# DSM-5 and Paraphilic Disorders

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Given that paraphilic disorders are diagnosed largely in forensic settings, virtually every significant change in the criteria has forensic implications. Several controversial changes were considered during the DSM-5 revision process, but most were ultimately not included in the published text. However, any changes that make it easier to assign a paraphilic disorder diagnosis to an individual must be considered with caution. Criterion A for paraphilic disorders has been changed to reduce one potential risk that could result in false-positive diagnoses (i.e., allowing evaluators to diagnose a paraphilic disorder based entirely on the presence of sexual acts). In contrast, many of the other changes including some of those in the text, make it easier to diagnose a specific paraphilia and thus increase the risk of false-positive diagnoses. Since the assignment of a paraphilic disorder diagnosis can result in adverse legal consequences, the actual forensic impact of the changes will depend on how the legal system incorporates these new definitions into statutes and case law.

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The paraphilic disorders are unique in DSM-5,[1] in that forensic considerations played a central role in many of the proposed changes in the diagnostic criteria and accompanying text. In contrast to the disorders from almost every other DSM-5 diagnostic class, individuals with paraphilic disorders, especially in the United States, are mainly seen in forensic settings.[2] They may be persons who have been arrested for a sex-related crime, such as child molestation, rape, or other sexual assault or for charges involving child pornography, or they may be individuals involved in child custody evaluations to determine their fitness to be a parent. Thus, any significant changes made in the definitions or specifiers for the paraphilic disorders are likely to have forensic implications.

In 1990, Washington state passed a sexually violent predator (SVP) involuntary commitment statute, allowing sex offenders to be civilly committed to mental hospitals after completion of their mandatory prison sentences Since then, 20 states and the federal government have enacted similar statutes.[3] As a result, the scope and wording of the paraphilia criteria sets and text have come under intense scrutiny by forensic examiners and lawyers. The constitutionality of SVP commitment statutes depends on the requirement that a violent sexual offender have a mental abnormality that predisposes him to commit sexual offenses, distinguishing him from dangerous sex offenders whose offenses are not the product of such abnormalities.[4] Although the statutorily defined mental abnormality is not equivalent to any clinically defined mental disorder diagnosis, the presence of a DSM diagnosis, particularly a paraphilic disorder, is almost always key evidence in SVP civil commitment adjudications.[5] Thus, any change in the wording of a diagnostic criterion or the addition of a new diagnostic category has important ramifications.

The determination of the presence (or absence) of a paraphilic disorder is also likely to have a significant impact on sentencing recommendations and the categorization of sex offenders into low, medium, or high risk under community-notification statutes (e.g., Megan's Law).[6] For example, Federal sentencing guidelines require that the sentence take into account the need to "protect the public from further crimes of the defendant".[7] Given that the presence of a paraphilic disorder is associated with an increased risk of recidivism[8] and thus a risk of future harm to the public, a diagnosis of a paraphilic disorder is likely to result in the imposition of a longer sentence or the assignment of the individual to a higher risk category after being released into the community. Moreover, the diagnosis will determine the sex offender treatment that will be mandated during incarceration. Similarly, the determination that a parent

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undergoing a custody evaluation has a paraphilia diagnosis may have adverse consequences on that parent's custodial and visitation rights.[9]

Changes in the diagnostic criteria for the paraphilic disorders are relatively few. There are, however, several more extensive changes in the descriptive text. Forensic experts (and attorneys) often carefully scrutinize the text, as well as the diagnostic criteria, for information to bolster their opinions. However, although the DSM-5 diagnostic criteria went through many layers of review and scrutiny during the revision process, the text, by comparison, was subjected to a much more limited review and vetting process. In some cases, the lack of review resulted in the application of a more lax empirical standard, as will be discussed below. It is therefore advisable to examine statements critically in the text for their empirical backing before considering them in legal arguments.

## Name Change from Paraphilia to Paraphilic Disorder

The term paraphilia was first introduced into DSM-III[10] to replace the DSM-II[11] term sexual deviation "because it correctly emphasizes that the deviation (para-) lies in that to which the person is attracted (philia)" (Ref. 8, p 267). Although paraphilia has been used to refer to disorders of atypical sexual arousal up through DSM-IV-TR,[12] no term was available in DSM-IV-TR to indicate nonpathological, atypical sexual interests. In contrast, DSM-5 redefines the term paraphilia so that it now refers to a persistent, intense, atypical sexual arousal pattern, independent of whether it causes any distress or impairment, which, by itself, would not be considered disordered.

