

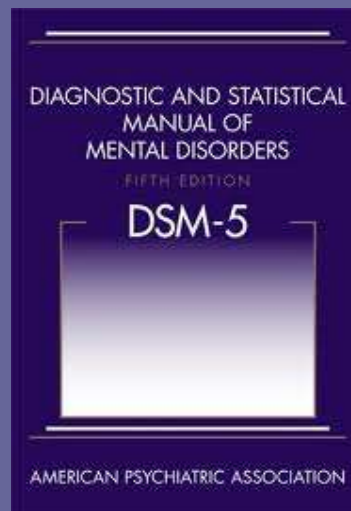
Sexual Offender Assessment: DSM-5 proposals modifying diagnostic criteria for paraphilias and related disorders

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Paraphilias Sub-WorkGroup

Sexual and Gender Identity Disorders WorkGroup for DSM-5

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American Psychiatric Association Disclaimer

It should be noted that the deliberations of the DSM-V Paraphilias Subworkgroup are ongoing and that the Subworkgroup's views may change with feedback from expert clinicians, clinical researchers, and other stakeholders. The clinical definitions and diagnostic criteria ultimately approved by the American Psychiatric Association may bear little or no resemblance to those presented at ATSA in 2010

Kafkaesque Disclaimer

Martin Kafka MD is an imposter who has been meticulously impersonating me and is relentlessly trying to ruin my personal and professional reputation.



Diagnostic and Statistical Manual, 5th Edition

<http://stage.dsm5.org/Pages/Default.aspx>

- A 10+ year effort
- Publication in May 2013
- Harmonization with the *International Classification of Disease, version #11 (ICD-11), Chapter V, Mental and Behavioral Disorders.*
- Over 600 international experts
- 13 Work Groups
- All experts vetted for conflict of interest with industry
- No payment from APA for DSM-5 activities

Sexual and Gender Identity Disorders

Ken Zucker Ph.D. Chairperson (Centre for Addiction and Mental Health)

- Sexual dysfunctions
- Gender Identity Disorders
- Paraphilias

Paraphilias SubWorking Group

- Ray Blanchard Ph.D. Chairperson (University of Toronto)
- Martin Kafka MD (Harvard University)
- Richard Krueger MD (Columbia University)
- Niklas Langstrom MD Ph.D.(Karolinska Institute)

DSM-5 Task Review Assignments

- Ray Blanchard, WG Chairperson
 - Operational definition for paraphilia
 - Pedophilic Disorder and Transvestic Fetishism
- Martin Kafka
 - Fetishism, Hypersexual Disorder
 - Paraphilia Not Otherwise Specified
- Richard Krueger
 - Sexual Masochism and Sexual Sadism
- Niklas Langstrom
 - Exhibitionism, Frotteurism, Voyeurism

Twelve DSM V Advisors to Paraphilia SWG

- Howard Barbaree Ph.D.
- David Delmonico Ph.D. hypersexual disorder
- Karl Hanson Ph.D.
- Stephen Hucker MB asphyxophilia
- Eric Janus J.D.
- Meg Kaplan Ph.D.
- Ray Knight Ph.D. paraphilic coercive disorder
- Michael Miner Ph.D. hypersexual disorder
- William O'Donohue Ph.D.
- Vernon Quinsey Ph.D. paraphilic coercive disorder
- Paul Stern J.D.
- David Thornton Ph.D. paraphilic coercive disorder
 - Our working group secured the maximum number of APA advisors

The Metamorphosis



DSM-5 outcome possibilities

- DSM-5 as a paper text
- A “living document’ on the Internet
 - modifications periodically incorporated based on accumulating scientific evidence.
- Three outcome possibilities
 - Incorporated into the primary text of DSM-5
 - Incorporated into the Appendix of DSM-5
 - no diagnostic codes
 - Rejected for DSM-5

General Goals

- Balancing scientific evidence with clinical utility
- Minimizing false positives
- Reducing stigma
- Adding dimensional features to categorical diagnoses
- Reducing Not Otherwise Specified (N.O.S)

