

Paraphilic Diagnoses in DSM-5

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ABSTRACT

Background: The DSM-5 has been under revision since 1999 and is scheduled for publication in 2013. This article will review the major proposed modifications of the Paraphilias.

Method: The information reviewed was obtained from PubMed, PsychInfo, the DSM-5.org website and other sources and reviewed.

Results: Pedohebephilia, Hypersexual Disorder and Paraphilic Coercive Disorder are new proposed diagnoses. Paraphilias have been assigned their own chapter in DSM-5 and a distinction has been made between Paraphilias and Paraphilic Disorders. Victim numbers have been included in diagnosis of paraphilias that involve victims and remission and severity measures have been added to all paraphilias. Transvestic Disorder can apply to males or females, Fetishistic Disorder now includes partialism, and Sexual Masochism Disorder has Asphyxiophilia as a specifier.

Limitations: This study is based on a literature review and influenced by the knowledge and biases of the authors.

Conclusions: The Paraphilic Disorders Section of the DSM-5 represents a significant departure from DSM-IV-TR.

scheduled for publication in May of 2013 (2). Major changes are being proposed for both the specific criteria and for the overall organizational structure of The Diagnostic and Statistical Manual of Mental Disorders (1, 3). The paraphilias are no exception to these changes (4). Significant controversy has surrounded both the DSM-5 (5) and its proposed revisions for paraphilic diagnoses (6). This article will review the major revisions proposed for the paraphilic disorders as well as some of the significant criticisms.

METHOD

A literature search was conducted on PubMed and PsychoInfo databases from the year 1990 through April of 2011. The search used search terms of “paraphilias,” “exhibitionism,” “voyeurism,” “frotteurism,” “sadism,” “masochism,” “fetishism,” “transvestic fetishism,” “paraphilia-related disorder,” “hypersexual,” “hypersexuality,” “sexual addiction,” “sexual compulsion,” “paraphilic coercive disorder,” “hebephilia,” “pedophilia,” and “paraphilic rape.” Titles and/or abstracts were inspected to ascertain if the article contained criticisms relevant to the current DSM-5. Relevance was ascertained by any mention of any of the Diagnostic Manuals, or by reference to criticism or diagnostic criteria in their title and/or abstracts. In addition, the authors drew upon, in an unsystematic way, secondary references, textbooks, textbook chapters, and newspaper articles that commented on the DSM or DSM-5. Finally, the DSM-5.org website was consulted extensively. Inevitably, the selection of articles was influenced by the experience and biases of the authors, but an attempt was made to present both positive and negative criticism on the major issues in a balanced way.

BACKGROUND

The revision of The Diagnostic and Statistical Manual of Mental Disorders began in 1999 (1) and DSM-5 is

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RESULTS

Proposed Changes Affecting All or Several of the Paraphilias

1. PROPOSED SEPARATE CATEGORIZATION FOR THE PARAPHILIAS

A significant proposed change is that the diagnostic category of Paraphilias has been moved from within the section of Sexual and Gender Identity Disorders in DSM-IV-TR to its own separate section, coequal with other disorders. Two new diagnoses, Paraphilic Coercive Disorder and Hypersexual Disorder, have been proposed for consideration for inclusion in the appendix (4, 7).

2. PARAPHILIAS VS. PARAPHILIC DISORDERS

A second change that affects all of the paraphilias is the distinction between paraphilias and paraphilic disorders. A paraphilia (8) corresponds to the A criteria, which define an atypical or deviant sexual interest, and would be “ascertained” according to the A criteria. However, to qualify for a diagnosis, the B criteria, which specify clinically significant distress or impairment, or, in the case of paraphilias which involve a victim (exhibitionism, frotteurism, pedophilia, sexual sadism and voyeurism) also include a specification that a person has acted on these sexual urges with a nonconsenting individual, must in addition be fulfilled.

