Chapter 1
Problems in the Classification and Diagnosis of the Paraphilias: What Is the Evidence That the DSM Warrants Use?

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A classification system in science or an applied science is designed to achieve several intellectual as well as practical goals. When it is successful at achieving these goals it is an invaluable and even essential contribution to both basic and applied pursuits. When it fails to accomplish these it can be an impediment to progress as well as competent, safe practice. When the classification system is attempting to demarcate behavioral health problems such as the DSM-V (American Psychiatric Association, 2015) the extent to which these ends are achieved has a direct impact on the beneficial or iatrogenic effects of professional behavior. Therefore, it is important to critically evaluate the quality of any proffered classification system.

This chapter reviews the quality of the DSM5 diagnostic categories of the paraphilias. Some of these problems are shared by other diagnostic categories and some are unique to the paraphilias. The major unsolved problems include:

1. It is unclear whether the paraphilias are natural kinds or social constructions.
2. It is unclear whether the paraphilias are better construed as categorical or dimensional entities.
3. It is unclear if each paraphilia is properly subtyped—especially as there is some unexplained variance in the way the DSM5 provides subtypes for each paraphilia.
4. The definitional strategy for each paraphilia is unclear, particularly whether each ought to be defined by necessary and sufficient criteria, by attributes as open concepts, by prototypes, or by an explication of their human history as social constructs. No argument is provided for the definitional strategy utilized.

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5. It is unclear who ought to properly define these and what interests these may represent and serve. It is possible that the conventional analysis of special interests do not apply to these constructs.
6. There are controversies whether the revisions were made with an open, transparent, fair, and reasonable process that was evidence-based. Explicit referencing of claims is not provided in the DSM5.
7. The justification supplied in the DSM5 for the revisions—i.e., that there was such significant progress in genetics, brain imaging, cognitive neuroscience and epidemiology that a revision became necessary does not seem to apply to the paraphilias.
8. The definition of mental disorders given in the DSM5 might possibly exclude some paraphilias as this definition specifically excludes sexual behavior that is socially deviant unless the deviance is due to dysfunction in the individual—and the exact nature of this internal dysfunction is not specified or known.
9. The general definition of mental disorder provided in the DSM5 necessitates that all mental disorders arise from a dysfunction ("in the psychological, biological or developmental processes underlying mental functioning") in the individual but the diagnostic criteria of the paraphilias fails to specify this dysfunction.
10. Strangely, instead of relying on the general definition of mental disorders the DSM5 surprisingly provides two problematic candidates for demarcating the paraphilias—their commonness (relative to other paraphilias) and their noxiousness/illegality. There at least is some tension with the earlier exclusionary criteria of "social deviance."
11. The DSM5 diagnostic criteria for paraphilia seem to be developmentally naïve. It is unclear how these diagnoses relate to the developmental spectrum although the DSM5 at times indicates that special consideration ought to be given to "old people."
12. The DSM5 states that for actual diagnoses to be made the clinician must consider predisposing, precipitating, and protective factors yet this is impossible for the paraphilias as these are unknown.
13. There seems to be no clearly explicated relationships between the individual paraphilia diagnostic categories. These seem to be more of a heap than systematic network of interrelated constructs.
14. Importantly, the interrater reliability of these diagnostic categories is unknown and has been for at least a third of a century.
15. These diagnostic categories have unknown construct validity and predictive validity.
16. Each of the paraphilias now requires a problematic distinction between a paraphilic orientation and a paraphilic disorder. It is unclear that a paraphilic orientation is actually benign and the interrater reliability of this distinction is unknown.
17. It is unclear if all the paraphilias are included in the DSM5; for example an attraction to rape—a nonconsenting partner is not included.
18. There is a possible overconcern with false positives in diagnostic categories due to the miscategorization of homosexuality as a paraphilia in past editions of the DSM.

19. There is an overreliance in the diagnostic criteria that rely on notoriously problematic self-report. In some paraphilic diagnoses—but not others—a simply denial seems sufficient for ruling out a diagnosis.
20. Other constructs commonly used in the diagnostic criteria of the paraphilias are also problematic—why is the duration 6 months?—why must the behavior be recurrent?—what does "acting upon" these exactly mean?—don't we all act on our sexual interests?
21. Why must a person be distressed by these to have this reach diagnostic significance? For example, isn't not being distressed by a sexual attraction to a child more of a problem instead of less of one—especially as the DSM5 acknowledges that Antisocial Personality Disorder is a common comorbid condition?
22. In places the DSM5 seems to claim that if the paraphilic interests are less intense than what it vaguely calls "normophilic interests" then this obviates a diagnosis—although why this is the case is unclear, not clearly specified in the individual diagnostic criteria, and it now requires the clinician to measure the intensity—whatever this means exactly—of all the client's sexual interests and behaviors. There is no evidence that intensity can be validly measured.
23. The DSM5 makes strange, unclear, vague, and undocumented epidemiological claims.
24. The DSM5 in its epidemiological claims seems to hide an important point made by the feminists—that sexual problems are a gendered problem—these are possessed by males and their victims are females.
25. Finally, the DSM seems at time to be clinically naïve—for example requiring masochists to be distressed by their preference for pain.

