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41st Annual Conference of the
Forensic Mental Health Association
Monterey, California
17 March 2016

# USING DSM-5 TO DIAGNOSE CONTROVERSIAL PARAPHILIAS

## THE DISTURBING SIDE OF SEXUALITY

What is "Mental Disorder"

?

## BEING STUCK IN IN A STATE LIKE THIS

No Meaning

No Love

No Creativity

## WHAT IS MEANT BY THE CONCEPT 'MENTAL DISORDER'?

1. Mental Disorders are abnormal behavior

   Versus

2. Mental Disorders are underlying entities that may explain abnormal behavior

***DSM-5 moves toward #2.***

## MENTAL DISORDER DSM-IV-TR

*"A clinically significant behavioral or psychological **syndrome or pattern** that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability, (e.g., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom."*

-DSM- IV Fourth Ed-Text Revision., xxxi

## MENTAL DISORDER DSM-5

*"a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion 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… 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."*

-DSM-5 p. 20

## WHAT IS PARAPHILIA?


www.theoi.com

## PARAPHILIA'S CONTROVERSIAL DIAGNOSTIC CONTEXT

- Criminal justice process, e.g. "Is mandated treatment necessary to prevent ongoing harm?"
- Political controversies & value judgments
  - Disordered? Atypical? socially condemned?
  - Do we avoid labeling clinical realities due to unwanted collateral consequences?
- Definitions are influenced by guesses about social consequences (e.g. civil commitment, victim advocacy)
- DSM continues to mis-characterize underlying arousal patterns as discrete entities that are present or absent despite that they really occur dimensionally and on continua

## WHAT IS THE FUNCTION OF DIAGNOSIS?

- Case formulation, communication, research & gate-keeping
- DSM codes the protypical outward manifestations of pathological internal processes
- DSM is intended to structure diagnosis carried out in the context of treatment; its use in forensic contexts is only secondary

***DSM offers general guidelines not absolute requirements for diagnosis.***

## CAUTIONARY STATEMENT FOR FORENSIC USE

1. DSM primary purpose is to assist clinicians:
   - clinical assessment
   - case formulation
   - treatment planning
2. As a reference for the courts and attorneys in assessing forensic consequences of mental disorders

## DSM-5 ON FORENSIC USE

*"When used appropriately, diagnoses, and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for subsequent legal determination (e.g., involuntary civil commitment) the use of an established system of diagnosis enhances the value and reliability of the determination…However, the use of DSM-5 should be informed by an awareness of the risks and limitations in forensic settings (p. 25)."*

## PREDECESSOR DSM DEFINITIONS OF PARAPHILIA

- *Paraphilia usually describes* ***a pattern of sexual arousal*** *in response to sexual objects or situations which may interfere with the capacity for reciprocal affectionate sexual activity.*
  -DSM-III-R, p. 292
- *The essential features are* ***recurrent, intense sexually arousing fantasies, sexual urges, or behaviors*** *generally involving non-human objects, the humiliation of oneself or one's partner, or children or other nonconsenting persons that occur over a period at least 6 months.*
  -DSM-IV-TR, p. 566

## DSM-5 PARAPHILIA

*Any* ***intense and persistent sexual interest other than*** *sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners.*

-DSM-5 p. 685

## MUST THE SEXUAL INTEREST BE PREFERENTIAL?

- Paraphilia is intense and persistent

  or
- If intense and persistent is difficult to apply, it is "greater than or equal to normophilic sexual interests."

  or
- Preferential

  *-DSM-5 p. 685*
- Short Answer=NO

***Caution: Opportunistic offenders do not engage in the behavior preferentially or persistently but transitorily. "Repeat" opportunistic offenders are not opportunistic.***

## WITH DSM-5 YOU ASCERTAIN A PARAPHILIA BUT DIAGNOSE A PARAPHILIC DISORDER

1. Ascertain the presence of a Paraphilia
   - A non-normophilic intense and persistent sexual interest (Criterion A)
2. Diagnose a Paraphilic Disorder
   - A paraphilia that is currently causing distress or impairment to the individual or whose satisfaction has entailed personal harm, or risk of harm, to others (Criterion B).
   - Criteria A + B