Blanchard argued that this distinction would be useful to researchers in that “It would prevent a paraphilia from becoming invisible to clinical science just because it lacks any secondary effect of disturbing the individual or others” (9, p. 307). Thus, researchers could contemplate epidemiological studies of alternative sexual interest patterns using the DSM-5 A criteria without the necessity that these would be disorders. Further, this new conceptualization addresses some of the concerns raised by groups advocating for those with paraphilic sexual interests, such as the National Coalition for Sexual Freedom, who demand that paraphilias be removed entirely from the DSM because their inclusion is stigmatizing, by listing these non-disordered paraphilias in the “Other Conditions That May Be a Focus of Clinical Attention” chapter of DSM-5 (10). Indeed Wright (11) described a child custody case in which the proposed revisions for DSM-5 were cited and a mother, involved with sexual sadism, was allowed to keep her children.

First (10) opined that this distinction “has strong conceptual and practical advantages” (p. 250). Wakefield (12) referred to this as a “welcome but more a terminological revision rather than an actual change in the criteria” (p. 203) and noted that this distinction had been implicitly recognized since DSM-III-R.

Others have been more critical. Moser, writing about the non-criminal paraphilias (13), suggested that “ascertainment” would not prevent misuse of these paraphilic diagnostic categories, and the impression that one had been “diagnosed” with such a paraphilia. Fedoroff (14) wrote that if an ascertained paraphilic interest was not causing any dysfunction, then it was not a mental disorder and should not be contained in the DSM at all. Further, he wrote that once a person’s paraphilic interest was ascertained, it would be difficult to imagine that he would not be considered as being diagnosed. O’Donohue (15) questioned the meaning and implications of the term “ascertained” and said that its use doubled the psychometric problems of the DSM because it would now have to ask questions about the reliability and validity not only of diagnosis, but also of ascertainment.

3. VICTIM NUMBER

The Paraphilias Subworkgroup suggested another broad change; this involved including a specific victim number in the B criteria for those disorders involving nonconsenting persons. Several rationales were given (8). One was that since the majority of patients evaluated were referred after a criminal offense they were not reliable historians. A reliance on a specific victim number, contained in criminal records, would lessen the dependence on self-report of urges and fantasies. A second rationale was that the words “recurrent” and “intense” in the DSM-IV-TR A criteria had been criticized as being too vague to be useful (16) and requiring a minimum number of victims would increase the certitude in diagnosing these disorders in non-cooperative patients.

This reliance on victim count has been vigorously criticized, especially in light of the requirements for data set forth as a precondition for criterion change in the DSM, which require, for a substantial change, that there be a broad consensus of expert clinical opinion, that there be empirical support from a number of validators, and that such change should not be based solely on reports from a single researcher or research team (17). First (18) reviewed the proposals for including a specific victim count, and found that for all of the disorders,

only a single study (20) was cited as justification for adopting a diagnostic threshold involving victims.

Another line of criticism against victim number has been that a requirement for a minimum number of victims would result in false negatives. In the case of Pedohebophilia, for instance, an individual who had abused only one child for at least 6 months would not necessarily make criteria for this diagnosis under DSM-5 (15). O'Donohue (15) also raised the question of why the unit of analysis was the victim, as opposed to the number of abusive incidents. On the other hand, Wakefield (12) expressed that setting such a threshold was a positive step against making false positive diagnoses.

4. REMISSION

The term "In Remission" has been added to the diagnostic criteria for each of the paraphilias. In fact, DSM-IV-TR allowed for the use of "in partial remission" or "in full remission" for most disorders (20, p. 2), but these were not specifically included as part of the diagnostic criteria for any of the paraphilias. The designation of remission also can only be given if the patient is in an uncontrolled environment; otherwise, a notation is made that the patient is in a controlled environment.

