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LETTER TO THE EDITOR

DSM-5, Paraphilias, and the Paraphilic Disorders: Confusion Reigns

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Six years ago, the American Psychiatric Association (APA) published a new edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013a), which is considered by some to be a definitive reference for the diagnosis of psychiatric disorders. The revision process involved the appointment of Workgroups (and SubWorkGroups) for each section (see APA, 2013b). The Paraphilias SubWorkGroup (PSWG) reviewed the latest research and considered 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 on their proposals from both the public and professionals. 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 Presumably, the feedback to the PSWG (both published and unpublished) was considered, and a final PSWG revision proposal was submitted for internal APA review. The text of the final proposal submitted by PSWG to the APA is confidential and not available. There is ample reason to believe that PSWG members were not completely satisfied with or supportive of the final version of the DSM-5 Paraphilic Disorders section (see Blanchard, 2013). The present article analyzes the issues raised by the Paraphilic Disorders section of DSM-5 as published. For simplicity, I will refer to the APA as the responsible party for the DSM-5 Paraphilic Disorders section.

All participants in the revision process were required to sign confidentiality pledges, so which proposed changes were rejected by the internal APA review process are shrouded in secrecy. In the age of evidence-based medicine where the goals to avoid conflicts of interest and to maximize transparency are clear, the confidentiality pledges suggest that the APA was influenced by internal (and possibly external) political agendas. By requiring these confidentiality pledges, the impartiality and validity of the DSM-5 have been compromised.

Despite the stated guideline that "no a priori constraints should be placed on change between DSM-IV and DSM-5" (APA, 2013a, p. 7), it appears that the APA never seriously considered removing the Paraphilic Disorders from DSM-5. Spitzer (2005) (editor of DSM-III; APA, 1980) stated, "First of all it is not going to happen…" (p. 115), referring to removing the paraphilias from the DSM. In an APA position statement released on June 17, 2003, Darrel A. Regier, M.D., M.P.H., 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." The APA has never documented why it considers Paraphilic Disorders a mental disorder or described the specific problems these interests engender. The APA never explains why sex crimes are treated differently from other crimes (e.g., In what way does repeatedly exposing one's genitals to unsuspecting strangers differ from repeatedly brandishing a gun at unsuspecting strangers in a robbery attempt?).

The DSM-5 is a consensus document like many in medicine, though it does not suggest treatment. These documents are created when a medical organization assembles a group of experts, who then review the literature and make recommendations to other health care providers concerning the diagnosis of patients with these medical conditions and when treatment is indicated. See James et al. (2014) as an example of a consensus document addressing the management of hypertension (chosen because it is freely available online). In that report, the scientific literature was reviewed, inclusion and exclusion criteria for which studies were reviewed was discussed, an evidence quality rating was assigned to the studies reviewed, guiding recommendations were made, and the strength of each recommendation was graded. This system is not perfect, but it is the way modern medicine usually works.

The credibility of the DSM-5 review process is in question when citations of the literature are missing, the rationale for inclusion or exclusion of articles from the literature reviews is absent, the evidence ratings of the research that were reviewed are

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omitted, and the grading of the strength of the recommendations are nonexistent. In the same way that James et al. (2014) grouped individuals in different groups (e.g., patients with diabetes and kidney disease) and recommended whether or not to treat and each group's treatment goals, the DSM also groups individuals into different types of disorders and recommends when to treat. Although some specific treatments are advocated for hypertension, the DSM-5 does not recommend specific treatments.

As a scientific document, it is unlikely that the Paraphilic Disorders chapter of the DSM-5 would pass the peer review process for publication in an academic psychiatry journal. DSM-5 as a consensus document is quite different from other evidence-based practice guidelines published by other medical organizations.

The supporters of the DSM-5 may note correctly that there is a dearth of high-quality research for most of psychiatry and especially for the Paraphilic Disorders. That fact highlights the importance of making clear statements on the level of evidence and strength of their recommendations (i.e., diagnostic criteria). The authors should admit that differences in opinion exist, so that mental health practitioners and others who rely on the DSM will not assume that all experts agree. When social or political influences color the analyses, as they often do, that should be acknowledged. Associating a specific recommendation with a specific research study might spur further research to confirm or repudiate that recommendation.

