

Defining Paraphilia: Excluding Exclusion

Author: Andrew C. Hinderliter

Department of Linguistics
University of Illinois, Champaign-Urbana, USA
Email: andrewc.hinderliter@gmail.com

Abstract

The development of the classification of the paraphilias is considered, with emphasis on justifications for their inclusion in DSM-III in light of the declassification of homosexuality. These justifications are found to be tenuous and do not work for the paraphilias in DSM-III-R because of changes made. Rationale for these changes is discussed based on inquiries made to DSM-III-R paraphilias committee members. Changes in DSM-IV and DSM-IV-TR are also discussed. After considering and critiquing more recent arguments for including the paraphilias in the DSM, recommendations are made regarding proposals for DSM-5, whether the paraphilias belong in the DSM, and whether they should be used in SVP commitment.

Keywords: Paraphilias, DSM-5, SVP Commitment

DSM-IV-TR (American Psychiatric Association, 2000b) defines a paraphilia as, “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, or 3) children or other nonconsenting persons” (p. 566); over at least six months. DSM-IV-TR lists eight paraphilias: exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, and voyeurism. It also has a not otherwise specified category (NOS) for less common paraphilias. In DSM-II (American Psychiatric Association, 1968), they were called sexual deviations, which is where homosexuality had been listed. Whether the paraphilias should even be in the DSM has been controversial, with a number of authors (e.g. Moser and Kleinplatz, 2005; Silverstein, 1984; Suppe, 1984;), arguing that the logic behind the removal of homosexuality should lead to the removal of all of these diagnoses.

With the DSM currently being revised, the DSM-5 Paraphilias Subworkgroup has made a number of controversial proposals to expand this group of diagnoses, including a proposal to change the definition of paraphilia to be “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, consenting adult human partners” (Blanchard 2009). Blanchard calls the DSM-IV-TR’s definition of paraphilia a “definition by concatenation”—essentially, it is little more than a list. It provides no basis for determining why certain sexual

interests should be labeled as paraphilias and does not even cover all of the paraphilia NOS diagnoses. He calls his proposed definition a “definition by exclusion”—it aims to define a range of so-called normative sexual interests and define paraphilia as any sexual interest other than that.

While this particular definition fails to define paraphilia as intended and could create serious forensic problems (DeClue, 2009; Hinderliter, in press-a), it serves as an occasion for reflection: Should the DSM attempt to define what are and are not “normative” sexual interests? If it should not, on what basis are the paraphilias included?

In this paper, I survey this class of diagnoses from DSM-I (American Psychiatric Association, 1952) to the present, focusing on the justifications for retaining them in light of the decision to remove homosexuality *per se* in 1973. Justifications for including them without a requirement of distress (unlike ego-dystonic homosexuality) in DSM-III (American Psychiatric Association, 1980) were given, but these were extremely tenuous and, even if accepted, they fail to justify the inclusion of the paraphilias in DSM-III-R (American Psychiatric Association, 1987) because of changes made from DSM-III to DSM-III-R. To understand the rationale for these changes, I contacted members of the DSM-III-R paraphilias committee, and these findings are reported. I then consider the empirical and (possible) ideological bases of these diagnoses, arguing that this further draws into question whether they should be in the DSM. Additional arguments that have been given for including various paraphilias in the DSM are considered, focusing attention on the reports of the DSM-5 Paraphilias Subworkgroup. Finding the basis for keeping the paraphilias in the DSM extremely tenuous, I make recommendations and consider the significance of my discussion of the paraphilias for their use in sexually violent predator (SVP) commitment.

Previous Definitions of Sexual Deviation(s)/Paraphilias in the DSM

Bayer (1987) discusses how homosexuality came to be regarded as a mental disorder by psychiatry, noting that it was done without any scientific basis. However, the details of how it and the rest of the sexual deviations came to be in the DSM is an historical question on which little has been written. According to Money (1984), the eight paraphilias listed in DSM-III are there “because of their forensic history, rather than their pathology and therapeutic need” (p. 164).

The third edition of the Standard Classified Nomenclature of Diseases (Jordan, 1942) included the diagnosis “Psychopathic Personality with Pathologic Sexuality,” and listed among the “symptomatic manifestations” homosexuality, erotomania, sexual perversion, and sexual immaturity (p. 106). DSM-I (American Psychiatric Association, 1952) calls this “sexual deviation” (a single diagnosis), instructing users to “indicate the pathological behavior: homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation)” (p. 39). The description of sexual deviation can hardly be called a definition—it is defined in terms of “deviant sexuality”—yet the term “deviation” suggests deviation from some implicitly understood norm (i.e. a “defini-

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tion by exclusion”). In DSM-I, sexual deviation is classified under sociopathic personality disturbance. This classification and the previous name of the diagnosis suggest that the reason these were first included in the DSM was the belief that such sexual interests were symptomatic of a serious personality disorder. Recently, even some defenders of having the paraphilias in the DSM (e.g. Krueger & Kaplan, 2002) claim that there are few, if any differences in terms of psychopathology between individuals with and without paraphilias (see also Berlin, 2000). If they are correct, and if a belief that “deviant” sexual interest indicated personality disorder is the reason that the Paraphilias were first included in the DSM, then these were first regarded as mental disorders because of a factual error. This would not necessitate their removal from the DSM, but it does suggest that whether they belong in the DSM needs to be reconsidered.

In DSM-II (American Psychiatric Association, 1968) they are named “sexual deviations” (plural),¹ and each sexual interest mentioned became a separate diagnosis. DSM-II’s definition of this category can be seen as a “definition by exclusion” in the italicized words:

This category is for individuals whose sexual interests are directed primarily toward objects *other than* people of the opposite sex, toward sexual acts *not usually associated with coitus*, or toward coitus performed under *bizarre* [emphasis added] circumstances, as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them. (p. 44)

The term “sexual interests not primarily directed toward” is not unlike the interpretation of “intense and persistent sexual interest” that Blanchard (2009) ascribes to his proposed definition.² If “of the opposite sex” is removed, and “coitus” is replaced with “genital stimulation,” the two definitions are remarkably similar, with the primary difference being that Blanchard’s definition focuses attention on the type of partner (i.e. “phenotypically normal consenting adult human partners”), whereas the DSM-II’s definition seems to subsume this in the phrase “bizarre circumstances” as seen above in the examples following that phrase.

¹ In an article introducing DSM-II that explains changes from DSM-I to DSM-II, Spitzer and Wilson (1968) note the change from a single diagnosis of *sexual deviation* to a category of diagnoses, but they use the term *sexual deviation* rather than the plural in their list of DSM-II diagnoses, suggesting that too much should not be read into the change from singular to plural.

² Blanchard (2009) asks, “[Intense] compared to *what?* [Intense] compared to *nonexistent*, or [intense] compared to *normophilic* interest?” [emphasis in original]. He answers that it means intense compared to normophilic interests. Hinderliter (in press-a) notes that this makes the intended meaning more similar to “sexual preference” than “intense and persistent sexual interest.”