5. SEVERITY MEASURES

DSM-5 has required dimensional ratings for all of its disorders (21-23) and these have been added for the paraphilias. Both clinician-rated and patient-rated severity measures have been suggested. The clinician rating scales involve a rating over the past two weeks, comparing paraphilic with normophilic interests and behaviors. These ratings range from 1 (mild), where the paraphilic sexual fantasies, urges or behaviors are weaker than normophilic sexual interests and behaviors (8), to 4 (very severe) where the paraphilic urges completely replace normophilic sexual interests and behaviors. In concert with the rest of DSM-5, there are also patient self-rating measures (8).

These severity ratings represent a substantial change from DSM-IV-TR, where there were guidelines for severity that could be applied to all of the diagnoses, but which only consisted of "mild," "moderate," and "severe" (20, p. 2). These new dimensional questions are clear and offer reasonable metrics which could help quantify the degree of severity of a paraphilia and which could be psychometrically validated. In fact, there are currently no validated instruments for rating the severity

of a paraphilia and these scales offer a significant step towards providing such scales.

PROPOSED CHANGES AFFECTING SPECIFIC PARAPHILIAS

1. PEDOHEBEPHILIC DISORDER

Perhaps the most controversial of the proposed paraphilic diagnoses in DSM-5 concerns Pedophilia. The Paraphilias Subworkgroup has recommended renaming Pedophilia to Pedohebephilic Disorder and expanding its definition to include hebephilia, which is a sexual desire for early pubescent children. In DSM-IV-TR, Pedophilia referred to an interest only in a prepubescent child or children, and the proposed revision for DSM-5 would expand this to include pubescent children.

Blanchard set forth the rationale for these changes (9, 24, 25) which were also listed on the DSM-5 website (26). The principal reasons given were: hebephilia and pedophilia are similar, with both involving attraction to immature persons; many men do not differentiate between prepubescent and pubescent children; many individuals who offend against pubescent children are being diagnosed as pedophilic anyway; and this change would harmonize the DSM with the ICD definition of Paedophilia, which is "A sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age" (ICD-10 F65.4. . .)" (26).

Some critics have asserted that such a definition pathologizes legal behavior, where, in much of the world, legal consent would permit sexual relations with pubescents, and that psychiatry is becoming an agent of social control (27, 28). Frances and First (29) wrote that the merger of pedophilia and hebephilia within the same diagnosis could be justified if there was empirical evidence demonstrating that across high-priority validators, such as familial aggregation, diagnostic stability, course of illness or response to treatment, these two conditions were identical; unfortunately, they could find no such studies. They also pointed to several studies (30-32) demonstrating that sexual arousal to pubescent individuals was common and within the range of normality. Finally, they suggested that because of the blurry dividing line between pubescent and prepubescent children, diagnosis would become more difficult and diagnostic reliability compromised. Others from the United States have argued that the extension of pedophilia to hebephilia is a back-door way of trying

to expand the scope of diagnoses that can be utilized in civil commitment procedures (where individuals with a severe history of sexual offenses can be committed indefinitely to a treatment facility)(12, 33). Wakefield (12) opined of this suggested change, "In sum, the hebephilia proposal is probably the Workgroup's most flawed and blatantly over-pathologizing paraphilia proposal. Hebephilia as a diagnosis violates the basic constraint that disorder judgments should not be determined by social disapproval. This is a case where crime and disorder are being hopelessly confused (p. 206)." Blanchard responded to these criticisms, saying that the criteria as they stand in DSM-IV-TR "would exclude from diagnosis a sizable proportion of those men whose strongest sexual feelings are for physically immature persons" and reviewed substantive research which supports this proposed change (34, p. 334).