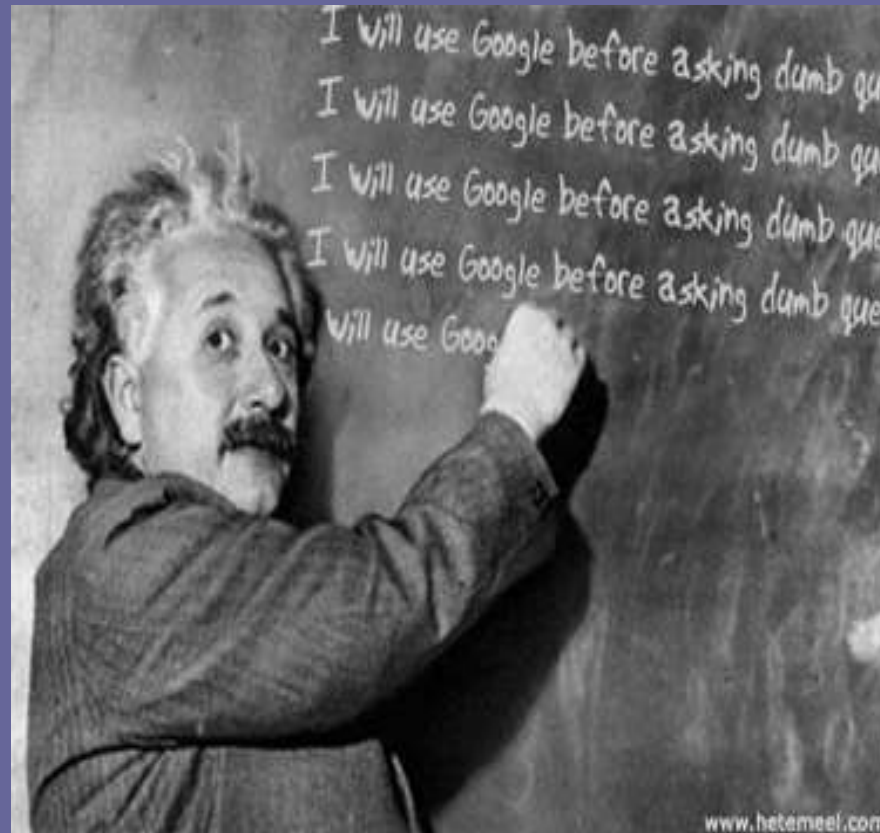
The Judgment

- Four major construction and deconstruction issues modifying or formulating a psychiatric disorder



I. Is there sufficient reliable data?

Different sources vs large samples



II. Discriminating cut points from continuous variables

– Can “bright lines” or taxons be defined?



III. “The Law of Unintended Consequences”



IV.

The Pros

and

Cons



of making changes

Prototypical Paraphilic Disorder template

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from _____ as manifested by fantasies, urges or behaviors.
- B. The person has clinically significant distress or impairment in important areas of functioning or has sought sexual stimulation from ___ or more unsuspecting strangers on separate occasions.
- C. Exclusionary criteria (when applicable)
- *Specifiers*
 - *Eg. course and remission*
 - *Eg. non-exclusive behavioral manifestations*

Paraphilia vs. Paraphilic Disorder

- A paraphilia is not a psychiatric disorder or diagnosis
 - Noted in DSM-IV (1994) and DSM-IV-TR (2000) but emphasized in DSM-5
 - Criterion A only
- A Paraphilic Disorder requires both A and B criteria
 - Can include B criterion minimum victim #, associated role impairment and duration of at least 6 months

Paraphilia vs Paraphilic Disorder

- Introduction of course specifiers
- Paraphilia <-----> Paraphilic Disorder
progression or regression

Specify if:

In a controlled environment

In Remission (No Distress, Impairment, or Recurring Behavior and in an Uncontrolled Environment): State duration of remission in months: _____

Addressing the limitations of self report

- Adding a minimum victim number

Maintains “fantasies, urges or behavior”

additional behavioral data required
typically from medical/legal records

Addresses “intense and recurrent” in A criterion

Increase reliability by adding a “cut point”

Minimum victim numbers

2 or more victims

on separate occasions, more than 6 months

Sexual Sadism

Pedohebephilia, pedophilic

3 or more victims

on separate occasions, more than 6 months

- Exhibitionistic Disorder, Voyeuristic Disorder, Frotteuristic Disorder, Paraphilic Coercive Disorder, Pedohebephilic Disorder, Hebephilic subtype

Proposed major diagnostic modifications

- **Pedohebephilic Disorder-** an expanded diagnosis
 - Blanchard, R. (2010) The DSM diagnostic criteria for pedophilia. Arch Sex Behav 39 (2):304-316
- **Paraphilic Coercive Disorder-** a third try
 - Knight, R.A. (2010). Is a diagnostic category for paraphilic coercive disorder defensible? Arch Sex Behav 39 (2):419-426
 - Quinsey, V.L. (2010) Paraphilic coercive disorder. Arch Sex Behav 39 (2) 405-410
 - Thornton, D. (2010) Evidence regarding the need for a diagnostic category for a coercive paraphilia. Arch Sex Behav 39 (2):411-418
 - Stern, P. (2010) Paraphilic coercive disorder in the DSM: the right diagnosis for the right reasons. Arch Sex Behav 39 (in press)
- **Hypersexual Disorder-** “nonparaphilic” disorder associated with paraphilic disorders
 - Kafka, M.P. (2010). Hypersexual disorder: a proposed diagnosis for DSM-5. Arch Sex Behav 39 (2) 377-400

