Use of the DSM-5 Paraphilias Taxonomy and its Residual Categories in Sexually Violent Predator Evaluations

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Abstract

Evaluators have used the taxonomy for the paraphilias and residual paraphilias from the Diagnostic and Statistical Manual of the American Psychiatric Association (APA) for 20 years to make mental abnormality determinations in sexually violent predator (SVP) cases. There are serious problems with including residual paraphilias in SVP evaluations. This chapter considers these issues from taxonometric, historical, and contemporary perspectives. It also describes details in DSM-5 that bear on SVP and sex offender evaluations. We discourage assigning residual diagnoses for various reasons. Two are that they are characterized by great reliability deficiencies that produce high levels of diagnostic uncertainty. Most damning is APA's explicit rejection of proposals to include paraphilic coercive disorder (rape), hebephilia, and hypersexuality in DSM-5. These labels were inappropriately included in SVP evaluations as residual paraphilias. Evaluators should warn the courts about the conceptual limits of using the paraphilias taxonomy to locate sex offenders on legal taxonomies.

Key words: DSM-5, sexually violent predators, sex offenders, paraphilias, paraphilia not otherwise specified, paraphilic coercive disorder, hebephilia, diagnostic reliability, diagnosis, assessment

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Residual Categories in Sexually Violent Predator Evaluations

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Evaluations including diagnostic assessments based on criteria sets from the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA) are completed for virtually all respondents to sexually violent predator (SVP) petitions before proceedings that may result in lifelong post-prison civil confinement. We have been involved with DSM's development, or with using DSM for teaching, research, or clinical purposes, since the late 1970s, when the descriptive "neo-Kraepelinian approach" (Compton & Guze, 1995; Decker, 2007; Klerman, 1978; Mayes & Horwitz, 2005; Rogler, 1997; Wilson, 1993; Winokur, Zimmerman, & Cadoret, 1988) of DSM-III (APA, 1980) replaced the more theoretical psychobiological and psychodynamic formulations of DSM-I (APA,1952) and DSM-II (APA, 1968). During the last 5 to 15 years we have also used DSM in SVP evaluations, testified in SVP proceedings about specified paraphilias like "Sexual Sadism" and "Pedophilia" or residual categories called "Paraphilia Not Otherwise Specified" (PNOS), and published several articles about psychodiagnosis (e.g., Frances, 2013; Frances & Wollert, 2012; Frances & First, 2011a; Frances & First, 2011b; Wollert, 2007; Wollert, 2011; Wollert & Cramer, 2011).

Each modern DSM before DSM-5 (APA, 2013) has included strong cautionary statements about the potential shortcomings of applying the DSM to legal taxonomies. The importance of using caution in forensic proceedings is reflected in the fact that DSM-III-R (APA, 1987), DSM-IV (APA, 1994), and DSM-IV-TR (APA, 2000) each included <u>two</u> such warnings. These warnings have stressed three points. First, DSM is a psychiatric taxonomy, or system for the classification of mental disorders, for clinicians and researchers. Second, the

DSM taxonomy is not isomorphic with any legislatively-defined taxonomy for adjudication. Third, DSM is susceptible to misuse in forensic settings due to this "disjunction" (First & Halon, 2008, p. 444).

The text of DSM-5 suggests APA may now have a less cautious stance. Whereas the three previous DSMs emphasized the risks that "diagnostic information will be misused in court settings were "significant" (APA, 1994, pp. *xxxii-xxxiii*), the new text (APA, 2013, p.25) reads

> *Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians … DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental disorders. As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research professionals rather than all of the technical needs of the courts and legal professionals.*

All DSMs since DSM-III-R have suggested that a DSM diagnosis might enhance forensic determinations, but none have differentiated between the DSM's applicability to the legal taxonomy for mental health civil commitments and its applicability to the legal taxonomy for SVP civil commitments. This is a serious oversight for two reasons. The first is that APA worked diligently with state legislatures to apply psychiatric symptomatology to achieve a workable and close alignment with the former taxonomy (Zander, 2005; Zonana, Bonnie, & Hoge, 2003). It explicitly rejected such an alignment with the SVP taxonomy. The APA Task Force on Dangerous Sex Offenders, for example, concluded that "Sexual predator commitment laws represent a serious assault on the integrity of psychiatry, particularly with regard to defining mental illness and the clinical conditions for compulsory treatment" (APA, 1999, p. 173).

Another unambiguous example of organized medicine's rejection of the SVP taxonomy occurred in 2012 when the DSM-5 Paraphilias Subworkgroup proposed adding paraphilic coercive disorder (rape), hebephilia, and hypersexuality as specified paraphilias. These terms had been frequently construed as residual subclasses by State experts in SVP trials. APA strongly rejected all of the proposals on the basis of numerous objective criteria summarized by DSM-5 forensic reviewer Paul Appelbaum (2014, p. 137). The depth of negative opinion about these terms was further reflected in decisions to ban each of them from a DSM-5 Appendix for disorders needing research (Frances, December 2, 2012).

The second reason APA should differentiate between using DSM-5 in mental health versus SVP commitments is that the paraphilias taxonomy is too weak to sustain a valid extension to the SVP taxonomy. There are many issues with using the paraphilias taxonomy to identify a person's location in the SVP taxonomy. Experts who claim the DSM taxonomy is highly accurate for SVP determinations without disclosing its limitations may face ethical sanctions.

This paper discusses these problems in relation to theoretical, historical, and contemporary contexts. The first section lays out a theoretical context by reviewing some basic principles of taxonomic classification. The second and third sections provide historical context by describing SVP laws and discussing events leading to the adoption of the paraphilias taxonomy as a vehicle for pursuing SVP convictions. Contemporary context is presented in the fourth section by discussing changes in DSM-5 that are relevant for evaluations of paraphilia. The fifth section draws on the earlier sections to summarize practice issues with using residual labels in SVP evaluations. It also considers how these limitations apply to some specified paraphilias because PNOS categories complement the specified paraphilias. Another reason for

including the specified paraphilias in our analysis is that a PNOS category might become a specified paraphilia (e.g., Frotteurism in 1987) or a specified paraphilia might become a PNOS category (Zoophilia in 1987). The Conclusion section makes a number of recommendations for APA and evaluators.