Another novel aspect of the proposed criteria for Pedohebephilic Disorder is the inclusion of child pornography in the criteria. According to the DSM-5 website, the rationale for the addition of this is that "Some research indicates that child pornography use may be at least as good an indicator of erotic interest in children as 'hands-on' offenses" (26). A 2006 study by Seto, Cantor and Blanchard (35) compared phallometric testing on 100 offenders arrested for charges involving child pornography with 178 sex offenders with child victims and demonstrated significantly greater arousal to children on the part of the child pornography offenders than on the part of the offenders against children. It is also makes intuitive sense that a person's pornography preference may be a more accurate indicator of his underlying sexual interest than other factors because "people opt for pornography that corresponds to their sexual interests" (36). However, First (10) analyzed this criterion and suggested that its inclusion as a B criterion, where use of it could lead to severe negative consequences because of its illegal nature, made it dependent on the particular legal system in which a patient might reside. This jurisdiction might not consider certain sorts of child pornography, such as virtual child pornography, where rendering did not involve any actual children, as illegal, and thus would not allow the person to fulfill the negative function of criterion B. Further, he pointed out this criterion was based on one study from one group, which may not at all be typical (10). Other studies have found that only a minority of individuals arrested for child pornography meet criteria for pedophilia (37, 38).

Finally, it should be noted that there are two ongoing studies, not funded or officially sanctioned by the American Psychiatric Association (39, 40), which should produce data to compare the DSM-IV-TR diagnostic criteria with the proposed DSM-V criteria. These studies, it should be noted, represent a substantial improvement over the studies supporting previous manuals. These studies represent a significant improvement over prior studies for the paraphilias in the DSM. Blanchard (41) summed the total of all patients studied in conjunction with prior revisions of the DSM involving paraphilias; there were only three.

2. PARAPHILIC COERCIVE DISORDER

The DSM-5 Subworkgroup has proposed Paraphilic Coercive Disorder for inclusion in the appendix. This disorder (42) would apply to men who obtained sexual arousal from sexual coercion and were not sexual sadists. The suggestion of this disorder for the DSM is not new; in 1985 the DSM-III Workgroup proposed the diagnosis of paraphilic rapism (43), which was extensively criticized at the time.

This proposed disorder has continued to draw criticism, especially in the United States, where it is seen as a diagnosis with little empirical support and one which could enable civil commitment, by expanding the number of diagnoses which could be used as a basis for commitment (44, 45). Indeed, a vote taken following a debate before forensic psychiatrists in Arizona in October of 2010 overwhelmingly decided against inclusion of the new paraphilic coercive disorder (along with pedohebephilia and hypersexual disorder) in the DSM-5 (44). On the other hand, Stern (46) suggested that this diagnosis would replace the misuse of Paraphilia Not Otherwise Specified diagnoses with specific criteria, which would lessen the likelihood of inappropriate diagnoses. Research continues to suggest that there are unique features to sexually coercive men (47) and field trials of this disorder examining both diagnostic reliability and validity are underway (40).

3. HYPERSEXUAL DISORDER

A third controversial diagnosis suggested by the DSM-5 Paraphilias Subworkgroup is Hypersexual Disorder (48). This disorder, which is now listed in the Sexual Dysfunctions part of the DSM-5 website and which is being considered for the appendix (49), identifies recurrent and intense normophilic sexual fantasies, urges, and behavior as being pathological if they are

excessively time consuming, in response to stress or dysphoric moods, cannot be controlled, disregard the risk of harm to others and cause distress or impairment in functioning.

This disorder has evoked much criticism. Zonana (50) noted that hypersexuality was a symptom, not a disorder, in DSM-IV, and both he and Fedoroff (14) opined that these criteria could easily apply to almost any adult who was sexually active. Halpern (51) asserted that this diagnosis medicalized aberrant sexual activity, was redundant, lacked an empirical base, and would result in false positive diagnoses. Moser (52) criticized this diagnosis as being “based on faulty and inconsistent logic, imprecise criteria, historical inaccuracies, and poorly conceived constructs” (p. 229).