Classification, Taxonomies and the DSM5

What are the overarching goals of a sound classification system? These are commonly taken to include: (1) an attempt to "carve nature at its joints" and both create classificatory categories that function as a placeholder for all entities that ought to be categorized *as well as facilitating the proper placement of all entities in the taxonomy*. These categories generally should be exhaustive (the classification system should leave out no entity that ought to be classified), mutually exclusive (generally an entity ought to belong to one and only one category), clear (an entity ought to be able to be reliably placed within the structure of the classification system) and, finally, ideally based on sound principles of classification (important distinctions are made while trivial ones are avoided). For example, a biological taxonomy would enumerate all key distinctions such as kingdoms, phyla, species, etc. and place these categories in their proper position relative to one another, as well as be conducive to the reliable and valid classification of phenomena within this structure, e.g., whether the entity to be classified is in plant kingdom or animal kingdom, vertebrates or nonvertebrates, mammals or nonmammals, etc. Thus, a classification system provides a comprehensive organization that reveals interrelationships. (2) In addition, a

sound classification system provides a *common language* and thus a system for cataloging and communicating knowledge. For example, in the periodic table of elements one knows clearly what is meant by when the term "oxygen" is used; and one even knows the scientific principles by which oxygen is placed between nitrogen and fluorine in the classification system. The organization of the periodic table of elements is founded on a deeper scientific knowledge of the phenomena to be classified—i.e., the atomic structure of these elements. In this sense, there is an important reflexive relationship between classification and basic science—carving nature at its joints allows scientific regularities to be found—but discovered scientific regularities also allows nature to be carved at its joints. (3) Finally, a classification system can function as a *useful inference generator* to lawful relations when it is based on these sound underlying scientific regularities. For example, the biological classification system allows the inference that species cannot interbreed and produce reproductively viable offspring. Elements with certain positions in the periodic table allows one to make inferences about which elements can combine with other elements and what kind of chemical bonds will be utilized.

However, it is also important to note that there are also some general controversies about taxonomies and classification in science:

1. *Natural kinds vs. social constructions*. There has been a significant debate in the last few decades in the philosophy of science whether the categories found in classification systems in science are "natural kinds," i.e., roughly that these categories describe what actually exists in reality in an objective way or, on the other hand, whether scientific entities are merely convenient verbal social creations or "social constructions"—i.e., conventions that are to some degree useful but have no real objective existence beyond these linguistic agreements (see for example, Foucault, 1990). For example, classifying balls and strikes in baseball are clearly social conventions—these can be alternatively defined and were created at a point in time and thus have a contingent human history. On the other hand, those that argue that science reveals natural kinds—objective "real" categories found in nature as opposed conventions created by humans, suggest that entities like sulfuric acid have a real, independent existence apart from human conventions—no matter how we divide the world in a linguistic system the kind of thing called sulfuric acid in high concentrations will damage or destroy human tissue. No words or changes in language can change this reality. The issue for our purposes is: Are mental disorders as defined in the DSM natural kinds or social constructions? Or more specifically for our interests in this chapter, are paraphilias natural kinds or social constructions? Given how few scientific regularities have been found with these categories, currently it is hard to argue that there is clear evidence that these diagnostic categories are natural kinds. Moreover, in general, the field of sexology or psychology, due to a variety of considerations, has seemed to regard these categories more as natural kinds (but see Foucault, 1990). On the other hand, there does seem to be something distinct between say someone who exposes himself to unsuspecting women and someone who does

not, especially given reliable and robust gender and age differences in the frequency of this kind of behavior.

2. *Are the key distinctions to be made categorical or dimensional?* A second general controversy is whether these entities ought to be classified along dimensions or whether these form discrete categories. For example, we can consider night and day to be either two discrete categories defined by essential properties (e.g., the presence or absence of sunlight). This is a categorical distinction. On the other hand, when we consider phenomena like dusk or dawn—which seem to have properties of both day and night—we may consider it more useful to construe these as points on a dimension—i.e., that the amount of sunlight can be measured and then a range of values on this dimension can be reported rather than a simple bifurcation of day vs. night. Kinsey (1948), for example, suggested that sexual orientation ought to be dimensional rather than categorical (heterosexual vs. homosexual). Kinsey (1948) used a scale from 0 that signified exclusive heterosexuality to 6 which signified exclusive homosexuality. Kinsey (1948, p. 639; 656) arguing for a dimension approach stated:

> Males do not represent two discrete populations, heterosexual and homosexual. The world is not to be divided into sheep and goats. It is a fundamental of taxonomy that nature rarely deals with discrete categories… The living world is a continuum in each and every one of its aspects.
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> While emphasizing the continuity of the gradations between exclusively heterosexual and exclusively homosexual histories, it has seemed desirable to develop some sort of classification which could be based on the relative amounts of heterosexual and homosexual experience or response in each history […] An individual may be assigned a position on this scale, for each period in his life. […] A seven-point scale comes nearer to showing the many gradations that actually exist. —Kinsey, et al. (1948). pp. (639, 656)

   The practical issue then becomes, should mental disorders or a particular paraphilia be a categorical or a dimensional entity? The DSM5 apparently considers these to be categorical entities but does not provide a sound argument for this decision. Of course, if these are to be better construed as dimensional entities one needs to explicate what are the relevant dimensions and valid measurement operations to place entities on these dimensions. No clear candidates have been brought forward, although a Kinsey-like dimension could be used.

3. A third controversy is the problem of subtyping. This is essentially a problem of when to stop making distinctions and new categories—when a taxonomy has made all important distinctions. Assuming that there is a legitimate superordinate category—the questions then becomes, "Are there subtypes of this category—and then are there subtypes of these subtypes, and so on"? If so, how would one tell? If not, how does one tell? Let's take the example of pedophilia: Is incest versus nonbiological attraction an important subtype? Is age or age range (say, 3–5 versus 8–10) of the child who is of sexual interest an important additional principle of categorization? What about gender preference? Whether the person is interested in grooming the child or not? Whether violence is part of the attraction? Whether the person is in denial or not? Whether the person has exclusively this orientation or not? Whether the individual has acted on the interest or not?

And so on. Currently, for pedophilia the DSM5 recognizes only three subtyping distinctions (without presenting an argument for these): (1) exclusive versus nonexclusive; (2) attracted to males, females, or both; and (3) limited to incest. However it is interesting to note that for many other paraphilias, the DSM5 uses different categories used for subtyping. For example, most of the other paraphilic disorders listed in the DSM5 allow subtyping along the dimensions of in full remission or not; or whether the individual is in a controlled environment or not. Why the diagnostic category of pedophilia does not contain this subtyping but has a unique set of distinctions is none too clear.

4. *What ought a definition of a category or dimension look like?*—Ought each distinction list sufficient and necessary conditions like "bachelors are unmarried male adults" or "oxygen has 16 protons in its nucleus"? Or should the category have some sort of other definitional attributes? The cognitive psychologist Eleanor Rosch (1975) has suggested that humans categorize by the use of prototypes. For example, the prototype for must of us for the category of bird is a robin. We then judge whether or not other candidates fit into the category of bird by how closely the candidate seems to be to the robin prototype. Ought we to at least help categorization by including these core prototypes? On the other hand, Meehl (1990) has suggested that diagnostic categories cannot have such clear definitional properties but rather are "open concepts." Open concepts are characterized by (a) fuzzy boundaries, (b) a list of indicators (i.e., signs and symptoms)—none of which are essential and that are indefinitely extendable, and (c) have essentially an unclear nature. Finally, those who orient toward a social constructionist view would suggest explicating the history, contingency, social forces, and special interests that have come to construct the open concept is important and goes a long way to understanding and defining the category.
5. *A fifth, and final, controversy is who gets to decide on such categorization?* Sometimes this is relatively uncontroversial—no one is really questioning the authority of the periodic table of elements or claiming it is just a product of certain social or political interests. Why psychiatry largely controls the diagnostic system is unclear as is how the DSM committees are chosen and how they function. Post-modernist critics of science (see O'Donohue, 2013 for a summary) have suggested that scientists have interests—sometimes personal such as fame, power, or money but sometimes more social or political ones such as either maintaining or changing the status quo. So these philosophers suggest analyzing science from the point of view of "Cui bono?"—whose interests are being served? Revisions of the DSM have also been plagued by these kinds of criticisms. To what extent are these moves simply in the interests of organized psychiatry, Big Pharma, white males, or medicine more broadly? On the other hand, there is a mode of analysis that might be more unconventional but possibly more telling: to what extent have GLBT interest groups or other sexual "liberation" groups had direct or indirect influence on this taxonomy? To what extent is serving these interests legitimate?

Lilienfeld (2014) has argued more generally that the DSM has had "many masters" and represents a compromise between multiple competing demands and constituencies. The DSM-5 revision has been controversial not only for the content of proposed changes to diagnostic criteria but also for its process that occurred to produce these changes. Part of the problem is that the process was unclear and at times was not transparent. There have been accusations of secrecy, lack of adequate representation by various groups and interests (for example, social work seems to have been relatively ignored), lack of quality control, failure to generate and explicate comprehensive and critical literature reviews to justify the changes, and an unjustified "paradigm shift" toward incorporating a biological etiology for which the justifying scientific evidence does not exist. Interestingly, this criticism has not been coming from the usual anti-psychiatric interests but rather from some of the most eminent and respected DSM experts within psychiatry itself—such as the previous DSM editors. Both Allen Frances, the Editor of the DSM-IV (1994), and Robert Spitzer, the chief editor of DSM-III (1980) and DSM-III-R (1987) and the single person most responsible for creating the modern symptom-based descriptive DSM psychiatric approach to diagnosis, have been loud critics of the DSM5 revision.