Pedohebephilic Disorder

- A. Over a period of at least six months, one or both of the following, as manifested by fantasies, urges, or behaviors:
 - (1) recurrent and intense sexual arousal from prepubescent or pubescent children
 - (2) equal or greater arousal from such children than from physically mature individuals
- B. One or more of the following signs or symptoms:
 - (1) the person is distressed or impaired by sexual attraction to children
 - (2) the person has sought sexual stimulation, on separate occasions, from either of the following:
 - (a) two or more different children, if both are prepubescent
 - (b) three or more different children, if one or more are pubescent
 - (3) repeated use of, and greater arousal from, pornography depicting prepubescent or pubescent children than from pornography depicting physically mature persons, for a period of six months or longer

Pedohebephilic Disorder

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

- Specify type:
 - Pedophilic Type—Sexually Attracted to Prepubescent Children (Generally Younger than 11)
 - Hebephilic Type—Sexually Attracted to Pubescent Children (Generally Age 11 through 14)
 - Pedohebephilic Type—Sexually Attracted to Both

- Specify type:
 - Sexually Attracted to Males
 - Sexually Attracted to Females
 - Sexually Attracted to Both

Pedohebephilic Disorder: pros and cons

- Allows for 2 methods of ascertainment
 - Absolute
 - DSM-III-R, DSM-IV and DSM-IV-TR model
 - Sexual arousal to children is “recurrent and intense”
 - » Blanchard, Kuban, Blak et al. (2009) *Sexual Abus*
 - Relative
 - DSM-III model definition (1980)
 - “...repeatedly preferred or exclusive method of achieving sexual excitement”
 - “repeatedly preferred” in comparison to adults
 - Evident using phallometric assessment in comparing child vs adult stimuli, even in the face of suppression of response

Pedohebephilic Disorder: pros and cons

- Persistent evidence of viewing child pornography
 - 6 or more months
 - Greater sexual arousal from child porn
 - Seto, Canter and Blanchard (2006). J Abnorm Psychol.

Pedohebephilic Disorder: pros and cons

- Prior to DSM-5, criticisms focused on the reliability and validity of pedophilia vs “child molestor”
- In DSM-5 proposal, the professional criticism has focused predominantly on the hebephilic component of pedohebephilia

Pedohebephilic Disorder: pros and cons

- Expands diagnosis to victims “age 11- 14”
- Cutoff was age 13 or younger (DSM-IV-TR)
 - empirical literature: repetitive child molesters include early pubertals as well as adolescents
- Reduces Paraphilia NOS-Hebephilia
- Harmonizes with current ICD-10 definition:
 - ”a sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age”

Pedohebephilic Disorder: pros and cons

- Is the data sufficient and reliable for hebephilia?
 - Criticisms of Blanchard et al methodology, Lykins, Wherrett et al.(2009) Arch Sex Behav
 - Age of consent is age 14 in several Eastern European countries
 - “Normal” males respond to visual images of post-pubertal adolescents but:
 - Clinical Hebephilia is a repetitive sexual preference
 - Hebephilia is early pubertal, not post-pubertal
 - The relative ascertainment model, phallometry
 - » Early puberty adolescent arousal > prepubertal and adult arousal
 - » The perpetrator must be at least 5 years older

Pedohebephilic Disorder: pros and cons

- Can we reliably distinguish early from mid-pubertal adolescents?
 - Pubertal onset now begins before “age 13”
- Expand or decrease the number of persons being diagnosed?
- Further legitimize civil commitment of incarcerated offenders?
- Will inclusion of possession of child pornography include too many false positives?

Paraphilic Coercive Disorder

- A. Over a period of at least six months, recurrent and intense sexually arousal focused on sexual coercion as manifested by fantasies, urges, or behaviors.
- B. The person is clinically significant distress or impairment in important areas of functioning or has sought sexual stimulation from forcing sex on three or more nonconsenting persons on separate occasions.
- C. The diagnosis of Paraphilic Coercive Disorder is not made if the patient meets criteria for a diagnosis of Sexual Sadism Disorder.

