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Paraphilia NOS and Sexual Disorder NOS[1]

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Abstract: Although the current psychiatric diagnostic manual, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*; American Psychiatric Association, 2000), includes a claim that it "reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication," it does not show a clear consensus regarding whether and how clinicians should address diagnosis of patterns of sexual functioning that involve attraction to pubescent humans, post-pubescent minors, and non-consensual sex. When forensic psychologists testify in cases such as the federal Adam Walsh Act or states' sexually violent predator (SVP) acts, they disagree not only about whether a person with a particular pattern of behavior meets legal criteria for classification as a sexually dangerous person, they also disagree about what the *DSM* defines as mental disorders. The author addresses proposed changes for *DSM-V* and suggests guidance for forensic evaluators using *DSM-IV-TR* in current legal cases.

Keywords: *DSM-IV-TR*, *DSM-V*, paraphilia, hebephilia, sexual disorder, forensic psychology, sexually violent predator, Adam Walsh Act

I. Introduction

Recently, as I was working on a forensic report regarding the question of whether a particular person meets criteria for civil commitment as an SVP, two items of interest appeared in my email inbox. One item is the decision in a federal legal case. The other is a presentation by the chair of the subworkgroup developing proposals for the next edition of the American Psychiatric Association's diagnostic manual, *DSM-V.* In this article, I note that the current manual does not provide useful guidance regarding some important questions about the diagnosis of paraphilias and other sexual disorders, I comment on proposed definitions and criteria for *DSM-V,* and I provide some guidance for forensic evaluators using *DSM-IV-TR* in current legal cases.

[1] Associate Editor's Note: This manuscript was submitted by the journal's editor and publisher. I supervised peer review, which was conducted by independent reviewers who were "blind" to the authorship of the article.

[2] Author's Note: Thanks to the anonymous reviewers who provided very helpful guidance.

II. *United States v. Carta*

The Introduction to the Court's decision in *U.S. v. Carta*, District of Massachusetts Civil Action No. 07-12064-JLT, June 4, 2009, (pp. 1-2)[3] includes the following:

> Petitioner the United States of America ("the Government") instituted this civil action on March 9, 2007, seeking to commit Todd Carta ("Respondent") as a "sexually dangerous person" pursuant to the Adam Walsh Child Protection and Safety Act of 2006 ("the Act"). . . .
>
> To commit Respondent, the Government must prove by clear and convincing evidence that Respondent is a sexually dangerous person, which the Act defines as "a person who has engaged or attempted to engage in sexually violent conduct or child molestation and who is sexually dangerous to others." An individual is "sexually dangerous to others" under the Act if he "suffers from a serious mental illness, abnormality, or disorder as a result of which he would have serious difficulty in refraining from sexually violent conduct or child molestation if released."
>
> This court held a three-day bench trial on this matter beginning on February 9, 2009. . . . This court concludes that the Government has failed to establish by clear and convincing evidence that Respondent currently suffers from a serious mental illness, abnormality, or disorder as required by the Act.

The written decision provides some information about Mr. Carta. He committed numerous sexual offenses over the course of his adult life, engaging in sexual behavior with teenaged males and females. He was never arrested for any of his sexual contact with minors. (It seems likely that the accounts of his sexual contact with minors come from him, including statements he made while in voluntary sex-offender treatment during his imprisonment.) Mr. Carta was arrested and convicted for the possession of child pornography, which is why his was a federal case. Mr. Carta pled guilty to Transportation of Child Pornography in 2002 and was sentenced to 60 months in prison and three years of supervised release. During his incarceration, he voluntarily participated in sex-offender treatment for seven months, but he did not complete the treatment program.

At Mr. Carta's civil-commitment trial, two experts testified, each using the *DSM-IV-TR* to diagnose Mr. Carta. The experts disagreed about whether Mr. Carta met criteria for a particular *DSM-IV-TR* diagnosis. More important for our purposes, the experts disagreed about what the words in *DSM-IV-TR* mean regarding the diagnosis of paraphilia

[3] See http://pacer.mad.uscourts.gov/dc/opinions/tauro/pdf/us%20v%20carta%20findings%20of%20fact%20and%20conclusions%20of%20law%20memorandum.pdf or http://tinyurl.com/os3o76.

for an adult who is sexually attracted to teenagers. Excerpts of the Court's findings include the following (pp. 12-14)[4]:

> The focus of Dr. P's[5] testimony, and the key issue in this case, is her diagnosis of "paraphilia NOS: hebephilia." The term "paraphilia" refers to an individual who experiences over a period of at least six months intense, recurrent, sexually arousing fantasies, urges, or behavior involving: (1) nonhuman objects; (2) humiliation of oneself or one's partner; or (3) children and other non-consenting persons. The *DSM-IV-TR* lists specific categories of paraphilia, such as pedophilia and sadism, but paraphilia NOS is the term used for "paraphilias that do not meet the criteria for any of the specific categories."
>
> Dr. P diagnosed Respondent with paraphilia NOS because of his "long-standing sexual arousal to post-pubescent boys." In her opinion, the term "children," as it appears in the paraphilia NOS diagnostic criteria, includes post-pubescent teenagers who have not attained the age of majority. The term "hebephilia" does not appear in the *DSM-IV-TR,* but Dr. P testified that it is an accepted term in the field and that it has appeared in peer reviewed articles. According to Dr. P, the term "hebephilia" denotes, not sexual arousal to prepubescent children, but sexual preference for "young teens . . . 'til about age seventeen." "Hebephilia" is not Dr. P's diagnosis, however, but is merely a descriptor of Respondent's paraphilia NOS because Respondent's condition does not fit a specific paraphilia category in the *DSM-IV-TR.*
>
> Dr. P based the diagnosis on Respondent's admissions that "he has acted out as an adult with thirteen-year-old children"; his history of seeking out fourteen- to eighteen-year-old teenagers on the internet and engaging in sex with them; his self-report that his primary sexual interest was in post-pubescent boys; and his possession of pornography mostly depicting children in the twelve- to seventeen-year-old age range. Dr. P testified that Respondent's paraphilia NOS qualifies as a serious mental illness, abnormality, or disorder because he was so fixated on his sexual interest in teenagers that "he has not been able to function as a normal human being."

The judge's description shows that Dr. P was able to read the words in *DSM-IV-TR* and, along with her other knowledge, training, and experience, explain what the words

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[4] The Court's decision is quoted at length because it shows how the judge thought about the testimony presented by the experts in the case.

[5] The testifying expert witness's names are not mentioned here because they are not important to the subject of the article and might be somewhat distracting. The same procedure is followed regarding the names of the judge and other witnesses. Interested readers can find the names in the court decision. For the readers' convenience, names of researchers are included here.

meant, and apply them to the case at hand. Excellent! That is just what we would hope from a diagnostic manual. If other experts reliably understand the words in *DSM-IV-TR* to mean the same thing—and if that meaning is what was intended by the writers of *DSM-IV-TR*—then the paraphilia section of the diagnostic manual is working well. So, what happened when the other expert in the case testified? The following is from pages 14-15 of the court's decision regarding Mr. Carta:

> Dr. B testified that neither "hebephilia" nor "paraphilia not otherwise specified" with a descriptor of "hebephilia" is a valid diagnosis. The first problem Dr. B identified with the diagnosis is that adolescents do not qualify as "children or non-consenting persons" within the meaning of the paraphilia diagnostic criteria. He maintained that the *DSM-IV-TR* makes clear that "children" refers to prepubescent youths and that "non-consenting" does not refer to legal consent. Second, Dr. B testified that the omission of hebephilia from the *DSM-IV-TR* indicates that it is not generally accepted in the psychiatric and psychological community. Third, Dr. B testified that hebephilia cannot be consistently defined and therefore has no consistent criteria that can be assessed and evaluated. Fourth, Dr. B testified that normal adults with no sexual offending histories find sexually mature adolescents arousing. Finally, Dr. B testified that the articles proffered by the Government in support of Dr. P's hebephilia diagnosis do not qualify as legitimate, peer-reviewed research.

After hearing testimony from the experts and other evidence, the judge in Mr. Carta's case needed to decide, among other things, whether the government had met its burden to show by clear and convincing evidence that Mr. Carta, at the time of the trial, suffered from a serious mental illness, abnormality, or disorder as a result of which he would have serious difficulty refraining from sexually violent conduct or child molestation if he were released. Of course, a diagnostic and statistical manual does not directly match state or federal statutes about what constitutes a mental disorder. But as a relevant step, the judge in *Carta* considered the experts' testimony and found no consistency *within DSM-IV-TR's diagnostic scheme* regarding

a. whether hebephilia or paraphilia NOS (hebephilia) is a mental disorder (p. 24),
b. exactly what the criteria for a diagnosis of hebephilia or paraphilia NOS (hebephilia) are or would be (p. 26), and
c. whether a diagnosis of hebephilia or paraphilia NOS (hebephilia) is supported by research in the field of psychology (28).