As much as possible, repetition of my past criticisms of the paraphilias as diagnoses will be avoided (Kleinplatz & Moser, 2005; Moser, 2001, 2002, 2009, 2010, 2011; Moser & Kleinplatz, 2002, 2005a, b; Shindel & Moser, 2011). Nevertheless, many of the problems identified in the present Letter were identified prior to the publication of DSM-5. Whether the APA agreed with these criticisms or not, the related issues were not clarified or addressed in the text. Field trials to test the reliability and validity of the new diagnostic criteria and the new paraphilia definition were not undertaken.

Types of Paraphilic Disorders

The Paraphilic Disorders are comprised of two very different types of disorders: the criminal and noncriminal. The diagnostic criteria of the criminal Paraphilic Disorders (Exhibitionistic, Frotteuristic, Pedophilic, and Voyeuristic Disorders) all require a nonconsenting[1] person, and individuals acting on these sexual urges would constitute a crime. The noncriminal Paraphilic Disorders (Fetishistic, Sexual Masochism, Sexual Sadism, and Transvestic Disorders) usually involve a consenting partner, and acting on these sexual urges would not constitute a crime necessarily. Of course, depending on local laws, any sexual act could be a violation of the law. Both types of disorders will be discussed separately throughout this Letter.

Paraphilias and Paraphilic Disorders

A supposedly 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 nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement" (APA, 1994, p. 525; APA, 2000, p. 568, bolded in both editions; see also First, 2014; Wakefield, 2011).

All the Paraphilic Disorder diagnoses 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 involved a nonconsenting individual. There were slight differences in wording for Criterion B among the different Paraphilic Disorders, but for brevity I will refer to Criterion B as requiring the paraphilia to cause distress or impairment. In previous DSM editions, just meeting Criterion A was not sufficient for a determination of a paraphilia or a diagnosis of a mental disorder. In DSM-5, satisfying Criterion A now indicates that the individual has a paraphilia, but not necessarily a mental disorder.

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 fact that it does change is noted (APA, 2013a; Blanchard, 2010; see also Müller et al., 2014).

A strict reading of current diagnostic criteria suggests that a short period of distress could convert a paraphilia to a

[1] Minors, by definition, cannot consent.

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 may be classified 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 diagnosis of a Paraphilic Disorder "in remission" indicates the resolution of the distress or impairment—not resolution of the paraphilia. For example, "The 'in full remission' specifier does not address the continued presence or absence of exhibitionism per se, which may be present after the behaviors and distress have remitted" (APA, 2013a, p. 689). Similar statements appear in the DSM-5 text for Frotteuristic and Voyeuristic disorders. The remission criteria are completely omitted for Pedophilic Disorder, presumably for political reasons (see Balon, 2014).

Many of the individuals who have criminal Paraphilic Disorders are living in a controlled environment (i.e., prison or a locked psychiatric unit), and the "in full remission" specifier requires the individual to be symptom free "for at least 5 years while in an uncontrolled environment" (APA, 2013a, pp. 687, 689, 692). That specifier makes it difficult, if not impossible, for those individuals ever to be judged as successfully treated (in full remission) and eventually released. The APA has equated committing a crime with a mental disorder that can never be resolved and only rarely can be in remission.

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 individuals are personally distressed by their interests, personally distressed by society's disapproval, or personally distressed by the consequences of societal disapproval. It is also not clear if the diagnosis is warranted when individuals with a paraphilia experience distress from multiple sources and their sexual interests are a minor source of their distress.

"Clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, 2013a, pp. 686, 689, 691, 694, 695, 700, and 702) are common among individuals without 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." There are no data to suggest that individuals with a paraphilia encounter clinically significant distress or impairment more frequently or more severely than individuals without a paraphilia. Why the same problem in an individual with a paraphilia fulfills the diagnostic criteria for a mental disorder is not clear.

There is an exception to the concept that a Paraphilic Disorder is not diagnosed in the absence of distress or impairment or the involvement of a nonconsenting person. Sexual Sadism Disorder would be diagnosed when acted upon with a consenting partner, without distress or impairment associated with the activity or interest. Specifically, double negative notwithstanding, only those who "do not act…would not meet criteria for Sexual Sadism Disorder" (APA, 2013a, p. 696). It seems the APA considers the sexual sadist, but not the sexual masochist, in a consensual BDSM relationship as having a mental disorder. It harkens back to when some considered only the receptive man to be homosexual and thus mentally disordered.