Further Problems and Controversies

Why Was a Revision of the DSM Necessary?

The DSM5 makes rather expansive claims that do not clearly apply to the paraphilia diagnoses such as "However, the last two decades since DSM-IV was released have seen real and durable progress in such areas as cognitive neuroscience, brain imaging, epidemiology and genetics" (p. 5). This sort of claim is the rationale for why a new edition of the DSM is needed. However, the section on paraphilias in the DSM5 is certainly devoid of any specifics regarding the alleged scientific progress on the cognitive neuroscience, brain imaging, epidemiology or genetics of the paraphilias. It is unfortunate that this general claim about scientific progress is not qualified to be more in line with at least some of the state of science in these disorders, especially because dysfunctions in these are the key properties proffered by the DSM to define mental disorders.

What Is a Mental Disorder According to the DSM5 and Do Paraphilias Fall Under This Definition?

The DSM5 defines a mental disorder as:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning.

> Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder, socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual as described above (p. 20).

The question becomes, "What sorts of sexual behavior fit this general definition, and, more specifically, do the categories of paraphilia contained in the DSM5 actually fit this definition of a mental disorder"? Unfortunately the answers to these important questions are none too clear. The phrase in the definition above "… socially deviant behavior (e.g., political, religious or *sexual*, italics added) … are not mental disorders unless the deviance or conflict results for a dysfunction in the individual as described above" adds considerable ambiguity and confusion. Why is the term "sexual" used here to exclude some socially deviant behavior from the realm of mental disorders? Unfortunately, no argument or further elucidation is given. How does one tell if the sexual issue is "primarily a conflict between the individual and society" or a "dysfunction in the individual"—and why are these regarded as mutually exclusive categories? What is the scope or extension of this exclusion—why does this not apply to all sexual deviation? If it does not apply to all sexual deviation, what principle demarcates those conditions that are internal dysfunctions versus those that are "societal conflicts" that are excluded? Finally, how exactly does one go about validly discerning if the sexual behavior "… results in a dysfunction in the individual as described above"? Presumably then this raises the question of, "Does this sexual behavior result from 'a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning'"? Given our very poor understanding of the etiology of the paraphilias, this again is none too clear. In fact, Moser and Kleinpelz (2005) have suggested that since the paraphilias do not meet the general definition of mental disorder as contained in earlier editions of the DSM that the paraphilias be dropped from the DSM.

Paradoxically, later when the DSM5 turns to its section on the paraphilias it seems to ignore the definitional criteria it had earlier laid out for mental disorders. Thus, the DSM5 is not even internally consistent. Instead in this section the DSM states,

"These disorders (i.e., paraphilias) have traditionally been selected for specific listing and assignment of explicit diagnostic criteria in the DSM for two main reasons: they are relatively common, in relation to other paraphilic disorders, and some of them entail actions for their satisfaction that because of their noxiousness or potential harm to others are classed as criminal offenses" (p. 685).

This shift is very strange indeed. Suddenly there is no talk about progress in cognitive neuroscience, brain imaging, genetics, predisposing or protective factors and disturbances in these resulting in disorders but rather the relatively pedestrian notions that the paraphilias are "relatively common" (whatever that precisely means and why something being common is considered to be disordered is somewhat paradoxical) and that they are noxious (noxious to whom? and why is this dimension

picked out to define a problem—many find metallic rock and roll noxious but certainly this—offensive taste—ought not be the criterion for a category of mental disorders). And that which is criminal ought not to determine that which is a health problem. Stealing is relatively common but not regarded as a mental disorder.

Further, the DSM5 (p. 685) states "The term paraphilia denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners." This seems to be a reasonable candidate for distinguishing abnormal from abnormal behavior. However, some additional issues could include: (1) explicating how this criterion obviates concerns expressed earlier in the DSM5 about conflicts between an individual and society; (2) how this generally meets the DSM5 definition of mental disorder (i.e., it arises from a dysfunction within the individual), and (3) how this applies to adolescents and children (paraphilias are adult disorders but much attention is given to the treatment of juvenile offenders (see for example Bromberg & O'Donohue, 2012). Finally, the DSM5 asserts somewhat unclearly "With old people the term paraphilia may be defined as any sexual interest greater than or equal to normophilic sexual interests (p. 685)." It is not clear why "old people" are given this special consideration and this involves an additional difficult measurement task; measuring the magnitude of multiple different sexual interests.

