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Paraphilias in the DSM-5

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Abstract

This review summarizes and critically examines the changes in how the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) characterizes paraphilias. Attention is paid to the diagnostic options that were included in DSM-5, the decision not to include criterion sets for two additional disorders (paraphilic coercive disorder and hypersexual behavior disorder), and the further decision not to modify the diagnosis of pedophilic to pedohebephilic disorder. The three most significant changes are (*a*) the move to distinguish paraphilias from paraphilic disorders (allowing unusual sexual interests to be studied by researchers but only regarded as disorders when they cause distress or dysfunction), (*b*) introducing criteria describing paraphilic disorders as being in remission (when they no longer cause distress or dysfunction), and (*c*) clarifying the relationship between behavior and paraphilias. Concerns are noted about the forensic use of diagnoses and the lack of funding for field trials in this revision of the DSM. Suggestions are given for future directions in order to further research efficacy and clinical diagnosis.

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INTRODUCTION

The American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has been the primary system for classifying mental disorders in the United States for more than 60 years, and it has gone through a number of major revisions over this period. DSM-I (Am. Psychiatr. Assoc. 1952) and DSM-II (Am. Psychiatr. Assoc. 1968) classified patients on the basis of potential symptoms, with no detailed descriptions of specific disorders. The DSM-III revision (DSM-III-R; Am. Psychiatr. Assoc. 1987) was an attempt to make the DSM more consistent with the diagnoses contained in the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (**http://www.who.int/classifications/icd/en/**). Although significant changes were made in the DSM-III-R, it was noted that some diagnoses required much more inference than was needed in previous editions. The development of the DSM-IV (Am. Psychiatr. Assoc. 1994) was driven by an attempt to be more informed by research evidence. This process consisted of setting up work groups to undertake literature reviews, data analyses to determine which criteria needed to be changed, and field trials. A major change in DSM-IV was that

***Diagnostic and Statistical Manual of Mental Disorders* (DSM):** sets out standard criteria for the classification of mental disorders

in order to make a diagnosis, an individual's symptoms had to cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Most diagnoses were left unchanged in a text revision, DSM-IV-TR (Am. Psychiatr. Assoc. 2000), although some were updated. DSM-5 (Am. Psychiatr. Assoc. 2013) is the first major change in the APA nomenclature in nearly 20 years. It contains extensively revised diagnostic criteria and diagnostic features as well as descriptions of the associated features that support diagnoses; in addition, extensive field trials were conducted.

***International Statistical Classification of Diseases and Related Health Problems*:** diagnostic tool for epidemiology and clinical purposes

Paraphilia: term derived from the Greek para (beside) and philia (friendship)

The term paraphilia first appeared in the DSM-III as a biomedical term used to describe atypical sexual arousal to objects, situations, or nonconsenting individuals (Beech & Harkins 2012). Hence, paraphilias are seen as being qualitatively different from adult sexual fantasy and role-play, where low-level aspects of sexual fetishism may be undertaken (see, for example, the popular book *Fifty Shades of Gray*; James 2011). However, a great deal of controversy remains regarding what a paraphilia actually is and when an unusual sexual interest becomes a disorder (Moser 2009). In fact, the concept of "deviant" sexual behavior is difficult to define in any absolute way, given the malleability of sexual norms across time and cultures (McManus et al. 2013). The DSM-5 revision has attempted to address this in part by adding the term disorder after every paraphilia diagnosis. This distinction makes it possible to engage in (some) atypical sexual behaviors without being defined as having a mental disorder. A disorder is defined as a "behavior that causes mental distress to a person or makes the person a serious threat to the psychological and physical well-being of other individuals" (**http://www.dsm5.org/Documents/Paraphilic%20Disorders%20Fact%20Sheet.pdf**, p. 1).

The DSM-5 notes that forensic reviews were carried out for disorders that frequently appear in "forensic environments and ones with potential for influencing civil and criminal judgments in courtroom settings" (Am. Psychiatr. Assoc. 2013, p. 9). This clearly pertains to a number of the paraphilic diagnoses in DSM-5, as the presence or absence of mental disorders that predispose to sexual offending can be one of the criteria to which forensic evaluations have to speak. The diagnosis of some paraphilias can therefore lead to imposition of longer sentences or civil commitment (First 2014). The issue is complicated because although there is some evidence that more intense offense-related sexual interests are associated with sexual recidivism (Mann et al. 2010), adult sexual proclivities are an inherently difficult arena for psychiatric diagnosis. Relatively little consensus exists regarding what is "normal" sexual behavior, and thus there is no useful boundary in deciding what constitutes a sexual mental disorder (e.g., Frances & First 2011). In fact, until the DSM-5 was published, the APA had not provided a definition of normal sexual behavior, in contrast with paraphilic interests. That is, paraphilic interests are not sexual interests in "genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (Am. Psychiatr. Assoc. 2013, p. 685). However, others (e.g., Joyal 2014) note that any attempt to define normative sexuality "depends heavily on historical, political and sociocultural factors" (p. 1241).

Other concerns exist regarding the paraphilic disorders included in the DSM-5. For example, Fedoroff and colleagues (2013) note that (*a*) paraphilic disorders are defined by what they are not (i.e., they are not what may be regarded as "normal" sexual activities); (*b*) whether the paraphilias in question really are the most common remains an issue (even in the DSM-5, the reported prevalence rates vary from 2% to 30%); (*c*) the paraphilic disorders are based on cultural or individually specific criteria, in that the amount of distress experienced will vary across cultures and over time; (*d*) the etiology of the paraphilic disorder in question is ignored; and (*e*) adequate field trials for paraphilic disorders are distinctly lacking in comparison with other diagnoses in the DSM-5.

Given the scope of these issues, the aim of this review is to shed some light on the current debates around the DSM-5. We outline the progression of the diagnostic criteria for paraphilias

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in the DSM; describe the evidence base for the current paraphilias; review the paraphilias that were originally mooted to be in DSM-5 but did not make it into the final version; comment on the problems, changes, and the inconsistencies in diagnostic criteria; and suggest future directions for this work in order to further research efficacy and clinical diagnosis.

DEFINING PARAPHILIAS IN THE DSM

The origin of the term paraphilia to describe atypical sexual interests has been attributed to Friedrich Salomon Krauss (1859–1938), who defined paraphilias as inverted erotic interests. The term first entered the English language, in reference to Krauss, by sexologist William J. Robinson (1913) and was then taken up by Karpman (1951), who noted that the term paraphilic is both more "scientifically correct and is more objective" (p. 184) than the term perversion, which was used by clinicians at the time. Money (1986) probably did the most to popularize the term as a less pejorative designation for unusual sexual interests, which he described as "a sexuoerotic embellishment of, or alternative to the official, ideological norm" (p. 139). As to the actual number of paraphilic interests, Aggrawal (2008) estimated that there are at least 547 (see **https://en.wikipedia.org/wiki/List_of_paraphilias**). However, in truth, there are innumerable paraphilias, in that there is little limit to the human imagination, and sexual drive is a strong, primal motivator. It is also fair to say that the term paraphilia remains pejorative in most circumstances, and the debate regarding technical accuracy, in which DSM-5 is centrally positioned, is ongoing.