The New Definition of a Paraphilia

A new definition of a paraphilia was presented in DSM-5: "The 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), Chair of the PSWG, 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 is missing from DSM-5. Without this guidance, mental health professionals, who are not experts in the diagnosis of Paraphilic Disorders, may conclude that only a very narrow range of sexual behaviors are normophilic. The proposed range of normophilic behaviors was not addressed.

The APA did attempt to clarify its new paraphilic 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. Measures of the strength of these interests from different techniques, testing paradigms, and testing sites often vary (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 that the strength of any sexual interest (or orientation) is constant over time; the opposite is true among women (Diamond, 2009) and probably

true among men (Diamond, 2013; see Müller et al., 2014). If the paraphilic interests decrease in strength or the normophilic interests increase in strength so that the individual no longer meets the definition of having a paraphilia, the paraphilia is still noted. Blanchard (2009), as chair of the PSWG, points out "patients who have been clearly ascertained as transvestic retain that label whether or not they report that cross-dressing continues to be accompanied by penile erection or subjective feelings identifiable as sexual excitement" (p. 368). This inconsistency contradicts the first paraphilia definition discussed (APA, 2013a).

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 which interactions are included or excluded. Nevertheless, most individuals with a paraphilia want to combine their paraphilic interest with copulation or equivalent interaction. Implicit in this concept is the premise that a preference for solitary masturbation over coitus is problematic.

If a man becomes aroused by the preparatory fondling of his partner's genitals and proceeds to coitus that would be classified normophilic. If a man becomes aroused by the preparatory fondling of his partner's genitals and he is distressed because he often ejaculates prior to coitus, a Premature (Early) Ejaculation diagnosis seems appropriate. If he becomes aroused by fondling his partner's feet and proceeds to coitus, is it preparatory fondling or a paraphilia? If he fondles his partner's feet and is distressed because he often ejaculates prior to coitus, is a diagnosis of Fetishistic Disorder, Premature (Early) Ejaculation, or both appropriate?

The APA (2013a) provides yet another definition, that is, that paraphilias are "better described as *preferential* sexual interests" (p. 685), thereby evoking memories of when homosexuality was considered a sexual preference. These different definitions and clarifications can and do contradict each other and do not 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.

The criminal Paraphilic Disorders (excluding Pedophilic Disorder from this discussion) are different, since by definition these involve nonconsenting partners. Many individuals who have criminal Paraphilic Disorders would prefer to engage in normophilic sex "with phenotypically normal, physically mature, consenting human partners." In my clinical experience, individuals with these paraphilias often 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, but does not appear to satisfy the diagnostic criteria of a criminal Paraphilic Disorder and should not be diagnosed. 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 these distinctions. I am not defending individuals who commit these crimes, but demonstrating that the new paraphilia definition and diagnostic criteria are not clear about their exclusion or inclusion.

None of the noncriminal Paraphilic Disorders (Fetishistic, 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 those rare individuals whose interests in genital stimulation are minor compared to their nonnormophilic desires would be classified as having paraphilias.

The concept of phenotypically normal, physically mature partners is confused as well. 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 he or she is an amputee does qualify. Does developing a relationship 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 being defined as a paraphilia?

Unintentional Paraphilias

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

The new definition of a paraphilia seems to include individuals with rape fantasies (common among men and women; and by definition "nonconsensual"), interest in partners with a shaved pubis (not phenotypically normal), a preference to be the receptive partner in anal intercourse (nongenital stimulation), a preference to stimulate a partner's genitals orally without reciprocation (not preparatory fondling), or a preference for transgender 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 many of us have paraphilias. Sexual fantasies focused on at least some paraphilic themes are common (Ahlers et al., 2011; Joyal, Cossette, & Lapierre, 2015). Normophilic individuals actually may be a sexual minority.

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). The mental disorder definition also specifically excludes socially deviant sexual, 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 the paraphilia. As mentioned earlier, distress and impairment are common among those without a paraphilia and do not lead to a 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 otherwise nonpathological distress or impairment.

The definition of a mental disorder includes an exception to the exclusion of socially deviant sexual, political, and criminal behavior, which is when the deviance "results from a dysfunction in the individual" (APA, 2013a, p. 20). Nevertheless, since paraphilias are not mental disorders, we must assume they are not dysfunctions. Their "problem" is their nonconforming sexual interest and lifestyle. The text of DSM-5 does not indicate and the scientific research does not identify any characteristic disturbance in cognition, emotion regulation, or behavior in individuals with a Paraphilic Disorder, aside from the behavioral expression of their paraphilia.