The judge considered those and other matters relevant to Mr. Carta's case and concluded (p. 31), "that the Government has failed to meet its heavy burden of proving by clear and convincing evidence that Respondent's sexual interest in pubescent and postpubescent adolescents qualifies as a serious mental illness, abnormality, or disorder within the meaning of the Act."

Comment. Authors of the American Psychiatric Association's diagnostic manuals (*DSM*) have, of course, recognized that testifying experts and courts use whatever version of *DSM* is current at the time to aid in decision making. Not just courts and testifying experts, but the authors of *DSM* also, have pointed to *DSM* as being useful for judicial decision making, and as reflecting a consensus of professional opinion:

> In most situations, the clinical diagnosis of a *DSM-IV* mental disorder is not sufficient to establish the existence for legal purposes of a "mental disorder," "mental disability," "mental disease," or "mental defect." In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the *DSM-IV* diagnosis. . . . It must be noted that *DSM-IV* reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication. . . . When the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, *DSM-IV* may facilitate the legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual (American Psychiatric Association, 2000, pp. xxx-xxxiii).

I consider the judge's findings in *Carta* to be quite reasonable (I strongly encourage interested readers to read the full decision). *DSM-IV-TR* provides clear guidance regarding the diagnoses of some sexual disorders (e.g., Pedophilia, Exhibitionism, and Premature Ejaculation), but *DSM-IV-TR* is vague regarding some patterns of sexual functioning that are important considerations in some current legal cases. With *DSM-IV-TR,* the diagnostic labels, criteria, descriptive text, and mentioned research do not provide a clear basis for general understanding of a diagnosis of hebephilia. It is neither specifically included nor excluded. There is room for an individual practitioner to use paraphilia NOS to encompass hebephilia, as did one expert who testified in *Carta.* There is also room for an individual practitioner to conclude that hebephilia is not a paraphilia within the *DSM-IV-TR* diagnostic scheme, which is how another expert in the case testified.

I consider the *Carta* decision to be an excellent illustration of a crisis in current psychodiagnosis. Although the authors of *DSM-IV-TR* tell us, "*DSM-IV* reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication," at this time it fails to provide guidance regarding whether certain patterns of sexual functioning constitute a mental disorder; if so, what the disorder should be labeled (e.g., paraphilia NOS versus sexual disorder NOS); and what specific criteria should be used to determine whether a particular person meets criteria for having a specific disorder.

The judge in *Carta* considered recent research and commentary regarding a diagnosis of hebephilia (Blanchard, 2009; Blanchard, Lykins, Wherrett, Kuban, Cantor, Blak, Dickey, & Klassen, 2009; DeClue, 2009; Franklin, 2009; Janssen, 2009; Moser, 2009; Plaud, 2009; Tromovitch, 2009; and Zander, 2009). Questions about consensus regarding diagnosis parallel those regarding a diagnosis of paraphilia NOS (rape) or paraphilia NOS (non-consent) (see, e.g., Cauley, 2007; DeClue, 2006, 2007; First & Halon, 2008; Sreenivasan, Weinberger, & Garrick, 2003; Vognsen & Phenix, 2004).

In the next section, we consider how the developers of *DSM-V* could address issues of consensus, labeling, and diagnostic criteria regarding such patterns of sexual functioning.

III. Blanchard's Proposal Regarding *DSM-V*

At the time of this writing (June 2009), a subworkgroup of the American Psychiatric Association is preparing a proposal for the paraphilia section of *DSM-V.* The subworkgroup's work is likely to largely shape the paraphilia section of *DSM-V.* By design, the subworkgroup works somewhat secretively, but members are encouraged to give public talks (Blanchard, personal communications, June 8, 2009) and the subworkgroup chair has posted one such public talk at the Annual Meeting of the Society for Sex Therapy and Research in Arlington, Virginia, in April 2009 (Blanchard, 2009). Commenting about a work in progress is in some ways inefficient[6] but, because the work is done somewhat secretively, it might be a serious mistake to withhold comments until the proposal has been finalized. At the time of this writing, Blanchard's presentation is, as far as I know, the only publicly available clue regarding the possible form and content of the paraphilia section of *DSM-V.* At this point, those reading this article online are encouraged to open Blanchard's presentation in a new browser or tab and toggle back and forth as needed. (The reader will probably not be able to fully understand this section of the current paper without taking the time to refer to Blanchard's presentation.) Here, we will focus primarily on Slides 2 – 11.

A. Alternative Definitions of Paraphilia

In Slides 2 – 3, Blanchard introduces alternative methods of defining paraphilias:

- *Option 1 – Concatenation:* The essential features of a paraphilia are recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, 3) children or other non-consenting persons, or 4) an atypical focus involving human subjects (self or others) that occur over a period of at least 6 months.