Prior to the publication of the DSM-I, atypical sexual interests were classified as cases of psychopathic personality with pathologic sexuality. In the DSM-I (Am. Psychiatr. Assoc. 1952), these were described as sexual deviations, and the only criterion was that "this diagnosis should be reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenia and obsessional reaction" (p. 38). Types of such pathological behavior were defined in DSM-I as homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, and mutilation). DSM-II (Am. Psychiatr. Assoc. 1968) continued to use the term sexual deviation, noting, "This category is for individuals whose sexual interests are directed primarily towards objects, other than people of the opposite sex, towards sexual acts not usually associated with coitus or towards coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism and fetishism" (p. 44). Except for the removal of homosexuality from the DSM-III (for obvious reasons), this definition has provided a general standard that has guided specific definitions of paraphilias in subsequent DSM iterations.

Paraphilias were introduced in the DSM-III (Am. Psychiatr. Assoc. 1980) as a subset of the category of psychosexual disorders, broadly defined as recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving nonhuman objects, the suffering or humiliation of oneself or one's partner, or children or nonconsenting persons (Spitzer 1981), and as noted in DSM-III-R (Am. Psychiatr. Assoc. 1987), these had to be of more than six months in duration. Including paraphilias within sexual and gender identity disorders suggested that the etiology and progression of paraphilias had much in common with other sexual dysfunctions (e.g., erectile dysfunction, vaginismus, premature ejaculation, hypoactive sexual desire). This definition put the paraphilias within the realm of sexual disorder and allowed clinicians and researchers to explore them as deviations from what is generally regarded as normal sexual behavior.

The move to DSM-IV brought in the notion of impairment, with DSM-IV-TR (Am. Psychiatr. Assoc. 2000) describing paraphilias as having two main criteria. Criterion A: recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors that occur over a period of at least six months and that generally involve (*a*) nonhuman objects, (*b*) the suffering or humiliation of oneself or one's partner, or (*c*) children or other nonconsenting persons; and criterion B: these cause clinically

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significant distress or impairment in social, occupational, or other important areas of functioning. Hence, this change brought in the issue of nonconsent, where part of the paraphilia examines the impact on others (i.e., children, partners, other nonconsenting individuals) as well the individual in question. In DSM-5, individuals have to meet criterion A and criterion B to be diagnosed with paraphilic disorder, with examples between being paraphilic and having a paraphilic disorder being given for each category.

Blanchard (chair of the Paraphilias Subworkgroup for the DSM-5 Work Group on Sexual and Gender Identity Disorders) suggested that the definition of the term paraphilia should be "Any powerful and persistent sexual interest other than sexual interest in copulatory or precopulatory behavior with phenotypically normal, consenting adult human partners" (Blanchard 2010a, p. 367). The final wording, however, that has been provided in DSM-5 is slightly wider in scope, in that a paraphilia is described as "an intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (Am. Psychiatr. Assoc. 2013, p. 685); it is clarified later in the text that paraphilic interests are sometimes better conceptualized as preferential rather than intense.

Paraphilias Subworkgroup: a group (chaired by Dr. Ray Blanchard) that considered in detail potential revisions from DSM-IV-TR to DSM-5

Partialism: a highly specific focus on nongenital body parts

Sexually violent predators: individuals with a history of sexual offending plus personality disorder/mental abnormality (typically paraphilic)

DESCRIPTION AND EVIDENCE BASE FOR PARAPHILIC DISORDERS IN THE DSM-5

In DSM-III through DSM-5, a number of basic paraphilic disorders have been described in which clinical distress is caused by urges, fantasies, and behaviors toward certain objects, nonsexual body parts (i.e., fetishes), children (pedophilia), or activities (e.g., exhibitionism, voyeurism, sadism, masochism, transvestic fetishism) (First & Halon 2008). These paraphilias were selected, according to the DSM-5, because they are "(i) relatively common; and (ii) some of them entail actions for their satisfaction that because of their potential harm (noxiousness) to others are classed as criminal offenses" (p. 685). However, as Fedoroff et al. (2013) note, it is unclear how noxiousness is being defined here, and no firm evidence is provided in the manual regarding the prevalence of these paraphilias in comparison with others, although some unreferenced percentages are given. These percentages would suggest that the rates of frotteurism are actually very high (30%) in the male population; masochism, sadism, and pedophilia are much lower (2% to 5%); and exhibitionism is somewhere in the middle (12%). Rates in females are described in the DSM-5 as somewhat lower.

A taxonomy change in the DSM-5 is a separation of the three classes of dysfunctions that made up the DSM-IV-TR Sexual and Gender Identity Disorders chapter into three distinct chapters: Sexual Dysfunctions, Gender Identity Disorders, and Paraphilic Disorders. This change suggests that these classes of disorders may have different etiologies and/or little functional relationship to each other. The DSM-5 is also the first version of the DSM in which a distinction is made between paraphilias that are anomalous target preferences and those that are anomalous sexual preferences; the latter are further divided into (*a*) courtship disorders, which is a theoretical construct in sexology in which certain paraphilias are seen as specific instances of anomalous courtship behaviors, particularly in men (Freund 1988, Freund & Blanchard 1986); and (*b*) algolagnic disorders, in which sexual arousal is dependent on pain and suffering.

In previous versions of the DSM, paraphilias that were not prevalent enough to include their own diagnoses were included in the category paraphilia not otherwise specified (NOS), and included telephone scatologia (making obscene phone calls), necrophilia (sexual activity with corpses), zoophilia (bestiality), urophilia (sexual arousal by urine), coprophilia (sexual arousal by feces), and partialism. It is of note that paraphilia NOS has been the second most common diagnosis (after pedophilia) for civil (involuntary) commitment proceedings for sexually violent predators (First & Halon 2008). Thus, paraphilia NOS has been used as a diagnosis for sexual coercion

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against adults (typically rape of a female adult). To tidy up this diagnosis, it was proposed that such paraphilias should be clearly defined as paraphilic coercive disorder in the DSM-5, but this did not take place (the reasons for this are discussed below). First (2014) notes that other controversial proposals that were not included in the DSM-5 were the operationalization of the nature of harm in criterion B by specifying the number of victims (Blanchard 2010b), and in the case of pedophilia, the inclusion of possession of child sexual abuse images (termed child pornography in many legal jurisdictions).

Two categories have been included in DSM-5: other specified paraphilic disorder (broadly replacing paraphilia NOS) and unspecified paraphilic disorder, a category used when the assessor chooses only to describe the diagnostic class,[1] but described by Fedoroff et al. (2013) as a catchall category. These two categories are included, as noted in the paraphilias introductory section in DSM-5, because "many dozens of distinct paraphilias have been identified and named," and such "diagnoses of other specified and unspecified paraphilic disorders are therefore indispensable and will be required in many cases" (Am. Psychiatr. Assoc. 2013, p. 685). The diagnosis of unspecified can be used when the clinician does not want to specify the nature of the paraphilic disorder. The paraphilic disorders for which criterion sets are provided that made the cut are described in more detail in **Table 1**.

A number of the paraphilias are legally defined sexual offenses (i.e., voyeuristic, exhibitionistic, frotteuristic, and pedophilic), and others may or may not be sexual offenses dependent on issues of consent (i.e., masochistic, sadistic) (**Table 1**). Other paraphilias, such as transvestic disorder and fetishistic disorder, are typically not illegal but may still be deemed socially unacceptable by particular societal groups in particular jurisdictions. As for the prevalence of paraphilias in criminal populations, an analysis of convicted male sex offenders found that more than half (58%) had a paraphilic diagnosis (Dunsieth et al. 2004).