Paraphilic Disorders and Criminal Behavior

Those mental disorders which predispose individuals to engaging in criminal acts are usually included in the chapter Disruptive, impulse-control, and conduct disorders which "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 not including sex offenses in this section has never been stated. There is no indication that most individuals with a paraphilia or a Paraphilic Disorder cannot control their behavior.

Of course, individuals with a variety of mental disorders can and do commit crimes, but with the exception of the Paraphilic Disorders, none of the mental disorders are pathologized specifically on the basis of having a nonconsenting partner. Crimes (even repetitive acts) are not mental disorders, i.e., there is no embezzlement disorder. Even when a mental disorder leads to repeated criminal acts (e.g., an individual with opioid use disorder who frequently steals money to obtain drugs), the diagnostic criteria do not mention the crime. Antisocial Personality Disorder mentions "repeatedly performing acts that are grounds for arrest" (APA, 2013a, p. 659), but the specific crime is not mentioned. Impulse-control disorders might imply a crime (e.g., Pyromania or Kleptomania), but note that most people who commit the crime do not have the disorder. In contrast, the APA implies that individuals who commit sex crimes, whether distressed or impaired because of their interests, are nonetheless mentally disordered; the crime is the disorder.

Preventive Incarceration

"The diagnosis of a mental disorder should have clinical utility …for their patients" (APA, 2013a, p. 20). The clinical utility of 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 (see Krueger, 2010). There is no evidence that Fetishistic Disorder or Transvestic Disorder are diagnosed in the general population either. Mandatory reporting laws limit the number of individuals with criminal Paraphilic Disorders who might seek treatment or be candid with their therapists for fear of being reported to the authorities.

A diagnosis of a Paraphilic Disorder is usually made as part of a court ordered evaluation after an individual is arrested as part of the adjudication process or prior to the individual's release from prison. If a Paraphilic Disorder diagnosis is made, the diagnosis may be used by the criminal justice system as evidence of the need to incarcerate the individual involuntarily (usually for life) under the so-called Sexually Violent Predator (SVP) statutes. Rather than having any clinical utility for the patient/inmate, the purpose appears to be preemptive incarceration under the guise of treatment supposedly to protect the public.

If we, as a society, 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 or legal control. At least at one time, the APA 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, see APA, 2013a, p. 25) 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. The organization has not acted to prevent their misuse in the future. Its leaders have not disciplined psychiatrists who invoke these diagnoses inappropriately to support involuntary confinement. This follows in the tradition of psychiatry when its diagnoses historically were used to persecute, institutionalize, and imprison individuals for same sex acts, masturbation, and "nymphomania".

Rape is an interesting exception as a "sex" crime. The APA has rejected a variety of proposals to add rape as a mental disorder to different editions of the DSM. The latest attempt, the proposed Coercive Paraphilic Disorder diagnosis (Quinsey, 2010), was rejected for inclusion in DSM-5 (as both a new disorder or as a condition for further study). By doing so, the APA confirms that, in their assessment, rape is just a crime and not a mental disorder (see Francis, 2011). Why some sex crimes come to be seen as mental disorders and others not is not clear. The logic behind this distinction has never been elucidated.

Pedophilia and Pedophilic Disorder

In the various editions of the DSM, pedophilia has been described as the erotic response to prepubescent individuals, but the text always indicated that this included minors generally age 13 or younger. Blanchard (2009), as chair of PSWG, recommended renaming the disorder as Pedohebephilic Disorder because "pubescent children are generally those from age 11 or 12 years to about 14 or 15; prepubescent children are those who are younger" (p. 311). The proposal to change the name was criticized for many reasons, and the recommendation was rejected (see Singy, 2015). So we are left with an incorrect definition of pedophilia, diagnostic criteria which do not correspond to developmental biology, and surreptitious inclusion of hebephilia as a mental disorder after the APA rejected that change.

The Pedophilic Disorder section also describes individuals who have sexual interests in children, but have not acted on their interests and are not distressed by them. "These individuals have a pedophilic sexual orientation but not a pedophilic disorder" (APA, 2013a, p. 698). The concept of a pedophilic sexual orientation ruffled too many political feathers, which led to a press release correction (APA, 2013d). After the APA correction, the sentence should now read, have a pedophilic sexual interest, not orientation. The distinctions among an orientation, an interest, and a paraphilia were not clarified. The press release also states that the "APA stands firmly behind efforts to criminally prosecute those who sexually abuse and exploit children and adolescents. We also support continued efforts to develop treatments for those with pedophilic disorder with the goal of preventing future acts of abuse" (APA, 2013d). I agree with the first sentence of the quote. The second sentence suggests that they are not treating those individuals with Pedophilic Disorder to relieve their pain and suffering, but rather to prevent further crimes.