[6] In the public talk, Blanchard cautioned: "It is important for me to stress that I am presenting options for possible changes to the *DSM*. We are just beginning the process of soliciting feedback on these options, and the diagnostic criteria that finally appear in print may bear little or no relation to the possibilities that I am about to show you."

- *Option 2 – Exclusion:* The term *paraphilia* denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, consenting adult human partners.

In Slide 4, Blanchard provides examples for the Definition by Exclusion:

- *Not paraphilic:* e.g., cunnilingus; fellatio; anal penetration with finger, penis, or dildo; anilingus; intracrural intercourse; cross-masturbation; kissing; and fondling

- *Paraphilic:* e.g., enemas; feces or urine; generalized sexual interest in amputees, paralyzed persons, physical deformities; bondage; whipping; cutting; hypoxia; sneezing or smoking persons; obscene telephone calls

Blanchard mentions two problems with the Definition by Concatenation: "The first is that it would have to be even longer [in *DSM-V* than it is in *DSM-IV-TR*] to cover all the phenomena that are currently diagnosed as paraphilia NOS—Not Otherwise Specified. The second is that it is intellectually rather empty. It's like defining dog by listing terriers, poodles, bloodhounds, Chihuahuas, and so on."

Comment. With the Definition by Exclusion, Blanchard would define normaphilic human sexuality, and then anything not in the normal sphere would be considered to be paraphilic. In the publicly posted document we are considering, I did not find a clear explanation of how the medical community would decide which behaviors are termed "not paraphilic" and which are termed "paraphilic." More discussion on the advantages and disadvantages of these two types of definition of paraphilia will follow, after we consider the proposed distinction between paraphilias and paraphilic disorders.

B. Paraphilia vs. Paraphilic Disorders

After dividing patterns of sexual interest into "paraphilias" and "not paraphilias" in Slides 2 – 4, in Slides 5 – 6 Blanchard subdivides paraphilias into "disorders" and "not disorders":

- A *paraphilic disorder* is a paraphilia that causes distress or impairment to the individual or harm to others.

- One would *ascertain* a paraphilia (according to actions and self report, e.g., sexual attraction to amputees or inanimate objects) but *diagnose* a paraphilic disorder (on the basis of distress and impairment).

- A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder.

- Generally, paraphilias are ascertained according to the "A" criteria, and paraphilic disorders are diagnosed according to the "A" and "B" criteria.

Blanchard writes, “This approach leaves intact the distinction between normative and non-normative sexual behavior, which could be important to researchers, but without automatically labeling non-normative sexual behavior as psychopathological. As with the general definition of paraphilia, we will be looking closely at feedback from multiple sources regarding this idea.”

Comment. As I understand it, first, the medical community would decide which patterns of sexual behavior are normative and which are not, pre-dividing patterns of sexual attraction into normative (not paraphilic) and non-normative (paraphilic). In utilizing *DSM-V* for psychodiagnosis, clinicians would ascertain whether a person’s pattern of sexual attraction fit the predetermined categories of normative or paraphilic attractions. If the *type* of sexual attraction (ignoring frequency, intensity, mutuality, etc.) was of a predetermined normative type, then that person could not be diagnosed with paraphilia no matter how many problems his sexual attractions and behavior caused for him and/or others. Only for people with sexual attractions of a predetermined non-normative type could clinicians consider a diagnosis of paraphilia.

Before we turn our focus to Blanchard’s proposals regarding hebephilia, let us consider how the proposed diagnostic scheme would work for strong sexual interest in two different types of sexual behavior: bondage, and putting a dildo in someone else’s anus. On Slide 4, Blanchard suggests that bondage would be included in the category of “paraphilic” sexual behaviors, and anal penetration with a dildo would be included in the category of “not paraphilic.” If so, then as I understand it, a person who developed serious problems involving bondage might eventually meet criteria for a diagnosis of paraphilia, but a person who developed serious problems related to sticking dildos in other people’s anuses never could.

With *DSM-IV-TR,* voyeurism, exhibitionism, sexual masochism, and sexual sadism are all considered to be potentially paraphilic, when the sexual urges or behaviors cause problems in a person’s life. However, within the *DSM-IV-TR* scheme, elements of each of these behaviors are recognized as being aspects of normal human behavior. With *DSM-IV-TR,* it may not be necessary for the medical community to predetermine which sexual fantasies, urges, or behaviors are normative and which are not normative. With *DSM-IV-TR,* if a person’s sexual fantasies, urges, or behaviors do not cause problems for oneself or others, then they do not constitute a mental disorder. If they do cause problems for oneself or others, then a clinician could attempt to determine, on a case-by-case basis, whether the problems warrant a diagnosis or not.