In addition, the DSM5 states, "it requires clinical training to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which physical signs and symptoms exceed normal ranges" (p. 19). However, the truth of this statement is dependent upon whether the basic science has actually made sufficient progress to uncover the "predisposing, precipitating, perpetuating and protective factors" and whether enough is none about normal variability to make a sound actuarial judgment about exceeding "normal ranges." It is clear that these broad almost promissory statements made in the DSM5 do not apply to the paraphilias that again, because no such basic information exists. These sorts of statements in the DSM5 seem to have a broad rhetorical function rather than a more careful descriptive function about the actual state of scientific progress.

What Are the Relations Between Broad Categories of Mental Disorders in the DSM5 or Within Specific Disorders Within a Broad Category?

There seems to be no scientific principles that are relevant to the relations between broad diagnostic categories. Personality disorders, substance disorders, and the paraphilias are all broad diagnostic categories but their taxonomic relationship appears to be nonexistent. These are contained in the same manual but are in no hierarchical or other order. Moreover, there seems to be no organizing principle with allows the understanding of subcategories of these. Pedophilia, voyeurism, and

fetishistic disorder are all subcategories of the superordinate category of paraphilia, but the relationship between these is totally unclear and unspecified. They are simply listed one after another in a seemingly arbitrary order.

Unknown Interrater Reliability of Each Paraphilic Disorder

There have been no field trials of the revisions contained in the DSM5 to show to what extent clinicians can make diagnoses of the paraphilias with acceptable interrater reliability. In fact although true, this statement is much too weak. For decades the paraphilias have been orphaned regarding studies of the diagnostic interrater reliability. Students of the history of the various versions of the DSM know that because of some evidence of the lack of diagnostic consistency in the first two versions of the DSM, the DSM-III was an attempt to correct this problem. It attempted to more clearly outline behavioral diagnostic criteria for reliable diagnosis. There was some evidence that this was at least partially successful for some of the major diagnoses such as depression and schizophrenia. However as Blanchard (2011) has astutely stated:

"One of the first questions one might ask about the field trials conducted for the DSM revisions is how many patients with diagnoses of paraphilia were studied." The field trials for DSM-III, which were sponsored by the National Institute of Mental Health, included three patients with paraphilias (Appendix F, Tables 1 and 2, pp. 470–471). That's it. Paraphilia diagnoses were not included in the field trials for DSM-III-R (American Psychiatric Association, 1987, Appendix F, pp. 493–495) or for DSM-IV (see O'Donohue, Regev, & Hagstrom, 2000, p. 98). Thus, the sum total of patients who have been studied in conjunction with revising the DSM diagnostic criteria for the paraphilias is 3. That is fewer than half the number of paraphilia diagnoses listed in the DSM. That means that most of the paraphilias diagnostic criteria were never looked at with a single patient as part of the DSM production process ever.

Unfortunately, this number—3—has not changed with the DSM5. In fact, there are reasons to think this concern over diagnostic interrater reliability has actually intensified. The DSM5 know requires the clinician to make a further distinction between a *paraphilic orientation* and a *paraphilic disorder*. And these concerns are multiplied because this applies to each diagnostic category, i.e., to a fetishitic orientation versus a fetishitic disorder or to an exhibitionistic orientation versus an exhibitionistic disorder, and so on. There are of course obvious reliability questions concerning this clinical judgment. Thus, to date, it is clear that for nearly a third of a century there has been no evidence that the paraphilias can be reliably diagnosed. Despite this important lacuna it has been the major diagnostic system used, with no real competitors. It is astonishing that there has been so little progress on this basic psychometric issue that has obvious implications for practice. If someone were to ask the question: "Is there scientific evidence that if a person were to receive a paraphilic diagnosis from one clinician that they would receive the same diagnosis from another clinician?" the answer is "No." Surprisingly, in contrast to worries

about this fundamental issue, the revisions contained in the DSM5 may make the psychometric issue more complex by calling for further distinctions and attendant judgments that can add to further unreliability.

Unknown Validity

Although the interrater reliabilities of the DSM5 paraphilic diagnoses are unknown it must be remembered that because validity is not a prerequisite for reliability, extremely high reliability can exist without validity. That is, another gap in our knowledge of the quality of the DSM5 paraphilic categories is that we have little evidence about their construct or predictive validity. It is difficult to make valid inferences from diagnostic categories when little is know about the etiology, treatment course, protective factors, or other regularities involving the entities.

Robins and Guze (1970) described several essential criteria for determining the extent to which a diagnosis is valid. Validity refers to the extent to which a diagnosis actually captures what it purports to measure. A valid diagnosis is "honest" in that it correlates in expected directions with external criteria. Robins and Guze specified four requirements for the validity of psychiatric diagnoses:

1. Clinical description, including symptomatology, demographics, precipitants, and differences from seemingly related disorders. The last-named task of distinguishing a diagnosis from similar diagnoses is called differential diagnosis.
2. Laboratory research, including data from psychological, biological, and laboratory tests.
3. Natural history, including course and outcome.
4. Family studies, especially studies examining the prevalence of a disorder in the first-degree relatives of probands—that is, individuals identified as having the diagnosis in question.