What is significant about these similarities is that, beginning with the seventh printing of DSM-II (American Psychiatric Association, 1974), the diagnosis “sexual orientation disturbance” is included, and the category of sexual deviations had a footnote:

This term and its definition are inconsistent with the change in thinking that led to the substitution of **Sexual Orientation Disturbance** for **Homosexuality** [emphasis in original] in [the list of diagnoses under Sexual Deviations]. However, since no specific recommendations were made for changing this category or its definition, this category remains unchanged for the time being. (p. 44)

Clearly, “other than people of the opposite sex” is inconsistent with that decision, but this would not explain why the term “sexual deviations” itself is inconsistent with that change in thinking. The reason seems to be that simply deviating from some “normal sexuality” is not sufficient justification for inclusion in the DSM.

Toward DSM-III: Declassifying Homosexuality and Defining Mental Disorder

A key part of the removal of homosexuality *per se* in 1973 involved defining “mental disorder.” Wanting to declassify homosexuality, but knowing that there would not be enough political support if doing so required saying that homosexuality was just as normal as heterosexuality, Robert Spitzer aimed to define homosexuality out of the DSM. He read through the DSM-II and tried to find something that everything but homosexuality had in common (Bayer 1987, pp. 127-8; Drescher, 2003). He concluded that, except for homosexuality and maybe some of the other sexual deviations, all of the diagnoses in DSM-II “regularly caused subjective distress or were associated with generalized impairment in social effectiveness or functioning. It was argued that the *consequences* of a condition, and not its *etiology* [emphasis in original] determined whether the condition should be considered a disorder” (Spitzer and Williams, 1982, p. 16). Since many homosexual individuals were socially functional and not distressed by their homosexuality, homosexuality *per se* was not a mental disorder. The diagnosis of sexual orientation disturbance for people distressed about homosexual desires was created as a politically viable compromise (Bayer, 1987).

One criticism of the move to remove homosexuality *per se* from the DSM was that the same logic would lead to the removal of the other sexual deviations. In a debate with Robert Spitzer published in the New York Times (Anonymous, 1973), Irving Bieber said that he did not think homosexuality was a mental disorder, but that it should be kept in the DSM, which, he stated, “contains other conditions [that do not satisfy Dr. Spitzer’s definition] that I don’t consider mental disorders either, such as voyeurism and fetishism.” Spitzer’s response is telling: “I haven’t given as much thought [as Dr. Bieber] to the problems of voyeurism and fetishism, and perhaps that’s because the voyeurs and fetishists haven’t organized themselves and forced us to do that” (p. 109, brackets in original).

Not only did those opposed to the declassification of homosexuality believe that the same logic would also imply the sexual deviations more generally should be declassified, Silverstein (2009) writes that this was “the long range goal of the [gay] activist committee” (p. 161) that met with the nomenclature committee in February 1973. He recently expressed explicitly what had been implicit in his argument there: “If there was no objective, independent evidence that a homosexual orientation is in itself abnormal, then what justification was there for including any of the other sexual behaviors in DSM?” (p. 162).

In working on DSM-III, Spitzer himself seems to have recognized this point. Describing work following the formation of a new Task Force on Nomenclature and Statistics, founded in 1975 and that Spitzer chaired, Spitzer and Williams (1982) write:

It became necessary to reconsider the appropriate boundaries of mental disorder. [One reason was that,] if the concepts used to resolve the homosexuality controversy were applied to such conditions as necrophilia (sexual attraction to dead bodies) or fetishism (sexual attraction to inanimate objects), commonly accepted as mental disorders, there would be startling results: Necrophilia and fetishism would only be considered disorders if the individuals with the conditions were distressed by them! Otherwise, such conditions would merely be considered normal variations of sexuality. (p. 17)

The exclamation point and the assumed force of this *reductio* suggest that the real reason for including these in DSM-III is not science, clinical utility, or even the DSM-III's definition of mental disorder, but a gut feeling that these are strange and/or bad.

The attempts of Spitzer, Williams, Skodol (1980), Spitzer (1981a), and Spitzer and Williams (1982) to justify including the sexual deviations in DSM-III, renamed paraphilias, are sometimes convoluted and not always consistent with each other or with how DSM-III defined paraphilia. All three of these articles discuss the matter after quoting DSM-III's definition of mental disorder, which I quote here:

In DSM-III 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 typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and the society. When the disturbance is *limited* [emphasis in original] to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder. (American Psychiatric Association, 1980, p. 6)

Spitzer and Williams (1982) comment:

Almost all of the disorders in DSM-III are associated with subjective distress or some impairment of functioning. However, some disorders, such as the Paraphilias, are not always; hence the statement *typically* [emphasis in original] associated with either a painful symptom (distress) or impairment in one or more important areas of functioning. (p. 20)

They later highlight the phrase “there is an inference that there is a behavioral, psychological, or biological dysfunction” and write:

This central concept was useful in justifying the inclusion in the DSM-III classification of the Paraphilias whether or not they were accompanied by distress. The key feature of a Paraphilia, that is, the need for either implicit or explicit coercion (for example, exhibitionism) or inanimate objects (for example, fetishism or necrophilia) reflects a dysfunction in the process of normal psychosexual development. (p. 21)

Under this logic, the paraphilias only fit the DSM-III’s definition of mental disorder because the word “typically” allows for exceptions and an assumption of some developmental theories that these represent pathological development: That is, they are mental disorders because they are. This circular logic could be used to justify regarding any form of social deviance as a mental disorder as long as there is the will to pathologize it—regardless of whether it causes the individual distress or impairment.

Sadler (2005) suggests that much of the literature on defining mental disorder may “primarily [be] a response to the challenge of Thomas Szasz and like-minded thinkers . . . who claimed that mental disorders and ‘mental illness’ were metaphorical concepts whose primary purpose was to regulate the social deviant” (p. 175).³ This would make Spitzer and Williams’ (1982) reasoning particularly troubling: If such logic is accepted, the DSM’s definition of mental disorder fundamentally fails to counter the claims of anti-psychiatry. Also troubling is that Spitzer, Williams, and Skodol (1980) give an entirely different explanation of how the paraphilias (and the sexual dysfunctions) fit DSM-III’s definition of mental disorder:

The concepts contained in this definition were helpful in deciding that it was not necessary to require distress before a psychosexual dysfunction, such as Inhibited Sexual Excitement (frigidity, impotence), would be diagnosed. Similarly, it was helpful in deciding that the diagnosis of such Paraphilias (Sexual Deviations in *DSM-II*) as Fetishism and Exhibitionism also need not require distress. The

³ Spitzer and Endicott (1978) had proposed a definition of mental disorder that aimed to define medical disorder and make mental disorders a subset of that. Responding to the alarm this created for many psychologists, Spitzer (1981b) said that the intention had been to “convince . . . Szaszians that psychiatry was a legitimate branch of medicine” (p.33).

task force concluded that inability to experience the normative sexual response cycle (as in frigidity or impotence) represented a *disability* in the *important area* [emphasis in original] of sexual functioning, whether or not the individual was distressed by the symptom. The same logic applied to the requirement or preference for inanimate objects (as in Fetishism) or bizarre acts (as in Exhibitionism) for sexual arousal. (p. 153-154)

According to this and Spitzer (1981a), the rationale for including the paraphilias and the sexual dysfunctions in DSM-III was the same. The logic only works if the paraphilic interest is necessary (or strongly preferred) for sexual arousal. The DSM-III's definition of paraphilia said it had to be necessary for sexual arousal (and not merely preferred): "The essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement" (American Psychiatric Association, 1980, p. 266). While this says, "imagery or acts," only pedophilia and zoophilia involve sexual fantasy in their diagnostic criteria; the other diagnoses focus only on sexual behaviors. DSM-III claimed that paraphilias "interfere with the capacity for reciprocal affectionate sexual activity" (p. 261). Whether this is true is questionable, as noted by Suppe (1984), who highlights another serious problem with the paraphilias in DSM-III: None of the paraphilias in DSM-III fit DSM-III's definition of paraphilia. Rather than require that some sexual interest be "necessary" for sexual arousal, most diagnoses only require that it be the "repeatedly preferred or exclusive method/mode of achieving sexual excitement." Exhibitionism did not even require that, and transvestism only required "recurrent and persistent cross-dressing . . . that during at least the initial phase of the illness is for the purpose of sexual excitement" (p. 269).