As for the demographic characteristics of those diagnosed with a DSM paraphilia, typically such interests begin in adolescence (Wiederman 2003) and are more common in males. This former observation is unsurprising given that sexual arousal/interests normally emerge around the age of puberty. All ethnic and socioeconomic groups are represented across the range of paraphilias, suggesting that these are not social constructions (Abel & Rouleau 1990, Wiederman 2003). Older studies note that those involved in one illegal DSM paraphilic activity will commonly also engage in others (Abel & Rouleau 1990, Wilcox et al. 2005). Such studies are limited, though, by focusing on behavior, which can be an expression of a paraphilia, rather than focusing on whether paraphilic disorders are actually present. The DSM-5 notes the comorbidity of voyeuristic, exhibitionistic, and frotteuristic disorders (Am. Psychiatr. Assoc. 2013, p. 693); sexual masochism and transvestic fetishism (p. 695); sexual sadism and other paraphilias (p. 697); pedophilia and other paraphilias (p. 700); and fetishistic disorder and hypersexuality (p. 703). We now briefly examine the evidence base for each of the paraphilic disorders. As a general point, we note the relative paucity of rigorous research plus the lack of references to prevalence rates reported in the DSM-5. However, we have managed to track down most of the reported prevalence rates.

We also note that although relatively few changes were made in the diagnostic criteria (specifically criteria A and B), extensive changes were made in the descriptive text, which could well play out in forensic arenas (e.g., child custody cases, civil commitment), given that paraphilic disorders are diagnosed largely in such settings. Hence, First (2014) notes that these descriptions will be extensively examined by forensic experts/attorneys in the future. We discuss the forensic ramifications of some of the changes from DSM-IV to DSM-5 in a subsequent section.

[1]These categories are available for all diagnostic classes in the DSM-5, not just paraphilic disorders.

Table 1 Description of paraphilic disorders

1a. Anomalous sexual preferences: courtship disorders
Voyeuristic disorder is described as the act of observing nonconsenting individuals naked, undressing, or engaged in sexual activity
Exhibitionistic disorder is defined by the individual having recurrent, intense, sexually arousing fantasies or behaviors involving exposing one's genitals to another person without the latter's consent
Frotteuristic disorder involves recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person. Such behaviors commonly occur in crowded public places (e.g., buses or trains). Due to the circumstances in which this paraphilia occurs, it is almost always difficult to identify the perpetrator
1b. Anomalous sexual preferences: algolagnic disorders
Sexual masochism disorder involves sexual arousal to the act of being humiliated, beaten, bound, or made to suffer in some other manner
Sexual sadism disorder is defined as the individual deriving sexual excitement from the physical or psychological suffering (including humiliation) of another person
2. Anomalous target preferences
Pedophilic disorder is described as an individual having recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with children 13 years old or younger. The individual is at least age 16 years and at least 5 years older than the victim/s
Fetishistic disorder involves a sexual interest in nonliving objects or a particular focus on nongenital body parts as indicated by fantasies, urges, or behaviors. The most common fetishistic targets of this paraphilia are female underwear, feet, and shoes (Beech & Harkins 2012)
Transvestic disorder typically describes a heterosexual man being aroused by the thought of himself as a female and hence cross-dressing (autogynephilia), or more rarely, a woman cross-dressing as a man (autoandrophilia)
3. New paraphilic disorders included in the DSM-5
Otherwise specified paraphilic disorder is applied when the paraphilia is not prevalent enough to include its own diagnosis; examples include telephone scatologia (obscene phone calls), necrophilia (sexual activity with corpses), zoophilia, coprophilia (being aroused by being defecated upon or defecating on others), and urophilia (being aroused by being urinated upon or urinating on others)
Unspecified paraphilic disorder is a category applied when "clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the Paraphilic disorders diagnostic class" (Am. Psychiatr. Assoc. 2013, p. 705). More specifically, this category is used when a reason is not given for a specific paraphilic disorder criteria being specified because sufficient information may not be available
4. Paraphilic disorders considered but not included in the DSM-5
Paraphilic coercive disorder applies to biastophilia (paraphilic rape)
Hypersexual disorder was a label proposed because it did not imply any specific theory for what causes hypersexuality
Pedohebephilia was suggested as a replacement for pedophilia

Voyeuristic Disorder

The DSM-5 reports that the lifetime prevalence for voyeuristic disorder is 12% in males and 4% in females, suggesting that this is a common problem. These figures are derived from study results reported by Långström & Seto (2006) in sample of 2,450 randomly selected 18- to 60-year-olds. The authors found that there are high levels (63%) of co-occurrence between voyeurism and exhibitionism. Although males commit most offenses (Lavin 2008, Mann et al. 2008), some females do meet the diagnostic criteria (Hurlbert 1992). The published literature on treatment efficacy is limited, with interventions being reported from single-case studies using pharmacological treatment approaches or psychoanalytic case studies. Treatment outcome has varied considerably, precluding any firm conclusions being drawn regarding such efficacy (Mann et al. 2008).

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Exhibitionistic Disorder

Cognitive-behavioral therapy (CBT): the most common method of treatment of all sex offenders (paraphilic and nonparaphilic)

Exhibitionistic disorder is a less frequent aberrant behavior than voyeurism: The prevalence is reported to be between 2% and 4%, according to the DSM-5, although perpetrators often commit multiple offenses on multiple occasions (Bader et al. 2008). It is primarily a male disorder, although some suggest that up to 32% of those experiencing this paraphilia are women (Långström & Seto 2006). Adolescents account for roughly 10% of cases of exhibitionist offenses (Bader et al. 2008). A DSM-5 revision from DSM-IV-TR is the provision of specifiers regarding whether the individual is sexually aroused to prepubertal children or mature individuals, which probably gives a better indication of attraction to children, adults, or both. As for a relationship with more serious sexual offenses, Rabinowitz Greenberg and colleagues (2002) found that one-third of their sample had escalated their behavior to a contact sexual offense following an initial conviction for exhibitionism. Långström (2010) found that of the 16,000 men convicted of "sexual harassment" offenses between 1973 and 2004 (offenses that were heavily dominated by exhibitionist acts), 15% had a prior or subsequent conviction for a contact sexual offense (i.e., rape, child molestation, sexual coercion). Sugarman and colleagues (1994) have found similar results. As for response to treatment, Alexander (1999) found positive effects with exhibitionists ($N = 331$) in a meta-analysis of sex offender treatment, in that no exhibitionists (typically without a formal DSM diagnosis) who had undertaken cognitive-behavioral therapy (CBT) had recidivated, compared to 21% of those who attended a group/behavioral/other program, and 57% of untreated samples. In contrast, Maletzky & Steinhauser (2002) investigated outcome over a 25-year follow-up from a CBT program ($N = 7{,}275$) and reported that exhibitionists (13.5%) had a comparatively worse response to treatment in comparison with child molesters with female child victims (6.3%) or with male child victims (9.4%), but the response was better than that found in rapists (21.2%).

Frotteuristic Disorder

Prevalence studies suggest that approximately 30% of the population has committed acts that would qualify as frotteuristic (e.g., Freund et al. 1997, Templeman & Stinnett 1991). Freund & Seto (1998) report that nearly 20% of the rapists in their sample reported engaging in frotteuristic activities. Frotteuristic activity usually starts in adolescence, with most acts occurring between the ages of 15 and 25, at which point there is a decline in the frequency of this paraphilia (Abel & Rouleau 1990). No studies specifically describe treatment outcome for those with frotteurism (Krueger & Kaplan 2008); instead, frotteurists are typically included among larger samples of individuals with other paraphilias.