4. TRANSVESTIC DISORDER

DSM-5 has (53) proposed changes in the criteria for this disorder so as to allow females to be so diagnosed and added specifiers of fetishism (being sexually aroused by fabrics, materials, or garments), autogynephilia (being aroused by the thought or image of oneself as female), and autoandrophilia (being aroused by the thought or image of self as male). Swedish health officials removed transvestism from the official list of diseases and mental disorders (54) and others have called for its removal from the DSM because they do not believe it is a mental illness (55). However, the World Professional Association for Transgender Health (WPATH), after a consensus process, advised retaining the diagnosis, albeit with some change in the criteria (56).

4. FETISHISTIC DISORDER

Fetishistic Disorder has undergone modest changes, expanding the diagnosis to include an interest in non-erogenous body parts in addition to an interest in non-living objects. Kafka (57) reviewed the literature for fetishism and found that for most of the history of this disorder it had been characterized by persistent arousal to both non-living objects and nonerogenous body parts (referred to as partialism). Accordingly, Fetishism was revised from its previous criteria which specified sexual arousal only towards nonliving objects to include “sexual arousal from either the use of non-living objects or a highly specific focus on non-genital body part(s) . . .” (58). Although this disorder has not received as much criticism as others, some have argued for its removal from the ICD-10 (59) because it stigmatizes those practicing these behaviors.

6. SEXUAL MASOCHISM DISORDER

Sexual Masochism, aside from the generic changes described earlier to the paraphilias, has remained largely unchanged, with the exception that the Specifier “With Asphyxiophilia (Sexually Aroused by Asphyxiation)” was added and the phrase “Real, not simulated” was deleted from the criteria, as it did not appear to add any real distinction and no rationale could be found for this in the literature (60). Hypoxyphilia, or the production of sexual excitement by asphyxia, was found in several studies on Sexual Masochism; the Paraphilias Subworkgroup discussed this and asked for an analysis of the literature by Hucker (61, 62). This concluded that individuals engaging in this behavior obtained sexual arousal mainly through restriction of breathing, originally termed “asphyxiophilia” by Money (63) and therefore this specification was added. This change was criticized by Fedoroff (14) as failing to distinguish between those who were aroused by being asphyxiated and those who were aroused by asphyxiating others. Shindel and Moser (64), citing lack of evidence that sexual masochism was harmful and asserting that continuing the diagnosis in the DSM continued the harmful labeling effect of this disorder, have called for its frank exclusion from the DSM.

LIMITATIONS

The main limitation of this study is the fact that it is a literature review, which is influenced by the knowledge and biases of the authors. Additionally, the paraphilias have not had the funding, research base, or development of scientific studies that other areas of psychiatry have enjoyed. Thus, many of the studies upon which the knowledge base of the paraphilias is based are drawn from samples of convenience, not from epidemiologically sound samples, and subject to bias. Finally, much of the data for this study was retrieved from the DSM-5 website, which has been revised and will continue to be revised as new information and feedback on the proposed criteria is obtained and responded to. Nevertheless, this article represents a comprehensive “snapshot” of the current major proposed changes in the DSM-5 Paraphilic Disorders at a late stage in their development.

CONCLUSIONS

The Paraphilic Disorders Section of the DSM-5 represents a significant departure from DSM-IV-TR. Many

changes have been proposed, including listing the paraphilias as a separate chapter in the DSM, making a distinction between Paraphilias and Paraphilic Disorders, requiring a specific victim number for those paraphilias that involve nonconsenting persons, including remission specifiers in the paraphilic diagnoses, and specifying severity measures for each of the paraphilias. Two major new diagnoses have been proposed for the appendix, Paraphilic Coercive Disorder, and Hypersexual Disorder, and a major change to an existing diagnosis, Pedohebephilic Disorder, has been suggested. More modest changes have been proposed for Transvestic Disorder, Fetishistic Disorder, and Sexual Masochism Disorder. All of these modifications have evoked considerable criticism and controversy. However, such controversy is not new to this field (65) and hopefully the criteria, which are still in a process of refinement and may still be revised (66), will be the better for it.

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