The assumption of the sexual-response cycle as a universal norm is itself deeply questionable (Davis, 1998; Tiefer, 2004) because of methodological and sampling problems with Masters and Johnsons' work (highly influential when DSM-III was written); because of the large cross-cultural variation in sexual norms; and because it is not clear why it should be normative for everyone to want to have and to enjoy sex. Recent work on asexuality, which is often defined in terms of experiencing little or no sexual attraction, challenges the pathologization of asexuality (e.g. Scherrer, 2008; Hinderliter, 2009; Carrigan, in press; Kim, in press), and some regard asexuality as a non-pathological variation of human sexuality, further challenging any universal sexual norm. This would mean that the DSM-III's justification for including the paraphilias was questionable, both theoretically (is lack of interest in [the right kind of] sex really a disability?) and empirically (does having a paraphilia impair ability to have a reciprocal sexual relationship?) and was not consistently applied so that it would still provide no justification for including exhibitionism or transvestism.

DSM-III-R

In DSM-III-R's definition of mental disorder, the word "typically" was removed, and a sentence was added requiring that, for a condition to be a disorder, "Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychologi-

cal, or biological dysfunction in the person” (p. xxii). Because of these two changes, Spitzer and Williams’ (1982) justification for including the paraphilias in the DSM fail to apply.

There were three major changes made across the paraphilias. First, the focus of the diagnostic criteria shifted from sexual behaviors to sexual fantasies and sexual urges. Second, a Criterion B was added to each diagnosis requiring that “the person has acted on these urges, or is markedly distressed by them.” Third, the definition of paraphilia changed so that the sexual interest had to be intense and recurrent rather than necessary (or preferred) for sexual excitement. Because of this third change, the paraphilias also failed to meet Spitzer, Williams, and Skodol (1980) and Spitzer’s (1981a) already tenuous justification for their inclusion in the DSM. The differences between DSM-III and DSM-III-R’s definition of paraphilia can be seen by comparing the following paragraph in the introduction to the paraphilias and its revision:

- (DSM-III) The imagery in a paraphilic fantasy or the object of sexual excitement in a Paraphilia is frequently the stimulus for sexual excitement in individuals without a Psychosexual Disorder. For example, women’s undergarments and imagery of sexual coercion are sexually exciting for many men; they are paraphilic only when they become necessary for sexual excitement. (p. 267)
- (DSM-III-R) The imagery in a paraphilic fantasy is frequently the stimulus for sexual excitement in people without a Paraphilia. For example, women’s undergarments are sexually exciting for many men; such fantasies and urges are paraphilic only when the person acts on them or is markedly distressed by them. (p. 279)

The changes from DSM-III to DSM-III-R are among the most significant changes to this class of diagnoses from DSM-III to the present, yet there is no DSM-III-R sourcebook and I have found only two brief explanations for any of the changes in the literature. To understand the rationale for these changes, I contacted members of the DSM-III-R Paraphilias committee about the matter. DSM-III-R lists nine people as having been on this committee, including Robert Spitzer and Janet Williams, who were on all of the DSM-III-R committees. After explaining the reason for my inquiry, I asked each person about the rationale for the increased focus on sexual fantasy, the rationale for the change from relative to absolute sexual interest, and whether there was much discussion on if or why these diagnoses should be in the DSM, especially with respect to the added Criterion B.⁴ In some cases follow-up questions were asked. Five people responded, four of whom provided at least some information relevant to my inquiries and the fifth did not remember. Of these four, three corresponded by email and one via a 15-minute telephone interview. All acknowledged problems stemming from faded

⁴ Initially, I only contacted two members, and based on this (and finding the responses were quite fragmentary) I sent a modified list of questions to all other members. The first two members contacted, were sent the modified set of questions some time later.

memory, so what I was able to find out was fragmentary but substantive. All responses directly bearing on my three main questions are summarized below.

From relative to absolute sexual interest.

Kurt Freund's courtship-disorder hypothesis (e.g. Freund & Blanchard, 1986) was influential at the time, and Gene Abel (Abel, Becker, Cunningham-Rathner, Mittelman, & Rouleau, 1988), a member of the DSM-III-R Paraphilias subcommittee, had done work indicating that many people had multiple paraphilias, yet if defined in relative terms, only the most arousing paraphilia can be diagnosed (R. Knight, personal communication, February 8, 2010).⁵ Additionally, the term "sexual preference" implies choice, which was felt to be inappropriate (F. Berlin, personal communication, February 16, 2010.) Abel (1989) writes that the requirement of paraphilic acts or imagery being necessary for sexual excitement was "an inappropriate restriction on the criteria for inclusion as a paraphilia [because] most individuals who commit paraphilic acts can also perform non-paraphilic sexual behaviors without the concomitant use of paraphilic fantasies or images" (p. 1069). V. Quinsey (personal communication, June 29, 2010) could not recall the reason for this change and thought that it must have been a mistake.

Focus on sexual fantasy.

The increased focus on sexual fantasy happened because research at the time indicated that sexual fantasy played an important role in maintaining Paraphilias (D. Barlow, personal communication, February 6, 2010). The distinction between sexual preference and sexual behavior was recognized, but phallometric data indicated a strong link between paraphilic fantasies and behaviors (V. Quinsey, personal communication, June 29, 2010). Also, the term "intense" is somewhat problematic. If asked to define heterosexuality or homosexuality, people are likely to have difficulty; they are probably unlikely to use the term "intense," but are likely to give answers in terms of desires and sexual fantasy (F. Berlin, personal communication, February 16, 2010).

Criterion B and the question of mental disorder.