   –DSM-5 p. 685

***No dysfunction = No disorder***

## DSM-5 DEVELOPMENT PROCESS

### SEXUAL AND GENDER IDENTITY DISORDERS WORKGROUP

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

1. Sexual Dysfunctions
2. Gender Identity Disorders
3. Paraphilias

   Paraphilias Sub Work 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)

## TWELVE ADVISORS TO PARAPHILIA SUB WORK GROUP

- Howard Barbaree Ph.D.
- David Delmonico Ph.D. hypersexual disorder
- Karl Hanson Ph.D
- Stephen Hucker MD 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

*The maximum allowable number of APA advisors

## AMERICAN PSYCHIATRIC ASSOCIATION DISCLAIMER ON DSM-5 PARAPHILIA REVISION PROCESS

It should be noted that the deliberations of the DSM-5 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 currently proposed.**

## DSM-5 PROPOSED NEW PARAPHILIA DIAGNOSES

| DSM-IV-TR | Proposed DSM-5 |
|---|---|
| Exhibitionism | Exhibitionistic Disorder |
| Fetishism | Fetishistic Disorder |
| Frotteurism | Frotteuristic Disorder |
| Pedophilia | Pedohebephilic Disorder * |
| Sexual Masochism | Sexual Masochism Disorder |
| Sexual Sadism | Sexual Sadism Disorder* |
| Transvestic Fetishism | Transvestic Disorder |
| Voyeurism | Voyeuristic Disorder |
| | Hypersexual Disorder * |
| | Paraphilic Coercive Disorder * |

## ARE THE DSM-5 PARAPHILIAS RESEARCH BASED?

- DSM-IV-TR paraphilia definitions reflected the consensus of eminent professionals at the time, modified by political pressures
- With DSM-5 substantial input was provided by experts, the existing literature was carefully reviewed…
- But ultimately field trials funding was cancelled and the proposed additions were dropped…
- Like DSM-IV-TR, the operational definitions in the DSM-5 paraphilias were never tested in official field trials although some studies occurred (i.e. Thornton, D'Orazio, Wilson, Reid and colleagues).

## GENERAL GOALS OF DSM-5 TASK GROUPS

- Balance scientific evidence with clinical utility
- Minimize false positives
- Reduce stigma
- Add dimensional features to categorical diagnoses
- Reduce Not Otherwise Specified (N.O.S)
- Reduce Net-Widening

## DSM-5 GOAL OF REDUCING NOS

- A DSM-IV-TR shortcoming was the prevalent use of Not Otherwise Specified (NOS) diagnoses
- In SOT, NOS was common for Personality Disorders & Paraphilias
- NOS diagnosing involves grappling with two competing threats:
  - Failing to ascribe a real mental disorder when it is actually present (false-)
  - Mistakenly treating some variation of normal functioning as a mental disorder (false+)
- Challenge for DSM-5 was how to increase clinical utility and reduce NOS without vastly expanding prevalence rates (net-widening)

## DSM-5 CONCERNS ABOUT NET-WIDENING

If DSM-5 adds or significantly changes the list of mental disorders would more people get diagnosed than with DSM-IV? Why does this matter?

- The prevalence rates of mental disorders among sexual offenders will increase
- Expand the need for treatment services
- Create additional treatment targets to existing treatment plans
- Increase the number of civilly committed sexual offenders

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## RESOLUTION: PARAPHILIA NOS BECOMES OTHER SPECIFIED PARAPHILIC DISORDER

- Researchers have always identified a much wider range of paraphilias than those specified in DSM (Money, 1986)
- DSM-5 expressly cautions that it does not list all known paraphilias about and **invites** diagnosis of those not listed
- "Other specified" will often be used in cases where PNOS was diagnosed (i.e. hebephilia, coercion, polymorphous, zoophilia, etc.)