Sexual Masochism Disorder

The prevalence of this disorder is difficult to gauge, but the DSM-5 reports on an Australian study (Richters et al. 2008) of 19,307 respondents. It was found that 2.2% of males and 1.3% of females reported bondage, discipline, sadomasochism, and submission behaviors. Individuals who engage in such consensual practices are generally found to be socially well adjusted (Sandnabba et al. 1999), with only a small proportion (6%) reporting that they were emotionally disturbed by their behavior (Moser & Levitt 1987). In some cases, masochists had been coerced into more extreme behaviors than they were comfortable with (Beech & Harkins 2012). Of those individuals reporting that they had sought help for this paraphilia, slightly less than one-third indicated that they felt there was a reasonable chance that their behavior could escalate to a dangerous extent (Hucker 2008). In addition, approximately one-third of masochists have been reported to engage

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in sadistic behavior (Beech & Harkins 2012). There are little data on treatment efficacy. Some positive results have been reported for behavior therapies in single-case studies (Hucker 2008). In particular, aversion therapy has been found to result in reduced arousal to masochistic fantasy in a number of narrative case studies (e.g., Marks et al. 1965, 1970; Pinard & Lamontagne 1967).

Sexual Sadism Disorder

The DSM-5 reports that the prevalence of sexual sadism disorder varies from 2% to 3%. Basic demographic information suggests that this paraphilia is most often found in white males (Dietz et al. 1990, Kingston & Yates 2008). The severity of sadistic acts can increase over time, especially when the disorder is associated with antisocial personality disorder, which may lead to sadistic individuals seriously injuring or killing their victims. The DSM-5 notes that the rate of sexual sadism in those who have committed sexually motivated homicides varies from 37% to 75% (Am. Psychiatr. Assoc. 2013) and that this paraphilia is found in 10% of civilly committed sex offenders in the United States. However, it is difficult to ascertain the real level of sexual sadism, as there is a lack of consensus in applying this diagnosis (Marshall et al. 2002). Even severe acts of mutilation in a murder do not necessarily indicate that these acts were a source of sexual satisfaction for the offender; rather, they may be committed as a result of explosive anger or simply a desire to hurt (Beech et al. 2005). Research examining treatment outcome for sexual sadists is sparse (Kingston & Yates 2008).

Pedophilic Disorder

The DSM-5 notes that the prevalence of pedophilic disorder in the male population is 3% to 5%, and the prevalence rate is much lower in females. All ethnic and socioeconomic groups are represented (Abel & Rouleau 1990, Wiederman 2003), and although individuals are typically male, the condition has been observed in females (Seto 2008). Pedophilic interest would appear to be stable across the individual's lifespan (Hanson et al. 1993) and typically first appears in adolescence (Wiederman 2003). Specifically, Abel & Rouleau (1990) report in a sample of 561 sexual offenders that 50% of those classified as pedophiles (with male victims) had developed their sexual interest by 15 years of age, and 40% of those with unrelated female victims had developed their sexual interest by 18 years of age. It is the most common paraphilic diagnosis in civil commitment procedures currently enacted in a number of states (Witt & Conroy 2013). Wilson et al. (2003) note that a pedophilic diagnosis was unrelated to long-term recidivism, suggesting its lack of utility in terms of assessment and as indication of treatment need. A modification of the criteria for pedohebephilic disorder diagnoses was developed by the DSM-5 Paraphilias Subworkgroup and included in their final submission to the APA Board of Trustees; the modification distinguished those whose victims were pubertal (ages 10–13) and those whose victims are prepubertal. The Board of Trustees rejected this proposal, and so by default the DSM-IV-TR criteria for diagnosing pedophilia were retained.

Relatively few studies have looked at treatment for those specifically diagnosed with pedophilia (Beech & Harkins 2012). In a narrative review of medical reports, Hughes (2007) concluded that behavior therapy in combination with antiandrogenic medication is effective for pedophilia. In a review of treatment for pedophilia, Kilmann et al. (1982) identified 11 single-case narrative studies that all used behavioral approaches. No pedophilic urges, in any of the cohort, were reported at the end of the treatment. More recently, Schober et al. (2005) reported that CBT combined with leuprolide acetate, compared to CBT alone, significantly reduced pedophilic fantasies, urges, and self-reported levels of masturbation, although this study's results are limited by its small

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sample size ($N = 5$). However, many studies have examined treatment outcome for men who have sexually abused children (e.g., Hanson et al. 2002, Lösel & Schmucker 2005). For example, in a study looking at treatment outcome over a 25-year follow-up of a CBT program for sex offenders ($N = 7{,}275$), it was reported that child abusers had a better response to treatment (6.3% for those with female victims, 9.4% for those with male victims) than either exhibitionists (13.5%) or rapists (21.2%) (Maletzky & Steinhauser (2002). A meta-analysis of 69 studies ($N = 22{,}181$) found positive effects of treatment for extrafamilial child abusers (most likely to be pedophilic) in nine studies but not for intrafamilial molesters in 10 studies (Lösel & Schmucker 2005), which is an indication of treatment efficacy for those diagnosed with pedophilic disorder.

Fetishistic Disorder

No prevalence rates are reported in DSM-5 for fetishistic disorder. The most common fetishistic targets are reported to be female items of clothing/objects; in the DSM-5 this is not limited to clothing used in cross-dressing or devices designed for sexual stimulation (e.g., vibrators) but rather is expanded to include any aspect of partialism (Kafka 2010a). Fetishists are most commonly male (Darcangelo et al. 2008). Although it is rare for this paraphilia to come to the attention of the authorities, some individuals will steal fetishistic objects for masturbatory purposes (Schlesinger & Revitch 1999). Most of the examinations of treatment efficacy for this group are based on single-case studies (Darcangelo et al. 2008).

Transvestic Disorder

The DSM-5 notes that 3% of males report having been sexually aroused by dressing in clothes associated with the opposite gender, but this is much less common in women. Blanchard (2010a) suggests that erotic cross-dressing can be labeled as transvestic disorder only if the individual is distressed or impaired by it. We could find little evidence for the psychological treatment of this paraphilia because it rarely comes to the formal attention of authorities and treatment providers.

Other Specified Paraphilic Disorder

Other specified paraphilic disorder is used in situations in which the presentation meets the general criteria for a paraphilic disorder and the erotic focus can be specified, but it is not one of the eight paraphilic disorders for which criterion sets have been provided. The DSM-5 notes that this category is provided (for all categories of disorder) "to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category" (Am. Psychiatr. Assoc. 2013, p. 15). The kinds of paraphilic interest that are likely to be diagnosed here can be broadly placed in two categories: rare sexual interests that are distinct from the eight paraphilias for which criterion sets are provided, and lesser forms of two of these eight paraphilias. The latter possibility relates to the fact that both erotic age preference and sexual sadism relate to aspects of sexual interest that are better understood as dimensional. The onus then is on evaluators wishing to make such a diagnosis to be markedly cautious and thoughtful in their interpretation of the available data.