Taxonometric Classification

Taxonometric classification is the process by which a specified set of target objects from the natural world is divided into a pre-existing and nonarbitrary set of classes and subclasses on the basis of shared characteristics (Hempel, 1961; Millon, 1991). The framework is a *taxonomy*, or a *nosology* when mental disorders are the classes, and the set of names for the divisions in a taxonomy is a *nomenclature*. Each subclass, or *taxon*, is ideally defined by whatever conditions a relevant object must have to belong to that particular subclass.

A taxonomy therefore sorts out a specified set of objects into different *taxa* by applying a set of classificatory concepts and terms of definition to these objects. The concepts and terms that are used in a field of science are called its *vocabulary of science* (Hempel, 1961, p. 6). *Diagnosis* is the process of identifying the state of a mental disorder concept in relation to a patient.

The value of a system for classifying human characteristics depends on how adequately it addresses three scientific challenges. The first is to formulate concepts that allow different observers to reliably sort target objects into distinct categories; vague criteria that elicit subjective judgments undermine reliability. Later, validity evidence needs to be collected indicating that the taxa are linked to other important concepts. Eventually, results derived from theory-building rather than observation are expected.

A diagnosis that meets the test of reliability may not meet the second test, that of validity. When Philosopher of Science Carl Hempel addressed APA members in the DSM-I era, he pointed out (1961, p. 14) that "characteristics of the elements which serve as criteria of membership in a given class" from a scientifically fruitful classification "are associated … with … extensive clusters of other characteristics … a classification of this sort should be viewed as somehow having objective existence in nature" due to its capacity for "carving nature at the joints." He also distinguished such taxonomies from more "'artificial classifications,' in which the defining characteristics have few … connections with other traits."

The SVP Taxonomy

In early 1990 the Washington State Legislature found "a small but extremely dangerous group of sexually violent predators exists" and passed the first statute in the U.S. for the post-prison civil commitment of those meeting the legal criteria as SVPs (APA, 1999). According to Section 71.09.020 (16) of the Revised Code of Washington, an SVP is defined as "any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence."

Although the meaning of a personality disorder was not codified when the law was passed, a mental abnormality, per Section 71.09.020 (8), has always been "a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts." At trials the burden of proof is on the State to show that an accused SVP, or "respondent," meets these criteria: Section 71.09.060 states that "the court shall determine whether, beyond a reasonable doubt, the person is a sexually violent predator."

About 20 states and the federal government followed Washington in adopting SVP or sexually dangerous person (SDP) statutes. There are wording differences in different laws (Jackson & Richards, 2008, pp. 185-189) but SVP and SDP laws are conceptually similar.

The U.S. Supreme Court has ruled SVP laws do not violate the Constitution. In *Kansas v. Hendricks* (1997), it considered a case where the Kansas Supreme Court had "invalidated the (Kansas) Act, holding that … 'mental abnormality' did not satisfy … the 'substantive' due process requirement that … commitment must be predicated on a finding of 'mental illness.'" The majority observed "we have never required State legislatures to adopt any particular nomenclature." They also indicated Kansas' law satisfied due process because it "coupled proof of dangerousness with … a … 'mental abnormality'" in such a way as "to limit … civil confinement to those who suffer from a volitional impairment … that makes it difficult … for the person to control his dangerous behavior."

In *Kansas v. Crane* (2002), it considered another case where the Kansas Court reversed a trial court's SVP finding because the court did not make a finding on whether the defendant could "control his dangerous behavior." This time the trial court's verdict was upheld on the logic that a "lack-of-control determination" was necessary, but all that was required was a showing that the respondent had "serious difficulty in controlling behavior" (p. 5) and met the other SVP criteria. The *Crane* Court did not further clarify what it meant by serious difficulty. It instead decided a "contextual" and "case-specific" approach should be followed because "States retain considerable leeway in defining the mental abnormalities" and "the science of psychiatry, which informs … legal determinations, is an ever-advancing science …" (pp. 5-6).

This decision equated the concept of serious difficulty controlling behavior with a volitional impairment but did not define the meaning of either.

The Paraphilias Taxonomy, PNOS, and SVP Evaluations

Paraphilias must meet the DSM criteria for Mental Disorder listed in the left column of Table 42.1 if they are to be included in the DSM. The right-hand column of Table 42.1 shows the DSM paraphilia criteria have been substantially revised since DSM-I, when sexual deviates were described as "ill … in terms of … conformity with the prevailing cultural milieu." This characterization was firmly discarded in DSM-III, which pointed out that mental disorders involved dysfunctions that were "more than a conflict with societal values." DSM-III also clarified that a mental disorder required the presence of a "syndrome" of symptoms and clinically significant syndromatic consequences such as "distress or disability." The former requirement has since been referred to as the "essential features" or "A criterion" while the latter is the "clinical threshold" or "B criterion." The right-hand column of Table 42.1 reflects the use of this convention in that items preceded by an **"A"** indicate characteristics referenced as "essential features" in one of the modern DSMs while items preceded by a **"B"** indicate "clinical threshold" conditions. The capital letters in the left-hand column, in contrast, stand for different elements of the mental disorder definition and thus do not necessarily refer to essential features or clinical thresholds.

Insert Table 42.1 about here

In *Crane* the Supreme Court endorsed a case-specific approach and left derivation of mental abnormality definitions in the hands of states with SVP laws. The states, in turn, relied on the case by case opinions of experts retained by the prosecution.

An example from Washington provides a plausible theory of how mental abnormalities have generally come to be defined within the context of this case-specific and expert-centered approach. Psychologist Robert Wheeler, retained extensively by state prosecutors, explained his

reasoning on this issue in 1992. He observed that DSM-III-R was "the … accepted source … for cataloguing … diagnostic terms" and that some of the paraphilias overlapped the mental abnormality concept in being associated with "compulsive sexual urges" (Wheeler, 1992, p. 2). He therefore considered specific paraphilias like Pedophilia and Sexual Sadism to be mental abnormalities.