Regarding the addition of Criterion B, a requirement of distress was not included because many sex offenders, possibly most, are not distressed about their actions, even though these cause considerable distress to others (V. Quinsey, personal communication, February 5, 2010). According to Spitzer and Wakefield (1999), these criteria were added to deal with the problem of false positives in light of the difficulty of drawing a line between normative sexual interests and pathological ones. F. Berlin (personal communication, February 16, 2010) said that these criteria were added

⁵ There are at least two ways around this issue while still defining paraphilia in relative terms. One is to define them relative to "normative" sexual interests rather than relative to any sexual interest. The other is when multiple paraphilic interests are combined in one sexual interest as in someone primarily sexually interested in watching unsuspecting prepubescents in locker-rooms.

because simply being different is not a disorder. However, it is important to be able to provide treatment to those who want it; thus, according to DSM-III-R, someone sexually attracted to children who has never acted on this attraction and has no difficulty restraining those desires does not have a mental disorder, whereas someone who has acted on those desires, or who is distressed by them and seeks clinical help in resisting those urges, does. He also said that the same Criterion B was used for all the paraphilias because of a desire to have consistency in DSM-III-R across all diagnoses in any given category. Similarly, V. Quinsey's opinion is that the inclusion of the paraphilias was connected to a belief that sex offenders were treatable. The paraphilias were considered pathological primarily because of a belief that they caused harm to others and to society in general. Distress was not required for a diagnosis because many sex offenders, possibly most, are not distressed about their behavior, although it causes distress to others (personal communication, February 5, 2010; June 29, 2010). D. Barlow (personal communication, February 6, 2010) felt that it was obvious that the paraphilias met the DSM's definition of mental disorder.

Discussion of changes and rationale.

Blanchard (2009) discusses the change from relative to absolute sexual interest and indicates a preference for DSM-III's use of relative sexual interest, writing that this is how his lab has viewed it. In other contexts, the distinction between defining paraphilias in terms of absolute versus relative sexual interests is confused or ignored. For instance, Thornton (2010) argues for including Paraphilic Coercive Disorder in DSM-5, proposing diagnostic criteria that define it in terms of absolute sexual interest, yet most of the evidence he cites to support this, including this diagnosis in DSM-5, are phallometric studies that operationalize paraphilias in terms of relative sexual arousal. Abel's (1989) justification for this change—that many people who engage in paraphilic acts can also engage in non-paraphilic acts—was not a novel finding: DSM-III explicitly recognized this fact and stated that, in such cases, the sexual interests were non-pathological. Neither was the existence of people with multiple paraphilic interests a novel finding. ICD-9 (World Health Organization, 1977) defines Sexual Deviation similarly to DSM-II, but includes the following statement: "It is common for more than one anomaly to occur together in the same individual; in that case the predominant deviation is classified" (p. 196).

Claiming that the sexual interest is a mental disorder if the person has acted on it makes much more sense for pedophilia than it does for fetishism. Using the same Criterion B for both suggests that the members of the DSM-III-R paraphilias committee were much more interested in the criminal paraphilias than in the non-criminal ones, which is consistent with the committee's membership.

DSM-IV to the Present

In DSM-IV, the definition of paraphilia was changed to remove any language of unusual, bizarre, or normative sexual interests/arousal patterns. These terms raise the problem

of identifying what is normative sexuality, and, as First and Halon (2008) explain, “DSM-IV sidestepped this thorny question by completely avoiding the normal/abnormal dichotomy and instead adopted a definition constructed to cover the specific paraphilias included in it” (p. 445).⁶ The definition of paraphilia being proposed for DSM-5 clearly does not try to sidestep this thorny issue.

From DSM-III-R to DSM-IV, for all the paraphilias, the language of “recurrent intense sexual urges and sexually arousing fantasies” was changed to “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors.” This change was made with the intention that the meaning of “acted on it” of DSM-III-R’s Criterion B would be present in “or behaviors” in Criterion A, allowing Criterion B to use wording standard for clinical significance criteria, which were added to most of the diagnoses in DSM-IV; also “behaviors” was intended to emphasize that people usually come to clinical attention because of behaviors. First and Halon (2008) claim that these changes would have no effect on caseness: “It was assumed that both the DSM-III-R wording and the DSM-IV wording would identify exactly the same set of individuals as having a paraphilia” (p. 447). First and Frances (2008), editor for DSM-IV and chair of the DSM-IV Task Force, respectively, state that this change was a mistake and that it has allowed some forensic evaluators to diagnose people with paraphilias solely on the basis of sexual offenses, which “blurs the distinction between mental disorder and ordinary criminality” (p. 1240). This was not the intention. Accompanying the addition of “behaviors,” the “and” of DSM-III-R’s definition of paraphilia was changed to “or.” Other than this, the only change to any individual diagnosis was the addition of the specifier “With Gender Dysphoria for Transvestic Fetishism” (for explanation, see Schmidt, Schiavi, Schover, Segraves, & Wise, 1998).

Because Criterion B no longer included the phrase “has acted on it,” a small-scale public relations disaster for the American Psychiatric Association resulted as some conservative groups felt that this meant that pedophilia was only a disorder if the person was distressed about it (Spitzer, 2005). In DSM-IV-TR, for pedophilia, exhibitionism, frotteurism, and voyeurism, the clinical significance criteria were modified so that “acting on” the sexual urges would meet Criterion B.⁷ For pedophilia, Sadler (2005, p. 246) cites personal correspondence with Michael First as writing that this change was made to enable those who have sexually offended against children to receive the diagnosis in light of the fact that many such individuals display no distress or disability.

Unless the clinical-significance criteria are used to tautologically justify the inclusion of the paraphilias in the DSM, the question of how the paraphilias fit the DSM’s definition of mental disorder remains in question. Indeed, a number of authors who have examined some or all of the paraphilias in light of the DSM’s definition of mental disorder have concluded that they do not fit that definition (e.g. Gert, 1992; Moser & Kleinplatz,

⁶ The term “unusual” is used in discussing the paraphilias in DSM-IV on pages 493 and 523, but not in the definition of Paraphilia itself.

⁷ This change was also made for sexual sadism, with the addition of “with a nonconsenting person” after “The person has acted on these sexual urges” (p. 574).

2005; Sadler, 2005). In a paper proposing a definition of “mental disorder” for DSM-5, Stein et al. (in press) consider the matter: “At first glance [the paraphilias do not appear to be] characterized by distress or impairment. . . . However, it could be said that symptoms of paraphilias reflect a disturbance in interpersonal functioning” (p. 3). What this means is unclear. One possible meaning is that some of the paraphilias involve criminal behavior, so interest in those things is a mental disorder because of the possibility of arrest. The other is where, if the paraphilia is preferred to “normative” sexual behaviors, this could constitute a disorder because of problems it could create for romantic/sexual relationships. The second of these would only work for how paraphilia was defined in DSM-III, and the first is troublingly close to medicalizing crime.

Further Problems with the Paraphilias

In the preceding survey of the paraphilias, I have argued that the basis for retaining these in the DSM is extremely tenuous, is inconsistent with the logic that led to the declassification of homosexuality *per se*, and that a “definition by exclusion” for paraphilia is inconsistent with that decision. In this section, I consider the scientific and ideological foundations of this group of “disorders,” arguing that these render even more tenuous the basis of having these in the DSM. Arguments that have been given for including several of these diagnoses in the DSM are considered and generally found unconvincing. Particular focus is given to the reports of the DSM-5 Paraphilias Subworkgroup for existing diagnoses.