I am doubtful that human sexual behavior is susceptible to that type of categorization, even if we had very rich and detailed research data. In the absence of rich and detailed research data, pre-classification of sexual attraction into normative and non-normative, without considering whether or not the individual person has problems, cannot extend to the whole range of human sexual attraction.

One more thing before we turn to Blanchard's discussion of hebephilia: We consider the problems Blanchard mentioned regarding Definition by Concatenation versus problems I see with Definition by Exclusion. Here we focus primarily on the perspective of a forensic psychologist. One of the two problems Blanchard mentioned with the Definition by Concatenation is that "It would have to be even longer to cover all the phenomena that are currently diagnosed as paraphilia NOS—Not Otherwise Specified." From the perspective of a forensic psychologist, this is a trivial concern. Of much more pressing concern are the types of sexual behaviors that have been determined to be illegal, and yet some people persist in doing them, even after experiencing negative consequences. For forensic psychologists, the pressing need is for the developers of *DSM-V* to determine whether and how to present diagnostic criteria for paraphilias involving nonconsensual sex, and sex with pubescent and/or post-pubescent minors in a way that is—or becomes—generally accepted in the psychological and psychiatric communities.

From a forensic psychologist's perspective, the primary tasks for the developers of the *DSM-V* section on paraphilia are straightforward (if not simple):

1. On the basis of research and, where research is lacking, consensus, decide whether or not to consider nonconsensual sex, sex with pubescent humans, and/or sex with post-pubescent minors to be potential paraphilic disorders.

2. For any of those in #1 that are determined to be potential paraphilic disorders, provide clear and unambiguous diagnostic criteria.

3. Refine the general definition of paraphilic disorders so that clinicians can more reliably apply the criteria to potential paraphilic disorders that are not specifically listed in *DSM-V*.

As a forensic psychologist, I do not care whether there are eight or eighteen paraphilic disorders specifically listed in *DSM-V,* but I do care whether there is a paraphilic disorder involving non-consent, and I do care whether there are paraphilic disorders involving sex with pubescent and/or post-pubescent minors. Forensic psychologists are not all in agreement about the answers to these questions, but our work would benefit if *DSM-V* would address the questions head on. In future cases forensic psychologists, lawyers, judges, and juries will attempt to apply whatever diagnostic criteria appear in *DSM-V.*

As he has considered possible revisions to the paraphilia section of the *DSM*, Dr. Blanchard noted that *DSM-IV-TR*'s approach is not intellectually neat. That prompted his proposal to define normative sexual interests and to call everything else non-normative (paraphilic). As a practicing forensic psychologist, I have little concern whether the diagnostic criteria are intellectually neat. Much more important is that they clearly address matters of significance to the public, and in particular those matters that are often of concern in legal cases. If the subworkgroup can develop a diagnostic scheme for *DSM-V* that is intellectually neater than the one in *DSM-IV-TR,* fine. More important is whether forensic psychologists, lawyers, judges, and jurors can open *DSM-V* to the paraphilia section and uniformly understand whether there is a paraphilia involving nonconsensual sex, and if so what are the criteria for that disorder. The same applies for questions regarding sex with pubescent and/or post-pubescent minors.

From the perspective of a forensic psychologist, I would much prefer a Definition by Concatenation than a Definition by Exclusion, if it would mean that the paraphilias of most concern in legal cases are clearly identified and defined, and the criteria for them are clearly delineated. With a Definition by Exclusion, everything that the subworkgroup forgets to put in the "not paraphilic" group could be interpreted as being paraphilic. My reading of the currently proposed Definition by Exclusion is that people who get considerable enjoyment out of solo sex would be identified as being paraphiles. Why?

Recall that the proposed Definition by Exclusion is "The term *paraphilia* denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, consenting adult human partners." Masturbation, alone, in private, is a sexual interest other than sex with a consenting adult partner. The same is true for genital stimulation with a vibrator, alone, in private. So, as I read the proposed definition, a person who gets as much sexual pleasure from solo sex as from sex with a partner would be identified as a person with a paraphile. How should we understand teenagers who opt for abstinence, but do not refrain from masturbation? How should we understand a late-middle-age or elderly widow or widower who elects not to date or remarry?