Wheeler was reticent about using PNOS diagnoses. For example, he cautioned colleagues about overusing PNOS because this was "not strictly adhering to the DSM-III-R" (p. 3).

Some of Wheeler's colleagues were less hesitant. As early as 1991 different experts in different cases had "diagnosed 'rape as paraphilia,' within the category of 'paraphilia not otherwise specified'" (APA, 1999, p. 21; *In re Young*, 1993).

Vance Cunningham and Andre Young, respondents committed on PNOS (Rape) diagnoses, appealed their convictions in part on the grounds that PNOS (Rape) was too broadly drawn to differentiate sex offenders with a mental abnormality from sex offenders without one (*In re Young*, 1993). The Washington State Supreme Court suggested a rape paraphilia would eventually be added to the DSM and indicated the legislature's adoption of an inclusive non-psychiatric taxonomy was within its discretion. The Court's citation of the following passage indicated that it envisioned a broad diagnostic perspective:

> *In using the concept of mental abnormality, the legislature has invoked a more generalized terminology that can cover a much larger variety of disorders. Some, such as the paraphilias, are covered in DSM-III-R; others are not. The fact that pathologically-driven rape, for example, is not yet in DSM-III-R does not invalidate such a diagnosis … What is critical … is that … clinicians who testify in good faith as to*

mental abnormality are able to identify sexual pathologies that are as real and meaningful as other pathologies … in the DSM. (Brooks, 1992, p. 733).

Psychologist Dennis Doren (2002) attempted to effect an unauthorized alignment of the paraphilias taxonomy with the SVP taxonomy that State evaluators could use for diagnosing SVP respondents with PNOS. He presented a five-level argument. *Conceptually,* he cited a DSM-IV passage (APA, 1994, pp. 522-523), also in Table 1, to claim (Doren, 2002, p. 56) that a paraphilia was defined as (A) "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 6 months," and (B) "the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social occupational, or other important areas of functioning." *Interpretively,* he took the term "nonconsenting" under item (A)(3) to mean any nonconsenting person who was sexually assaulted and the term "children" to mean pubescent minors. *Definitionally,* he consistently equated the "B" criterion of impairment with incarceration for being convicted of a sex crime. *Pragmatically,* he concluded that "examiners … need to rely on documentation of the subjects' behaviors alone" (p. 66) because examiners "do not typically enjoy the benefit of a fully honest disclosure of the subject's sexual fantasies and urges." Finally, at a *social acceptance* level, he assured readers that a PNOS diagnosis was "considered just as meaningful by the writers of the DSM-IV as … any of the individually listed diagnoses" on the *condition* that it included a qualifier that produced a "differentiation of this specific type of paraphilia from others listed as NOS" (p. 67).

A criminal history that included charges for sexual abuse of an adolescent or rape on different occasions therefore included all that Doren's formulation needed for a viable PNOS

diagnosis: Recurrence, sexual behavior against nonconsenting adults or adolescent minors, and impairment via incarceration. The addition of behavioral qualifiers per Doren's last proposition produced "PNOS (nonconsent)" and "PNOS (hebephilia)."

Doren's (2002) book was widely circulated. Many State experts accepted his two labels. They also had the ring of science in court. In reality, however, Doren's attempt to extend the paraphilias taxonomy to the SVP taxonomy was a rogue action that did not have APA's approval.

Observing that "there has been a great deal of struggle concerning what the concept of "affecting … 'volitional capacity' means," Doren's book also acknowledged that "describing the relevant impairment … can be tricky" (p. 15). In a three-page section on this challenge (pp. 14-17) he proposed that evaluators might deal with it by claiming that evaluees who repeated criminal behaviors in spite of their consequences had volitional impairments (Zander, 2005).

Doren did not explicitly advise evaluators to ignore the issue of volitional control but he did not encourage them to get too close to it either. In a "Sample Precommitment Evaluation Report" he suggested that experts might conclude their reports with the following text that dispositively alludes to an impairment's presence without describing it (pp. 223-224):

> *Mr. T. was found to suffer from three psychiatric conditions, two of which qualify as a mental abnormality … Specifically, this examiner came to the opinion … that Mr. T. suffers from Pedophilia, and Antisocial Personality Disorder, each of which, for Mr. T., is an acquired or congenital condition affecting his emotional or volitional capacity that predisposes him to commit sexually violent acts …*

Bernard Thorell was found to be an SVP in 1998. He appealed his conviction on the grounds that a mental abnormality determination required a separate finding of volitional

impairment. In 2003, the Washington Supreme Court ruled that a serious difficulty test was required by *Crane*, but that this "lack of control determination may be included in the finding of a mental abnormality" (*In re Thorell*, 2003, p. 376). Thereafter, a mere diagnostic label was accepted as meeting a fact finder's legal needs for making a mental abnormality determination (Jackson & Richards, 2007, p. 193).

We have used anecdotal and formal methods to evaluate the possibility that SVP laws, decisions like *Young* and *Thorell*, and Doren's book produced an increased rate of PNOS diagnoses among sex offenders. In one anecdotal approach we reviewed a few reports for confined offenders who were evaluated on at least one occasion before RCW 71.09 and as possible SVPs on at least one occasion after 71.09. A striking difference in these reports was that specified diagnoses stood out in the earlier evaluations while PNOS diagnoses were evident in later ones. In another, a small group of providers who treated sex offenders prior to the SVP laws told us the level of professional interest in PNOS diagnoses during that era was virtually nil.

More formally, we were able to identify two studies reporting data on the prevalence of PNOS among sex offenders. The first, by psychiatrist Gene Abel and colleagues (Abel, Becker, Cunningham-Rathner, Mittleman, & Rouleau, 1988), assessed 561 U.S. sex offenders in the "1977 to 1985" (p. 154) pre-SVP period. By our calculation the maximum estimate of the PNOS prevalence rate in Abel's cohort approximated 10% (57/561 =10.1%).