Scientific Foundation of the Paraphilias

In his argument before the American Psychiatric Association’s Nomenclature Committee in February 1973, Charles Silverstein criticized existing psychological research on homosexuality noting that, before 1957, all dealt with only two populations: patients wanting to be “cured” of their homosexuality and prison inmates (Silverstein, 1977). Even today, the situation for the rest of the “Sexual Deviations” is not much different. Consider what Abel (1989) writes regarding the evidential basis of the paraphilias around the time that DSM-III-R was published:

Information regarding the occurrence of paraphilias has . . . accumulated through records from arrested or incarcerated paraphiliacs, data from victims of paraphilic behaviors, and information from outpatient treatment programs that provide services for those seeking assessment or treatment or both. (p. 1070)

While he does go on to acknowledge the limitations of the sources of data relied on, the scope of the problem is ignored. Would a theory of heterosexuality based on clinical and correctional populations be considered trustworthy? A theory about paraphilias with such an empirical base is equally suspect. Abel (1989) appears to give a justification for relying on such sources of data: “Examinations of the presence of paraphilias in the general population has not been possible, but it is clinically suspected that individuals with paraphilic interests are infrequent” (p. 1070). This suspicion was

not universally shared. Money (1984) writes that DSM-III was incorrect in stating that the majority of paraphilias are atypical, and even at the time Abel made the above comment, there was strong empirical evidence suggesting he was wrong. Sue (1979) observed, “‘Deviant’ sexual fantasies are often reported by sexual offenders. However, in [the college sample in Sue’s study], themes related to sadism, masochism, and exhibitionism were relatively common” (p. 304). Similarly, Crépault and Couture (1980) found various paraphilic fantasies to be quite common in non-clinical populations. Ahlers et al. (in press), investigated the prevalence of paraphilic interests in a community sample of 367 men and found that 62.4% of them indicated at least some sexual arousal to at least one paraphilic category; over half of these regarded it as intensely sexually arousing.

It has sometimes been claimed that the DSM’s classification of sexual disorders is based on a “male model” of sexuality (e.g. Tiefer, Hall & Tavis, 2002), but the inclusion of the paraphilias draws this into question and lends appeal to a suggestion by Moser (2001) that the DSM relies on an image of sexual normality that comes “straight out of a bad romance novel” that “pathologizes most of history” (p. 98).

Ideological Foundations

Historically, the Western world has relied on a belief that sex is for reproduction and that non-reproductive sex is deviant. While this has become less dominant, a variant exists in the use of evolutionary psychology to justify sexual ideologies (Tiefer, 2004). With respect to the paraphilias, this is most commonly seen when defending their inclusion in the DSM by using the Harmful Dysfunction (HD) analysis of disorder, advanced by Jerome Wakefield (Wakefield, 1992a, 1992b, 1993). According to him, “disorder” has both scientific and valuational components—a “dysfunction” is when an internal mechanism fails to function as it has been “designed” by evolution to function and is “harmful” if it receives negative societal valuation. While this analysis has been controversial, especially regarding the “dysfunction” aspect (e.g. Sadler & Agich, 1995; Lilienfeld & Marino, 1995; Clark, 1999), it has gained some popularity, and been used by a number of authors to justify regarding pedophilia as a mental disorder (e.g. O’Donohue, Regev, and Hagstrom 2000; Seto, 2002; Spitzer, 2005; Spitzer & Wakefield, 2002).

Spitzer and Wakefield (2002) suggest that it is obvious that the purpose of sexual attraction is to facilitate finding fertile sexual partners with whom to reproduce. They define pedophilia as strong sexual attraction to prepubescent children (i.e. DSM-III-R’s definition except without requiring clinical significance), and then they argue that pedophilia, defined in exclusive or preferred sexual interest (i.e. DSM-III’s definition) indicates a dysfunction in some, and possibly all, cases. Raising the obvious issue of homosexuality, they give two possibilities: one is that at least sometimes homosexuality is a dysfunction, and the other is that “homosexuality does not necessarily involve harm to self or others and thus cannot be classified as a disorder” (p. 500), though, as Green (2002b) points out, they give no evidence that sexual attraction to children *necessarily*

causes harm to self or others.⁸ It is curious that Spitzer and Wakefield define pedophilia in terms of DSM-III-R and then argue that it is a dysfunction under DSM-III's formulation, without noting that they have done so or that this is not how the DSM presently defines it. This is especially curious given that the change from relative to absolute sexual interest was made in DSM-III-R, of which Spitzer chaired the Task Force.

Spitzer, Wakefield, and Seto's arguments intersect with an interesting problem for the HD analysis that Lilienfeld and Marino (1995) hint at by raising the issue of appendicitis. Appendicitis is not a failure of the appendix to do what it is supposed to do; it is a disorder because the appendix is doing something it is not supposed to do, which I will call a dysfunction of "commission" as opposed to a dysfunction of "omission." The HD analysis deals much more easily with dysfunctions of omission. To deal with dysfunctions of commission, Wakefield (not acknowledging this distinction) is forced to rely on a vague notion of "range" of selected function (Wakefield, 1999) to deal with it, which potentially makes any function not specifically selected for dysfunctional. In Spitzer and Wakefield's analysis, pedophilia is a dysfunction because of a lack of sexual interest in the right kinds of people (omission) and is harmful because of interest in the wrong kinds of people (commission), which is both awkward and requires an unproven causal link between the two, a causal link that is suspect because it is possible to be interested in either, both, or neither.

O'Donohue, Regev, and Hagstrom (2000)⁹ argue that pedophilia might fit the DSM's definition of mental disorder and does fit the HD analysis. For the latter, they argue that pedophilia is a "dysfunction" not because of lack of interest in the "right" kind of sex, but because it is an interest in non-reproductive sex. This move is necessary for them to justify their position that any sexual attraction to children is a disorder, regardless of whether the person acts on it, is distressed by it, and regardless of whether it is "intense." Western culture's historical negativity toward non-reproductive sexual expression is alive and well and plays a significant role in pathologizing the paraphilias.

Another dominant ideology is that sex is for love and intimacy. As Abel (1989) states: "Although sexual behavior plays a role in the preservation of the species, its major function for human beings is to assist in bonding, to express emotion between individuals, and for recreation" (p. 1069). As the paraphilias are sexual interests that (he supposes) do not conform to a sex-is-for-pair-bonding model, they are deviant. Likewise, Spitzer (2005), arguing that pedophilia is a mental disorder, asks what sex is for. "It is obvious," he answers, "Sexual arousal brings people together to have that interpersonal sex. Sexual arousal has the function of facilitating pair bonding which is facilitated by reciprocal affectionate relationships" (p. 114).

⁸ Spitzer and Wakefield (2002) cite Schmidt (2002) to justify their assumption of harm. While Schmidt argues that adult-child sex is morally wrong, he acknowledges that sexual attraction to children does not always lead to sexual interaction with children, and that such sexual interaction is not always harmful.

⁹ O'Donohue was selected by the DSM-5 Paraphilias Subworkgroup to be one of their advisors.