## DSM-5 ATTEMPT TO REDUCE NOS

*"Many dozens of distinct paraphilias have been identified and named, and almost any of them could, by virtue of its negative consequences for the individual or for others, rise to the level of a paraphilic disorder… The diagnoses of the other specified and unspecified paraphilic disorders are therefore indispensible and will be required in many cases."*

-p. DSM-5, 685

## DSM-IV-TR PARAPHILIA CRITERIA TEMPLATE

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving
.
B. The person has acted on these sexual urges (with a nonconsenting person), or the sexual urges or fantasies cause marked distress or interpersonal difficulty
C. Minimum Age (Pedo 16 & 5yrs older); fetish object exclusion for Fetishism
D. Specifiers

## DSM-5 PARAPHILIC DISORDER TEMPLATE

A. Over a period of at least six months, recurrent and intense sexual arousal from _____ **as manifested by fantasies, urges, or behaviors** (except Pedo).
B. The individual **has acted on these sexual urges** with a non consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (**The fantasies, sexual urges, or behaviors** cause clinically significant distress or impairment in social, occupational, or other important areas of functioning for SM, Fetish., Transv.).
C. Minimum Age specified only for Voyeuristic (18) & Pedo (16 & 5yrs older); fetish object exclusion for Fetishistic
D. Specifiers

***DSM-5 clarifies that paraphilias can be inferred from behaviors***

## CONCEPTUAL ISSUES

Paraphilia related disorders are often characterized by time-consuming sexual fantasies, urges, and behaviors. – i.e. Kafka, 1997; Kafka & Prentky, 1992a, 1994, 1998

THREE salient manifestations:

1. Urges= The desire, or drive, to act. Arousal is a physiological response to a stimulus, be it sensory (physical, olfactory, visual, auditory, etc.) or mental.

2. Fantasies – Often conditioned through fantasies which may act as a form of rehearsal (can include masturbation or not); about half of admitting offenders disclose fantasizing about sexual offending (Marshall et al., Prentky, 1983; Deu & Edelman, 1997; MacCullough et al, 1993)

3. Behavior – Acting on the underlying arousal. Acting despite harm and consequences is a sign of inadequate control

## "SIX MONTHS?"

- The six month time frame is intended to be a rough estimate of "persistent"

## BEHAVIOR

Paraphilia is a disorder of intention.

*"The disorders of intention are recognized by unusual eroticism and often socially destructive behaviors such as sex as with children, rape, exhibitionism, voyeurism, masochism, obscene phone calling, or sexually touching strangers."*

- M. First & A Tasman, 2004, p. 1085

## IDENTIFYING & DEFINING PARAPHILIC BEHAVIOR

- The core construct of a paraphilia is deviant sexual arousal
- A single sexual act (criminal or not) is not sufficient to diagnosis a paraphilia
- **Behavior** that is repetitive implies motivation and an arousal pattern

## INFERRING PARAPHILIA FROM BEHAVIOR

- Diagnoses are frequently confirmed by behavioral observations (e.g., schizophrenia, depression)
- In absence of self-disclosure or other evidence of fantasies and urges, behavioral repetition is required
- Per DSM, the disorder can apply to those who engage in the paraphilic behavior but deny getting sexually aroused
- E.g. "Recurrent voyeuristic behavior constitutes sufficient support for voyeurism (Crit. A) and simultaneously demonstrates that this paraphilically motivated behavior is causing harm to others (Crit. B) *(p. 687, DSM-5)."*

## OBJECTIVE MEASURES:

- Objective measures can be useful in identifying paraphilic disorders
- These typically fall into two types:
  - ERECTILE RESPONSE
  - VISUAL REACTION TIME

## ABEL, PPG, OR NEITHER?

- Consider using AASI or PPG IF these are true:

  -reason to suspect deviance (e.g., multiple victims; chronic offending)
  -subject denies; or admits but minimizes
  -subject can afford testing

- PPG or AASI? — If Yes, Use:

| | |
|---|---|
| -awareness of how VRT works? | PPG |
| -intrusiveness a major concern? | AASI |
| -in pre-trial forensic case, unwilling to take poly? | Usually neither |

## VISUAL REACTION TIME: HISTORY

- Rosenzewig Studies of 1942
- Sexual Interest is correlated with 1) visual attention, 2) movement toward a stimulus, and 3) Penile tumescence (Singer)
- Visual Reaction Time is highly correlated with rating of image attractiveness, sexual arousal, and sexual stimulation (e.g. Lang, Searles, & Adesso, 1980; Quinsey, Ketetzis, Earls, & Karamanoukian, 1996; Quinsey, Rice, Harris, Reid, 1973; Landolt, Lalumiere, Quinsey 1995)

## VRT

- Objective measures of sexual interest taken beyond the client's awareness.
- 160 images of preschool and grade school children, teens, and adults; male and female; Caucasian and African-American; also paraphilia categories (exhibitionism ag ad. f, voyeurism ag ad. f, frottage ag ad. f, sadomasochism ag f & m, fetishism).
- The models in all of the images are clothed; one model per image; no sexual content represented in the images.
- The client sees seven images in each sexual interest category to ensure reliability of responding.
- The client views every image twice – 320 images in less than half an hour (no audio, just still pictures).