DSM-5 instead uses the term paraphilic disorder to refer to the disorder-worthy entities included in The Manual, which are defined as persistent and intense atypical sexual arousal patterns that are accompanied by clinically significant distress or impairment. Concomitant with this name change, DSM-5 also introduces the novel distinction between ascertaining a paraphilia and diagnosing a paraphilic disorder. According to DSM-5, "the term diagnosis should be reserved for individuals who meet both Criterion A and Criterion B (i.e., individuals who have a paraphilic disorder)" (Ref. 1, p 686). Examples of the difference between ascertaining a paraphilia and diagnosing a paraphilic disorder are provided throughout the text.

Although the intent of this change is to reduce stigma by clarifying that atypical sexual arousal patterns are not evidence of psychopathology, the decision to repurpose the existing term paraphilia, understood for the past 34 years to be indicative of psychopathology in both medical and legal circles, is likely to create much confusion.[13,14] It is easy to imagine how the technical difference between a paraphilia and a paraphilic disorder might be lost on judges, juries, and others not well versed in the subtleties of the DSM and thus the redefinition of paraphilia is likely to blur rather than sharpen the distinction between a disorder and a nondisorder. Moreover, in the context of child custody evaluations, receiving an ascertained label of a paraphilia such as pedophilia is likely to be as damaging as being diagnosed as having a paraphilic disorder.[15]

## Summary of Changes in the Paraphilic Disorders Criteria Sets

During the DSM-5 revision process, proposed changes in the DSM-IV[16] paraphilias engendered a great deal of spirited debate in regard to their forensic implications. Particularly contested were proposals to add two new disorders (i.e., paraphilic coercive disorder and hypersexual disorder) and to broaden the pedophilic disorder diagnosis to include attraction to pubescent as well as prepubescent children. Other controversial proposals involved making significant changes to the criteria sets, including operationalizing the harm component by having it depend on the number of victims[17] and including the use of child pornography.[18] Ultimately, the proposals for adding paraphilic coercive disorder and hypersexual disorder and for expanding pedophilia to include hebephilia were rejected. Moreover, most of the other proposed criteria set changes were not implemented, so that the final criteria sets closely resemble their DSM-IV-TR counterparts.

Table 1 lists the DSM-5 criteria sets for the paraphilic disorders, with the DSM-IV-TR criteria sets provided for comparison. Conceptually, the diagnostic criteria are split into two constructs, both of which are required for the diagnosis of a paraphilic disorder. Criterion A is the paraphilia component of the disorder, which requires an atypical focus of sexual arousal and an arousal pattern that is recurrent, intense, and persists for at least six months. Criterion