Some authors also have suggested that a valid diagnosis should ideally be able to predict the individual's response to treatment (Waldman, Lilienfeld, & Lahey, 1995). Unfortunately, nearly all of this information is missing in the paraphilic diagnoses contained in the DSM5. No genetic studies are described. Very little information is given about course and outcome. No laboratory research—either physiological or psychological—is described. Some descriptive psychopathology is given although at times (more below) only very vague statements are made which are either heavily qualified or have such a range that the information has very limited use. Thus, there is little information in the diagnostic categories that support the validity of these.

Are All Paraphilic Diagnostic Categories Included?

Two categories that have not been included are a "rapist" diagnostic category—roughly either those that are attracted to sex with a nonconsenting individual or can maintain arousal through active nonconsent. In addition, Blanchard et al. (2009) has advocated a hebephilic diagnostic category—or expanding the pedophilic category

to something along the lines of "hebopedophilia" to combine both a sexual attraction to pre-pubescent and early pubescent children by someone who is at least 5 years older. Because no clear candidate for a demarcation of "abnormal sexuality" has been explicated in the DSM—it is more difficult to understand the rationale for why these categories have been excluded.

What Is the Justification for the Diagnostic Categories That Are Included?

It is reasonable to hypothesize that the field is very sensitive to the mistake that in the past homosexuality was regarded as a mental disorder. There is very little dissent that this was a horrible mistake and one that should be avoided in the future at all costs. This may be called the problem of the false positive—i.e., that some entity is considered a mental disorder and perhaps especially a paraphilia when it actually is not. Humans can have the tendency to overcorrect mistakes and it may be the case that this is happening now in the field. There seems to be more concern about falsely categorizing something as deviant sexual behavior than the converse: not calling something deviant sexuality when it actually is. It appears that each paraphilia has its corresponding "sexual liberation" movement which argues that the same mistake of falsely categorizing this behavior as a mental disorder is being made. Part of this seems to be reflected in the new distinction between a so called "paraphilic orientation" and a "paraphilic disorder." This is a new distinction in this edition—which again there is no evidence can be reliably made by clinicians. However, what about its validity—why is such a distinction valid? These are important issues made all the more difficult by the DSM's conflicting and unclear or sometimes absent statements about why a particular paraphilia is in fact to be properly considered a mental disorder. However, it appears that the field is a bit weak kneed about this: and perhaps this is due to being overly impacted about the past mistake of miscategorizing homosexuality. It seems like an important intellectual task to more clearly demarcate why each paraphilia is indeed a mental disorder (using better criteria than they are "common" or "noxious" or are based on a "dysfunction" in the individual).

Difficulties Applying the DSM5 Diagnostic Criteria of Paraphilia

O'Donohue, Regev, and Hagstrom (1990) have previously suggested that there are ambiguities that lead to assessment problems for the clinician that can lead to inter-rater reliability problems contained in the DSM-IV. It appears that most of these concerns still apply to the DSM5. First, part of the difficulty involves that some sexual behavior is covert—it is experienced in heads and thus is not readily

observable by others. Sexual fantasies, sexual dreams, sexual intentions, cognitive arousal, etc. are all not observable by others. Yet these are all relevant to understanding and evaluating the extent to which a person's sexual behavior or orientation is disordered or not. If a client fully and accurately reported this covert behavior there would be little problem. However, because we know that many individuals with paraphilias are in denial or directly lie about their behavior, the field faces an important measurement problem related to defining diagnostic categories that rely on covert behavior and hence accurate self-report. A fundamental strategic and conceptual question is as follows: To what extent should covert behavior which often is not reported accurately—and to which that field really has no validity check—ought to be part of the DSM5 diagnostic criteria? There seems to be an essential tension between recognizing that such covert behavior is an important part of one's sexuality but at the same time including it in diagnostic criteria when there is motivation to distort and being unable to check the validity of any self-report.

Most strangely of all at times the DSM5 seems to take self-report as face valid and appears to be uninterested in its accuracy. For example, for Sexual Masochism Disorder it states, "The diagnostic criteria for Sexual Masochism Disorder are intended to apply to individuals who freely admit to having such paraphilic interests" (p. 694). Thus, a simple denial (even a false one) is sufficient to exclude this diagnosis! This is quite strange.