In the second study, psychiatrist Reinhard Eher and colleagues (Eher, Rettenberger, Matthes, & Schilling, 2010) administered routine assessments between 2002 and 2005 to 119 incarcerated child molesters in Austria, which does not have an SVP law. About 7.6% of the offenders were classified as meeting PNOS criteria at some time during their lives.

In contrast to these findings, data on 1,362 SVPs from 5 states (Jumper, Babula, & Casborn, 2011) show that 47.3% (*N*=645) were assigned a PNOS diagnosis (Jumper et al., 2011). PNOS ranked alongside Pedophilia as the most widely-assigned diagnosis in SVP evaluations by State-retained psychiatrists and psychologists.

This history points to three conclusions. First, decisions such as *Hendricks*, *Crane*, *Young* and *Thorell* have lowered the legal bar for classifying offenders as SVPs. Second, the practice of assigning PNOS diagnoses to SVP respondents has exploded since the adoption of SVP laws. Third, SVP convictions can be obtained with controversial diagnoses that do not require additional proof of impairment.

Such developments affect the attitudes of experts towards their own behavior. Some have even reached the point of claiming they do not have to assign ***any*** type of authorized diagnosis to make an SVP determination. Dismissing the SVP significance of any paraphilias in DSM-5, psychiatrist Douglas Tucker and attorney Samuel Brakel (2012, p. 533) echoed language from *Young* to argue that "the various courts … are all in agreement that … it does not matter what the mental abnormality is called … the critical point … is that … clinicians who testify in good faith as to a mental abnormality are able to identify sexual pathologies that are conceptually and empirically meaningful, regardless of whether they are listed in the DSM".

Tucker and Brakel's opinions reflect the extent to which SVP proceedings came to be marked by subjective rather than scientific judgment prior to the publication of DSM-5.

DSM-5 and the Paraphilias Taxonomy

Four important changes in wording outside the Paraphilic Disorders Chapter (PDC) have been made to DSM-5 that hold implications for diagnosing the paraphilias. The most straightforward one, in the "Elements of a Diagnosis" section of the DSM-5 Introduction states

that "a DSM-5 diagnosis is usually applied to the individual's *current presentation*" (p. 22, our emphasis).

A more subtle change to the mental disorder definition, also included in Table 42.1, is that the evidence for a "dysfunction" necessary to identify a mental disorder is characterized as a "reflection" in DSM-5 rather than as the "inference" that was needed in DSM-III, DSM-IV, and DSM-IV-TR. In science, a reflection is a response that returns from a target when a source observes it or sends it a signal. The *reflection requirement* reinforces the *current presentation requirement* by emphasizing the importance of recent data as evidence for a dysfunction.

The third important general change stems from a step the DSM-5 Task Force took to address a "growing inability to integrate DSM disorders with the results of genetic studies and other scientific findings" (p. 10). To address this dilemma the Task Force decided "to enhance diagnostic specificity" (p. 15) by replacing "the previous NOS designation with two options for clinical use: other specified disorder and unspecified disorder." This was not meant to imply that clinicians can use residual diagnoses willy-nilly, as a modifying passage indicated that "In an emergency department setting, it may be possible to identify only the most prominent symptom expressions associated with a particular (disorder) chapter– so that an "unspecified" disorder in that category is identified until a fuller differential diagnosis is possible" (pp. 19-20).

Regarding the last of the general changes, Table 42.1 indicates that all modern DSMs have included the concept of disability, equated with an "impairment," as a clinical significance criterion for making a DSM diagnosis. They also all shared the problem of not providing a definition for impairment. DSM-5 addresses this oversight in two ways. One is that it discusses the impairment concept in a new section in its Introduction on the "Criterion for Clinical Significance" (p. 21). The other is that it includes a number of psychosocial assessment

instruments for measuring disability and impairment in a new "Assessment Measures" section (pp. 733-748). These measures clarify a DSM impairment is a difficulty in adjustive functioning that has been present within one or more of the past four weeks due to mental disorder.

The significance of this clarification is reinforced by wording in the PDC Introduction. The last sentence in the next to last paragraph (p. 686), for example, begins with the declaration that "the distress and impairment stipulated in Criterion B are … the … *result of the paraphilia* (our emphasis)*."* It closes by pointing out that distress and impairment "may be quantified with multipurpose measures of psychosocial functioning or quality of life." The only measures meeting this description are in the DSM-5 Assessment Measures section and no other measures for this purpose are recommended. Evaluators who claim to use DSM-5 for diagnostic purposes therefore need to use the DSM-5 Assessment Measures section for the impairment assessment required for the assignment of a diagnosis.

This clarification also refutes Doren's *definitional assumption* that a restriction of liberty due to incarceration is a psychiatric impairment.

The PDC includes five other noteworthy features. One is that its first sentence states the term "nonconsenting" applies only to "frotteuristic disorder" and the term "children" applies only to "pedophilic disorder" (p. 685). This refutes Doren's (2002) *interpretive assumptions* about the meaning of "nonconsent" and "children."

The second noteworthy PDC change is that the *paraphilia* concept has been modified by introducing a *paraphilic disorder* concept. In previous DSMs a paraphilia referred to an authorized diagnosis. A paraphilia is now defined as any sexual interest that is "greater than or equal to normophilic sexual interests" (p. 685). To meet this A criterion a person must have non-

normophilic "recurrent and intense arousal" that is "manifested by fantasies, urges, or behavior" for a 6-month period.

A *paraphilic disorder*, in contrast, 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" (pp. 685-686). These negative consequences satisfy the B criterion. Only those who meet both criteria A and B can be diagnosed with a paraphilic disorder.

