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COMMENTARY ON DSM-5

DSM-5 and the Paraphilic Disorders: Conceptual Issues

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Introduction

The American Psychiatric Association (APA) has published the fifth edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013a), which is considered to be a definitive reference for the diagnosis of psychiatric disorders. The DSM-5 revision process involved the appointment of Workgroups (and subworkgroups) for each section. The paraphilias subworkgroup (PSWG) reviewed and recommended changes to the diagnostic criteria and text of the newly renamed Paraphilic Disorders section. The members of the PSWG published their initial reviews and recommendations in the *Archives of Sexual Behavior* and solicited comments from both the public and professionals on their proposals. Those comments were published in the *Archives of Sexual Behavior*, other professional publications, or were communicated directly to the PSWG. Presumably, the feedback to the PSWG (both published and unpublished) was considered and a final PSWG proposal was submitted for internal APA review. The rest of the process was shrouded in secrecy, because all participants in the revision process were required to sign confidentiality pledges (for more details, see APA, 2013b). The rationale for why specific changes were included or rejected is not known due to the confidentiality pledge. This commentary analyzes the conceptual issues raised by the Paraphilic Disorders section of DSM-5 as published. Any criticism, actual or implied, of the DSM-5 is directed at the process that created it. There is ample reason to believe that PSWG members were not completely satisfied with or supportive of the final document (see Blanchard, 2013). For simplicity, I will refer to the APA as the responsible party for problems with the DSM-5 Paraphilic Disorders section. As much as possible, repetition of my past criticisms of the paraphilias as diagnoses will be minimized (Kleinplatz & Moser, 2005; Moser, 2001, 2002, 2009, 2010, 2011; Moser & Kleinplatz, 2002, 2005a, b; Shindel & Moser, 2011). Nevertheless, all problems identified in this commentary were identified and discussed in earlier publications. The reasons the text was not clarified, as per previous recommendations, are not clear. Field trials to test the usefulness and consistency of the new diagnostic criteria (including the new paraphilia definition), surprisingly, were not undertaken.

The rationale for the continued inclusion of the Paraphilic Disorders as mental disorders inexplicably is still lacking. The APA has never justified why it considers nonstandard sexual interests a type of mental disorder or the specific problems these interests engender. It never explains why sex crimes are treated differently from other crimes (e.g., In what way does exposing one's genitals to an unsuspecting stranger differ from brandishing a gun at an unsuspecting stranger during a robbery?). Despite the criticisms, the APA never seriously considered removing the paraphilias from DSM-5. Spitzer (2005), the Editor of DSM-III (APA, 1980), stated, "First of all it is not going to happen…" (p. 115). In an APA position statement released on June 17, 2003 (APA, 2003), Regier, who was then the Director, American Psychiatric Association's Division of Research and later appointed Vice-Chair of the DSM-5 Task Force, stated "there are no plans or processes set up that would lead to the removal of the paraphilias from their consideration as legitimate mental disorders." It is reasonable to conclude that the APA's insistence on the retention of these diagnoses is not based on an analysis of the latest scientific research (see Shindel & Moser, 2011).

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Distinguishing Between a Paraphilia and a Paraphilic Disorder

All the paraphilic disorder diagnostic criteria contain at least two criteria. "Criterion A specifies the qualitative nature of the paraphilia…and Criterion B specifies the…distress, impairment, or harm to others" (APA, 2013a, p. 686). The harm to others was added when Criterion A specified the activity involves a nonconsenting individual. The wording for Criterion B varied slightly among the different paraphilic disorders, but for brevity I will refer to Criterion B as requiring the paraphilia to cause distress or impairment.

A significant change in the DSM-5 is a new explicit distinction between a paraphilia and a paraphilic disorder: "A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder and a paraphilia by itself does not necessarily justify or require clinical intervention" (APA, 2013a, p. 686). Whatever the APA's motivation was for distinguishing between a paraphilia and a paraphilic disorder, the concept that the "paraphilias are not *ipso facto* mental disorders" (APA, 2013a, p. 816) was present in both the DSM-IV and DSM-IV-TR: "A paraphilia must be distinguished from the non-pathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement" (APA, 1994, p. 525; APA, 2000, p. 568; see also First, 2014; Wakefield, 2011). In previous DSM editions, just meeting Criterion A was not sufficient for a determination of a paraphilia, a diagnosis of a mental disorder, or worthy of note.