Unspecified Paraphilic Disorder

The diagnosis of unspecified paraphilic disorder may seem to be a puzzle: How can you have the data that justify suggesting that someone has a paraphilic disorder but not have the information

required to describe it? In one possible scenario, the assessor is confident that one of two paraphilic disorders applies but is not sure of which one. The DSM-5 notes that this allows the clinician maximum flexibility in diagnosis. An example brought to the attention of one of the authors (D.T.) was a case in which a psychologist was deliberating between sexual sadism disorder and other specified paraphilic disorder (necrophilia). From the behavioral data available, there were good grounds to suppose that one of these disorders applied, but without more information on the perpetrator's state of mind, it was not clear whether the humiliation and physical destruction of the victim was the erotic focus or whether he was aroused by the opportunity to have sex with a corpse. Of course, unspecified and other specified are provided for all other diagnoses in DSM-5 as part of a general recognition that the criterion sets provided for disorders are not sufficient to fully diagnose mental disorders.

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PROPOSED PARAPHILIAS THAT WERE NOT INCLUDED IN THE DSM-5

Two paraphilic disorders (paraphilic coercive disorder and hypersexual behavior disorder) were considered for inclusion in DSM-5 but were not added. In the following sections, we examine the putative reasons for these decisions.

Paraphilic Coercive Disorder

After receiving input from various advisors (i.e., Knight 2010, Thornton 2010), the DSM-5 Paraphilias Subworkgroup initially proposed a diagnostic category for sexual arousal to coercion, labeled paraphilic coercive disorder (PCD). The suggested criterion set for this disorder was not included in the final proposal submitted to the APA Board of Trustees. Three issues might have contributed to PCD not forming part of the final proposal: (*a*) concerns over interrater reliability; (*b*) difficulty differentiating PCD conceptually from sadism, with empirical data suggesting that PCD may be regarded as a lesser form of sadism; and (*c*) a wider concern regarding the medicalization of criminal behavior.

The paraphilic focus of PCD is defined as arousal from forcing sex upon another person. While the meaning of this may be apparent at a theoretical level, it has some critical areas of vagueness. For example, what level of force is required, and from whose perspective? What about the situation in which sexual activity takes place without either affirmative consent or expressed nonconsent? Surely this is not likely to have equivalent implications for the psychology of the perpetrator to an archetypal physically brutal rape. Yet different interpretations as to what level and kind of force are required would lead to different conclusions as to whether the diagnosis was applicable. Furthermore, apparent behavioral evidence for the underlying arousal pattern, such as repeatedly forcing sex on other people, runs into the problem that such behavior might be motivated in multiple ways. For example, for a callous or antisocial person, forcing sex on another person might just be a convenient way of obtaining sex; alternatively, it might be motivated by a desire to demean or control the victim. Consistent with these theoretical concerns, research with the proposed PCD criterion set produced variable results. Two field trials (i.e., Thornton et al. 2011, Wilson et al. 2011) resulted in interrater reliability of $\kappa = 0.68$ and $\kappa = 0.50$, indicating good and moderate agreement, respectively. These results suggest that whereas the PCD criterion set could be applied in some circumstances, in others its reliability was concerning.

There are also conceptual and empirical difficulties in distinguishing PCD from sadism. The definition of sadistic disorder (see previous discussion) includes arousal to psychological suffering. Being coerced into unwanted sex clearly engenders psychological suffering. Furthermore, the

most obviously coercive forms of rapes are brutal. Thus, when data are sufficient to confidently justify a diagnosis of PCD, the data would also often permit a diagnosis of sadism. Consistent with this theoretical concern, research has indicated the existence of a single agonistic dimension that incorporates both PCD and sadism (Knight et al. 2013). Thus, fantasizing about killing, hurting during sex, overpowering sexually, or forcing sex can be seen as part of the same dimension. These results have two implications. On the one hand, they support the idea that fantasies of forcing sex are part of an abnormal sexual arousal pattern, and on the other hand, they indicate that this is better understood as a lesser form of sexual sadism.

Finally, although PCD is conceptualized as arousal from forcing sex on an unwilling person, the most common behavioral evidence for attributing the diagnosis is likely to be a pattern of repeatedly forcing sex on unwilling persons. This, arguably, in practice if not in theory, might amount to the medicalization of serial rape. This is also an issue for the other specifically illegal paraphilias, particularly pedophilic and exhibitionistic disorders.

Hypersexual Disorder

It has long been recognized that certain individuals, usually men, exhibit an excessive level of sexual behavior and preoccupation that interferes with their ability to make and maintain social bonds and often is experienced as distressful. Increased interest in excessive or out-of-control sexual behavior has resulted in the development over the past three decades of hundreds of self-help groups and private treatment programs, which usually use the concept of sexual addiction. Excessive, impersonal sexual behavior has been included since DSM-III as an example of psychosexual disorder NOS. Hypersexual disorder was proposed as a new sexual disorder for the DSM-5 by Kafka (2010b), but it was not included. Critics of the proposal argued that hypersexual disorder was a medical manifestation of moral and religious prohibitions on high-frequency sex, sex outside the confines of intimate interpersonal relationships, and the use of pornography (Moser 2011, Voros 2009, Wakefield 2012). The fundamental problem, according to Wakefield (2012), is that the criteria do not distinguish normal from high levels of sexual desire/activity. Prause and colleagues (Prause & Pfaus 2015, Prause et al. 2013, Steele et al. 2013) argue that the physiological findings of those who report problems controlling consumption of pornography can be better explained by sexual desire than any of the measures of sexual compulsivity or hypersexual disorder (see also Giles 2006, Ley et al. 2014, Moser 2011). The final decision regarding hypersexual disorder was likely complicated by two competing conceptualizations. Kafka (2010b) described hypersexual disorder as a sexual disorder and argued that it has more in common with paraphilias and sexual dysfunctions than it does with addictions. Other groups have argued that hypersexual disorder is, in fact, a behavioral addiction, along with pathological gambling (the only behavioral addiction included in the DSM-5).

COMMENTARY ON THE PROBLEMS, CHANGES, AND INCONSISTENCIES IN THE DSM-5

In this section, we outline how these changes in the DSM-5 will have an effect upon paraphilic definitions. We also note a number of inconsistencies, which include the age at which the disorder is first thought to manifest itself, whether or not the disorder can be in remission, and the use of specific terminology, for example, marked or clinically significant distress. These inconsistencies would appear to have implications for when, and for whom, various paraphilic disorders are applied, and they could have implications for both clinical and forensic practice. As noted previously, the lack of field trials is a major concern, and we turn to this first.

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Lack of Field Trials for the Paraphilic Disorders Contained in the DSM-5

In the development of the DSM-5, extensive field trials were conducted for 23 disorders (15 adult and 8 child/adolescent) on 2,246 patients who were interviewed by 279 clinicians; most patients were interviewed twice, on the basis of the putative DSM-5 criteria, in order to assess the reliability of diagnosis. This process indicated that in just over 60% of disorders (14), the interrater reliability was found to be "good" or "very good." In nine disorders, the interrater reliability was either "questionable" or "unacceptable." However, field trials were not funded for the paraphilic disorders included in the DSM-5. Blanchard (2011) has noted that this is unsurprising, given that there is little evidence of field trials in DSM-III-R or DSM-IV, with a sum total of just three patients seen for field trials! Blanchard has attempted to plug this gap in a series of studies that looked at transvestic fetishism (Blanchard 2010a) and pedohebephilia (Blanchard 2010b) diagnoses. The lack of field trials is troubling, given that the reliability of diagnoses of some of the paraphilias included in DSM-IV-TR was found to be variable, with only good agreement for pedophilia ($\kappa = 0.65$); reliability was moderate for exhibitionism ($\kappa = 0.47$) and any paraphilia ($\kappa = 0.47$), and only fair for sexual sadism ($\kappa = 0.30$) and paraphilia NOS ($\kappa = 0.36$) in a sample of 277 sexually violent predators in Florida (Levenson 2004). This lack of reliability is concerning given that paraphilic NOS is the second most common diagnosis for civil commitment in the United States (First & Halon 2008).