Regarding the third, the "Highlights of Changes from DSM-IV to DSM-5" section (p. 816) states that "an overarching change for DSM-IV is the addition of *in remission*" as a course specifier "for all the paraphilic disorders" (p. 816). The most general definition of *in remission*, included in all the criteria sets for disorders that often result in incarceration except Pedophilia, is that "the individual has not acted on the urges (from the A criterion) with a nonconsenting person, and there has been no distress or impairment … for at least 5 years while in an uncontrolled environment." This change rules out the assignment of a paraphilic disorder to a person who has lived in the community for five years without further problems. The wording of the "Highlights" section also indicates that the *remission* rule applies to Pedophilia. Its omission is thus an editorial error. A member of the DSM-5 Paraphilias Subworkgroup has verified this (R. Krueger, personal communication, January 10, 2014).

Regarding the fourth, psychiatrists Michael First and Allen Frances (2008) explained an editorial mistake was made when – as DSM-IV Text Editor and Task Force Chair – they moved the behavioral "has acted on urges" passage from the DSM-III-R B criterion (see Table 42.1) into the A criterion. The B criterion consequently stated "the disturbance causes clinically significant distress or impairment … " (p. 1240) while the A criterion stated the essential feature of a paraphilia was "recurrent, intense sexually arousing fantasies, sexual urges, *or behaviors*"

(our emphasis). Focusing on the proposed B criterion change, some religious groups voiced concern DSM-IV did "not recognize Pedophilia as a mental disorder unless it caused distress." First reinstated the DSM-III-R B criterion in DSM-IV-TR to settle this dispute but overlooked deleting "or behaviors" from the A criterion (First and Halon, 2008). An unintended consequence of this inclusionary mistake was that Doren and others used the DSM-IV-TR A criterion "to justify making a paraphilia diagnosis based solely on a history of repeated acts of sexual violence" and then argued that their diagnosis met the "statutory mandate for … a 'mental abnormality'" (Frances & First, 2011a, p. 1250).

Although First and Frances (2008) advised it would be "important to … restore criterion A to its DSM-III-R wording," the DSM-5 Paraphilias Subworkgroup retained the mistake. The A criterion and the B criterion for all of the specified paraphilias in DSM-5 could therefore still be satisfied by behavior alone if the *current presentation*, *reflection*, and *impairment assessment* requirements had not been added to DSM-5.

Regarding the last important feature, the residual PNOS category from the three previous DSMs has been replaced by two residual categories. One is "Other Specified Paraphilic Disorder" (OSPD) and the other is "Unspecified Paraphilic Disorder" (UPD). This is a potentially significant change because each previous DSM confined its discussion of PNOS to a comment in the Paraphilias Chapter Introduction that PNOS was uncommon and included a two-sentence description at the chapter's end that did not include any criteria sets. The PNOS descriptions for all DSMs are presented in Table 42.2

Insert Table 42.2 about here

DSM-5 departs from this minimalist tradition in that the last three sentences of the PDC introduction extol the potential significance of OSPD and UPD by stating (p. 685) that

The eight listed (specified) disorders do not exhaust the list of … paraphilic disorders. Many dozens … have been … named, and almost any of them could … rise to the level of a paraphilic disorder. The diagnoses of the other specified and unspecified paraphilic disorders are therefore indispensable …

The complete definitions for OSPD and UPD, which are much more extensive than the PNOS definitions in previous DSMs, are included in the bottom row of Table 3.

Issues in Using the DSM-5 Paraphilias Taxonomy and Residual Categories

We believe that SVP evaluators should refer to the following issues in their evaluations and testimony when relevant.

Normophilia Does Not Adequately Conceptualize the Paraphilias

The PDC defines normophilia as "sexual interest in genital stimulation or preparatory fondling with phenotypically normal, consenting adult partners." A person with any intense and persistent interest other than this for a 6-month period has a paraphilia. Psychologist Ray Blanchard, who chaired the Paraphilias Subworkgroup, referred to this as a "definition by exclusion" (Blanchard, 2009). Table 42.1 shows that DSM-II and DSM-III also attempted to capture the paraphilias with exclusionary language, using terms like "bizarre" rather than normophilic (Hinderliter, 2010). These terms were discarded in DSM-III-R because psychiatrist and Task Force Chair Robert Spitzer had concerns about their "subjectivity and unreliability" (Frances & First, 2011b, p. 79). The same taxonomic criticisms apply to normophilia. Normophilia is also susceptible to a high false positive rate because of its cultural relativity: Any sexual behavior that conflicts with U.S. norms may qualify as a paraphilia.

Evaluators should alert the courts to this weakness.

The Residual Diagnoses are Unreliable

Frances and First assumed residual paraphilias have poor reliability coefficients because "NOS categories do not have criteria sets" (2011a, p. 558). Their "poor reliability theory" was first addressed by Human Services Professor Jill Levenson (2004), who collected dual-rater data on the diagnostic status of 277 offenders evaluated for civil commitment. She calculated kappa coefficients (Cohen, 1960) to estimate the reliability for various criteria sets. Her kappa for PNOS was .36, which she considered inadequate.

Psychologist Richard Wollert (2007, p. 179) calculated another reliability measure for PNOS, the likelihood ratio (LR), from Levenson's data. His LR for PNOS, obtained by dividing a sensitivity of .47 by the complement of a specificity of .56, was 1.07. This value did not differ from chance (i.e., where the LR equals 1.0), was smaller than the LRs for all 7 of Levenson's alternatives with specified criteria sets, and did not meet the taxonomic standard that "reliable diagnostic grouping requires … (favorable) specificity and sensitivity" levels (Greenberg, Shuman, & Meyer, 2004, p. 3; Karson, 2010).

Residual Diagnoses Are Associated with Great Diagnostic Uncertainty

The LR for PNOS does not differ from 1.0. The level of certainty for making a diagnosis equals the disorder's prevalence rate when its LR is 1.0 (Wollert, 2007; Wollert, 2011; Wollert & Waggoner, 2009). The prevalence rate of PNOS does not exceed 10% in studies that have controlled for the inflationary effects of SVP laws (Abel et al., 1988; Eher et al., 2010). The level of uncertainty for a PNOS diagnosis thus equals 90%. The PDC's insinuation that forensic evaluators are able to assign the residual diagnoses with high levels of diagnostic certainty (p. 685) is mathematically false.