**Table 1.** DSM-IV-TR and DSM-5 Criterion Templates for the Paraphilic Disorders[1,12]

| DSM-5 | DSM-IV-TR |
|---|---|
| Template for Paraphilic Disorders involving Nonconsenting Victims (i.e., Voyeuristic Disorder, Exhibitionistic Disorder, Frotteuristic Disorder, Sexual Sadism Disorder) except Pedophilic Disorder (see below). | Template for Paraphilias involving Nonconsenting Victims (i.e., Voyeurism, Exhibitionism, Frotteurism, Sexual Sadism) except Pedophilia (see below). |
| A. Over a period of at least 6 months, recurrent *and* intense *sexual arousal* | A. Over a period of at least 6 months, recurrent intense *sexually arousing fantasies, sexual urges, or behaviors* . . . |
| *from* observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity [Voyeuristic Disorder] | *involving* the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity [Voyeurism]. |
| *from* the exposure of one's genitals to an unsuspecting person [Exhibitionistic Disorder] | *involving* the exposure of one's genitals to an unsuspecting person [Exhibitionism] |
| *from* touching or rubbing against a nonconsenting person [Frotteuristic Disorder] | *involving* touching or rubbing against a nonconsenting person [Frotteurism] |
| *from the physical or psychological suffering of another person* [Sexual Sadism Disorder] | *involving acts (real, not simulated) in which the psychological or physical suffering* (*including humiliation*) *of the victim is sexually exciting to the person* [Sexual Sadism]. |
| . . . *as manifested by fantasies, urges, or behaviors.* | |
| B. The *individual* has acted on these sexual urges *with a nonconsenting person,* or the sexual urges or fantasies cause *clinically significant* distress *or impairment in social, occupational, or other important areas of functioning.* | B. The *person* has acted on these sexual urges, or the sexual urges or fantasies cause *marked* distress *or interpersonal difficulties.* |
| C. [for Voyeuristic Disorder only]: *The individual experiencing the arousal and/or acting on the urges is at least 18 years of age.* | |
| *For Exhibitionistic Disorder only:* | |
| Specify whether: | |
| Sexually aroused by exposing genitals to prepubertal children | |
| Sexually aroused by exposing genitals to physically mature individuals | |
| Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals | |
| Specify if: | |
| In a controlled environment: this specifier is primarily applicable to individuals living in institutional or other settings where opportunities to [engage in paraphilic behavior] are restricted. | |
| In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment. | |
| Template for Paraphilic Disorders not involving nonconsenting victims (including Sexual Masochism, Fetishistic Disorder, and Transvestic Disorder) | Template for Paraphilic Disorders not involving nonconsenting victims (including Sexual Masochism, Fetishistic Disorder, and Transvestic Disorder) |
| A. Over a period of at least 6 months, recurrent and intense sexual arousal | A. Over a period of at least 6 months, recurrent, intense *sexually arousing fantasies, sexual urges, or behaviors* . . . |
| . . . *from* the act of being humiliated, beaten, bound, or otherwise made to suffer . . . [Sexual Masochistic Disorder] | . . . *involving* the act (*real, not simulated*) of being humiliated, beaten, bound, or otherwise made to suffer [Sexual Masochism] |
| . . . *from* the use of nonliving objects *or a highly specific focus on nongenital body part*(*s*) . . . [*Fetishistic Disorder* | . . . *involving* the use of nonliving objects (e.g., female undergarments) [Fetishism] |
| . . . *from* cross-dressing [Transvestic Disorder] | . . . *involving* cross-dressing in a *heterosexual male* [Transvestic Fetishism]. |
| . . . *as manifested by fantasies, urges, or behaviors.* | |
| B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. | B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. |

B is the harm component, which requires the presence of distress, impairment in functioning, or involvement of nonconsenting victims. Three different wording templates for the diagnostic criteria have been used: one for paraphilic disorders that may involve the participation of nonconsenting persons (i.e., voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, and sexual sadism disorder),

**Table 1.** Continued

| DSM-5 | DSM-IV-TR |
|---|---|
| C. [For Fetishistic Disorder only:] The fetish objects are not limited to articles of clothing used in cross-dressing (as in Transvestic Disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator).<br>*For Transvestic Disorder only*:<br>Specify if:<br>With fetishism: if sexually aroused by fabrics, materials, or garments.<br>With autogynephilia: if sexually aroused by thoughts or images of self as female.<br>*For Sexual Masochism Disorder only:*<br>Specify if:<br>With asphyxiophilia: If the individual engages in the practice of achieving sexual arousal related to restriction of breathing.<br>*For Fetishistic Disorder only:*<br>Specify:<br>Body part(s)<br>Nonliving object(s)<br>Other<br>Specify if:<br>In a controlled environment: this specifier is primarily applicable to individuals living in institutional or other settings where opportunities to [engage in paraphilic behavior] are restricted.<br>In full remission: there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment. | C. [For Fetishism only:] The fetish objects are not limited to articles of *female* clothing used in cross-dressing (as in Transvestic Fetishism) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator).<br>*For Transvestic Fetishism only:*<br>Specify if:<br>With Gender Dysphoria: if the person has persistent discomfort with gender role or identity |
| Template for Pedophilic Disorder | Template 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 13 years or younger). | 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 13 years or younger). |
| B. The *individual* has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. | B. The *person* has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. |
| C. The *individual* is at least age 16 years and at least 5 years older than the child or children in Criterion A.<br>Note: do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old. | C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.<br>Note: do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old. |
| Specify whether:<br>Exclusive type (attracted only to children)<br>Nonexclusive type<br>Specify if:<br>Sexually attracted to males<br>Sexually attracted to females<br>Sexually attracted to both<br>Specify if:<br>Limited to incest | Specify type:<br>Exclusive type (attracted only to children)<br>Nonexclusive type<br>Specify if:<br>Sexually attracted to males<br>Sexually attracted to females<br>Sexually attracted to both<br>Specify if:<br>Limited to incest |

Italics highlight the differences.



shown in the top section of Table 1; one for paraphilic disorders that do not involve nonconsenting victims (i.e., sexual masochism disorder, fetishistic disorder, and transvestic disorder), shown in the center section; and one for pedophilic disorder, shown in the bottom section.