The simple solution is that the proposed Definition by Exclusion should be expanded if we do not want to characterize solo sex as being non-normative (paraphilic). The broader problem is that unless the developers of *DSM-V* anticipate every possible sexual pattern that should be considered normative, anything that gets left out would be considered to be paraphilic. Whatever intellectual neatness a Definition by Exclusion would add to the process, the mess it would create for legal cases would outweigh the possible advantages.

C. Pedohebephilia

In Slides 8 – 11, Blanchard presents proposals regarding pedophilia and hebephilia as a combined disorder. First, he lists Diagnostic Criteria Options for Pedohebephilic Disorder:

A. Over a period of six months, the person is intensely aroused sexually by children under the age of 15, or is equally or more aroused by such children than by physically mature adults, as indicated by self-report, laboratory testing, or behavior.

B. The person is distressed or impaired by such arousal, or the person has sought sexual stimulation from three or more children under 15 on separate occasions, or has used child pornography for a period of six months or longer.

C. The person is at least age 18 years and at least 5 years older than the children in Criterion A.

Blanchard lists Age-of-Object Specifier Options for Pedohebephilic Disorder:

- Sexually Attracted to Children Younger than 11 (Pedophilic Type)
- Sexually Attracted to Children Age 11 to 14 (Hebephilic Type)
- Sexually Attracted to Both (Pedohebephilic Type)

Blanchard also lists Gender-of-Object Specifier Options:

- Sexually Attracted to Males
- Sexually Attracted to Females
- Sexually Attracted to Both

As I understand this, these proposed criteria for Pedohebephelia could be used whether the general approach that is adopted is Definition by Concatenation or Definition by Exclusion.

Comment. My biggest question regarding Blanchard's proposed criteria for paraphilia is the same one that the judge in Mr. Carta's case considered to be the most important: Where is the research? Is there sufficient research to show that it is non-normative for a person to be equally sexually attracted to pubescent humans and post-pubescent humans? How unusual is that? (See Blanchard, 2009; Blanchard, Lykins, Wherrett, Kuban, Cantor, Blak, Dickey, & Klassen, 2009. But see also DeClue, 2009; Franklin, 2009; Janssen, 2009; Moser, 2009; Plaud, 2009; Tromovitch, 2009; and Zander, 2009.)

To create a more specific example, what if a 60-year-old male finds himself to experience more sexual attraction to the sight of an average 14-year-old than he does to the sight of an average person his age? Do we know how unusual that is? Where are the data? Without such data, I do not see a scientific or rational basis for deciding whether

hebephilia is a non-normative pattern of sexual attraction—and such a determination is crucial to Blanchard's proposal regarding diagnosis of paraphilia.

IV. Differential Diagnosis of Paraphilia NOS versus Sexual Disorder NOS

Until this point in this article, we have considered questions about whether a particular pattern of sexual functioning satisfies criteria for one type of mental disorder: paraphilias. Now we shift the focus to how to approach questions of whether a person meets criteria for a diagnosis of sexual disorder.

Within *DSM-IV-TR,* there are hierarchical categories of mental disorders. One major category is Sexual and Gender Identity Disorders, and within that category are Sexual Dysfunctions, Paraphilias, Gender Identity Disorders, and Sexual Disorder Not Otherwise Specified (NOS).

The Differential Diagnosis subsection of the Paraphilia section of *DSM-IV-TR* (p. 568) includes, "A paraphilia must be distinguished from the nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement in individuals without a paraphilia. Fantasies, behaviors, or objects are paraphilic only when they lead to clinically significant distress or impairment (e.g., are obligatory, result in sexual dysfunction, require participation of nonconsenting individuals, lead to legal complications, interfere with social relationships)."

Is a pattern of sexual attraction to and sexual behavior with pubescent humans a *para*philia? *DSM-IV-TR* only mentions and categorizes a small number of specific paraphilias. Although sexual attraction to prepubescent humans (pedophilia) is clearly included in the paraphilias, sexual attraction to pubescent humans is neither specifically included nor specifically excluded.

The introductory paragraphs (p. 535) in the *DSM-IV-TR* section Sexual and Gender Identity Disorders include this brief description of paraphilias: "The paraphilias are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning." (Here, "objects" includes humans.) As we saw in *U.S. v. Carta,* the judge did not find scientific evidence showing that sexual attraction to pubescent humans is non-normative, nor did he find a consensus of opinion among mental-health professionals on the issue. Although, as quoted above, the authors of *DSM-IV-TR* claim, "*DSM-IV* reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication," neither *DSM-IV-TR* nor subsequent research shows a consensus about whether sexual attraction to pubescent humans is unusual (and therefore, potentially, the stuff of a paraphilia).