However more specifically, the diagnostician faces further ambiguities:

1. Most diagnoses require that the other diagnostic criteria persist over a period of 6 months. Why "over a period of 6 months"? The basic idea in all likelihood is to show some temporal stability. However is this really necessary—are there actually cases where someone was attracted to children for a 2 month period and then it spontaneously remitted? It seems that these problems are chronic not acute. In addition, why 6 months as opposed to some other time period? No justification is given in the DSM5.
2. The DSM5 requires that the behavior be "recurrent"? Does that simply mean more than once? For example for Exhibitionistic Disorder the DSM5 states "'Recurrent' genital exposure to unsuspecting others (i.e., multiple victims, each on a separate occasion) may, as a general rule, be interpreted as three or more victims on separate occasions." Why three victims? Why isn't doing this one time sufficiently noxious, criminal, or indicating a dysfunction in the individual? What if a person exposed themselves hundreds of times to only one victim? They still wouldn't deserve a diagnosis? Why isn't two victims sufficient—especially as we know that it is usually the case that known victims are usually much less than all victims?
3. The DSM5 requires the behavior to be "intense"? How is intensity to be assessed? Intense relative to what? There is no objective valid way to measure this. Again, this wording forces the field to rely on self-report. In addition, there is a principle of assessment that we ought to not ask what clients are unable to tell us. Here we need to ask if the person's fantasies, urges or behaviors were "intense." What if they were to ask, "What exactly do you mean by intense, and how would I tell if my fantasy yesterday met this criterion or criteria?" It would seem that we could

not answer this. Moreover, do we really want to say that repeated "nonintense" sexual fantasies regarding children do not meet the diagnostic threshold?
4. What is "sexual behavior"? Or more specifically, what exactly is the extension of this term? It seems clear that intercourse would be included, but what about other possible candidates for "behavior"? Is "flirting" with a child sexual behavior? Is looking at an attractive person sexual behavior? Is smiling at an attractive person sexual behavior? Is placing a towel at a beach so an attractive person can be more easily viewed a sexual behavior? Is buying a present for a person you are attracted to a sexual behavior? Is choosing to be a school bus driver a sexual behavior? Again, the scope of this term is none too clear. It can even be argued that all our behaviors are sexual behaviors in that our sexual orientation is a deep and pervasive part of our personality.
5. What does "acting on" mean? How is this causal relation to be assessed? Don't we all act on our sexual interests in many ways? Isn't it impossible not to? Aren't all these "micro-sexual behaviors" listed above examples of acting on? However, there are other difficult questions: what about unintentional behaviors such as sexual dreams, would these be acting on? Or does acting on mean only an illegal act or an act involving genitals?

The DSM5 requires that the condition cause "marked distress" or "interpersonal difficulties"? Why? Why can't these conditions be pathological in and of themselves? O'Donohue et al. (2000) suggested that this part of the definitional criteria would rule out a "contented pedophile" and raise the question of why someone who is not distressed by this ought to be regarded as more pathological not less. The DSM5 states "… a paraphilia by itself does not nearly justify or require clinical intervention" (p. 686). Thus, the DSM5 paradoxically would indicate that someone who is sexually attracted to children does not need therapy. It views this proclivity to harm children as not sufficient for intervention. It seems to assume that individuals can over prolonged periods of time, not act on their sexual interests, although the evidence for this is not given. Or the individual needs to be personally distressed by this—the distress of parents or children is irrelevant. For example, the DSM5 states that Antisocial Personality Disorder is a relatively common comorbid condition with pedophilia but apparently not recognizing that when this condition is comorbid it is also less likely that the this person would be distressed by his pedophilic interests. In addition, there is also the issue of what kinds of distress and what levels. Finally, it is difficult to parse "interpersonal difficulties" as sometimes these seem legitimate but in other situations these are not. Being African-American in the South has caused individuals "interpersonal difficulties" as does homosexuality but these as seen not the individual's problem but really the problem of others. Beyond parsing whose fault the interpersonal difficulties are to be attributed, the question becomes also, what kinds of interpersonal difficulties, what levels of these, and how they are to be measured. The DSM5 states further: "a paraphilic disorder is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm to others" (p. 685–686). Are "interpersonal difficulties" to be confined to personal harm or

risk of harm to others? Finally, the DSM5 states for exhibitionistic disorders: "since these individuals deny having urges or fantasies involving genital exposure, it follows that they would also deny feeling subjectively distressed or socially impaired by such impulses. Such individuals may be diagnosed with exhibitionistic disorder despite their negative self report" (p. 690)—this seems perfectly reasonable why this statement is only included for exhibitionistic disorder and not for other paraphilic disorders. The same phenomena of denial would be observed. This inconsistency is none too clear.

Can Stronger "Normophilic" Sexual Interests Obviate a Paraphilic Sexual Interest?

The DSM5 also states problematically:

> "the most widely applicable framework for assessing the strength of a paraphilia itself is one in which examinees paraphilic sexual fantasies, urges or behaviors are evaluated in relation to their normophilic sexual interests and behaviors. In a clinical interview or on self administered questionnaires, examinees can be asked whether their paraphilic sexual fantasies urges or behaviors are weaker than, approximately equal to, or stronger than their normophilic sexual interests and behaviors. The same type of comparison can be and usually is employed in psychophysiological measures of sexual interest such as penile plethysmography in males or viewing time in males and females (p. 686)."