The Distinction Between a Paraphilia and a Paraphilic Disorder

A theoretically significant change introduced with the DSM-5 is the distinction between paraphilias and paraphilic disorders. Previous versions of the DSM built the notion of dysfunction into the definition of a paraphilia, and something was counted as a paraphilia only if it led to clinically significant distress or impairment. Although this formulation made sense from a mental health point of view, it also muddled distinct things (e.g., the focus of interests of individuals with their capacity for self-regulation). It also led to a psychiatric conception of paraphilias that was distinct from the conception in the more general sexology literature. Finally, it probably impaired research into our understanding of the etiology of paraphilias by only attending to their dysfunctional forms. The DSM-5 adopts a more open definition of what counts as a paraphilic interest and is more consistent with the way in which sexologists or researchers would view them because it carefully distinguishes dysfunctional sexual interests as paraphilic disorders. This makes for greater conceptual clarity and a better connection between diagnostic concepts and research while explicitly recognizing that unusual sexual interests are not mental disorders.

This move was undoubtedly intended to depathologize unusual sexual interests. Some commentators have argued that the distinction between a paraphilia and a paraphilic disorder, although well intentioned and designed to reduce the stigma associated with atypical sexual interests, may actually have the effect of confusing the legal and medical community (see Appelbaum 2014, First 2014, Hinderliter 2011). That is, a paraphilia has historically been used to label the mental disorder associated with atypical sexual interest, and thus describing an individual as being sadistic is likely to be viewed the same as if one diagnosed such an individual with sadistic disorder. Additionally, in certain forensic contexts, such as child custody evaluations, receiving a paraphilic label may have the same detrimental effect as receiving a paraphilic disorder diagnosis (First 2014).

Inferring Paraphilias from Behavior

A confusing element in the DSM-IV-TR was the "or behavior" language in the template for criterion A for each paraphilia. Specifically, the following language was used for each paraphilia:

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"Over a period of at least 6 months, recurrent, intense sexually arousal fantasies, sexual urges or behaviors . . . ." (Am. Psychiatr. Assoc. 2000, pp. 569–575). The confusion arose because the "or behavior" language led some people to see sexual behavior as the paraphilia rather than seeing the paraphilia as a sexual interest that could be manifested in behavior or in other ways (i.e., internal urges, fantasies, etc.). This could lead clinicians to diagnose a paraphilia when they see potentially related behavior without considering whether evidence was sufficient to ascertain that the behavior arose from a paraphilic sexual interest. First & Frances (2008) assert that this was essentially a drafting error, and the DSM-5 has hopefully cleared this up. The template for criterion A of paraphilias makes clear that behavior is merely one of several possible signs of the underlying arousal pattern, with the latter, not the behavior, constituting the paraphilia. Of course, in forensic contexts, recorded behavior patterns may be the primary data available to an evaluator. The DSM-5 makes clear that recurrent patterns of relevant sexual behavior are a legitimate basis for diagnosis even when the individual denies sexual motivation, fantasies, urges, and so forth. For example, in relation to sexual sadism disorder, individuals may be diagnosed, despite their negative self-report, if they show recurrent episodes of "sexual behavior involving the infliction of pain or suffering on a nonconsenting individual" (Am. Psychiatr. Assoc. 2013, p. 696).

This emphasis on recurrent relevant sexual behavior is not without its difficulties, since it does not constitute a validated behavioral rating scale. Despite the DSM-5's advocacy of this kind of clinical reasoning, empirical evidence is needed as to what pattern of behavioral signs best indicates underlying arousal patterns and the level of diagnostic accuracy obtainable from different kinds of behavioral record. Some empirically validated scales are largely of the type required, including the Screening Scale for Pedophilic Interest (Seto & Lalumière 2001) and the Severe Sexual Sadism Scale (Nitschke et al. 2009). These also perhaps suggest a more dimensional approach to the understanding of paraphilic problems.

The Inclusion of the Paraphilias in Remission Specifications

The DSM-5 introduced the idea that paraphilic disorders can be in remission. In the diagnostic criteria for paraphilic disorders, specifiers can be applied that describe the individual as either "in a controlled environment" or "in full remission." This proposal is puzzling at first sight because sexual interests are more often thought of as enduring characteristics. The concept becomes clearer, however, when taken in conjunction with the distinction between paraphilias and paraphilic disorders. According to the DSM-5, a paraphilic disorder can be described as being in full remission when the paraphilic interest has ceased to cause dysfunction for at least five years in an uncontrolled environment. This idea is not inconsistent with the notion that paraphilic interests themselves are enduring. However, it is not clear that empirical data support this. Perhaps relevant is the finding that sexual recidivism risk approximately halves for each five years spent offense-free in the community (Hanson et al. 2014). This finding is particularly apparent for higher-risk sexual offenders who more commonly would meet criteria for various paraphilias. Again, the DSM-5 seems to be propounding ideas that are plausible but that need more of an evidence base.

Pedophilia is the only paraphilic disorder that does not include specifiers for remission in the DSM-5. The omission of any specifiers for this disorder would seem to be deliberate (Balon 2014), but there appears to be no scientific evidence that pedophilic disorder is more intractable than any other disorder. In fact, the DSM-5 itself points out that the symptoms can fluctuate over time and age. This leaves one to assume that although the sexual interest in children may be lifelong, the disorder could ameliorate, thus leaving a particular individual in a state that could be defined as remission. Hence, Briken and colleagues (2014) note, by omitting the remission specifiers, the authors of the DSM-5 are conflating paraphilia and sexual orientation.

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Another interesting discrepancy is that exhibitionistic disorder has specifiers for targeting prepubertal children, physically mature individuals, or both. This seems to assume that the sexual arousal from exposing one's genitals is target specific. That is, some individuals' urges and fantasies have prepubescent targets, whereas others have physically mature targets. It is not clear that this is always the case, and it may be that the behavior of individuals is toward persons to whom they are otherwise attracted. Again, it would appear that the specifiers included in the DSM-5 may go beyond where the scientific evidence leads. It is not clear from the rather small literature base on exhibitionism that there are differences in preferential targets. It may be that targets are sometimes chosen either at random, due to availability, or because the individuals believe that they are unlikely to be identified and arrested. Exhibitionistic disorder is also the only paraphilia disorder that has an age specifier. Such a specifier is not included in voyeuristic disorder, which would seem to have the same variation in target as exhibitionism.

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Age Discrepancies Between Disorder Criterion A Specifiers

The criteria for voyeuristic disorder state that the individual must be at least 18 years of age, yet the criteria for pedophilic disorder indicate that the individual must be at least 16 years of age, or at least five years older than the child(ren) in criterion A. The reasons for the two-year discrepancy between voyeuristic disorder and pedophilic disorder are unclear. To add to the inconsistency with regard to age, the DSM-5 does not have age criteria for any of the other paraphilic disorders. Therefore, the clinician/evaluator is left in a quandary regarding the age at which a paraphilia is thought to develop and when such an interest may develop into a disorder. One can speculate that the emphasis on being 18 years old reflects it being considered the age of majority in many US states, but that seems more salient to criminal responsibility than it does to the onset of a psychiatric disorder. It appears that the APA is saying that sexual arousal to covertly watching individuals naked or engaging in sexual activity is normative prior to age 18, and then becomes abnormal once one reaches 18 years of age. There is, however, no specific developmental change that occurs at age 18 that would lead one to believe that something that was sexually arousing prior to that age would fail to be arousing after reaching age 18.