- Use of VRT is very limited for all of the paraphilias *except* pedophilia
- SM and other non-pedophilia category scores (e.g., exhibitionism, fetishism, etc.) have little or no research support
- SM category seems to be better measure of bondage than sadism
- Probability Value:
  - has it been *independently* validated ?
  - exactly what determines this value?
- Emerick Trauma Scales

## VALIDITY

- The typical range of error is between 26% and 32%. However, some research suggests that, with proper administration, the error can be reduced to 10% (Gray).
- Sensitivity and Specificity are both around 75%.

## PENILE PLETHYSMOGRAPH (PPG)

- Also called phallometric assessment
- Directly measures male erectile changes – circumferentially – while viewing and/or listening to erotic stimuli
- PPG results constitute *one of several data points* that support diagnosing a paraphilia

## PROBLEMS ASSOCIATED WITH PPG

- Intrusiveness – humiliating, shameful, PTSD, objectionable for religious reasons, might stimulate deviant thoughts
- High Non-Responder Rate: difficulty achieving arousal in laboratory setting
- Lack of standardization
  + Camilleir, J. A., Quinsey, V. L., 2008; Marshall, 2006

## PPG VALIDITY

- Sensitivity 44% to 86%
- Specificity about 95%
- False negative ranges from 14 to 56 percent

+ (Freund et al., 1991; Freund, K, Blanchard, et al., 1989; Hall, et al., 1995).

## DSM-5:TWO NEW SPECIFIERS

**Specify If:**

**In a Controlled Environment**

Individuals living in institutional or other settings where opportunities to engage in _____ are restricted.

**In Full Remission**

Has not acted on the urges with a non-consenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

**IFR does not address the continued presence or absence of the paraphilia, which may still be present after behaviors and distress have remitted*
**IFR does not apply to Pedophilia*

## DSM– 5 PARAPHILIC DISORDERS

1. 302.82 (F65.3) Voyeuristic Disorder
2. 302.4 (F65.2) Exhibitionistic Disorder
3. 302.89 (F65.81) Frotteuristic Disorder
4. 302.83 (F65.51) Sexual Masochism Disorder
5. 302.83 (F65.51) Sexual Sadism Disorder
6. 302.81 (F65.0) Fetishistic Disorder
7. 302.3 (F65.1) Transvestic Disorder
8. 302.2 (F65.4) Pedophilic Disorder

## ALTERNATIVE EXPLANATIONS

- Differential Diagnosis
  - Conduct disorder and antisocial personality disorder
  - Substance use disorder
  - Intellectual Disabilities
  - Psychotic Disorder
- Comorbid disorders
  - Depressive disorder, bipolar disorder, anxiety disorder, substance use disorders, hypersexuality, ADHD, antisocial

## Exhibitionistic Disorder

## 302.4 DSM-5: EXHIBITIONISTIC DISORDER

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors.

B. The individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

## EXHIBITIONISTIC DISORDER SPECIFIERS:

1. Sexually aroused by exposing genitals to prepuberal children
2. Sexually aroused by exposing genitals to mature adults
3. Sexually aroused by exposing genitals to prepuberal children and mature adults

AND

1. In a controlled environment
2. In full remission

## KRIS 1 EXHIBITIONISTIC DISORDER?

- 23 year old male who was referred for evaluation after an adult female saw him masturbating on a park bench. He was subsequently arrested. He tells you that he masturbated publically 10x over the course of six weeks. He said that about 3 of the women he exposed to, ignored him, 3 of the women displayed shock and walked away, 2 women showed "interest" and watched him, and 2 women rebuffed him. He said that he was most aroused by the women who expressed interest but was also aroused by the "shock."
- He dated consistently through his adolescence and was involved in a relationship when engaged in this behavior.