Criterion A arbitrarily fixes the duration of interest in the paraphilia at 6 months. Nevertheless, the text is clear that the "6 months, should be understood as a general guideline, not a strict threshold, to ensure the sexual interest…is not merely transient" (APA, 2013a, p. 694). Blanchard (2010), the chair of the PSWG noted, "I have not suggested any alteration of the qualifying phrase, 'over a period of at least 6 months,' but I will note that it might be better applied to Criterion B than to Criterion A.…There does not, therefore, seem to be any particular need to stress the duration of signs and symptoms in Criterion A. Some duration condition might actually make more sense in Criterion B, because the distress…could fluctuate…according to levels of self-acceptance that could change" (p. 368). No rationale is given for continuing the 6 month time frame included in Criterion A. The possibility that the intensity or persistence of the interest could change over time does not appear to be a consideration in making or resolving the diagnosis, though the text recognizes that it does change (APA, 2013a; see also Müller et al., 2014).

As currently stated, a short period of distress could convert a paraphilia to a paraphilic disorder. Once the distress or impairment resolves, then the DSM-5 would label the symptom-free individual with the paraphilic disorder diagnosis for five more years! After 5 years, the symptom-free individual is labeled as having a paraphilic disorder in full remission, never reverting back to a paraphilia per se. The concept of a disorder in remission implies that relapses are common, but there are no data suggesting that the distress or impairment recurs after resolution. Mental disorders that are known to have relapses have much shorter symptom-free periods prior to being designated as "in remission" (e.g., 2 months for Depressive Disorders and 12 months for Alcohol Use Disorder and Opioid Use Disorder) (APA, 2013a). It is important to emphasize that even if the paraphilic interest is constant, the designation of a paraphilic disorder diagnosis as "in remission" implies that it is the distress or impairment that is recurrent.

A similar argument can be made concerning the criminal paraphilia (i.e., exhibitionism, frotteurism, and voyeurism; pedophilia will be discussed separately), except that the individuals could be diagnosed on the basis of behavior with a nonconsenting partner, without any evidence of distress or impairment. Many of these individuals would have the specifier of "In a controlled environment" (i.e., prison or a locked psychiatric unit) affixed to their diagnoses. Individuals in a controlled environment cannot be in full remission. The diagnostic criteria for the criminal paraphilias add the phrase that the individual "has acted on these sexual urges with a nonconsenting person" (APA, 2013a, pp. 686, 689, 691). This specifier also suggests that these individuals can never be in remission. These modifiers make it difficult, if not impossible, for those individuals to be judged as successfully treated and eventually released. The APA has thus equated committing a crime with a mental disorder that can never be in remission or resolved.

The APA (2013a) indicates that distress and impairment "are special in being the immediate or ultimate result of the paraphilia and not primarily the result of some other factor" (p. 686). It is not clear how to interpret this statement, but the APA (2013c) published a fact sheet which clarifies that "people with these interests…feel personal distress about their interest, not merely distress resulting from society's disapproval." Unfortunately, most professionals who use the DSM-5 will not be aware that the fact sheet even exists. Even when using the fact sheet, it still is not clear how a clinician can ascertain whether the individual is personally distressed by their interest, personally distressed by society's disapproval, or personally distressed by the consequences of societal disapproval.

The DSM-5 text for each paraphilic disorder explains how individuals, who are neither distressed nor impaired by their sexual interests, nor have not acted upon their sexual urges with a nonconsenting person, should not be diagnosed with a paraphilic disorder. Rather, these individuals are recognized with the attributes of the associated paraphilia, which is not a mental disorder. What is lacking from the text is how to evaluate and distinguish between the impairment caused by the paraphilia as opposed to the impairment caused by other aspects of the individual's life. Difficulties in social, occupational, or other important areas of functioning are common among individuals with-

out a paraphilia. Those problems are not classified as mental disorders in DSM-5, but as "Other Conditions That May Be a Focus of Clinical Attention." Why the same problem in an individual with a paraphilia fulfills the diagnostic criteria for a mental disorder is just not clear. There are no data to suggest that individuals with a paraphilia encounter these problems more frequently or more severely than individuals without a paraphilia.