Pedophilia may be a "sexual orientation" by some definitions (see Moser, 2016), and it is unclear if psychiatric treatment can change any sexual orientation. By implying that pedophilia is a sexual orientation and not a mental disorder, which is not amenable to change, the legal basis for SVP programs is questionable. Legally, these individuals must be incarcerated for treatment—not for preventive custody.

Nothing in this section should suggest that the author condones sexual behavior by adults involving children, which is a crime and should be prosecuted as such. Whether it is a mental disorder or not is the question.

Noncriminal Paraphilic Disorders

"The diagnostic criteria for sexual masochism disorder are intended to apply to individuals who freely admit to having such paraphilic interests" (APA, 2013a, p. 694). "The diagnostic criteria for Sexual Sadism Disorder are intended to apply both to individuals who freely admit to…and to those who deny" (APA, 2013a, p. 696) having such paraphilic interests. This distinction suggests individuals who deny sexual masochistic interests, despite evidence to the contrary, should not be diagnosed with Sexual Masochism Disorder. In contrast, individuals who deny "sexual arousal from the physical or psychological suffering" (APA, 2013a, p. 695) of a consenting adult partner still could be diagnosed with Sexual Sadism Disorder. Someone who denies an interest in Sexual Sadism presumably would also deny distress or impairment related to that interest. Such an individual would still be diagnosed. As mentioned previously, Sexual Sadism Disorder is the only paraphilia involving a consenting partner that can be diagnosed just by participation in the activity.

In both the Sexual Masochism Disorder and Sexual Sadism Disorder sections, "If these individuals also report *psychosocial difficulties* because of their sexual attractions or preferences… they may be diagnosed with…" Sexual Masochism Disorder or Sexual Sadism Disorder (emphasis added, APA, 2013a, pp. 694, 696). In the other noncriminal Paraphilic Disorders, Criterion B can be satisfied by "psychosocial role impairment" in Fetishistic Disorder or impairment of "social or interpersonal functioning" in Transvestic Disorder (APA, 2013a, pp. 701, 703). The reason for the use of different terms, difficulties, and role impairment is not explained.

Psychosocial difficulties may include finding partners, being ostracized from groups with whom the individual formerly socialized, concern that one is mentally disordered by virtue of the diagnosis in the DSM-5, social awkwardness, etc. Psychosocial difficulties, which are common in any minority group, are not consistent with the DSM-5 definition of a mental disorder

(APA, 2013a). Even if the psychosocial difficulties rise to the level of clinically significant distress or impairment, but were the result of discrimination or bias, it would not fulfill Criterion B. "The distress and impairment stipulated in Criterion B are special in being the immediate or ultimate result of the paraphilia and not primarily the result of some other factor…" (APA, 2013a, p. 686). It would appear that the APA's bias is showing; the same presentation is a reason to diagnose individuals with a paraphilia with a paraphilic disorder, but is not worthy of a diagnosis in normophilic individuals. There are no data to support treating these groups differently. This difference continues the stereotyping of individuals with a paraphilia and perpetuates the psychiatric bias against individuals with a paraphilia.

The research on Sexual Sadism and Sexual Masochism has not distinguished between the practitioners of these paraphilias and the general population except by their sexual interests (see Khan, 2014; Shindel & Moser, 2011). Any group may have some members with mental disorders, but the APA must make a case for why people who have paraphilias have a unique mental disorder. If all blondes are diagnosed with Panic Disorder, then the diagnosis is Panic Disorder—not being a blonde—and treatment should focus on the Panic Disorder, not on dying their hair.

Fetishism (i.e., an erotic interest in an inanimate object) "now reincorporates *partialism* (i.e., an exclusive focus on a body part)" (APA, 2013a, p. 701). Prior to DSM-5, someone could be a foot partialist and a shoe fetishist. The definition suggests that a focus on both buttocks and feet (not exclusive) would not meet the definition for partialism, but an equal focus on socks and shoes would meet the definition. "Devices specifically designed for the purpose of tactile genital stimulation (e.g., a vibrator)" (APA, 2013a, p. 700) are excluded from the diagnosis, but water jets in the hot tub would not be excluded.