## KRIS 2

When Kris was 15 years old, while standing in his window, he viewed a peer-aged female neighbor undress in her bedroom. He saw this three times. He went on the internet to look for voyeurism photos. While doing that he discovered media (photos and videos) of men and women exposing. He developed the fantasy of exposing himself and masturbating but never acted on it other than during masturbatory fantasies until he was 23.

He dated consistently through his adolescence and was involved in a relationship when engaged in this behavior.

## THE AGONISTIC PREFERENCE CONTINUUM

## THE AGONISTIC CONTINUUM

- Refers to the individual's sexual preference regarding the degree partner agony
- i.e. mutually consenting…equal consenting & coercion…coercion w/o brutality…equal brutality & coercion… brutality (sexual sadism)
- DSM has declined to list a diagnosis for recurrent and intense interest in sexual coercion separate from sexual sadism
- DSM-5's subtly changed the text and criterion set for sexual sadism extends the diagnosis further down the continuum to include arousal to coercion without extreme brutality
- OSPD is also a specified diagnostic option for labeling coercion specific clinical realities

## DSM-5: SEXUAL SADISM DISORDER

A. *Over a period of at least six months, recurrent and intense sexual arousal from the physical or psychological suffering of another person as manifested by fantasies, urges, or behaviors.*

A. *The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.*

*Specify if: In a Controlled Environment/In Full Remission*

*-p. 695, DSM-5*

*Text does not include examples of extreme brutality.
*Crit. A no longer requires acts be "real, not simulated."
*Text states 6mos persistence is a general guideline not strict threshold.

## DIAGNOSING WHEN SEXUAL SADISM IS DENIED

- "The diagnostic criteria for sexual sadism disorder are intended to apply both to individuals who freely admit…and to those who deny any sexual interest in the physical or psychological suffering of another despite substantial objective evidence to the contrary."
- Recurrent and intense sadistic sexual arousal (Crit A.) can be inferred from multiple victims,"…multiple victims…are a sufficient but not a necessary condition for diagnosis." Multiple victims satisfies Crit. A & B.
- Multiple victims is 3 or more victims on separate occasions OR fewer than 3 if there are multiple instances of infliction of pain and suffering to the same victim, OR if there is evidence of a strong or preferential interest in pain and suffering involving multiple victims.
- Must rule out that the sadistic sexual interest is not merely transient

-p. 696

## FRED: SEXUAL SADISM DISORDER?

Fred is recently released from serving a sentence involving robbing a victim at gunpoint, sexual torture and rape. In outpatient treatment with you, he disclosed that he has been raping women in similar ways since he was a juvenile when he observed his father doing the same thing. He states this is what men do where he is from to protect themselves from being "taken by all the bitches." He has had some consensual sex but he does not find it as arousing as the thrill or rape and robbery.

## TIMOTHY: SEXUAL SADISM DISORDER?

Tim is convicted of Rape by Foreign Object. He allegedly met a woman at a bar and the two agreed to go back to his apartment. Shortly after she voluntarily disrobed, he locked the doors, shut the windows and took a box out from under the bed containing handcuffs, a whip, and duct tape. He forcibly bound and whipped her against her protests and resistance then sodomized her. He told her he was going to leave her there to die. The next morning he released her and threatened to murder her should she tell anyone. The investigation revealed that over the past year he had been frequenting S&M clubs and had accessed bondage and violence themed pornography as well as consensual themed pornography. He denies the sex crime, stating the victim consented to the bondage, whipping and sex acts. He denies any interest in non-consensual sex.

## PARAPHILIC AROUSAL TO COERCION

- In DSM-IV, "Paraphilia Not Otherwise Specified, Non-Consent" was commonly utilized to describe paraphilic arousal to coercion
- About 25% high risk sexual offenders diagnosed with mental disorders are diagnosed with PNOS, Non-Consent

D'Orazio, Wilson & Thornton. Prevalence of Pedohebephilia, Paraphilic Coercive Disorder, and Sexual Sadism Diagnoses with the Proposed DSM-5 Criterion Sets. ATSA 2011.