Paraphilic Coercive Disorder: pros and cons

- Many serial “non-sadistic” rapists are specifically aroused by coercive sex > mutuality (Rape Index)
- Serial rapists predominate in forensic samples
 - Physical evidence of sadism is absent in the majority of serial rape cases
- Sadists are less interested in coital or penetrative sex
- Paraphilia NOS-nonconsent has no diagnostic criteria
 - “non-consent” describes the victim, “coercive” describes perpetrator’s sexual arousal
 - 30-60% of civil commitments associated with PA-NOS:nonconsent

Paraphilic Coercive Disorder: pros and cons

- A minimum victim number of 3
 - intended to reduce false positives
- Distinct physical characteristics associated with “coercive” versus “sadistic” sexual behavior
 - Doren’s text (2002)
 - PCD checklist (Zinik and Padilla, 2010, ATSA)
 - Seeking expert input and consensus
 - 3 or more victims
 - Evidence of a rape kit
 - Evidence of rituals or repetitive patterns
 - Use of force not greater than necessary to subdue

Paraphilic Coercive Disorder: pros and cons

Rejected from DSM-III (Sexual Assault Disorder) and DSM-III-R (Paraphilic Coercive Disorder)

– proposed since 1980, there must be something there

- Can PCD be distinguished from nonparaphilic repetitive rape and from sexual sadism? (Knight, 2010; Quinsey 2010)
 - When is it “different” and when is it a matter of degree? (Richards and Jackson 2010, in press)

Paraphilic Coercive Disorder: pros and cons

- Isn't all “coercion” intrinsically sadistic?
 - For the victim, yes but for the paraphilic person?
Sadism: sexual arousal associated with excess use of violence, “power”/control and gratuitous humiliation/suffering of the victim
- Coercive fantasy: sexual arousal or lack of inhibition?
- Merely an endorsement of Paraphilia NOS-nonconsent?
- Expand dimensional sexual sadism?
- Is the data sufficient?
 - Field testing in progress
 - Can we construct a polythetic definition for PCD?

Hypersexual Disorder

- A. Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges, and sexual behavior in association with four or more of the following five criteria:
 - (1) Excessive time is consumed by sexual fantasies and urges, and by planning for and engaging in sexual behavior.
 - (2) Repetitively engaging in these sexual fantasies, urges, and behavior in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
 - (3) Repetitively engaging in sexual fantasies, urges, and behavior in response to stressful life events.
 - (4) Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges, and behavior.
 - (5) Repetitively engaging in sexual behavior while disregarding the risk for physical or emotional harm to self or others.

Hypersexual Disorder

- B. There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges, and behavior.
- C. These sexual fantasies, urges, and behavior are not due to the direct physiological effect of an exogenous substances (e.g., drugs of abuse or medications) or to Manic Episodes.
- D. The person is at least 18 years of age.

Specify if:

- Masturbation
- Pornography
- Sexual Behavior With Consenting Adults
- Cybersex
- Telephone Sex
- Strip Clubs
- Other:

Hypersexual Disorder: pros and cons

- Criterion A items derived from validated rating scales
 - addiction, compulsivity, desire dysregulation models integrated
 - Rating scales tested in clinical and non-clinical samples
- Polythetic
- Reduce use of Sexual Disorder N.O.S.
- Recognition of a serious sexual behavior disorder with public health consequences
 - Associated with STDs including HIV infection, severe pair bond disruption, divorce

Hypersexual Disorder: pros and cons

- Associated with paraphilias
 - “heavy users of pornography” and recidivism
(Kingston, Federoff, Firestone et al (2008))
 - Hypersexual Disorder: pornography, masturbation
 - may include Pedohebephilia
 - Hypersexual Disorder: sex with consenting adults
 - may include Sexual Masochism
 - Multiple Hypersexual Disorders associated with paraphilias may increase offender recidivism risk
(Kafka, 2003)

Hypersexual Disorder: pros and cons

Is this psychiatric diagnosis just an excuse for “bad behavior”?

alcohol abuse had the same issues

Is this the same as sexual addiction?

tolerance and withdrawal

Is this a distinct condition or a comorbidity?

mood disorders, ADHD

Is this too culture bound?

Hypersexual Disorder: pros and cons

- Forensic misuse or forensic excuse?
- Too many false positives?
 - Sexual fantasies, urges and behaviors
 - How many A criterion items are optimal?
 - Is 4/5 too stringent?
 - Combine A.2 and A.3 (sexualized coping)?

The Trial

- Field Testing diagnostic criteria
 - David Thornton Ph.D. Principal Investigator
Pedohebephilia, Paraphilic Coercive Disorder and Hypersexual Disorder
 - Sand Ridge Treatment Center Wisconsin (*In The Penal Colony*)
In conjunction with the WI Dept of Health Services
 - Robin Wilson Ph.D., Florida Civil Commitment Center
 - Diedre D' Orazio Ph.D. in California, outpatients

- Rory C. Reid, Ph.D., LCSW. Principal Investigator UCLA Department of Psychiatry and Biobehavioral Sciences
Hypersexual Disorder
 - Timothy Fong, M.D. UCLA
 - Sheila Garos, Ph.D. Texas Tech University
 - Bruce N. Carpenter, Ph.D. Brigham Young University
 - California and Utah, outpatients

DSM-5: *Description of a Struggle*

- “And you will be damned if you do-And you will be damned if you don't.’ ”



“C'mon, c'mon — it's either one or the other.”