As was the case with DSM-IV-TR, Criterion B for those paraphilic disorders in which the paraphilic interest potentially involves a nonconsenting victim requires that the individual act on the sexual urges or that the sexual urges or fantasies cause distress or impairment, whereas Criterion B for the other para-

philias requires only that the fantasies, urges, or behaviors cause distress or impairment. The behavioral expression of pedophilic disorder often involves nonconsenting victims, since prepubescent children cannot legally give consent to sexual activity. However, the diagnostic criteria for pedophilic disorder have retained their DSM-IV-TR wording and thus differ from the DSM-5 diagnostic criteria for the other paraphilic disorders involving nonconsenting victims.

Although many of DSM-5's wording changes occurred for editorial purposes and are likely to be forensically inconsequential (e.g., in frotteuristic disorder Criterion A, changing "involving touching or rubbing against a nonconsenting person" (Ref. 10, p 570) to "from touching or rubbing against a nonconsenting person" (Ref. 1, p 691)), some of the changes have important forensic implications. Most notably, the overall structure of Criterion A has been changed in a way to address a forensically significant editing error introduced into DSM-IV[16] (and perpetuated in DSM-IV-TR). This error, a misplaced "or," allowed the diagnosis of a paraphilia to be based entirely on the presence of criminal sexual behavior, sidestepping the requirement that the behavior be a manifestation of a deviant sexual arousal pattern.[5,19]

The DSM-IV work group never intended to change the operational definition of paraphilia diagnoses. As part of an effort to make the wording of the clinical significance criteria (CSC) consistent across the DSM-IV disorders, Criterion B for all of the paraphilias was replaced in DSM-IV by the standard CSC wording: "the fantasies, sexual urges, or behaviors cause clinically significant impairment in social, occupational, or other important areas of functioning" (Ref. 16, p 523). Criterion A was amended by adding "behavior" along with "fantasies" and "urges" to emphasize that it is behavior that most typically brings individuals to clinical attention.

Nevertheless, some forensic evaluators interpreted the phrase "or behaviors" to indicate that a paraphilia diagnosis could be based solely on the presence of the criminal sexual behavior, without trying to connect that behavior causally to the paraphilic arousal pattern. In fact, not every offender's sexually deviant behavior is driven by a paraphilic sexual arousal pattern, and sexually violent behavior, such as child molestation or rape, is not indicative that a paraphilic arousal pattern is the cause of the behavior. For example, in an analysis of the psychiatric diagnoses of a sample of 113 male sex offenders, Dunsieth and colleagues[20] found that only 58 percent had a paraphilic disorder.

The change in the Criterion A wording places the presence of a persistent and intense atypical sexual arousal pattern at the center of the definition of a paraphilia, moving behaviors (along with sexual urges and fantasies) into subsidiary roles as possible manifestations of the deviant sexual arousal pattern. In theory, behavioral data such as repeated sexual offenses should be considered indicative of a paraphilia only if it can be established that the behavior is being driven by a persistent and intense deviant sexual arousal pattern. In practice, however, given that individuals evaluated in forensic settings are likely to be less than forthcoming about their sexual proclivities, establishing the presence of a paraphilic sexual arousal preference can be challenging. Forensic evaluators will by necessity sometimes have to infer its presence from the nature and pattern of the person's behaviors (e.g., repeated frotteuristic behavior in an individual who has ample opportunities to engage in nonfrotteuristic sexual behavior with consenting partners). Nevertheless, given the explicit requirement that the behaviors be a manifestation of an atypical sexual arousal pattern, forensic evaluators should endeavor to provide additional support for their inference. Acquiring such support requires attempts to establish that other explanations for the behaviors, such as substance intoxication or opportunistic behavior in a person with antisocial personality disorder, have been ruled out.[5]

Notably, these corrections to Criterion A have not been incorporated into the DSM-5 criteria for pedophilic disorder, thus perpetuating the risk that the diagnosis of pedophilic disorder will be made solely on the basis of criminal behavior. As a result of a quirk in the DSM-5 revision process, the ultimate rejection[21] of proposed changes in the pedophilia criteria set resulted in the default reversion to the DSM-IV-TR criteria.[12] Thus, the criteria for pedophilic disorder in DSM-5 are virtually identical to those in DSM-IV-TR and still include the misplaced and problematic "or" in Criterion A. This discrepancy in wording should not be construed as indicative of some fundamental difference between pedophilic disorder and the other paraphilic disorders in terms of the importance of establishing that the behavior is a manifestation of an atypical sexual arousal

pattern. In fact, compared with other paraphilic disorders, child molestation is even more likely to occur for nonparaphilic reasons. For example, a study by Seto and Lalumiere[22] of more than 1,000 child molesters, conducted with phallometric testing as a validator, demonstrated that less than one-third had an underlying pedophilic arousal pattern.