Apfelbaum (1984) addresses the question of what sex is for and argues persuasively that the most popular beliefs on the matter are maintained only by dismissing the reality of what people actually do and relying instead on an idealized sex of the imagination. He aptly counters the claim that sex is for procreation, pointing out that humans do not have estrus cycles. He then counters the claim that sex is for love and intimacy, drawing attention to the often objectivizing character of portrayals of and discourse about sexuality, and he points out the reality of “inflatable dolls, spike heels and patent leather, as well as fanny pinching and the other varieties of rape and harassment.” These are worth reflecting on. The ways that people talk about sex and the things connoted in sexual terms often have little to do with emotional intimacy. Sexual coercion is widespread, often committed by “normal” people; in human history, rape in wartime has been the norm, not the exception. Sex is often more about power than pair-bonding, and Apfelbaum highlights this in his reference to kinky sex, where the power aspect is indulged and delighted in. He counters a claim that sex is for pleasure and the release of tension, observing that “people do not eat bull's testicles or powdered rhinoceros horn to increase their capacity for tension release or sensual responsiveness (much less to achieve greater intimacy).” If Apfelbaum is correct, the ideological foundation of labeling the paraphilias as mental disorders rests on *a priori* beliefs about what sex is that require the dismissal of much—possibly most—actual sex; it is not based on reality, but on a dismissal of it.

Justifications for Including the Paraphilias in the DSM

In the December 2002 issue of *Archives of Sexual Behavior*, Green (2002a), in what can be seen as an *a fortiori* argument against including any of the paraphilias in the DSM, argues on grounds similar to those leading to the declassification of homosexuality that pedophilia is not a mental disorder. The same issue has an article on the ethics of adult-child sex (Schmidt, 2002) and a number of peer commentaries on Green and Schmidt's articles, making this a good place to look for arguments in favor of regarding pedophilia as a mental disorder. Six of the commentaries give positive arguments for regarding Pedophilia as a mental disorder. Spitzer and Wakefield (2002) and Seto (2002), discussed above, rely on Wakefield's HD analysis. Dixon (2002) argues that pedophilia is a disorder because it is “bizarre” and “abnormal.” Friedman (2002) writes that regarding it as a mental disorder would be “more helpful than harmful” thinking that the alternative would be to “turn away people requesting treatment for these conditions and instead refer them to the legal system” (p. 485). Krueger and Kaplan (2002) express hope that regarding Pedophilia as a mental disorder will promote understanding, tolerance, and the development of better treatments; they stress the clinical significance criterion, noting that, restricted to these cases, Pedophilia does meet the DSM's definition of mental disorder. Berlin (2002) appears to adopt what Wakefield (1992a) calls an “all value view” of disorders, explicitly stating that regarding Pedophilia (or cancer) as disordered is a value judgment. Feeling that our society has good reasons for prohibiting adult-child sexual interactions, there is need to help people with pedophilia resist these urges, and this sometimes includes pharmacological treatment. His argument is explicitly pragmatic: “If labeling them as disorders allows

mental health professionals to be better able to help such people, then doing so can serve a useful purpose” (p. 480).

Dixson’s argument, insisting that something is a disorder because it is “bizarre,” is nothing more than prejudice. In using the clinical significance criterion to justify including pedophilia in the DSM, Krueger and Kaplan fail to observe the inherent tautology.¹⁰ The arguments of Friedman, Krueger, and Kaplan, and especially Berlin, are more pragmatic in nature, but the use of pedophilia for SVP commitment poses a profound problem for these: If pedophilia is regarded as a mental disorder principally to provide help to people wanting help, this would provide no justification for its use to civilly commit anyone.

There is also reason to be skeptical that including the paraphilias in the DSM is helpful for effecting these pragmatic goals. In his literature review on Exhibitionism, Voyeurism, and Frotteurism, Långström (2010) acknowledges that “shame, social stigma, and *negative legal consequences* [emphasis added] prevent people from being open about their symptoms” (p. 323). He explicitly acknowledges that these diagnoses *harm patients* and create an environment where patients feel they cannot be honest with clinicians. This seriously draws into question their therapeutic value. Because of the use of the Paraphilias in SVP commitment, these diagnoses are used to label people as “sexually violent predators,” a designation unlikely to decrease stigma. Providing treatment for people who are attracted to children and who are wanting help to not act on that attraction is a real need, but it is not clear that the current diagnosis of pedophilia effectively facilitates this. Moreover, even if such a justification is used to keep pedophilia in the DSM, it clearly does not apply for a number of the other paraphilias, such as fetishism and transvestic fetishism. It certainly would not justify a *definition by exclusion*.

Reports of the Paraphilias Subworkgroup

The DSM-5 literature reviews for fetishism (Kafka, 2010); transvestic fetishism (Blanchard, 2010b); exhibitionism, voyeurism, and frotteurism (Långström, 2010) all ignore the question of why these diagnoses should be in the DSM. Hinderliter (in press-b) argues that Långström (2010) provides considerable reason for removing those diagnoses but ignores this. Regarding pedophilia, Blanchard (2010a) addresses the matter in a footnote. Noting that the DSM-IV-TR’s definition of mental disorder involves the phrase “an important loss of freedom,” he writes, “Since sexual acts against children are serious criminal offenses, they are closely associated with criminal conviction and incarceration (loss of freedom).” Essentially, sexual acts with children are illegal, therefore sexual interest in them is a mental disorder. This would both dangerously blur

¹⁰ Any behavioral or psychological condition, if it causes distress or impairment, is a behavioral or psychological condition that causes distress or impairment. If the use of a clinical significance criterion is used to justify how a diagnosis fits the DSM’s definition of mental disorder, virtually any behavioral or psychological condition could be included, which is clearly inappropriate.

the domains of psychiatry and the law, and it would make age-based erotic interests dependent on the age of consent where one lives. Krueger (2010a, 2010b) defends in more detail the idea of keeping sexual masochism and sexual sadism in the DSM, so these will be addressed at some length.

Sexual Masochism.

Recognizing that “masochistic and/or sadomasochistic behavior occur with some frequency in the population and is associated with generally good psychological or social functioning,” Krueger (2010a) defends including sexual masochism in DSM-5 anyway because “there are a very small number of cases where masochistic fantasy and behavior result in severe harm or even death. These cases clearly indicate a sexual interest pattern that has become pathological” (p. 353). According to this logic, if interest in heterosexual coitus sometimes leads to serious harm (STDs) or even death (AIDS), heterosexuality itself (and not merely the STD) could be regarded as a disorder. The expert consensus, however, does not seem to be to “cure” people of their heterosexuality, but to provide information, education, and resources necessary for assisting and encouraging people to engage in safer sexual practices. Krueger gives no justification for why sexual masochism should be any different. Because, on rare occasion, masochistic interests are practiced in dangerous, even fatal, ways, Krueger argues, “Since so little is know [sic] about this behavior, further research is indicated, and inclusion in the DSM would facilitate this” (p. 353). This diagnosis has been in the DSM since 1968, yet it has produced extremely little research on the matter—as Krueger’s literature review makes clear. Keeping it in the DSM and expecting different results makes little sense. Krueger also gives a second reason:

Although there are only a small number of studies that report on the occurrence of sexual masochism in forensic populations, one of these (Hill et al., 2006) reported that, of 166 sexual murderers, 5.4% received a diagnosis of sexual masochism, and 14.8% of those with sexual sadism also had sexual masochism. Further, because of the association of sadism with masochism, and because the studies of forensic populations did not use structured diagnostic inventories, the occurrence of sexual masochism in forensic populations could be substantially higher. In my opinion, retention of the diagnosis of Sexual Masochism in the DSM would allow for further research to be done on Sexual Masochism in forensic populations. (p. 353)

Neither of Krueger’s justifications involves any evidence that this diagnosis is clinically or forensically useful. In the absence of any data that sexual masochism plays any significant role in these crimes, keeping it in the DSM because there *may* be a connection to another diagnosis is questionable,¹¹ especially in light of the problems with that diagnosis.