## DSM-5: OTHER SPECIFIED PARAPHILIC DISORDER, COERCION

Other Specified Paraphilic Disorder:

*"This category 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 paraphilic disorders diagnostic class…(C)ommunicate the specific reason that the presentation does not meet the criteria for any specific paraphilic disorder (e.g. Other specified paraphilic disorder, zoophilia)".*

*–DSM-5, p. 705*

## CAUTION ABOUT PARAPHILIC AROUSAL TO COERCION!

- Distinguishing a normophilic sexual arousal pattern combined with callous/antisocial personality features vs. an abnormal arousal pattern involving equal arousal to consensual and coercive themes is challenging
- How is the garden variety antisocial rapist distinguished from the paraphilic rapist?

## COERCION PREFERENCE IS DISTINCT FROM SADISM PREFERENCE

- Arousal to coercion is distinct from arousal to injury
  - Self-identified sadists show elevated arousal to injury over coercion
  - Rapists show arousal to coercion over injury
- Evidence of more general sexual sadism (arousal to brutality) is absent in many cases who show clear sexual arousal to rape

## CLUES: AROUSAL TO COERCION

- Evidence of Planning, Rape-kits etc
- Evidence of a script being repeated
- History of multiple sexual assaults that use threats or violence to gain control of the victim
- Rapes when consensual sex was available
- Evidence of salient coercion, or behavior deliberately designed to induce fear, suffering or injury, beyond that required to control the victim during sexual assaults
- Coercive elements in consensual sexual behavior (e.g. themes of humiliation, punishment, inducing fear, defecation/urination, punishing through sex)
- Partners/victims report his/her arousal seemed to increase top distress cues (e.g. resistance, crying, pleading).
- PPG data
- Self-report of rape or sadistic fantasy/ urges
- Coercive themed pornography

## CLUES: AROUSAL TO BRUTALITY

- Offender tortures victim; inflicts intense pain (pain substantially beyond that intrinsic to being raped) – for example inserting needles or hanging the victim
- Offender humiliates victim (humiliation substantially beyond that intrinsic to being raped) – for example forcing the victim to crawl in front of the offender or by using bodily secretions/excretions
- Offender mutilates sexual body parts of the victim
- Offender mutilates non-sexual body parts of the victim
- Offender uses a physical object to inflict pain to sexual areas of the victim's body
- Offender makes threats designed to terrify rather than coerce the victim
- Offender uses excessive/gratuitous force (beyond that required to gain compliance)
- Offender strangles, cuts or stabs the victim prior to or during the sex act
- Self-report of fantasies / urges that include the above sadistic elements
- PPG data indicating arousal to the above sadistic elements
- Use of violence themed pornography (i.e. torture, mutilation, body damage)
- Collateral victims (i.e. requires child to watch sexual assault of mother)

## The Age Preference Continuum

### PEDOPHILIA & HEBEPHILIA

## THE AGE PREFERENCE CONTINUUM

"*The erotic orientations toward prepubescent, pubescent, and physically mature persons represent regions along a dimension rather than discrete taxa (Blanchard et al., 2010 ; see also Blanchard, 2010b ). This finding supports re-focusing the revision of the diagnostic criteria away from the search for a single, objective cleavage point in nature toward a more realistic approach in defining the boundaries of disordered sexual behavior*."

-Blanchard, R. A Brief History of Field Trials of the DSM Diagnostic Criteria for Paraphilias. Arch Sex Behav (2011) 40:861–862.

## DIAGNOSING AGE PREFERENCES OTHER THAN PEDOPHILIA, WHAT'S AN EVALUATOR TO DO?

- The age preference continuum is a dimension of sexual interest that refers to the age preference of sexual partners (i.e. age 0-100).
- Preferred partner age (proxy for dev. stage) determined by history, self-report, and indices of fantasies, urges and behaviors.
- Attractiveness of potential partners is influenced by closeness to the preference point although opportunity often leads to ages adjacent.
- DSM has declined to list diagnoses for recurrent and intense interest in age preferences other than pedophilia (i.e. hebephilia, ephebophilia, gerontophilia)

## DSM-5: PEDOPHILIA

A. Over a period of at least six months, recurrent, intense sexual fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (**generally age 13 or younger**)
B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty
C. The person is **at least age 16 years and at least 5** years older than the child or children in Criterion A

## DSM-5: PEDOPHILIA SPECIFY IF

- Sexually attracted to Males
- Sexually attracted to Females
- Sexually attracted to Both

- Limited to Incest

## DSM-5: PEDOPHILIA SPECIFY TYPE

- Exclusive Type (attracted only to children)
- Non-exclusive Type

## APA STATEMENT ON DSM-5 TEXT ERROR

- "Sexual orientation" is not a term used in the diagnostic criteria for pedophilic disorder and its (error is on page p. 698)
- use in the DSM-5 text discussion is an error and should read "sexual interest." In fact, APA considers pedophilic disorder a "paraphilia," not a "sexual orientation."