Several other changes in the diagnostic criterion wording may also have forensic implications. Revisions of the definitions of the atypical focus for sexual sadism disorder, transvestic disorder, and fetishistic disorder may result in a more inclusive application of the diagnostic criteria. Criterion A in sexual sadistic disorder in DSM-5 does not include the DSM-IV-TR requirement that the sadistic acts be "real, not simulated" (Ref. 12, p 574), potentially broadening the definition by adding those who are only interested in simulated acts involving suffering. The DSM-IV-TR restriction for transvestic disorder that limited the diagnosis to heterosexual males has been removed, thus allowing the diagnosis to be made in females and homosexual males as well. The definition of fetishistic disorder has been expanded beyond a focus on nonliving objects to include a highly specific focus on nongenital body parts. This paraphilic focus previously was identified as partialism and was diagnosed in previous DSM editions under paraphilia NOS. The extent to which these changes will in fact cause more individuals to be included in these categories is unclear.

The wording of Criterion B, the harm component, for those paraphilic disorders that may involve nonconsenting participants has been changed in several ways. The criterion now clarifies that acting on paraphilic urges qualifies for the diagnosis only if the behavior involves a nonconsenting individual: for example, a diagnosis of frotteuristic disorder in which the individual's behavior involves rubbing against a person on a crowded subway car. Behavior that occurs with a consenting partner, such as sexually sadistic acts with a partner who has sexual masochism, is now explicitly excluded from the diagnosis.

The second half of the harm criterion has also been changed, replacing the DSM-IV-TR phrase "marked distress or interpersonal difficulties" (Ref. 12, p 568) with "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Ref. 1 , p 689). This change effectively broadens the diagnoses in two ways. First, it expands on the types of functioning that can be impaired as a result of the paraphilic urges or fantasies. The DSM-IV harm requirement was limited to the interpersonal realm, whereas DSM-5's includes both occupational functioning and "other important areas of functioning." Second, the DSM-IV requirement for "marked distress" has been replaced with the phrase "clinically significant distress." Depending on how one interprets the meaning of the terms "marked" and "clinically significant," this change could be construed as lowering the required level of distress needed to meet Criterion B.

A new Criterion C, which requires a minimum age of 18, has been added to the criteria set for voyeuristic disorder, restricting the diagnosis to adult individuals. According to DSM-5, because "adolescence and puberty generally increase sexual curiosity and activity," this criterion was added "to alleviate the risk of pathologizing normative sexual interest and behavior during pubertal adolescence" (Ref. 1, p 687). Therefore, intense and persistent voyeuristic urges, fantasies, or behaviors can be considered indicative of a paraphilic disorder only if they persist into adulthood. As noted by Federoff and colleagues,[15] however, it is not clear why adolescent curiosity involving voyeuristic acts should be treated differently from similar adolescent curiosity and activity about other sexual behaviors that would still be diagnosable as paraphilic disorders in DSM-5, even if they occurred before age 18.

## Changes in the Paraphilia Course Specifiers

DSM-5 includes two new course specifiers, "in full remission" and "in a controlled environment," that apply to every paraphilic disorder (again with the exception of pedophilia, for the reasons mentioned above). According to the rationale that was provided on the DSM-5 web site (the Rationale section for paraphilic disorders on the DSM-5 Development Web Site, accessed October 16, 2012, no longer accessible), whereas "there is no expert consensus about whether a longstanding paraphilia can disappear spontaneously or be removed by therapy . . . there is less argument that consequent psychological distress, psychosocial impairment, or the propensity to do harm to others can be ameliorated by therapy or reduced to acceptable levels." Thus, the in-full-remission specifier acts as an indicator of the persistent absence of distress, impairment, or harm to others (Criterion B) without regard to the possible contin-

ued presence of the paraphilic sexual arousal pattern (Criterion A). Moreover, "because the propensity of an individual to act on paraphilic urges may be more difficult to assess objectively when the individual has no opportunity to act on such urges" (the Rationale section for paraphilic disorders on the DSM-5 Development Web Site, accessed October 16, 2012, no longer accessible), the in-full-remission specifier applies only to individuals not living in a controlled environment. For those individuals living in settings where there are no opportunities to act on their paraphilic urges, the specifier, in a controlled environment, would apply.