¹¹ If simply being correlated with at least one disorder suffices for labeling a condition as a disorder, the number and breadth of absurd implications are mind-boggling.

Sexual Sadism.

Krueger (2010b) gives the following justification for retaining sexual sadism in the DSM: “Sexual Sadism is a prominent diagnosis and entity in forensic populations. It, along with other psychiatric diagnoses, presents a clear target of treatment. Treatment of psychiatric conditions is a cornerstone in addressing and reducing risk in forensic populations” (p. 340-341). The value of this diagnosis in dealing with offender populations is deeply questionable, especially because of its problems of reliability. Marshall and Kennedy (2003) review previous literature on sexual sadism among sex-offenders and conclude, “Neither crime scene data, phallometry, self-report measures, nor Knight and Prentky’s (1990) MTC:R3¹² archival data have proved to be reliable indicators of sexual sadism” (p. 15). Expressing doubt that any future attempts at operationalization of sexual sadism will solve the problems they found in their review, they question the utility of this diagnosis and suggest that it fails to contribute “to our understanding of these offenders to know that they are sexually aroused by such brutality... [and that] all relevant purposes will be better served by setting aside concern about sexual motivation and focusing on the features of the behaviors” (p. 16). To further investigate this diagnosis, Marshall, Kennedy, and Yates (2002) examined existing data from 51 sex offenders in certain prisons for whom a request had been made for evaluation by a forensic psychiatrist. In terms of offense features, there were only two significant differences between the sadist and non-sadist groups: the offenses of the sadists involved significantly *less* beating and torture than the non-sadists. Marshall, Kennedy, Yates, and Serran (2002) investigated the reliability of the diagnosis. The kappa coefficient for interrater agreement was 0.14. Below 0.6 is considered poor. Further data on the reliability of this diagnosis comes from Levenson (2004) who examined all 295 offenders who had received face-to-face evaluations for SVP civil commitment during a one-year period who had received evaluations from more than one forensic evaluator. The Kappa coefficients for the four paraphilias for which data are given range from pedophilia at the highest (0.65) and sexual sadism the lowest (0.30).¹³ The results of these studies seriously draw into question the forensic value of this diagnosis, and make even more problematic retaining it in the DSM solely on the basis of its supposed use with sex offenders.

The widespread existence of consensual sexual sadism compounds these problems. While Krueger acknowledges the potential of this diagnosis to stigmatize consensual

¹² MTC:R3 is a taxonomic classification of sex-offenders developed by Knight and Prentky.

¹³ Packard and Levenson (2006) did a data reanalysis for Levenson’s data, arguing that the low kappa coefficients were misleading and that if other statistics are used, the reliability appears much better. However, in that reanalysis they found that the paraphilias had positive predictive values (the probability that both raters would agree given that the first made a positive diagnosis) ranging from 0.2 for Sexual Sadism to 0.76 for pedophilia. As such, the data reanalysis provides little support for the reliability of sexual sadism.

practitioners of BDSM,¹⁴ the severity of the problem is ignored: there is no evidence sexual sadists are more likely to commit rape than anyone else (Moser & Kleinplatz, 2005). Using the term “hyperdominance” to describe people “who seek to inflict pain or humiliation, but only on willing partners,” (p. 532) Cantor, Blanchard, and Barbaree (2009) suggest two possible explanations of the relationship to consensual and non-consensual sexual sadism. One is that hyperdominance and sexual sadism are different phenomena that superficially resemble each other; the other is that these represent the same erotic interests and that these groups differ in non-sexual ways, such as antisociality, psychopathy, and tendency to misinterpret sexual partners’ mental states.

If the latter explanation is the case, supposedly pathological and non-pathological varieties of sexual sadism differ in ways orthogonal to the sexual interest itself, which should draw into question why the sexual interest is the focus of the diagnosis. For the other possibility, it seems unlikely that being hyperdominant would make it impossible for someone to commit rape (although this seems to be the implication of their way of defining it).¹⁵ Given that such individuals seem to be a significant minority of the general population, they should be a significant minority in offender populations, creating a necessity to distinguish between sexual sadists and hyperdominant people in offender populations, likely decreasing the reliability of this diagnosis.

Recommendations

Blanchard’s (2009) proposed definition of paraphilia reveals that the purpose of having these diagnoses in the DSM is simply that they are different. This is the whole point of a “definition by exclusion,” and it is unjustifiable. The Paraphilias Subworkgroup is proposing, along with this definition, a distinction between paraphilias (the sexual interest) and paraphilic disorders (the sexual interest and clinical significance), but this does not solve the problem. Including some sexual interests—but not others—in the DSM creates a fundamental asymmetry and communicates a negative value judgment against the sexual interests included. The case of ego-dystonic homosexuality is worth considering. The introduction to the DSM-III-R lists issues considered in changing diagnoses and then lists two more that were relevant for proposals to “[drop] a category from the DSM-III classification (e.g., ego-dystonic homosexuality) or [add] a new diagnosis to the classification (e.g., late luteal phase dysphoric disorder).” First, “does the proposed category meet the requirements of the DSM-III definition of mental disorder?” Second, “How compelling is the research or clinical need for the category?” (p. xxi). If homosexuality, even with the stipulation that it is only a disorder if it causes distress, did not meet the DSM’s definition of mental disorder, there seems little justification for claiming that the rest of the “sexual deviations” do.

¹⁴BDSM (Bondage/Discipline, Sadism/Masochism) lacks a consistent definition (Kleinplatz & Moser, 2006), but generally involves the consensual use of pain and/or power, often for the purpose of sexual excitement.

¹⁵ Heterosexuality is not defined in terms of only being interested in sex with consenting partners, so defining *hyperdominance* in such terms makes little sense.

The only basis for including fetishism and tranvestic fetishism seems to be that they are “non-normative” sexual interests. This is unjustifiable. The indefensibility of retaining these in the DSM is probably why Kafka (2010) and Blanchard (2010b) ignored all criticisms of these diagnoses and did not attempt to justify retaining these in the DSM. These, along with sexual sadism and sexual masochism, should be removed. Blanchard’s (2009) proposed definition of paraphilia should not be included in DSM-5. Exhibitionism, voyeurism, and frotteurism should also be removed because these too have minimal scientific support or clinical utility and because they harm patients and discourage them from being honest (see Hinderliter, in press-b). If the inclusion of “paraphilia” as a category is unjustifiable, paraphilia NOS should also be deleted. This leaves only the issue of pedophilia. The arguments considered so far render highly tenuous the basis of retaining it in the DSM, but the issue is complicated because there is a legitimate treatment issue involved—people distressed about their attraction to children wanting clinical help in resisting these desires should have access to such help. Whether the current state of this diagnosis is effective for promoting such treatment, especially in non-correctional populations, and how (and if) it could be modified to better support such treatment are important questions deserving further research and consideration (for concerns that these have not been taken seriously in the DSM revision process, see B4U-ACT, 2010). Even if pedophilia is kept in the DSM on the basis of pragmatic arguments about facilitation of treatment, this still leaves serious doubt about whether it is an appropriate diagnosis on which to base indefinite civil commitment.