## DEVELOPMENT AND COURSE

- Pedophilia is typically a life long condition.
- May change over time with or without treatment

  Due to: 1) subjective distress (e.g. guilt, shame, frustration etc..); 2) psychosocial impairment, and/or 3) "the propensity to act out with children."

## STAN: PARAPHILIA DIAGNOSIS?

- 60 yr old Caucasian male
- 1st acting out at age 13→ 9 yr-old m.
- Age 17 arrested not charged→ 11-yr old m.
- Age 41 convicted L&L Ch. Under 13→ 11-yr-old m.
- Admits to numerous sexual acts with young male prostitutes
- Reports he prefers males age 11 to 17 m.

  Characteristics: sparse body hair, minimal muscle development, feminine demeanor, ideally Asian or Hispanic

## AGE VERSUS DEVELOPMENT

- What does "pre-pubescence" mean?
  - Does it end at the onset of any signs of puberty?
  - Does it end when puberty is fully complete?

## PHYSICAL DEVELOPMENT

- Girls begin puberty at ages 10–11
- Boys at ages 11–12
- The average age for completion of pubertal development is 16- 17 years of age
- Some researchers proposed a younger age maximum for pedophilia of "*less than age 11" (*Blanchard, 2009)

## TANNER STAGES: FEMALES

Reference: "Teenage Growth & Development: 11 to 14 Years". Palo Alto Medical Foundation/pamf.org. Retrieved 2013-11-09

**Stage One**

- This stage is the period before pubertal development begins.

**Breast Development**

- The breast shows no outwardly noticeable changes. There is no development. Only the papilla is elevated.

**Pubic Hair**

- No pubic hair.

## STAGE TWO*

**Breast Development**

- Areola widens, darkens slightly, and elevates from the rest of the breast as a small mound. The mound (nipple) may be visible, and lying under the areola is a bud of breast tissue (breast bud) that is palpable (noticeable to the touch).

**Pubic Hair**

- First appearance of pubic hair, which is sparse, straight, or only slightly curled, longer but still downy hair, slightly pigmented, and appearing chiefly along the labia.

## STAGE THREE*

**Breast Development**

- Breast bud enlarges beyond the areola, the areola experiences early changes including pigmentation, and small glands, called Montgomery glands, form on the areola. There is further breast enlargement, but there is no separation of the contours of the areola from the breast. This is all one mound.

**Pubic Hair**

- The hair is considerably darker, coarser, and more curled. The hair spreads sparsely over the middle of the pubic bone.

## STAGE FOUR

**Breast Development**

- The areola and nipple project above the contour of the breast to form a secondary. The areola becomes more pigmented and enlarged, and the nipple also becomes pigmented.

**Pubic Hair**

- The hair is adult-like in appearance. The area covered is still smaller than that in the adult. There is no hair spread to the medial thighs.

## STAGE FIVE

**Breast Development**

- Development is the mature, adult breast. There is projection of only the papilla with recession of the secondary mound back to the contour of the breast, and there is a further increase in breast size.

**Pubic Hair**

- The hair is adult-like in appearance and distributed in the classic female triangle. Some individuals may have hair spread to the medial thighs.

## DIAGNOSING PEDOPHILIA FOR OLDER CHILD AGE PREFERENCES

- Challenge=diagnosing in settings where positive impression management abounds
- How to diagnose when victims are under 14 but older than 11 and he/she denies?
- Clues: secondary sex characteristics? normative age interests? A fluke or a pattern? Contextual issues? descriptions of victims in police reports, offense narratives, relationship history
- Encourage law enforcement to describe what victim looks like in reports
- May diagnose Pedophilia when victims had some signs of pubescence and were as old as 13

## HOW TO DIAGNOSE PARAPHILIC AROUSAL TO EARLY PUBESCENT CHILDREN?

- Hebephilia= intense sexual interest or preference in children in the early stages of puberty (Tanner 2 & 3/roughly age 11-14)
- DSM-5 is ambiguous and unhelpful on how to diagnose Hebephilia
- Criteria age range for Pedophilia subsumes Hebephilia ("generally age 13 and under").
- **Option #1**: Diagnose Pedophilic Disorder. Must describe that arousal is toward older children/early pubescents.
- **Option #2**: Other Specified Paraphilic Disorder, Hebephilia/or Early Pubescent Children.