DSM-IV-TR allows for the diagnosis of paraphilias not specifically listed in the manual by providing a diagnostic category of 302.9 paraphilia NOS. The descriptive section is short, and is reproduced here in its entirety (p. 576):

> This category is included for coding paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

Therefore, with *DSM-IV-TR,* if a clinician decides that a person has a sexual disorder that involves an unusual pattern of sexual attraction that is not specifically listed in *DSM-IV-TR* (e.g., exhibitionism, voyeurism, etc.), a diagnosis of 302.9 paraphilia NOS would be considered. What if a clinician does not consider sexual attraction to pubescent humans to be unusual? Does *DSM-IV-TR* allow for diagnosis of a sexual disorder involving sexual attractions that are not considered to be unusual enough to be classified as paraphilias? Yes, it does.

The *DSM-IV-TR* section on 302.9 Sexual Disorder Not Otherwise Specified is also short, and it, too, is reproduced in its entirety (p. 582):

> This category is included for coding a sexual disturbance that does not meet the criteria for any specific sexual disorder and is neither a Sexual Dysfunction nor a paraphilia. Examples include
>
> 1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity.
>
> 2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used.
>
> 3. Persistent and marked distress about sexual orientation.

We should consider one more important step before addressing differential diagnosis of paraphilia NOS versus sexual disorder NOS. We need a definition of mental disorder that is consistent with the current diagnostic manual and is applicable to court cases. I suggest the following: *a clinically significant pattern of sexual behavior that is a symptom of a dysfunction in an individual and that is associated with present distress or disability or with an important loss of freedom.* Please see Appendix A for the derivation of this definition.

On a case-by-case basis, how could a forensic psychologist assist a court in a legal case such as those involving the Adam Walsh Child Protection and Safety Act (a federal statute) or various states' SVP acts? If the psychologist uses the current diagnostic manual, *DSM-IV-TR,* then I recommend that the first diagnostic question be whether the person meets *DSM-IV-TR* criteria for having a mental disorder. Consideration of what type of mental disorder should follow, and in some cases that will involve differential diagnosis of paraphilia NOS versus sexual disorder NOS.

When a forensic evaluator determines that a person does have a mental disorder involving sexual functioning, what comes next? If the significant pattern of sexual functioning fits one of the eight paraphilias specifically described in *DSM-IV-TR,* diagnosis can proceed in a straightforward fashion regarding diagnosis of a paraphilia. If the pattern fits one of the seven paraphilias mentioned as examples of paraphilia NOS but not described in detail in *DSM-IV-TR,* then the question is whether the person meets criteria for paraphilia NOS. However, if the pattern is of sexual dysfunction not specifically described or mentioned in *DSM-IV-TR* Paraphilia section*,* then the clinician is likely to be faced with the task of considering whether the particular person's pattern of sexual dysfunction is a paraphilia or a non-paraphilic sexual disorder.

First and Halon (2008, p. 445) write, "The core diagnostic construct that forms the basis of the paraphilia category is that the person becomes sexually aroused in response to stimuli considered to be abnormal." The problem, of course, is that with few exceptions neither *DSM-IV-TR* nor any other authoritative text clearly establishes a consensus regarding which patterns of sexual functioning are abnormal, or which are so (rare?) that they should be considered abnormal rather than just, say, unusual.

In cases in which the forensic evaluator can clearly establish a dysfunction that clearly involves abnormal sexual arousal, then a diagnosis of paraphilia is likely to be warranted. In cases in which a dysfunction is clearly present, but it is not clear that the pattern of arousal is abnormal, then a diagnosis of paraphilia might not be warranted; a diagnosis of sexual disorder NOS might be.

Guidance about how severe a non-paraphilic pattern of sexual dysfunction need be in order to warrant a diagnosis of mental disorder is provided on page 582 of *DSM-IV-TR* in the form of the three examples quoted above. In my opinion, in SVP cases in which a pattern of paraphilia is not clearly warranted, a diagnosis of sexual disorder NOS should be considered.

Conclusions

As a forensic psychologist, I look to *DSM* to guide me about whether a person meets criteria for a mental disorder, and if so, what mental disorder. The disorders of most interest to me are the disorders of most relevance to court cases. Although some people might disagree with the judge in the case of *U.S. v. Carta,* I believe the judge showed a reasonable analysis of the facts and opinions presented to him and reasonably concluded that the government failed to show that there is a consensus of

opinion in the psychiatric and psychological communities about any of the following: whether hebephilia is generally considered by the psychological and psychiatric communities to be a mental disorder; if so, whether it is a serious mental disorder; if it is a disorder, what the criteria for diagnosis are; and whether there is a sufficient scientific basis to show that it *should* be considered to be a mental disorder. As I read *U.S. v. Carta* (and as I observe and participate in somewhat similar cases), it appears to me that two smart, knowledgeable experts came to different conclusions using the same diagnostic manual.