Zander (2005) examines the diagnoses most often used in SVP commitment, finding serious problems with their validity and reliability. He concludes, “Civil commitment laws that rely on conceptually invalid and unreliable psychodiagnosis not only [may fail to pass Constitutional muster], they disgrace the professionals who employ the diagnosis, and subject committed persons to injustice” (p. 72). The history recounted above and the conceptual issues discussed add considerable weight to Zander’s concerns.

Historically, the American Psychiatric Association has strongly opposed SVP laws. In *Kansas v. Hendricks* (1997), they filed an Amicus Brief (American Psychiatric Association, 1995) arguing that Kansas’ SVP law was unconstitutional. In *Kansas v. Crane* (2002), they filed an Amicus Brief (American Psychiatric Association, 2000a) arguing that the considerably expanded understanding of that same law that the state of Kansas was arguing for was unconstitutional. The American Psychiatric Association (1994) assembled a task force to investigate the SVP laws, which issued a report (Zonona et al., 1999), whose position was unequivocal:

In the opinion of the Task Force, sexual predator commitment laws represent a serious assault on the integrity of psychiatry. . . . By bending civil commitment to serve essentially non-medical purposes, sexual predator commitment statutes threaten to undermine the legitimacy of the medical model of commitment. . . .

Psychiatry must vigorously oppose these statutes, to preserve the moral authority of the profession and to ensure continuing societal confidence in the medical model of civil commitment (p. 173)

A number of authors arguing against proposed expansions to the paraphilias (e.g. Frances, 2010; Franklin, 2009, in press; Green, 2010; Knight, 2010; Zander, 2009) regard undesirable legal consequences—especially regarding civil commitment—as serious reasons for rejecting those proposals (though not the only reasons). Applying the same logic to whether the paraphilias should be kept in the DSM at all, their abuse in SVP commitment adds weight to existing arguments for their removal (e.g. Moser, 2001; Moser and Kleinplatz, 2005; Silverstein, 1984; Suppe, 1984).

Perhaps the primary motivation for keeping the paraphilias in the DSM is fear that, as Spitzer (2005) predicts, removing them “would be a public relations disaster for psychiatry” (p. 115). In the current atmosphere of public fear and hatred of sex offenders, there would likely be massive negative response to the removal of pedophilia from the DSM, and many in the public would have little interest in the fact that whether sexual relations between children and adults/adolescents should be illegal and whether experiencing sexual attraction to prepubescents should be considered a mental disorder are entirely different questions. If this were the primary motivation for keeping the paraphilias in the DSM, it would explain the inconsistent and tortured logic that Spitzer and colleagues have used to justify retaining the paraphilias in the DSM—they are trying to protect guild interests. In light of the American Psychiatric Association’s historic opposition to SVP commitment, should this be the primary reason for the paraphilias’ continued inclusion in the DSM, the irony of their use in SVP commitment is indeed bitter.

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Appendix A: Definitions of Sexual Deviation(s)/Paraphilias from DSM-I to the Present

Standard Nomenclature of Disease 3rd edition (Jordan, 1942)

Name: Psychopathic personality with pathologic sexuality.¹⁶

Additional Text: “Indicate symptomatic manifestations (page 508), e.g., 991 homosexuality, 992 erotomania, 993 sexual perversion, 994 sexual immaturity.”

DSM-I (American Psychiatric Association, 1952)

Definition: “This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenia and obsessional reactions. The term includes most of the cases formerly classed as ‘psychopathic personality with pathologic sexuality.’ The diagnosis should specify the type of the pathological behavior, such as homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, mutilation)” (pp. 38-39).

Diagnoses listed: Sexual Deviation is a single diagnosis.

DSM-II (American Psychiatric Association, 1968)

Definition: “This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances, as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them” (p. 44).

Diagnoses listed: Fetishism, Pedophilia, Transvestitism, Exhibitionism, Voyeurism, Sadism, Masochism, Other sexual deviation, Unspecified sexual deviation.

DSM-III (American Psychiatric Association, 1980)

Introduction to the Psychosexual Disorders: “The Paraphilias are characterized by arousal in response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity” (p. 261).

¹⁶ Other varieties of psychopathic personality were also listed.

Introduction to the Paraphilias: “The essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement. Such imagery or acts tend to be insistently and involuntarily repetitive and generally involve either: (1) preference for use of a non-human object for sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation, or (3) repetitive sexual activity with nonconsenting partners” (p. 266).

Diagnoses listed: Fetishism, Transvestism, Zoophilia, Pedophilia, Exhibitionism, Voyeurism, Sexual Masochism, Sexual Sadism.

Atypical Paraphilias: Coprophilia, Frotteurism, Klismaphilia, Necrophilia, Telephone Scatologia, Urophilia

DSM-III-R (American Psychiatric Association, 1987)

Introduction to the Sexual Disorders: “The Paraphilias are characterized by arousal in response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity” (p. 279).

Introduction to the Paraphilias: “The essential feature of disorders in this subclass is recurrent intense sexual urges and sexually arousing fantasies generally involving either (1) nonhuman objects, (2) the suffering or humiliation of oneself or one’s partner (not merely simulated), or (3) children or other nonconsenting persons. The diagnosis is made only if the person has acted on these urges, or is markedly distressed by them” (p. 279).

Diagnoses listed: Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Transvestic Fetishism, and Voyeurism.

Paraphilia NOS: Telephone scatologia, Necrophilia, Partialism, Zoophilia, Coprophilia, Klismaphilia, Urophilia.

DSM-IV (American Psychiatric Association, 1994)

Introduction to the Sexual and Gender Identity Disorders: “The **Paraphilias** [emphasis in original] 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” (p. 493).

Introduction to the Paraphilias: “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, or 3) children or other nonconsenting persons, that occur over a period of at least 6 months

(Criterion A). . . . The behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B)” (p. 522-523).

Diagnoses listed: Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Voyeurism, Transvestic Fetishism.

Paraphilia NOS: telephone scatologia, necrophilia, partialism, zoophilia, coprophilia, klismaphilia, urophilia.

DSM-IV-TR (American Psychiatric Association, 2000)

Introduction to the Sexual and Gender Identity Disorders: Same as in DSM-IV.

Introduction to the Paraphilias: “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, or 3) children or other nonconsenting persons, that occur over a period of at least 6 months (Criterion A). . . . For Pedophilia, Voyeurism, Exhibitionism, and Frotteurism, the diagnose is made if the person has acted on these urges or the urges or sexual fantasies cause marked distress or interpersonal difficulty. For Sexual Sadism, the diagnosis is made if the person has acted on these with a nonconsenting person or the urges, sexual fantasies, or behaviors cause marked distress or interpersonal difficulty. For the remaining Paraphilias, the diagnose is made if the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (p. 566).

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