Of particular interest from a forensic perspective was the decision to provide a specific duration threshold indicating the minimum amount of time (i.e., at least five years) during which the individual must not have acted on his paraphilic urges nor have experienced any clinically significant distress or impairment. Although research suggests that the longer an individual in the community has not acted on his urges, the lower his risk of acting on them in the future,[23] there is in fact no empirical evidence that the five-year point represents an inflection point in decreased risk of relapse. Nonetheless, because of the tendency in the legal system and elsewhere to reify the DSM criteria,[24] there is a strong likelihood that the five-year duration enshrined in the DSM-5 remission specifier will be used inappropriately to justify setting minimums for duration of commitment.

## Diagnosing Paraphilic Disorders in Nonforthcoming Individuals

Perhaps the clearest indication that some of the changes in the paraphilic disorders section of DSM-5 were guided by forensic concerns is the various additions to the text addressing the challenge of applying the diagnostic criteria to individuals who are not forthcoming about the presence or impact of sexual pathology. Individuals, particularly in forensic settings, are motivated to deny or minimize deviant sexual urges or behaviors to avoid the negative forensic and social consequences of paraphilic disorder diagnoses. The DSM-IV-TR text was largely silent about the use of the paraphilic disorder diagnoses in forensic settings, noting only that "individuals who act out with a non-consenting partner in a way that may be injurious to the partner may be subject to arrest and incarceration" (Ref. 12, p 566).

In contrast, DSM-5 contains numerous additions to the descriptive text for paraphilic disorders intended to provide guidance to evaluators in forensic contexts. Specifically, the texts for the voyeuristic, exhibitionistic, frotteuristic, sexual sadism, and pedophilic disorders were written using the same template and include similar statements regarding their application to nondisclosing individuals. For example, the first sentence in the Diagnostic Features section for all of these disorders states: "The diagnostic criteria for [X] disorder are intended to apply both to individuals who more or less freely disclose this paraphilic interest and to those who categorically deny any sexual arousal from [X] despite substantial objective evidence to the contrary" (e.g., Ref. 1, p 687). Each Diagnostic Features section also includes a paragraph describing the various ways that nondisclosing individuals may present, followed by the comment that "despite their non-disclosing position, such individuals may be diagnosed with [a paraphilic disorder]" (e.g., Ref. 1, p 692). Each paragraph ends with the explicit statement that a history of recurrent paraphilic behavior is sufficient to meet criterion A: for example, "Recurrent frotteuristic behavior constitutes satisfactory support for frotteurism (by fulfilling Criterion A)" (Ref. 1, p 692). As discussed above, statements such as these that suggest that recurrent sexually offending behavior alone is sufficient to ascertain the presence of a paraphilia are in conflict with the evidence ([20,22]) that a substantial proportion of sex offenses are not a manifestation of a paraphilic arousal pattern.

Moreover, such statements appear to run counter to the change in the Criterion A wording intended to clarify that the behaviors must be a manifestation of a paraphilic sexual arousal pattern. However, much depends on whether one interprets phrases such as frotteuristic behavior to mean implicitly that the modifier frotteuristic requires the behavior to be a manifestation of a frotteuristic arousal pattern or whether it is simply descriptive of the type of behavior (i.e., rubbing against an unsuspecting individual). It is too soon to tell to what extent this subtle difference in interpretation will be used in forensic evaluations to argue for or against the necessity of establishing that the behavior is a manifestation of a paraphilic arousal pattern.

Voyeuristic, exhibitionistic, frotteuristic, and sexual sadism disorders each include additional text indicating that the construct of "recurrent" behaviors

can be interpreted as "having acted on the sexual urges with three or more victims on separate occasions" (Ref. 1, p 687) or with fewer victims if there are multiple occasions of acting on the paraphilic urges with the same unwilling individual. Victim count requirements were originally part of the proposed diagnostic criteria sets for these paraphilic disorders (as well as for pedophilic disorder), but were ultimately rejected from inclusion in the criteria sets[25] because of the lack of broad clinical consensus. Moreover, the proposal to include victim count requirements in the diagnostic criteria was derived entirely from a single study[26] that examined the diagnostic sensitivity of phallometric testing for pedophilia. Given that this study did not include any subjects with the four DSM-5 paraphilic disorders that actually include this victim count threshold in their descriptive texts, the validity of these thresholds should be considered questionable and raise concerns regarding both false-positive and false-negative diagnoses. Curiously, although the text for pedophilic disorder also notes that the "presence of multiple victims . . . is sufficient but not necessary for diagnosis" (Ref. 1, p 698), it avoids offering a specific victim count.