The New Definition of a Paraphilia

A new definition of a paraphilia was presented in DSM-5: "[T]he term *paraphilia* denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (APA, 2013a p. 685). There is a lack of research that demonstrates that this is either a reliable or valid definition. Blanchard (2009) correctly noted "At first glance, this definition seems to label everything outside a very narrow range of sexual behaviors as paraphilic," but direction about how to apply this new definition properly is missing from the final document. We are left with Blanchard's original statement that only a very narrow range of sexual behaviors is normophilic. As the ostensibly definitive reference on psychiatric nomenclature, the DSM-5 inexplicably fails to explain why some interests are deemed paraphilic and others not, how to distinguish clinically paraphilic from normophilic interests, or even why this is an important distinction.

The APA attempted to clarify its statements, perhaps in order to preempt criticism of the new definition. A paraphilic interest might not be intense, but would include "any sexual interest greater than or equal to normophilic sexual interests" (APA, 2013a, p. 685). There is no accepted standard of how to measure the strength of paraphilic or normophilic interests; different techniques, testing paradigms, and testing sites often give divergent results (see APA, 2013a). With the exception of pedophilia, there is essentially no research which compares the strength of paraphilic and normophilic interests. In fact, most individuals with a paraphilia also manifest normophilic interests (Chivers, Roy, Grimbos, Cantor, & Seto, 2014; Langevin, Lang, & Curnoe, 1998). There is also no research to show the strength of any sexual interest is constant over time; the opposite reputed to be true of women (Diamond, 2009) and probably true of men (see Müller et al., 2014).

The APA (2013a) attempted to clarify further its definition by suggesting that a paraphilia implies "…interest in these activities that equals or exceeds the individual's interest in copulation or equivalent interaction with another person" (p. 685). It is not clear what "equivalent interaction" means. Does it include anal sex, oral sex, or masturbation? What interactions are not covered? Most individuals with a paraphilia want to combine that interest with copulation or equivalent interaction. The focus on coitus seems to say more about the sexual concerns of the APA than it does about any nosology of sexual interests based on scientific or psychiatric data.

The APA (2013a) provides yet another definition, that is, that paraphilias are "better described as *preferential* sexual interests" (p. 685), evoking memories of when homosexuality was considered a *sexual preference*. These different definitions and clarifications can contradict each other and do not help to clarify the concept. One can imagine a person who states a preference for blond partners, has the strongest response in the laboratory to brunette partners, but admits to an intense and persistent interest in redheaded partners in a clinical interview.

If a man prefers to stimulate his penis by contact with his partner's genitals, that is not a paraphilia. Presumably, if he prefers to stimulate his penis by contact with his partner's mouth, that does not "count" as a paraphilia either. If he prefers to stimulate his penis by contact with his partner's feet, that does seem to be a paraphilia. There is no research basis to support this distinction. If there is a logic behind this distinction, the APA has chosen not to share it.

The criminal paraphilic disorders are a bit different, since by definition these involve nonconsenting partners. Nevertheless, many individuals with criminal paraphilic disorders would prefer to engage in normophilic sex "with phenotypically normal, physically mature, consenting human partners." Often individuals with these paraphilias report concurrent fantasies that the "victim" will want to develop a relationship or have sex with them. Technically, exhibitionism, frotteurism, and voyeurism are paraphilias only if the individual has eroticized the nonconsensual aspect of the activity. An interaction with a nonconsenting individual, when the perpetrator is not aroused by the nonconsensual aspect of activity, is a crime and does not satisfy diagnostic criteria of a criminal paraphilic disorder. The same behavior with a consenting individual is not indicative of a paraphilia and should not be used to support a paraphilic disorder diagnosis. It is doubtful that most clinicians would recognize that distinction. I am not defending individuals who commit these crimes, but pointing out that the new paraphilia definition and diagnostic criteria do not clearly include them. A nonsexual act with a nonconsenting person is a crime, not a mental disorder. A sexual act with a nonconsenting person is also crime, but the APA has not shown it to be indicative of a mental disorder.