***Caution: Do not diagnose based on oldest or youngest partner/victim but consider the entire age distribution and strength of fantasies, urges, behaviors.***

## DIFFERENTIAL DIAGNOSIS FOR PEDOPHILIC DISORDER

- Adolescent experimentation
- Opportunity
- Substance intoxication
- Incest and dysfunctional family dynamics
  -marital problems
  -child as surrogate
- Antisocial/psychopathic man who "takes" sex out of convenience
- Hypersexual or "pan sexual" man
  -but this is difficult, as may simply be pedophilic, too
- Hebephilia
  -persistent interest in pubescent children (12-14?)

## The Hypersexuality Continuum

## THE HYPERSEXUALITY CONTINUUM & DSM

- Dimension involving the intensity and time involved in sexually motivated activity (internal & external).
- i.e. “He sees the world through a sexual lens.” v. “He has a low libido
- DSM-IV: hypersexuality diagnosed as Sexual Disorder, NOS
- APA Board of Trustees declined to add Hypersexuality Disorder to DSM-5 despite recommendation from the sub-workgroup
- DSM-5 drops “Sexual and Gender Identity Disorders” section and replaces with the separate sections “Sexual Dysfunctions”, Gender Dysphoria”, and Paraphilic Disorders”-none of which hypersexuality fits.

## WHAT IS HYPERSEXUALITY?

Recurrent and intense sexual fantasies, sexual urges, and sexual behavior associated with compulsive, obsessive, or excessive sexual arousal that leads to clinically significant distress or impairment. Often several of the following will be present:

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.

## HYPERSEXUALITY CAN MANIFEST IN ONE OR MORE…

- Excessive Masturbation
- Excessive Pornography Use
- Excessive Sexual Behavior With Consenting Adults
- Focus on Impersonal Sex
- Cybersex
- Telephone Sex
- Strip Clubs
- Diverse Sexual Outlets
- Other:

## HOW TO DIAGNOSE HYPERSEXUALITY WITH DSM-5

*"The failure of HD to achieve any designated placement in DSM-5 leaves clinicians with the quandary of how to adequately diagnose or categorize persons who would otherwise have been designated by Sexual Disorder Not Otherwise Specified, a residual diagnostic category in prior DSM editions. HD is neither a sexual dysfunction nor a paraphilia, but can be considered an impulsivity disorder and thus can be diagnosed as* ***"Other Specified Disruptive, Impulse-Control, and Conduct Disorder: HD*** *(ICD 312.89) (American Psychiatric Association, 2013, p. 479)."*

-Kafka, M.P. 2014. What happened to hypersexual disorder? Arch Sex Behav 43, 1259-1261.

## WOULD YOU DIAGNOSE HYPERSEXUALITY?

- Bruce (54-yrs-old) was a medical doctor in a small town who was recently convicted of drugging then raping a date. After he was arrested four other women came forth will similar allegations but charges were dropped through plea bargain. During the prison interview, Bruce denied drugging women. He reported he had no need to drug women because he had no problem getting sexual partners given his financial status and good looks; he claimed in fact he could easily get the evaluator to have sex with him if he met her on the outside. He reported having at least three different sexual partners weekly for the past two years since his 3rd wife left him. He admits to daily use of consensual themed internet pornography both in prison and in the community. He estimates his current number of sexual outlets per week is 4-6. He has incurred five Institutional Rules Violations for exposure, which he denies were anything other then attempts to masturbate privately.

## NO MAJOR CHANGES TO THESE DISORDERS

- 302.82 (F65.3) Voyeuristic Disorder
- 302.89 (F65.81) Frotteuristic Disorder
- 302.81 (F65.0) Fetishistic Disorder
  (*allows dx of arousal to non-genital body part(s) in addition to non-living objects)
- 302.83 (F65.51) Sexual Masochism Disorder

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