Although *DSM-IV-TR* includes the claim, "It must be noted that *DSM-IV* reflects a consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication," the manual does not allow mental-health professionals, lawyers, judges, or juries to discern whether or not there really is a consensus regarding some diagnostic questions of great import to society.

If *DSM-V* follows the subworkgroup's proposal to distinguish between a *paraphilia* and a *paraphilic disorder,* then it will be necessary to have a subsection within sexual disorders for people who have sexual dysfunctions that are not of a paraphilic nature. In *DSM-IV-TR* that includes, among others, people with erectile dysfunction, low sex drive, and an NOS category with examples like "distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used." It is almost 100% certain that *DSM-V* will have a diagnostic category for such disorders, because it is very likely that there will be a category of sexual disorders, and that there will be a diagnosis of sexual disorder NOS. A question is whether the developers of *DSM-V* will attempt to provide a "consensus about the classification and diagnosis of mental disorders derived at the time of its initial publication" relevant to patterns of sexual arousal and behavior that are not paraphilic and that cause serious problems.

For example, if *DSM-V* includes a diagnosis for hebephilia, then it will be important to *show* that there is a consensus that it is a mental disorder, not just claim that there is. In addition, there should be a clear, explicit, scientific rationale for declaring that it is non-normative (paraphilic) or normative (non-paraphilic). If research is not definitive, then the developers of *DSM-V* should describe how they determined that the consensus was one way or the other (paraphilic or not) for hebephilia at the time *DSM-V* goes to press.

Similarly, if *DSM-V* includes a diagnosis for non-consensual sex, it will be important to provide clear criteria for the disorder. If the decision is made that sexual arousal to non-consensual sex is paraphilic only when it is preferential or obligatory, then it will be important to clearly address whether non-paraphilic (by definition) patterns should be considered to be a sexual disorder when they reach clinical proportions. For example, consider a person who is equally attracted to and aroused by sex with a consenting or non-consenting partner, the pattern is repetitive and long-lasting, and it causes serious problems in the person's life (DeClue, 2006). If the developers of *DSM-V* decide to exclude that from the definition of paraphilia, they still need to explicitly address whether

it can be a sexual disorder. The developers of *DSM-V* should also explicitly address a pattern of sexual functioning in which the person's attraction to non-consensual sex may not be as great as or greater than his attraction to consensual sex, but the fantasies, urges, and behaviors are associated with clinically significant distress or disability or social dysfunction. (This would be somewhat comparable to nonexclusive pedophilia.)

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Appendix A

Several sections of *DSM-IV-TR* are useful in considering how to use the manual for diagnosis in an SVP case.

First, we consider the prefatory sections regarding the definition of mental disorder and the use of the manual in forensic settings (pp xxx-xxxiii):

> Although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies the precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions. . . . In *DSM-IV*[7], each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

What happens if we rewrite the last sentence, focusing on those elements most germane to diagnosing some sexual disorders? "… a clinically significant behavioral ~~or psychological syndrome or~~ pattern that occurs in an individual and that is associated with present distress ~~(e.g., a painful symptom)~~ or disability ~~(i.e., impairment in one or more important areas of functioning)~~ or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom." Thus, a subset is "a clinically significant behavioral pattern that occurs in an individual and that is associated with present distress or disability or with ~~a significantly increased risk of suffering death, pain, disability, or~~ an important loss of freedom." And a smaller subset is "a clinically significant behavioral pattern that occurs in an individual and that is associated with ~~present distress or disability or with~~ an important loss of freedom." A final subset is *a clinically significant behavioral pattern that occurs in an individual and that is associated with present distress or disability or with an important loss of freedom. DSM-IV-TR* continues:

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[7] In this segment from *DSM-IV-TR,* the text refers to itself as *DSM-IV.*

> Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

For the last sentence, if we focus solely on the part about deviant sexual behavior, it becomes, *Deviant sexual behavior is not a mental disorder unless the deviance is a symptom of a dysfunction in the individual, as described above.* Combining the relevant portions of those few sentences in *DSM-IV-TR,* we get the following potential mental disorder: *a clinically significant pattern of sexual behavior that is a symptom of a dysfunction in an individual and that is associated with present distress or disability or with an important loss of freedom.*