The concept of phenotypically normal, physically mature partners is also confused. Both men and women spend considerable amounts of time and money to alter their appearance, often in ways that are not phenotypically normal. Purple hair, hairless bodies, tattoos, piercings, silicone augmented breasts, etc. are not phenotypically normal. I doubt the APA meant to categorize the individuals who eroticize these characteristics as having a paraphilia. Blanchard (2009) noted that developing a relationship with an amputee does not indicate a paraphilia, but developing a relationship with someone because they are

an amputee does. Does initiating relationships with prospective partners because they have desirable characteristics (blond, large breasts, muscular physique, or intelligence) indicate a paraphilia? What, if any, characteristics can serve as the basis of ongoing sexual attraction without fulfilling part of the diagnostic criteria for a paraphilic disorder?

Unintentional Paraphilias

None of the noncriminal paraphilic disorders (Fetishism, Sexual Masochism, Sexual Sadism, and Transvestic Disorders) clearly fit the new paraphilia definition (Fedoroff, Di Gioacchino, & Murphy, 2013; Moser, 2011). The vast majority of individuals who have these interests also have an intense interest in genital stimulation with phenotypically normal, physically mature, consenting human partners. Therefore, only the rare individual whose interest in genital stimulation is minor compared to the "disordered" desire would be classified as having a paraphilia.

Asexual individuals, who are not interested in genital stimulation, could paradoxically be ascertained to have a paraphilia if they have even a slight sexual interest in nongenital contact (hugging, kissing, stroking, etc.) with a partner. I do not believe this was the APA's intent, but it is what they wrote.

The new definition has the unintentional result of creating new paraphilias and potentially new paraphilic disorders. These might include, for example, fantasies of being raped (common among men and women and, by definition, "nonconsensual"), interests in shaved pubis (not phenotypically normal), a preference to be the insertee in anal intercourse (nongenital stimulation), or a preference for transgendered or transsexual partners (not phenotypically normal preoperatively and possibly postoperatively). Arousal to romance novels (which rarely focus on copulation) and arousal to images of breasts and buttocks suggest that the many of us have paraphilias. There are many other possible new paraphilias. The belief that paraphilias are rare appears to be false. Sexual fantasies focused on at least some paraphilic themes are common (Joyal, Cossette, & Lapierre, 2015).

Are Paraphilic Disorders Mental Disorders?

The APA also introduced a new definition of a mental disorder in the DSM-5. Surprisingly, the new definition of a Paraphilic Disorder does not fulfill the criteria of the new definition of a mental disorder. A mental disorder is "characterized by clinically significant disturbance in an individual's cognition, emotion regulation or behavior" (APA, 2013a, p. 20). Paraphilias are not mental disorders, so the clinically significant disturbance must be the distress and impairment associated with a paraphilic disorder, not the sexual interest. The mental disorder definition also specifically excludes socially deviant sexual (and political and criminal) behavior. So the disturbance in cognition, emotional regulation, or behavior indicative of a Paraphilic Disorder must result from the distress and impairment associated with that disorder. As mentioned earlier, distress and impairment is common among those without a paraphilia and does not lead to mental disorder diagnosis. Without clarifying what is different about the distress and impairment associated with a paraphilic disorder, it is logically inconsistent to diagnose an individual with a mental disorder on the basis of a nonpathological characteristic. We can conclude that the paraphilic disorders do not meet the definition of a mental disorder.