"Knowledge of and appropriate consideration for normative aspects of sexual behavior are important factors to explore to establish a clinical diagnosis of fetishistic disorder and to distinguish a clinical diagnosis from a socially acceptable sexual behavior" (APA, 2013a, p. 701). This statement epitomizes the real problem with the Paraphilic Disorders as psychiatric diagnoses: We have little to no data on what constitutes normative sexual behaviors. Nonnormative sexual behaviors do not imply necessarily that these behaviors are pathological. What is normative for one culture or social group may not be in another culture or group. Psychiatric diagnoses should not change from one social milieu or location to the next.

"Typical impairments associated with fetishistic disorder include sexual dysfunction during romantic reciprocal relationships when the preferred fetish object or body part is unavailable during foreplay or coitus" (APA, 2013a, pp. 701–702). With this one statement, the APA has pathologized everyone. Sexual dysfunction during romantic reciprocal relationships secondary to lack of a sexually arousing partner is now grounds for a diagnosis. I would argue that sexual dysfunction during an interaction with a nondesired partner is not a dysfunction, but an expected outcome.

Hypersexuality

Kafka (2010) proposed to add Hypersexual Disorder to DSM-5, but the APA declined to add it as either a new diagnosis or as a condition for further study. Kafka noted that the paraphilias and hypersexual disorder were related disorders. He stated both were "associated with intense and repetitive, sexually arousing fantasies, sexual urges, and behaviors" (Kafka, 2010, p. 392).[2] He conceptualized paraphilias as focused on deviant forms of sexual arousal and hypersexual disorder as focused on normophilic sexual arousal. I have argued previously (Moser, 2013) that hypersexuality was not mentioned as a component of any of the paraphilia diagnoses in DSM-IV-TR (APA, 2000). It appears the APA "fixed" that omission by adding hypersexuality[3] to the "Development and Course" sections of Voyeuristic, Exhibitionistic, Frotteuristic, Sexual Masochism Disorders; the "Comorbidity" sections of Voyeuristic, Exhibitionistic, Frotteuristic, Fetishistic Disorders; the "Differential Diagnosis" section of Sexual Sadism Disorder; but omitted hypersexuality in text of the Pedophilic and Transvestic Disorders sections. I am unaware of any research which supports the addition of hypersexuality to the Paraphilic Disorders text, especially in this manner. Without appropriate research supporting the addition of hypersexuality, this appears to be another example of political influence on a supposedly scientific document and foreshadowing of another attempt to add this diagnosis in the future.

Hypersexual disorder is not a recognized diagnosis and currently devoid of any long-term outcome data. Therefore, it stands to reason that all treatment must be considered experimental at this time. There is no indication that the programs or individuals who treat hypersexuality have obtained Institutional Review Board approval of their experimental treatment program or informed consent from the "patients." By adding hypersexuality indirectly, the APA appears to be supporting these ethically questionable programs.

Conclusion

In any critique, a goal is to find balance, emphasizing both new problems and solutions to previously identified problems. Unfortunately, the Paraphilic Disorders chapter of DSM-5 has

[2] This is the Goldilocks Double Bind: We treat individuals with low desire trying to help those individuals develop intense sexual fantasies, urges, and behaviors, but we discourage fantasies, urges, and behaviors when they do not conform to societal expectations.

[3] Hypersexuality does not appear in the DSM-5 index, but does appear in the glossary, "A stronger than usual urge to have sexual activity" (APA, 2013a, p. 823).

few positives in comparison with its previous edition, DSM-IV-TR (APA, 2000).

The present critique highlights the logical inconsistencies in the APA's conceptualization of the paraphilias and Paraphilic Disorders in the DSM-5. It is not clear that the distinction between a paraphilia and a Paraphilic Disorder is meaningful. It is not clear that the new DSM-5 definition of a paraphilia includes paraphilias listed in DSM-5. It is not clear that the definition of a Paraphilic Disorder is consistent with the new definition of a 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 for the need for and continued inclusion of the paraphilic disorders in the DSM is lacking. Logic contradictions are strewn throughout the Paraphilic Disorders chapter, rendering the chapter uninterpretable.

The APA may suggest that the DSM is a policy and social document, as much as it is 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 the DSM-5 is a failure. The reputation of the APA as a scientific organization is in jeopardy when it uses its authority to incarcerate criminals after their sentences are completed.