Two Residual Diagnoses Are Unnecessary and Counterproductive

One DSM-5 section indicated all DSM-IV-TR chapters included a residual category but a second was added "to enhance diagnostic specificity" (p. 15). Another section suggested this was done to accommodate advances in studying the "major and mild neurocognitive disorders" because "biological markers" were discovered that separated them "into specific subtypes" (DSM-5, pp. *xii-xiii*).

This rationale doesn't apply to OSPD or UPD because neither have biological validators.

Time constraints may make it necessary to temporarily assign residual diagnoses to neurology patients seen in emergency rooms (APA, 2013, pp. 19-20). These conditions don't apply to SVP respondents who are in custody. The addition of another residual option with poor reliability to the PDC is also likely to further consolidate the inadequate reliability of the residual paraphilias and invite time-wasting courtroom argumentation.

The Residual Paraphilias Have Not Been Empirically Validated

A simple and informative approach to determining whether a taxon is associated with Hempel's "extensive cluster of characteristics" is to simultaneously assess the taxon and a battery of characteristics with which it should be correlated (Campbell & Fiske, 1959). No one, to our knowledge, has undertaken such a study of the residual paraphilias in general. Examining rapists and sexual sadists, psychologist Ray Knight (2010) and his colleagues were unable to differentiate a group who might meet the criteria for a PNOS-nonconsent taxon.

Validational research has challenged even the specified paraphilias. Award-winning research by psychologist Evelyn Hooker (1957) found that "male overt homosexuals" and heterosexual males were equally well-adjusted. Such research and subsequent protests by gay rights activists (Bayer, 1987; Silverstein, 2009), led to the removal of homosexuality from the DSM (Mayes & Horwitz, 2005; Rogler, 1997; Hinderliter, 2010).

Many psychiatrists and others have since suggested the entire PDC should be eliminated from DSM because it either pathologizes cultural and preferential variations in sexual behavior among nonclinical populations or medicalizes criminal behavior (Green, 2002; Hinderliter, 2010; Keenan, 2013; Milner, Dopke, & Crouch, 2008; Moser & Kleinplatz, 2005; Silverstein, 2009; Tallent, 1977).

It is also the case that empirical studies have not provided compelling evidence for the validity of even the specified paraphilias. Research on Pedophilia, for example, has "indicated … few significant differences between pedophilic and non-pedophilic molesters" (Kingston, Firestone, Moulden, & Bradford, 2007) and nonsignificant correlations – from - .02 to .08 – with sexual recidivism (Eher et al., 2010; Wilson, Abracen, Looman, Picheca, & Ferguson, 2010). Four long-term studies have also reported nonsignificant correlations – from 0 to .12 – between Sexual Sadism and sexual recidivism (Berner, Berger, & Hill, 2003; Eher et al., 2010; Hill, Haberman, Klusmann, Berner, & Briken, 2007; Kingston, Seto, Firestone, & Bradford, 2010).

Pre-DSM-5 Arguments for Assigning PNOS Diagnoses in SVP Cases Have Been Refuted

Frances and First (2011a, p. 556) refuted Doren's *conceptual assumption*, explaining that "the … DSM-IV Paraphilia section was written long before the issue of SVP commitment arose … it was never anticipated that the opening sentence … would be considered a forensic definition of paraphilia … it was meant … as … a simple table of contents."

Doren's *definitional assumption* equating impairment with incarceration has been refuted by the PDC's declaration (p. 686) that "the distress and impairment stipulated in Criterion B are … the … *result of the paraphilia*."

First and Frances (2008, p. 1240) disputed Doren's *pragmatic assumption* by claiming he capitalized on a DSM-IV-TR wording error – where "or" rather than "and" was used in Criterion A – to conclude a PNOS diagnosis could be made solely from past behavior. DSM-5's definition of mental disorder also precludes the assignment of a diagnosis solely from past behavior.

In the following statement Frances and First (2011a, pp. 557-558), who *were* primarily responsible for writing DSM-IV, forcefully disagreed with Doren's *social acceptance assumption* that PNOS diagnoses are "considered just as meaningful by the writers of the DSM-IV as … individually listed diagnoses":

> *DSM-IV includes 46 NOS categories to … code patients who do not fit well into any of the official categories … The NOS categories are provided because psychiatric presentations are so … idiosyncratic … NOS diagnoses are meant to be no more than residual wastebaskets provided by DSM-IV to encourage research and for the convenience of clinicians … The problem is that PNOS has been widely misapplied in SVP hearings to criminals who have no mental disorder by evaluators who have misinterpreted DSM-IV. Psychiatric diagnoses … are generally considered admissible in court because they are accepted by the field … By virtue of their residual and idiosyncratic nature, cases given the label of NOS are by definition outside of what is generally accepted … as … reliable and valid … Furthermore, the NOS categories do not have criteria sets and therefore can never be diagnosed reliably … The use by evaluators of the PNOS diagnosis fails to satisfy the standards … for expert testimony.*

Evaluators who assign PNOS or equivalent labels to offenders in the future should inform the court about the total inadequacy of Doren's (2002) assumptions and explain why they believe these diagnoses are authorized for use in SVP proceedings.

Conclusion

Evaluators have used the taxonomy for the paraphilias and PNOS for 20 years for making mental abnormality determinations. The courts have recognized that legal nomenclatures and taxonomies differ from psychiatric taxonomies and the DSM developers have made the same point.

The value of a source taxonomy for determining a person's location in a target taxonomy depends on the quality of the alignment between the taxonomies and the reliability and validity of the source taxonomy. The psychiatric symptomatology in the DSM, by common consensus, has been of great value for determining the mental health status of respondents to mental health civil commitment petitions. The value of the paraphilias taxonomy for sex offender civil commitment, in contrast, has been fiercely contested since the first law was adopted.