There also appears to be an assumption that although sexual interest in watching others is normal prior to age 18 and becomes abnormal following age 18, sexual arousal to prepubescent children begins at age 16. Again, this seems to be arbitrary rather than based on any developmental literature. Current neurodevelopmental data indicate that the central nervous system continues to develop into the mid-20s (Jetha & Segalowitz 2012), and thus the brain of a 16-year-old is probably not much different from the brain of an 18-year-old. It is also not clear that sexual interest is fixed by age 18 any more than by age 16. So, why is pedophilia diagnosed at age 16, while voyeurism is not diagnosed until age 18? This seems to be simply an artifact of the APA's decision to adopt the pedophilic disorder criteria from the DSM-IV-TR unchanged while rejecting the proposed changes from the Paraphilia Disorders Subcommittee (Balon 2014, First 2014). As a result, pedophilia stands out from the other paraphilia disorder diagnoses in a number of ways, which have been discussed in this review. However, this does not explain why voyeuristic disorder begins at age 18 while other paraphilic disorders presumptively can be diagnosed in children. Given the fluidity of sexual interest, how is it that a child may have a sadistic, exhibitionistic, or transvestic disorder? This again seems rather arbitrary and doesn't take into account child and adolescent development. It would also appear to open the door for applying highly stigmatizing labels to young people, most likely those who have committed some type of sexual crime that will justify draconian interventions and public policies.

On the Decision Not to Revise Pedophilic Disorder to Pedohebephilic Disorder

Hebephilia is described as adult sexual interest in pubescent adolescents (typically ages 11 to 14), whereas pedophilia (as noted previously) is the primary or exclusive sexual attraction to prepubescent children. It was proposed that to take into account those who offend against children of different ages, the category should be revised from pedophilia to pedohebephilic disorder (Blanchard et al. 2009). However, this proposal was not accepted. In fact, the phrase "sexual activity with a prepubescent child or children (generally age 13 or younger)" in DSM-5 (Am. Psychiatr. Assoc. 2013, p. 697) has been carried forward from earlier versions of the DSM. This idea dates back to when the onset of puberty was later than it is today (the beginning of puberty now typically occurs around age 10; see Sun et al. 2002). In practice, clinicians/evaluators rarely have reliable information about the actual degree of sexual development of the victim/s, and as a consequence the primary data used are the ages of the offender's known victims. This combined with the "generally age 13 or younger" phrase in the diagnostic criteria has meant that men who have victims aged 12 or 13 will usually be diagnosed with pedophilic disorder even though these children are not likely to be prepubescent, which leads to two substantial problems. First, from a clinician's point of view, diagnosing pedophilic disorder will mischaracterize the individual's arousal pattern. Second, from a researcher's point of view, inclusion of such individuals among those diagnosed with pedophilic disorder will make it harder to discern the characteristics and etiology of pedophilia by diluting the "pedophilic disorder group" with persons who do not have a primary arousal to prepubescent children. The eventual decision of the APA Board of Trustees to reject the Paraphilia Subworkgroup's proposed revision of the criterion set for pedophilia, we would argue, has had the effect of leaving unchanged the deeply flawed DSM-IV-TR criteria.

CONCLUSIONS

There are many positive aspects and some problems in the paraphilias as described in the DSM-5. The positive aspects include the distinguishing of paraphilic disorders from paraphilic interests, the clearing up of the "or behavior" language, the introduction of the "in remission" categories, and the noninclusion of hypersexual disorder and the paraphilic coercive disorder diagnoses. The negative aspects include the promulgation of the traditional descriptions of eight paraphilias (carried all the way through from the DSM-II to the DSM-5), the nonupdate of the pedophilia diagnosis, the lack of field trials for the included diagnoses, and the relatively little consideration of the etiology of the paraphilias. We now briefly examine each of these points.

Positive Aspects of the Current DSM-5 Paraphilic Classifications

The distinction between paraphilic interests and disorders has potentially reversed the progressive merger of unusual interests with dysfunction in previous versions of the DSM. This merger has muddled unusual interests and the concomitant distress to the individual in question (or, for most paraphilias, behavior to nonconsenting others). The APA, in the latest DSM revision, has finally hit upon a definition of paraphilias in contrast with normal sex, which we believe opens up the concept of paraphilia in a way that researchers will find useful. Although at first the notion that paraphilic disorders can be in remission may seem odd because sexual interests are often thought of as enduring characteristics, it becomes clearer when taken in conjunction with the distinction between paraphilias and paraphilic disorders. According to the DSM-5, a paraphilic disorder can be described as being in full remission when the paraphilic interest has ceased to cause dysfunction for at least five years in an uncontrolled environment. Thus, the DSM-5 provides clinicians with the ability to describe the progress of their patients toward controlling and ameliorating the

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dysfunctions related to their sexual interests and lends increased clarity to treatment planning and forensic processes.

The confusing element in the DSM-IV-TR of the "or behavior" language in the template formula for criterion A has also been cleared up (First 2014), which is particularly significant in forensic settings in which recorded behavior patterns may be the primary data available to an evaluator. The DSM-5 template for criterion A of paraphilias makes clear that behavior is merely one of several possible signs of the underlying arousal pattern, with the latter rather than the behavior constituting the paraphilia.

As for the noninclusion of hypersexual disorder, this might seem sensible given that the decision was complicated by two competing ideas. Kafka (2010b) described hypersexual disorder as a sexual disorder and argued that it has more in common with paraphilias and sexual dysfunctions than it does with addictions. Other groups have argued that hypersexual disorder is, in fact, a behavioral addiction, along with pathological gambling (the only behavioral addiction included in the DSM-5). As for the decision between these competing ideas, Reid & Kafka (2014), the latter being one of the primary proponents of its original inclusion, have acknowledged that the current scientific literature raises questions about the existence and characteristics of hypersexual disorder and probably does not support its inclusion in the DSM at this time. Although there was a great deal of debate around the inclusion of PCD in the DSM-5, many conceptual and empirical difficulties exist in distinguishing PCD from sadism. Being coerced into unwanted sex clearly engenders psychological suffering. Furthermore, the most obviously coercive forms of rapes are brutal. Hence, although PCD is conceptualized as arousal from forcing sex on an unwilling person, the most common behavioral evidence for attributing the diagnosis is likely to be a pattern of repeatedly forcing sex on unwilling persons. This, arguably, in practice if not in theory, might amount to the medicalization of serial rape, and it is probably why PCD was rejected for inclusion in the DSM-5.

Negative Aspects of the Current DSM-5 Paraphilic Classifications

The DSM-5 provides definitions of eight paraphilias that are more a continuation of a psychiatric tradition from the DSM-III onward than distinct entities identified and defined on the basis of scientific research. Relatively little change has been made between the DSM-III and the DSM-5, with any modifications being mainly in the details, which can well play out in forensic arenas (e.g., child custody cases, civil commitment) given that paraphilic disorders are diagnosed largely in such settings. Some argue (e.g., First 2014) that these modifications could lead to more confusion rather than to clarity. Another concern is the lack of changes for pedophilic disorder, which still describes sexual activity with children under 13 with little concern for the fact that (*a*) there is clearly a group of individuals who target older children and (*b*) the age of puberty is now closer to 10 than 13. Also of note is that the failure to fund field trials on the existing paraphilic disorder criteria leads to major concern regarding the current DSM-5 nomenclature, especially given that paraphilic disorder diagnoses often have profound effects on forensic decision making. Increasing evidence indicates that certain paraphilic diagnoses (e.g., sexual sadism disorder) have poor reliability (Levenson 2004). It is unfortunate that the opportunity was not taken to develop and field test criteria that might allow greater reliability for this diagnosis.