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 more formal separation of a paraphilia from a paraphilic disorder may have some immediate effect on the discrimination that individuals with a paraphilia face in civil 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 are still included in the DSM. Despite many attempts, the APA has not been able to define the concepts clearly. Having a paraphilia has been used to support the discrimination (social, occupational, and legal) against those individuals so designated, despite the lack of data to support their inclusion as a mental disorder.

References

Ahlers, C. J., Schaefer, G. A., Mundt, I. A., Roll, S., Englert, H., Willich, S. N., & Beier, K. M. (2011). How unusual are the contents of paraphilias? Paraphilia-associated sexual arousal patterns in a community-based sample of men. *Journal of Sexual Medicine, 8*(5), 1362–1370. https://doi.org/10.1111/j.1743-6109.2009.01597.x.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (1996). Amicus Curiae brief of the APA in support of Leroy Hendricks, Kansas v. Hendricks. *Hendricks, 95–1649,* 95–9075.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Fourth ed., text rev.) Washington, DC: Author.

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Press.

American Psychiatric Association. (2013b). *From planning to publication: Developing DSM-5*. Downloaded September 6, 2016, from https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-Development-of-DSM-5.pdf.

American Psychiatric Association. (2013c). *Paraphilic disorders*. Downloaded October 6, 2013, from www.dsm5.org/Documents/Paraphilic%20Disorders%20Fact%20Sheet.pdf. https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets.

American Psychiatric Association. (2013d). *APA statement on DSM-5 text error*. Downloaded August 7, 2016, from http://www.dsm5.org/Documents/13-67-DSM-Correction-103113.pdf. https://www.psychcongress.com/article/apa-correct-error-dsm-5-terminology-regarding-pedophilic-disorder.

Balon, R. (2014). Politics of diagnostic criteria: Specifiers of pedophilic disorder in DSM-5 [Commentary]. *Archives of Sexual Behavior, 43,* 1235–1236.

Blanchard, R. (2009). *Paraphilias and the DSM-V: General diagnostic issues and options exemplified with pedohebephilic disorder*. Paper presented at the 19th WAS world congress for sexual health, June 25, 2009, Göteborg, Sweden. Retrieved February 17, 2014, from http://individual.utoronto.ca/ray_blanchard/index_files/WAS_DSM.html.

Blanchard, R. (2010). The DSM diagnostic criteria for transvestic fetishism. *Archives of Sexual Behavior, 39,* 363–372. https://doi.org/10.1007/s10508-009-9541-3.

Blanchard, R. (2013). A dissenting opinion on DSM-5 pedophilic disorder [Letter to the Editor]. *Archives of Sexual Behavior, 42*(5), 675–678.

Chivers, M. L., Roy, C., Grimbos, T., Cantor, J. M., & Seto, M. C. (2014). Specificity of sexual arousal for sexual activities in men and women with conventional and masochistic sexual interests. *Archives of Sexual Behavior, 43,* 931–940. https://doi.org/10.1007/s10508-013-0174-1.

Diamond, L. M. (2009). *Sexual fluidity: Understanding women's love and desire*. Cambridge, MA: Harvard University Press.

Diamond, L. M. (2013). *Just how different are female and male sexual orientation?* Retrieved July 31, 2016, from Cornell University, Human Development Outreach and Extension Program. http://www.cornell.edu/video/lisa-diamond-on-sexual-fluidity-of-men-and-women.

Fedoroff, J. P., Di Gioacchino, L., & Murphy, L. (2013). Problems with paraphilias in the DSM-5. *Current Psychiatry Reports, 15*(8), 363. https://doi.org/10.1007/s11920-013-0363-6.

First, M. B. (2014). DSM-5 and paraphilic disorders. *Journal of the American Academy of Psychiatry and the Law, 42,* 191–201.

Francis, A. (2011). DSM-5 rejects coercive paraphilia: Once again confirming that rape is not a mental disorder. *Psychiatric Times*. Downloaded September 7, 2016, from http://www.psychiatrictimes.com/blogs/dsm-5-rejects-coercive-paraphilia-once-again-confirming-rape-not-mental-disorder.

James, P. A., Oparil, S., Carter, B. L., Cushman, W. C., Dennison-Himmelfarb, C., Handler, J., et al. (2014). 2014 evidence-based guideline for the management of high blood pressure in adults: Report from the panel members appointed to the Eighth Joint National Committee (JNC 8). *Journal of the American Medical Association, 311*(5), 507–520. https://doi.org/10.1001/jama.2013.284427.

