there are numerous flaws with his proposal. “Arousal despite coercion” does not identify a paraphilic interest in coercive sex, since laboratory studies have shown that noncoercive male subjects can become sexually aroused to coercive stimuli.<sup>18,20,30</sup> The indicators in “rape motivated by more than sex” are flawed. For example, “raping when the victim had already been willing to have consensual sex” is counterintuitive. If an individual is preferentially aroused by coercive sex, then a victim expressing consent should reduce his sexual interest and potentially dissuade him from continuing. The second indicator, “raping when had cooperative sexual partners available” is likely to be true of rapists regardless of their motivation or degree of interest in coercive sex. Finally, “coercive, humiliating, frightening, brutalizing behaviors beyond those required to get the victim to comply” are all consistent with the sexual behaviors of individuals with sexual sadism disorder, not someone with a paraphilic interest in rape. An individual with a genuine sexual interest in coercion would not want a victim to comply and therefore would not encourage compliance, since it is the lack of compliance that generates the arousal. Furthermore, the definition of sexual sadism disorder indicates that the individual is aroused by another’s humiliation and suffering, which would foreseeably result from “humiliating, frightening, brutalizing behaviors beyond those required to get the victim to comply.” Thornton’s categories of “strong propensity to rape” and “sustained intention to rape” fail to differentiate the various motivations for raping, specifically a paraphilic interest versus an opportunistic or predatory motive. The only category that addresses the fundamental definitional elements of a paraphilia is the “fantasy enactment” category consisting of

“script/ritual apparent across rapes” and “repeated pattern of behaviors during the rape.” There are no data to indicate that having a script, ritual, or repeated pattern of behavior is consistent with a genuine sexual interest in rape itself. In a case involving such consistent behaviors, it indeed may be the ritualistic elements that are the focus of arousal, rather than the fact that the victim does not provide consent.

## Implications

### Ethics

In 2008, attorney and psychologist Thomas Zander expressed concern that the use of PCD/PNOS (nonconsent) in SVP proceedings violates basic ethics principles promulgated by organizations like the American Psychological Association, the American Psychology-Law Society, and the American Academy of Psychiatry and the Law.<sup>31</sup> He noted that psychiatrists and psychologists testifying to opinions made by “reasonable medical certainty” or “reasonable psychological certainty” should not utilize NOS diagnoses that were intended for situations of diagnostic uncertainty. He also opined that testimony involving PNOS (nonconsent), a diagnosis specifically excluded from DSM-IV-TR, was based on insufficient scientific evidence and lack of consensus, as well as misleading to legal decision-makers. Similarly, one of the authors has reviewed the reports of numerous forensic evaluators describing how they made a diagnosis of OSPD (nonconsent) using “DSM-5 criteria,” when no such criteria exist. Such practice, Zander suggested, could be grounds for action against an evaluator’s professional license.

The ethics problems have not changed appreciably with the transition of PNOS (nonconsent) to OSPD (nonconsent). Unlike DSM-IV-TR’s not otherwise specified categories, DSM-5’s other specified and unspecified diagnostic categories are not meant to communicate uncertainty, but “to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class” (Ref. 32, p 15). To some, then, the other specified category may seem like *carte blanche* to make diagnoses that are not listed as specified disorders. In the Cautionary Statement for Forensic Use of DSM-5, the text makes clear the risks associated with using psychiatric diagnoses in forensic settings. It notes that “there is a risk that diagnostic information will be misused or misunderstood” and

that “[u]se of DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised” (Ref. 32, p 25). We suggest that the use of OSPD (nonconsent) itself is evidence that the evaluator is “insufficiently trained” in the use of DSM-5, given that the diagnosis was purposefully excluded from the text. Insufficiently trained evaluators should certainly not be providing diagnostic opinions in high-stakes forensic evaluations that could result in lifetime civil commitment. Furthermore, the continued efforts of some experts to train and teach idiosyncratic methods of diagnosing paraphilic coercion are perhaps more concerning, as they perpetuate flawed diagnostic practices.

### Legal

The often-vague language of SVP statutes may contribute to the use of ill-defined constructs like OSPD (nonconsent). To civilly commit someone as an SVP, most states require a finding of a “mental abnormality” that predisposes the person to sexually violent acts. The “mental abnormality” is rarely defined on the basis of diagnostic categories or other clinical concepts, but instead as a condition affecting the “emotional or volitional capacity” of the offender. Perhaps it is not surprising, then, that evaluators bend the language of the DSM to label repeat rapists as mentally ill. In fact, SVP laws do not require the use of DSM diagnoses at all, though their use is standard practice and some jurisdictions have excluded testimony on OSPD (nonconsent) because of its lack of general acceptance, including its exclusion from the DSM.<sup>1</sup> While it is true that other non-DSM conditions like complex PTSD and battered woman syndrome are sometimes used in forensic contexts, the deliberate adoption of DSM nomenclature to obfuscate an unsubstantiated concept like paraphilic rape demands further scrutiny.