It seems that the DSM5 is saying that if a person has a paraphilic sexual interest that is weaker than a normophilic sexual interest that this has some diagnostic relevance-perhaps even obviating a paraphilic diagnosis. This is troublesome for two major reasons. First, it presents a difficult assessment task to the clinician: he or she must accurately measure the strength of two sexual interests. The DSM5 hints that this might be done through self-report—but this seems naïve psychometrically especially in forensic cases. However, secondly, it seems confused. Is a person not to be diagnosed with a paraphilic interest if this interest is less than his interest in normal sexual behavior? If a person says he would prefer having sex 10 times a week with adults but only 6 times a week with children, does this person then not deserve a pedophilic diagnosis? It would seem that this issue of the relative strength of the paraphilic sexual interest is a red herring—if it is present it is sufficient for a diagnosis—a stronger "normophilic" interest is not an overriding mediator.

Strange or at Least Surprising Epidemiological Claims

It is unfortunate that the DSM5 does not use normal referencing procedures so that the warrant for its assertions could be understood and evaluated. It makes strange claims about the incidence and prevalence of the paraphilias. For example the DSM5 states that "frotteuristic acts" … "may occur in up to 30% of adult males in

the general population" (p. 692). Of course the word "may" is a bit of a weasel word in this context but this seems quite high. In addition sometimes the range of prevalence is extremely large: for example for Sadism the DSM5 states unhelpfully that the range is between 2 and 30 %. Finally, at times it is not as clear as it could be that paraphilias are very uncommon in females. Feminists have pointed out that many sexual problems are gendered: it is males who are the perpetrators and females who are the victims. The DSM5 seems to obscure this fundamental point. For example, with voyeurism the DSM5 states "… in nonclinical samples, the highest possible lifetime prevalence for voyeuristic disorder is approximately 12% in males and 4% in females" (p. 688). This implies that males suffer from this at three times the frequency of females. This ratio is surprising and seems way too low. Based on arrest rates and clinical presentation it would seem that males are aroused by viewing unsuspecting individuals at ratios much greater than 3 to 1. Exhibitionistic acts according to the DSM5 occur in a 2:1 male to female ratio—again what appears to be a sex ratio that is way too low. Similar questions could be raised about making more explicit gender statements in other areas such as pedophilia.

A Lack of Clinical Astuteness and Understanding Reflexivity

The DSM5 states for the diagnostic criteria for Sexual Masochism Disorder: "the diagnostic criteria for sexual masochism disorder are intended to apply to individuals who freely admit to having such paraphilic interests …. In contrast, if they declare no distress, exemplified by anxiety, obsessions, guilt or shame, about these paraphilic impulses and are not hampered by them in pursuing other personal goals, they could be ascertained as having masochistic sexual interest but should *not* be diagnosed with sexual masochism disorder." (p. 694).

Does this not miss perhaps how masochistic tendencies may play a role in the larger personality? Would a person who enjoys pain—even if it largely confined to sexual pain—perhaps also have less of a tendency to report being bothered by the sequelae of such interests and behaviors? Could again, this be an additional part of the problem and not an obviating condition? Ought at least this sort of issue be considered in the diagnostic criteria—a lack or normal reporting of distress due to perhaps more generalized masochistic tendencies?

Conclusions

The DSM5 diagnostic categories of the paraphilias face a myriad of problems. Taken individually these 25 problems are all significant but taken collectively they represent a serious indictment of the DSM5. Unfortunately, there seems to be little progress from the DSM4 to the DSM5 meaning that there has been little improvement in a third of a century. Some of may be due to a failure to recognize these

problems, but some of this seems to be that the field ignores these problems. The DSM5 paraphilia diagnoses seem to mainly be used because of their inclusion in a document that has strengths associated with other diagnostic categories (although many other problems in other diagnostic categories) and because of its lack of competitors. However, it is perplexing that although this emperor has no clothes, few have pointed this out and attempted to remedy these problems. Rather it seems that the social forces associated with the influence of this document rather than the scientific adequacy of these categories have functioned to persuade.

Classification is an important scientific pursuit—it provides the fundamental entities for a field. When early chemistry thought there were four fundamental elements—earth, fire, air, and water—little progress occurred because of this fundamental error related to carving nature at its joints. These problems in the DSM5 classification system surely have direct implications for other problems in the field. One needs valid classification in order to do meaningful treatment outcome studies. One needs valid classification in order to devise accurate and meaningful assessment devices. And most importantly one needs valid classification in order to both help individuals and to protect the interests of other members of society. Clearly overcoming the problems in the classification of the paraphilias ought to be more of a priority.

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