As noted previously, other limitations of the current paraphilic disorder diagnoses are the lack of good data on their incidence and prevalence as well as little research on the etiology of many of them. We are gaining increasing understanding about pedophilia, at least in terms of pedophilic disorder if not the sexual interest per se. However, little work is being conducted on the other paraphilias. This is concerning, especially since more empirical work was done on the two rejected paraphilia disorders, PCD and hypersexual disorder, than on any of the disorders

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included in the DSM-5. In fact, the concerns about hypersexual disorder could similarly be raised about voyeuristic, exhibitionistic, transvestic fetishistic, fetishistic, and masochistic disorders.

Finally, the DSM process continues to attempt to categorize mental health problems rather than seeing them in terms of underlying dimensions. An interesting manifestation of this categorization is that in rejecting inclusion of PCD, one of the arguments was that it represents a point on a continuum of a sadistic/aggression dimension. However, the sadistic disorder criteria were not changed to reflect such a dimension, which could have been accomplished by doing the same thing that was done in autism and substance use disorders, that is, including specifiers for mild, moderate, and severe.

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SUMMARY POINTS

1. The term paraphilia is defined in the DSM-5 as "an intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (Am. Psychiatr. Assoc. 2013, p. 685), which can be seen as a definition of "normal" sex by default.
2. Eight specific paraphilias are described in the DSM-5: voyeuristic, exhibitionistic, frotteuristic, sexual masochism, sexual sadism, pedophilic, fetishistic, and transvestic. Two categories have also been included in the DSM-5: other specified paraphilic disorder (broadly replacing paraphilia not otherwise specified) and unspecified paraphilic disorder, which are used when the assessor chooses to describe only the diagnostic class.
3. The DSM-5 makes a distinction between paraphilia and paraphilic disorder. This addition, it is argued in DSM-5, distinguishes between a behavior and a disorder stemming from the behavior, and it is more consistent with the views of sexologists and researchers. However, the distinction may actually have the effect of confusing the legal and medical communities.
4. Forensic reviews were considered in the development of the DSM-5 for disorders that frequently appear in forensic environments; however, there is no evidence that the APA funded any field trials. Field trials carried out by others (e.g., Thornton et al. 2011, Wilson et al. 2011) informed the Paraphilias Subworkgroup's decisions.
5. Two new paraphilic disorders (paraphilic coercive disorder and hypersexual behavior disorder) were considered for inclusion in the DSM-5 but were ultimately rejected.
6. A modification of the criteria for diagnosis of pedophilia to pedohebephilic disorder was suggested to distinguish those whose victims are pubertal (ages 10 to 13) and those whose victims are prepubertal. This proposal was rejected for inclusion in the DSM-5, leaving the criteria for pedophilic disorder unchanged from the DSM-IV-TR.
7. The age criteria for diagnosis is inconsistent, with the text silent on the age of onset for most paraphilic disorders but requiring individuals be age 18 years before they can be diagnosed with voyeuristic disorder and 16 years before they can be diagnosed with pedophilic disorder.
8. In summary, the paraphilic disorder diagnostic criteria suffer from uncertain reliability and unclear etiology, and for many of the criteria, a lack of empirical support. Therefore, sexual behavior and sexual interest may be best considered along a continuum, or sets of continua, including age and violence/coercion.

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FUTURE ISSUES

1. The APA did not fund field trials for DSM paraphilia/paraphilic disorders; however, limited trials were carried out and in part informed the recommendations made by the Paraphilias Subworkgroup panel. Although these trials provided reliability and prevalence estimates, the results were not published and thus were not subjected to peer review. The range of sites involved was narrow, with an overrepresentation of treatment centers for sexually violent predators. This is clearly something that needs to be addressed in future versions of the DSM in order to adequately assess both reliability of diagnoses and actual prevalence rates. Hence, we recommend that the APA properly fund such field trials as they have done for a number of other disorders included in DSM-5.
2. The current Paraphilias Subworkgroup panel appears to be drawn from professionals who are typically involved in the assessment, management, and treatment of sex offenders. Thus, there appears to have been limited expertise on those paraphilias that are not sex offenses or on individuals who have certain paraphilias (e.g., pedophilia) but have either not acted in an illegal manner or have not been apprehended. Inclusion of a wider range of experts, especially those in the field of sexology, would be useful in future changes to definitions/diagnoses of paraphilias.
3. Little is known of the etiology of the paraphilias. Some suggest neurodevelopmental problems are a possibility (e.g., Cantor et al. 2004, 2005, 2006; Rahman & Symeonides 2008), whereas others suggest that a link between developmental instability and maternal immunity may play a role in variant sexual preferences among otherwise healthy heterosexual men. The neurobiology of paraphilias has been explored in pedophilia to a limited extent. However, there has been little similar exploration of other paraphilias, and most conceptualizations of etiology are based on outdated behavioral theories. A more rigorous biopsychosocial exploration of paraphilias is clearly needed.
4. As with other areas of problematic psychological functioning, it seems likely that the underlying phenomena of paraphilic disorders are better understood dimensionally rather than as categories (see, e.g., Weeks 2015). As noted in the main body of the present review, evidence indicates that persons having one paraphilia tend to have others. This suggests a general susceptibility to paraphilias. Systematic research into underlying dimensions of sexual interest would provide a more helpful organizing framework than the present, rather arbitrary, categorical scheme.
5. The lack of overall development in the DSM-5 does not make a good basis for developing diagnostic systems that are helpful in the practical business of identifying treatment needs, carrying out risk assessments, or developing new knowledge through research. General psychopathological factors would seem to operate both more generally and more specifically than the current diagnostic level, and therefore this is an issue that needs to be considered in future developments in this area (e.g., Caspi et al. 2014, Krueger et al. 2005). Already major research funding bodies in the United States have moved on to alternative schemes [see the National Institute of Mental Health's Research Domain Criteria (**http://www.nimh.nih.gov/research-priorities/rdoc/index.shtml**)], which suggests that classifying mental disorders on the basis of behavioral dimensions and neurobiological measures may be a better way forward than the categorical approach of the DSM.

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RELATED RESOURCES

DSM-5 website: http://www.dsm5.org/Pages/Default.aspx

This website aims to serve as a resource for clinicians, researchers, insurers, and patients. The site includes information on implementation of the manual, answers frequently asked questions, lists DSM-5 corrections, and provides a mechanism for submitting questions and feedback regarding

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implementation of the manual. The site also provides links to educational webinars about the DSM-5.

DSM-5 paraphilias worksheet: **http://www.dsm5.org/Documents/Paraphilic%20Disorders%20Fact%20Sheet.pdf**

NIMH Research Domain Criteria: http://www.nimh.nih.gov/research-priorities/rdoc/index.shtml

This project implements Strategy 1.4 of the 2008 NIMH Strategic Plan: to provide new ways of classifying mental disorders on the basis of behavioral dimensions and neurobiological measures. This initiative attempts to bring the power of modern research approaches in genetics, neuroscience, and behavioral science to the problems of mental illness, studied independently from the classification systems by which patients are currently grouped.

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