The legal outcomes from the continued use of OSPD (nonconsent) are astounding. In 2007, 43 percent of the SVPs in Washington state had a nonconsent diagnosis.<sup>33</sup> In California, a state with approximately 1,000 SVPs, the estimated percentage is even higher at 50 percent.<sup>34</sup> An empirical review of legal cases found that references to the nonconsent diagnosis grew from one in 1998 to 30 per year by 2011. The nonconsent diagnosis was disproportionately represented in cases from New Jersey, Washington, Minnesota, and Wisconsin. In 77

percent of cases there was no challenge raised regarding the admissibility of the diagnosis.<sup>35</sup>

In 2020, Holoyda described how OSPD (nonconsent) fails to meet most admissibility criteria.<sup>34</sup> Its repeated rejection from the DSM indicates that it lacks general acceptance in psychology and psychiatry. Interrater reliability studies have repeatedly demonstrated that its inconsistent application would lead to a high error rate beyond the error of its use at all. Though it has been subject to publication and peer-review, the relevant studies have failed to establish its validity. Finally, there is no testable method by which to make the diagnosis, as evidenced by the recurrent iterations of idiosyncratic and often rejected criteria that various experts promote.

Recently there have been some cases in which OSPD (nonconsent) has been challenged and deemed inadmissible by the courts. In *State of New York v. Jason C.*,<sup>36</sup> the court found that OSPD (nonconsent) was not generally accepted in the psychological community based on its lack of a definition and criteria, the inability to distinguish paraphilic rape from other motivations, and the studies supporting it failing to reflect a coherent body of research. Similarly, in *State of New York v. Kareem M.*,<sup>1</sup> the court found that OSPD (nonconsent) was not generally accepted because of its repeated rejection from the DSM, the lack of studies on the predictive validity of the diagnosis, the dearth of research examining why rapists offend, and the fact that there are no published field trials on the use of the diagnosis in practice. In a *Daubert* hearing in an SVP case in St. Louis County, Missouri,<sup>37</sup> the court excluded testimony about the diagnosis of OSPD (nonconsent) because of its lack of general acceptance, noting, among other findings, its repeated rejection for inclusion in the DSM.

### Evaluative

Understanding the history of and current state of the research on OSPD (nonconsent) enables a forensic expert to assist in the evaluation of would-be SVPs diagnosed with it. It is critical to analyze an expert’s purported methodology used to make the diagnosis. Any reference to the use of DSM-5 criteria or definitions is misleading and inaccurate, as the diagnosis was explicitly rejected from the text. Any definition or criteria that an expert provides are idiosyncratic and lack a basis in research or commonly accepted diagnostic practice in the fields of psychiatry and psychology.

After reviewing the purported methodology of an evaluator, one can then analyze the evidence that the expert uses to try to substantiate OSPD (nonconsent). Experts alleging a diagnosis of OSPD (nonconsent) often do not demonstrate evidence of an actual paraphilic interest in coercive sex. Often they simply recapitulate the offender's sexual offenses, which frequently suffices to convince a jury that the individual has a mental disorder. It is therefore the asymmetric task of the opposing expert to prove that an evaluatee committed his sexual offenses for reasons other than a paraphilic interest in rape. Motivations for rape include opportunism, or the opportunity to obtain sex during the commission of another crime; anger, resentment, revenge, vindictiveness, hatred of women, or other emotions; and disinhibition or aggression related to substance intoxication. By identifying the specific cognitive and affective components of an offender's motivation for committing sexual offenses, one can rebut the purported evidence that the motivation was an "intense and persistent sexual interest" (Ref. 32, p 685) in rape, as required by the DSM-5 definition of a paraphilia.

## Conclusion

Courts have an important role in determining how to manage high-risk sexual offenders, including in SVP proceedings. Though forensic psychiatrists and psychologists may be able to assist in providing evidence for such decisions, they have exceeded the science in their efforts to do so, in the process mangling and transforming psychiatric diagnosis into a form of pseudoscience. The available evidence does not support that PCD's most recent iteration, OSPD (nonconsent), is a valid or reliable construct, suggesting that many sex offenders have been and continue to be civilly committed based on a disorder they do not actually have. To promote the principles of honesty and justice and the field's credibility, forensic psychiatrists and psychologists who evaluate sexual offenders must prepare to testify to the limitations of psychiatric diagnosis, rather than promote invalid, unreliable, and untestable constructs like OSPD (nonconsent).

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