## Use of Other Specified Paraphilic Disorder and Unspecified Paraphilic Disorder

DSM-5, as did its predecessor DSM-IV-TR, includes eight specific paraphilic disorders: voyeuristic, exhibitionistic, frotteuristic, sexual masochism, sexual sadism, pedophilic, fetishistic, and transvestic. These eight disorders were selected for inclusion in DSM-5 because they are relatively common, and some of them involve behaviors that "because of their noxiousness or potential for harm to others, are classed as criminal offenses" (Ref. 1, p 685). However, the range of stimuli that can form the basis of a persistent and intense sexual arousal pattern is potentially limitless, and some of these patterns can undoubtedly lead to negative consequences in some individuals. The question thus arises regarding the appropriate use of the residual other specified paraphilic disorder and unspecified paraphilic disorder categories for presentations that do not meet criteria for one of the eight specified paraphilic disorders.

The DSM-IV diagnosis paraphilia NOS has been replaced with two disorders in DSM-5, other specified paraphilic disorder and unspecified paraphilic disorder, as the result of a system-wide standardized DSM-5 change to each residual DSM-IV not otherwise specified (NOS) category. Both other specified disorder and unspecified disorder categories are considered to be residual. They are intended to be used for presentations that do not meet the criteria for any specific DSM-5 disorder; for presentations of uncertain etiology with respect to whether the condition is substance induced, due to another medical condition, or primary; and for presentations where there is insufficient information to make a more specific diagnosis. In the case of the paraphilic disorders, these residual categories are intended to be used when there is an atypical sexual focus that is not covered by one of the eight specific types of paraphilic disorders and the atypical sexual focus causes clinically significant distress in social, occupational, or other important areas of functioning.

Whether a sexual arousal pattern should be considered atypical depends on the definition of the term paraphilia. In defining paraphilia, DSM-5 has reversed the trend (present since DSM-III), to sidestep attempts to define typical versus atypical sexual arousal patterns explicitly. The last edition of the DSM that defined abnormal sexuality, DSM-II, indicated that the sexual deviation category applied to "individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances, as in necrophilia, pedophilia, sexual sadism, and fetishism." (Ref. 11, p 44). DSM-III defined paraphilias rather vaguely as "unusual or bizarre imagery or acts necessary for sexual excitement" (Ref. 10, p 266). DSM-III-R[27] and DSM-IV offered no definition whatsoever, simply defining a paraphilia by concatenating the types of sexual arousal patterns that comprise the eight specific paraphilias.

In contrast, DSM-5 defines a paraphilia by exclusion by first defining normal foci of sexual arousal (i.e., "sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners") (Ref. 1, p 685) and then defining a paraphilia as being intense and persistent sexual interest in anything else. Although intended to be more precise than the DSM-IV-TR definition, the definition in DSM-5 has been criticized as providing even less clarity.[28] It has also been criticized as being overly broad[28,29] (e.g., in-

cluding viewing individuals who are aroused by nonpenile and nonvaginal sex[15] and those aroused by looking at pornography[30] as paraphilic).

The decision to use other specified paraphilic disorder versus unspecified paraphilic disorder depends on whether the clinician wants to specify explicitly the type of atypical paraphilic focus. If the other specified paraphilic disorder is used, the clinician is expected to add the name of the atypical paraphilic focus that is causing the clinically significant distress or impairment (e.g., other specific paraphilic disorder, coprophilia). The unspecified paraphilic disorder diagnosis is used in situations in which the clinician knows but chooses not to specify the atypical paraphilic focus or in situations in which there is insufficient information available to indicate the precise nature of the atypical paraphilic focus.