Some aspects of this controversy have to do with psychometric findings and differences of interpretation. Other aspects almost certainly have to do with the ongoing conflict between the state and organized medicine over this issue. The state's power to restrict the liberty of U.S. citizens via civil commitment or public health policies is greatly legitimized by inputs from organized medicine. This is illustrated in quarantine laws and the mental health civil commitment laws. Organized psychiatry has, however, strongly opposed sex offender civil commitments for many years and is likely to continue to do so. There is a good chance that SVP laws will eventually come to be viewed as nothing more than an exercise of the state's police power. This could result in an increased perception of the SVP laws as unconstitutional because civil confinement or quarantine requires not just dangerousness, but dangerousness due to illness (*Foucha v. Louisiana*, 1992). Residual diagnoses that are used to "shoehorn" respondents into the mental abnormality criterion may also be rejected by the courts. In the first test of the admissibility

of OSPD (non-consent) under the "Frye" (*Frye v. U.S.*, 1923) criteria, for example, a New York trial court ruled that such a diagnosis was inadmissible because the state was unable to identify a generally accepted set of criteria that defined it and distinguished it from other conditions (*State of New York v. Jason C.*, 2016).

Although a second Frye hearing on OSPD (non-consent) has been ordered in California (*People v. LaBlanc*, 2015), it is unlikely that the question of the admissibility of residual diagnoses in SVP proceedings will be resolved by the courts in the near future. Meanwhile, many courts may continue to accept paraphilic diagnoses as proxies for mental abnormalities. This possibility raises questions about how the APA and evaluators might conceptualize and respond to the challenge of SVP laws.

Regarding the APA, we believe the additions of the "Assessment Measures" section and the *current presentation*, *reflection*, and *remission* rules provide needed quality controls to SVP evaluations. APA's plans for ongoing revisions to DSM-5 (p. 13) could also be valuable for correcting errors in wording, disseminating statements on the use of the DSM for mental health civil commitment evaluations versus SVP civil commitment evaluations, and generating other DSM-related policies that impact the SVP adjudication process.

With respect to evaluations, we recommend that evaluators consider incorporating the concepts discussed in the section DSM-5 and the Paraphilias Taxonomy in their evaluation procedures and adopting a proactive stance towards discussing in court and in their reports the limitations of the paraphilias taxonomy and the residual paraphilias – cited in the section Issues in Using the DSM-5 Paraphilias Taxonomy and Residual Categories – for mental abnormality determinations. We advise against assigning the equivalent of a PNOS diagnosis in SVP cases for the reasons stated in the latter section.

We also advise against making any SVP determinations on the basis of unauthorized diagnoses because they have no connection with a vocabulary of science or accepted scientific methods of conceptualization, hypothesis testing, determination of reliability and error rates, peer-review, and professional acceptance. The likelihood of identifying a "meaningful" sexual pathology in the isolated context of an idiosyncratic diagnosis is minimal.

Our last piece of advice to evaluators is to keep the major events in the compilation of DSM-5 and the previous DSMs in perspective. Each new DSM introduces some revisions and retains some errors. Trying to explain these details in court is tempting but fruitless. It is much more important to concentrate on the big picture of the APA's basic position on the paraphilias and the residual paraphilias. This position is unmistakably obvious in the decisions the APA has made on proposals for expanding the list of specified paraphilias. From this vantage point, three facts should guide all SVP evaluations. The first is that "paraphilic rapism (has) been considered and ruled out" (Frances, March 1, 2011; Frances & First, 2011a, p. 557) of DSM-III, DSM-III-R, and DSM-IV. The second is that Hebephilia, Hypersexuality, and the latest iteration of paraphilic rapism known as Paraphilic Coercive Disorder – all ideas grounded in an expansion of the PNOS concept – were excluded from DSM-5 (Appelbaum, 2014). The third is that the proposed paraphilias were even rejected as concepts "in need of further research" (Frances, 2012).

The consistency of these decisions over time speaks much louder than any change in wording that is susceptible to multiple parsings by different sides in an SVP case. Taken together, they indicate clear support for a reliance on authorized diagnoses. This, more than any other diagnostic principle, should be conveyed to the court.

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Table 42.1 Definitions and descriptions of "mental disorder" (left column) and "paraphilia" (right column) in each DSM

DSM-I: Mental disorder was not defined. A comprehensive system of "concepts of modern psychiatry and neurology" that facilitated communication and research was envisioned (pp. *v-vi;* Section IIA, p. 9).	(Section IIB., pp. 38-39). All "sexual deviations" were listed in the Psychopathic Personality Disturbance chapter. Class members were described as "ill … in terms of … conformity with the prevailing cultural milieu." The diagnosis was "for deviant sexuality which is not symptomatic of … schizophrenic and obsessional reactions … (it) will specify the … behavior: homosexuality, transvestism, pedophilia, fetishism, and sexual sadism."
DSM-II: Mental disorder was not defined, but it was discussed in the same way as in DSM-I.	(Section 3, p. 44). All sexual deviations were listed as Personality Disorders. The diagnosis was for those "whose sexual interests are … toward objects other than people of the opposite sex, toward sexual acts not … associated with coitus, or toward coitus … under bizarre circumstances." Eight specific labels were listed without explanation: Homosexuality, Fetishism, Pedophilia, Transvestitism, Exhibitionism, Voyeurism, Sadism, and Masochism.
DSM-III (p. 6). **A:**[a] Each mental disorder is a clinically significant behavioral or psychological syndrome that is **B:** typically related to either distress (a painful symptom) or disability (impairment in one or more important areas of functioning). **C:** There is an inference that it is a behavioral, psychological, or biological dysfunction in the person **D:** that is more than a conflict with societal values.	(pp. 266-267). **A:**[b] The essential feature is that unusual or bizarre imagery or acts are necessary for sexual excitement. **A1:** They tend to be insistently and involuntarily repetitive, and **A2:** Generally involve nonhuman objects, pain or humiliation, or nonconsenting partners. **A3:** Previous classifications call these Sexual Deviations. **A4:** The term Paraphilia better clarifies the deviation (para) is in that to which one is attracted (philia). **A5:** Paraphilias in this manual have traditionally been identified by previous classifications. **A6:** Paraphiliacs are usually seen by mental health professionals when their behavior has brought them into conflict with society.
DSM-III-R (p. xxii). **A:** DSM-III A, above. **B:** DSM-III B, but "typically" is omitted and "present" precedes "distress." **C:** or with a significantly increased risk of suffering, pain, disability or an important loss of freedom. **D:** DSM-III C, except "currently" follows the first "is." **E:** The syndrome is not a typical response to an event like death of a loved one. **F:** Sexually deviant behavior is not a disorder unless it results from a dysfunction in the person.	(pp. 279-280). **A** (replaced DSM-III A and A1, above): The essential feature is recurrent intense sexual urges and sexually arousing fantasies. **A1** (changes DSM-III A2): Generally involving (1) nonhuman objects, (2) suffering or humiliation of oneself or one's partner, (3) children or other nonconsenting persons. **B:**[c] A diagnosis is made only if the person has acted on these urges, or is markedly distressed by them. **B1:** DSM-III A3. **B2:** DSM-III A4. **B3** (added)**:** Paraphilic preferences are episodic in some cases. **B4:** DSM-III A5, except "traditionally" is removed. **B5:** DSM-III A6, except "sexual partners or" is added after "with".