Joyal, C. C., Cossette, A., & Lapierre, V. J. (2015). What exactly is an unusual sexual fantasy? *Journal of Sexual Medicine, 12,* 328–340. https://doi.org/10.1111/jsm.12734.

Kafka, M. P. (2010). Hypersexual disorder: A proposed diagnosis for DSM-V. *Archives of Sexual Behavior, 39,* 377–400.
Khan, U. (2014). *Vicarious kinks: S/M in the socio-legal imaginary*. Toronto: University of Toronto Press.
Kleinplatz, P. J., & Moser, C. (2005). Is S/M pathological? *Lesbian & Gay Psychology Review, 6*(3), 255–260.
Krueger, R. (2010). The DSM diagnostic criteria for sexual sadism. *Archives of Sexual Behavior, 39,* 325–345. https://doi.org/10.1007/s10508-009-9586-3.
Langevin, R., Lang, R. A., & Curnoe, S. (1998). The prevalence of sex offenders with deviant fantasies. *Journal of Interpersonal Violence, 13*(3), 315–327.
Långström, N. (2010). The DSM diagnostic criteria for exhibitionism, voyeurism, and frotteurism. *Archives of Sexual Behavior, 39*(2), 317–324.
Moser, C. (2001). Paraphilia: A critique of a confused concept. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (pp. 91–108). Philadelphia: Brunner-Routledge.
Moser, C. (2002). Are any of the paraphilia in the DSM mental disorders? *Archives of Sexual Behavior, 31*(6), 490–491.
Moser, C. (2009). When is an unusual sexual interest a mental disorder? *Archives of Sexual Behavior, 38*(3), 323–325.
Moser, C. (2010). Problems with ascertainment [Letter to the Editor]. *Archives of Sexual Behavior, 39*(6), 1225–1227.
Moser, C. (2011). Yet another paraphilia definition fails [Letter to the Editor]. *Archives of Sexual Behavior, 40*(3), 483–485.
Moser, C. (2013). Hypersexual disorder: Searching for clarity. *Sexual Addiction & Compulsivity, 20,* 48–58.
Moser, C. (2016). Defining sexual orientation [Commentary]. *Archives of Sexual Behavior, 43*(3), 505–508. https://doi.org/10.1007/s10508-015-0625-y.
Moser, C., & Kleinplatz, P. J. (2002). Transvestic fetishism: Psychopathology or iatrogenic artifact? *New Jersey Psychologist, 52*(2), 16–17.
Moser, C., & Kleinplatz, P. J. (2005a). DSM-IV-TR and the paraphilias: An argument for removal. *Journal of Psychology and Human Sexuality, 17*(3/4), 91–109.
Moser, C., & Kleinplatz, P. J. (2005b). Does heterosexuality belong in the DSM? *Lesbian & Gay Psychology Review, 6*(3), 261–267.
Müller, K., Curry, S., Ranger, R., Briken, P., Bradford, J., & Fedoroff, J. P. (2014). Changes in sexual arousal as measured by penile plethysmography in men with pedophilic sexual interest. *Journal of Sexual Medicine, 11*(5), 1221–1229. https://doi.org/10.1111/jsm.12488.
Quinsey, V. L. (2010). Coercive paraphilic disorder. *Archives of Sexual Behavior, 39,* 405–410. https://doi.org/10.1007/s10508-009-9547-x.
Shindel, A. W., & Moser, C. (2011). Why are the paraphilias mental disorders? *Journal of Sexual Medicine, 8*(3), 927–929.
Singy, P. (2015). Hebephilia: A postmortem dissection. *Archives of Sexual Behavior, 44*(5), 1109–1116.
Spitzer, R. L. (2005). Sexual and gender identity disorders: Discussion of questions for DSM-V. *Journal of Psychology & Human Sexuality, 17*(3/4), 111–116.
Wakefield, J. C. (2011). DSM-5 proposed diagnostic criteria for sexual paraphilias: Tensions between diagnostic validity and forensic utility. *International Journal of Law and Psychiatry, 34*(3), 195–209.
Wright, S. (2014). Kinky parents and child custody: The effect of the DSM-5 differentiation between the paraphilias and paraphilic disorders [Commentary]. *Archives of Sexual Behavior, 43*(7), 1257–1258. https://doi.org/10.1007/s10508-013-0250-6.