The other specified and unspecified paraphilic disorders diagnoses are provided (as are all of the residual other specified and unspecified categories in DSM-5), to ensure that a diagnostic code is available for any conceivable psychiatric presentation that a clinician might encounter. When used in forensic settings, however, these residual categories do not carry with them the same degree of utility as the specific named categories and thus have the potential to be misused. Indeed, the paraphilia disorder NOS category, with the nonofficial addenda of the terms nonconsent or hebephilia, has been used in SVP evaluations as the basis for claiming that individuals convicted of rape or of having sexual relations with underage individuals have a paraphilia and thus qualify for civil commitment under SVP statutes.[31,32] DSM diagnoses are generally admissible in court because they are considered by the field of psychiatry to be widely recognized and clinically valid categories that can be reliably assessed. By virtue of their residual and often idiosyncratic nature, cases diagnosed as other specified paraphilic disorder or unspecified paraphilic disorder are, by definition, outside of what is generally accepted by the field and thus should be used in forensic contexts only with great caution. Moreover, unlike the specific DSM paraphilic disorders categories that have an accompanying psychiatric body of literature indicating a range of likely courses and treatment responses, the paucity of such information for these residual categories greatly limits their forensic utility.

The provision for allowing the clinician to include the name of the atypical sexual focus within the other specified paraphilic disorder rubric may be misleading, especially to judges and juries who are not familiar with DSM-5 naming conventions. These residual specifiers may give the appearance that these categories are equivalent to the eight specific paraphilic disorders in terms of their acceptance by the field and their empirical backing and thus may appear to be equivalent in appropriateness for use in sexually violent predator commitment proceedings. However, the ability to incorporate the name of the atypical sexual focus within the other specified paraphilic disorder rubric was intended only to facilitate clinical communication of the reason for the use of the residual category and not to provide quasi-legitimacy for the use of these as yet not officially accepted categories for forensic purposes.

## Unsuccessful Proposals to Include Additional Specific Paraphilic Disorders in DSM-5

During the DSM-5 revision process, some of the most controversial proposals were those that would have expanded the pool of individuals who would qualify for a diagnosis of a specific paraphilic disorder. These included proposals to add a new paraphilic disorder for individuals who are sexually aroused by sexual coercion (paraphilic coercive disorder) and the expansion of pedophilic disorder to include attraction to pubescent children (pedohebephilia). Concerns about these proposals revolved around their impact on the evaluation of sex offenders charged with rape (in the case of paraphilic coercive disorder) and sexual offenses against adolescents (in the case of pedohebephilia).

Proponents argued that there are individuals with these foci of sexual arousal and that there is research and forensic utility in including the diagnoses as specific paraphilias in DSM-5.[33–37] Opponents raised concerns about validity, reliability (for example, the lack of data establishing reliability in differentiating nonparaphilic rapists from those driven by a rape paraphilia), and potential for misuse, especially with regard to use in sexually violent predator commitment evaluations.[31,32,38–41] Ultimately, proposals to include these as official categories in DSM-5, as categories in the research appendix of "Conditions For Further Study," or as examples of other specified paraphilic disorders, were rejected because of concerns about the strength of their empirical bases and their potential for false positives.

The rejection of these proposed categories should cast doubt on the appropriateness of their use in forensic settings, especially for the purposes of qualifying individuals for sexually violent predator commitment. However, the new paraphilia definition, which includes sexual interest in nonphysically mature and nonconsenting individuals, seems to suggest that such sexual interests could be included under the rubric of other specified paraphilic disorder. Whether it will now be easier or more difficult to make a convincing argument that a sexual offender charged with rape should have a diagnosis of other paraphilic disorder, nonconsent, as the qualifying mental disorder and thus be considered for civil commitment remains to be seen.

## Conclusion

Paraphilic disorders, by virtue of their forensic import, exemplify the difficulty of integrating psychiatric concepts and concerns with those of the legal system and society in general. Although all DSM-5 changes require consideration of potential false positives and false negatives, the impact of the paraphilia diagnoses on such determinations as eligibility for SVP commitment, parental custodial and visitation rights, length of incarceration, and the risk category for community notification laws highlights the importance of achieving the right balance.

Even though virtually every change in the paraphilic disorder categories and criteria potentially has significant forensic ramifications, it is too soon to tell what their actual forensic impact will be. Will these changes make it easier to assign psychiatric diagnoses to sexually violent predators and therefore to commit them involuntarily after prison terms? Will it make a difference in treating them and reintegrating them into the community? Will the newly formalized distinction between paraphilias and paraphilic disorders reduce the stigma for those with atypical sexual interests who do not cause harm? Their ultimate impact will depend on how the legal system incorporates these new definitions into statutes and case law.

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