DSM-IV (pp. xxi-xxii). **A:** DSM-III A. **B-F:** DSM-III-R B-F.	(pp. 522-523). **A**: (replaced DSM-III-R A, important changes are underlined): <u>Over 6 months</u> the essential feature is recurrent, intense sexually arousing fantasies, sexual urges, <u>or behaviors</u>. **A1**: DSM-III-R A1. **B:** (replaces DSM-III-R B): The behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. **B1**: DSM-III-R B3. **B2**: DSM-III-R B4. **B3**: DSM-III-R B5.
DSM-IV-TR (p. xxxi)**. A-F:** DSM-IV A-F.	(p. 566). **A-A1**: DSM-IV A-A1. **B** (replaces DSM-IV B): For Pedophilia, Voyeurism, Exhibitionism, and Frotteurism, the diagnosis 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 urges with a nonconsenting person or the urges, sexual fantasies, or behaviors cause marked distress or interpersonal difficulty. For the remaining Paraphilias, the diagnosis is made if the behavior, sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). **B1**: DSM-III-R B3. **B2**: DSM-III-R B4. **B3**: DSM-III-R B5.
DSM-5 (A-E from p. 20; F from p. 22)**. A:** A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that **B:** reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. **C:** DSM-III B, so that "usually" precedes "related" and DSM-III-R C has been removed. **D:** DSM-III-R E. **E:** DSM-III-R F. **F**: A diagnosis is usually applied to the individual's current presentation.	(pp. 685-686). **A**: The term *paraphilia* refers to any sexual interest that is qualitatively "greater than or equal to normophilic sexual interests" (p. 685). To meet the criterion for the presence of a paraphilia a person must go through a 6-month period having non-normophilic "recurrent and intense arousal" that is "manifested by fantasies, urges, or behavior." **B**: A *paraphilic disorder* is a paraphilia that is currently causing distress or impairment to the person or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. **B1**: Only those who meet both **A** and **B** should be diagnosed with a paraphilic disorder. **B2**: Others may be said to have a paraphilia but not a paraphilic disorder. **B3**: DSM-III A5, with the explanation that there are eight specific paraphilias because they are relatively common and some are crimes.

[a] Capital letters in the left column stand for different elements of the mental disorder definition.

[b] Items preceded by the letter "**A**" stand for the "essential features" criterion that defines a paraphilia. "**A1**," etc., elaborates on the "A criterion."

[c] Items preceded by the letter "**B**" stand for the "clinical threshold" criterion for a paraphilia. "**B1**," etc., elaborates on the "B criterion.

Table 42.2. Definitions and descriptions of residual paraphilia categories in each DSM

DSM-I (pp. 38-39)**:** Five sexual deviations (homosexuality, transvestism, pedophilia, fetishism, and sexual sadism) were specified but not defined. A residual category was not included.

DSM-II (p. 44)**: Other sexual deviation** and **Unspecified sexual deviation** were inserted at the end of an enumerated list that referenced the DSM-I deviations plus 3 additions (exhibitionism, voyeurism, and masochism). No information about any of the 10 terms was provided.

DSM-III (p. 275)**: Atypical Paraphilia. "**This is a residual category for individuals with Paraphilias that cannot be classified in any of the other categories. Such conditions include: Coprophilia (feces); Frotteurism (rubbing); Klismaphilia (enema); Mysophilia (filth); Necrophilia (corpse); Telephone Scatologia (lewdness); and Urophilia (urine)."

DSM-III-R (p. 290)**: Paraphilia Not Otherwise Specified (PNOS). "**Paraphilias that do not meet criteria for any of the specific categories. Examples: Telephone scatalogia … Necrophilia … Partialism (exclusive focus on part of body) … Zoophilia (animals) … Coprophilia … Klismaphilia … Urophilia."

DSM-IV (p. 532)**: PNOS. "**Is for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatalogia … necrophilia … partialism … zoophilia … coprophilia … klismaphilia … and urophilia."

DSM-IV-TR (p. 576)**: PNOS.** Same as DSM-IV.

DSM-5 (p. 705)**: Other Specified Paraphilic Disorder (OSPD)**. "Applies to presentations in which symptoms characteristic of a Paraphilic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the … class. OSPD is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific … disorder. This is done by recording 'other specified Paraphilic disorder' followed by the specific reason (e.g., 'zoophilia').

Examples of presentations that can be specified using the 'ospd'designation include, but are not limited to, recurrent and intense sexual arousal involving telephone scatologia … necrophilia … zoophilia … coprophilia … klismaphilia … or urophilia … that has been present for at least six months and causes marked distress or impairment in social, occupational, or other important areas of functioning. Other specified Paraphilic disorder can be specified as in remission and/or as occurring in a controlled environment."

DSM-5 (p. 705)**: Unspecified Paraphilic Disorder (UPD).** "(first sentence the same as OSPD) … The UPD category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific Paraphilic disorder, and includes presentation in which there is insufficient information to make a more specific diagnosis."