"The diagnosis of a mental disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans, and potential outcomes for their patients" (APA, 2013a, p. 20). The clinical utility in these diagnoses is questionable. In almost one-half billion office visits to psychiatrists, urologists, general/family/internal medicine physicians, and obstetricians/gynecologists, no diagnoses of Sexual Sadism or Sexual Masochism (previous terms for Sexual Sadism Disorder and Sexual Masochism Disorder) were made (Krueger, 2010). There is no evidence that Fetishistic Disorder or Transvestic Disorder are diagnosed in the general population either.

These diagnoses are used by the criminal justice system as a pretext to incarcerate individuals (usually for life) under the so-called Sexually Violent Predator (SVP) statutes, rather than having any clinical utility for the patient/inmate. If as a society we wish to extend the sentences of sex offenders, we should act through our legislative representatives to do so explicitly. The APA should act proactively to prevent the misuse of its diagnoses for social control. The APA at least at one time agreed that it had "…a strong interest in ensuring that medical diagnoses not be improperly invoked to support involuntary confinement…[and SVP's] are not mentally ill under normal standards justifying civil commitment" (APA, 1996, p. 1). In a rather cavalier statement, Långström (2010), a member of the PSWG, stated, "I am not convinced that psychiatric nosology should change primarily because of the potential or actual misuse of diagnoses in the judicial system" (p. 323). Other areas of medicine (including psychiatry) often act proactively to prevent potential or actual misuse of their diagnoses. The APA has not disclosed any rationale for ignoring the misuse of the paraphilic disorder diagnoses or not acting to prevent their misuse in the future. This follows the tradition of psychiatry (and the APA) when its diagnoses were used to persecute, institutionalize, and imprison individuals for being homosexual, masturbators, and "nymphomaniacs."

For the diagnosis of the criminal paraphilias, there is an added option of engaging in the behavior with a nonconsenting individual, which is a criminal act. This is also odd because nonsexual criminal acts, even repeated acts, are not the *sine qua non* of a mental disorder, i.e., there is no embezzlement disorder. The inconsistency is compounded by noting that not all sexual

criminal behaviors are pathologized, rape being the most obvious example. Rape was not mentioned after DSM-I (APA, 1952) and numerous attempts to insert it into later editions of the DSM have failed. The latest proposal to insert a variation of rape, Coercive Paraphilic Disorder, in DSM-5 also was rejected.

Mental disorders which involve engaging in criminal acts are usually included in the chapter discussing "Disruptive, Impulse-Control, and Conduct Disorders." These disorders "are manifested in behaviors that violate rights of others…and/or that bring the individual into significant conflicts with societal norms" (APA, 2013a, p. 461). The APA's rationale for omitting sex offenses from this section has not been stated.

Conclusion

The present critique highlights the logical inconsistencies in the APA's conceptualization of paraphilias and paraphilic disorders in DSM-5. It is not clear that the paraphilias listed in DSM-5 meet the new definition of a paraphilia. It is not clear that the distinction between a paraphilia and a paraphilic disorder is meaningful. It is not clear that the definition of a paraphilic disorder meets the criteria of mental disorder. It is not clear that a paraphilic disorder diagnosis assists the clinician (or patient) in any way. The scientific basis demonstrating that the paraphilic disorders are mental disorders is absent. The rationale and need for the continued inclusion of the paraphilic disorders in the DSM is lacking. The APA may suggest that the DSM is a policy and social document, as much as a scientific document. If so, then the APA should state clearly when the science does not support its position. If it is a policy and social document, then the APA should be held accountable for the harm DSM-5 causes. As a scientific document, the Paraphilic Disorders section of DSM-5 is a failure.

The APA is well aware of these criticisms and has a duty to either address them or articulate why they do not apply. If the APA continues to ignore these criticisms, it is as much as admitting that the criticisms are valid.

Although the separation of a paraphilia from a paraphilic disorder may have some immediate effect on the discrimination these individuals face in civil and criminal courts (see Wright, 2014), it surely will not address all the problems these diagnoses have engendered. The APA, its members, and those promoting its policies should pause and ask why these diagnoses which they have not been able to define clearly, which have no data to support their inclusion as a mental disorder, and which have been used to support the discrimination (social, occupational, and legal) against these individuals are still included in the DSM.

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