

Paraphilic Disorders in DSM-5

Forensic Mental Health Association of California

40th Anniversary

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Goals

- Present general information on DSM-5
- Present specific information on paraphilic disorders
- Present information relevant to forensic use
- Thanks to Michael First for many of these slides

Declaration of Conflicts

- Member of DSM-5 Paraphilias Workgroup
- Member of ICD-10 revision workgroup
- No income from drug companies or otherwise
- Have intellectual interest in diagnosis of paraphilic disorders and in ICD-11

Value of Making a DSM Diagnosis

- Well defined and reliable terminology facilitates communication among clinicians, administrators, lawyers, patients, and families
 - Provides convenient short-hand when describing psychiatric presentations
- Assigning DSM diagnosis provides direct access to psychiatric literature about treatment, prognosis, etc.
 - Journal articles, practice guidelines, textbooks for past 33 years have been geared to DSM definitions of mental disorders
- Facilitates assignment of diagnostic code for payment

Limitations of Making a DSM diagnosis

- Most treatment decisions are geared to symptoms regardless of diagnosis (e.g., psychosis)
- Diagnostic heterogeneity limits predictive power of diagnoses
- Diagnoses are not informative about etiology or pathophysiology
- High rates of NOS limit clinical utility in terms of communication and access to the literature

Why a DSM-5 Was Needed

- Longest gap between DSM's ever
 - DSM-IV criteria sets reflect research base circa 1993 (20 year gap)
 - Text reflects research base circa 1999 (14 year gap)
- Need to coordinate with ICD-11 (to be published in 2017)
- Potential for DSM-5 to update definitions to reflect most recent research findings and to address identified weaknesses

Was DSM-5 More “Etiological” and/or Based on Objective Measures?

- The simple answer: No
- Genetics, neuroimaging, biological markers, etc. were included in definitions of disorders in DSM-5/ICD-11
 - Exception: polysomnography in sleep disorders and hypocretin in Narcolepsy
- Problem remains lack of diagnostic specificity on an individual patient level
 - Tests able to identify clear differences between groups but not between individuals because of within group variability (i.e., some non-affected people will have abnormal value on test that is higher than “affected” individuals)

Changes in Diagnostic Groupings (“Metastructure”)

- DSM-IV diagnostic classes mostly based on shared symptom presentation (e.g., anxiety disorders)
- DSM-5 regrouping of disorders reflects 20 years of research on how the brain functions and interactions between genes and environment
 - Groupings are based on putative common underlying factors (e.g., internalizing vs. externalizing) and underlying vulnerabilities
- Ordering of diagnostic groupings also reflects relationships among disorders
 - (e.g., bipolar disorders following schizophrenia spectrum)

DSM-5 “Metastructure” - I

DSM-5	DSM-IV
Neurodevelopmental disorders Includes Intellectual Disability, Global Developmental Delay, Autistic Spectrum Disorders, Learning disorders, Communication Disorders (including Social Pragmatic Communication Disorder), ADHD, Motor Disorders (Tics, Stereotyped Movement, Coordination)	Childhood Disorders Mental Retardation, Learning Disorders, Communication, PDD, Tic Disorders, part of Disruptive Behavior
Schizophrenia Spectrum and Other Psychotic Disorders Includes Schizophrenia, Schizotypal PD, Schizoaffective, Brief Psychotic, Delusional Disorder, Substance-Induced Psychotic Disorder, Psychotic Disorder Due to AMC, Catatonia Associated with Another Mental Disorder, Catatonia due to AMC	Schizophrenia and Other Psychotic Disorders Schizotypal in PD

DSM-5 “Metastructure” - II

DSM-5

Bipolar and Related Disorders

Includes Bipolar I, Bipolar II, Cyclothymic, Substance-Induced Bipolar, Bipolar Due to AMC

Depressive Disorders

Includes MDD, Chronic Persistent Depressive Disorder, DMDD (Disruptive Mood Dysregulation Disorder), PMDD (Premenstrual Dysphoric Disorder), Substance-Induced, Due to AMC

DSM-IV

Mood Disorders

DSM-5 “Metastructure” - III

DSM-5

Anxiety Disorders

Includes Separation Anxiety, Selective Mutism, Social Anxiety, Specific Phobia, Panic, Agoraphobia, GAD, Substance-Induced Anxiety, Anxiety due to AMC

Obsessive-Compulsive and Related disorders

Includes OCD, BDD, Hoarding, Trichotillomania, Excoriation Disorder, Substance-induced, Due to AMC

Trauma- and Stress-Related Disorders

Includes PTSD, Acute Stress, Reactive Attachment, Disinhibited Social Engagement Disorder, Adjustment Disorders

DSM-IV

Anxiety Disorders

Separation Anxiety within Childhood
Reactive Attachment within Childhood
Trichotillomania within Impulse Control

Adjustment Disorders

DSM-5 “Metastructure” - IV

DSM-5

Dissociative Disorders

Includes Depersonalization/derealization, Dissociative amnesia, DID

Somatic Symptom Disorders

Includes Somatic Symptom Disorder, Illness Anxiety, Conversion Disorder, Factitious Disorder, PFAMC

Feeding and Eating Disorders

Includes Anorexia, Bulimia, Binge Eating Disorder, Avoidant/Restrictive Food Intake, Pica, Rumination Disorder

Elimination Disorders

Includes Enuresis, Encopresis

DSM-IV

Dissociative Disorders

Somatoform Disorders

Factitious Disorders

Feeding Disorders

Eating Disorders

Elimination Disorders

Formerly in Childhood

DSM-5 “Metastructure” - V

DSM-5

Sleep/Wake Disorders

Includes several new disorders from ICD-10 including REM Sleep behavior, Restless Leg Syndrome

Sexual Dysfunctions

Includes Male Hypoactive Sexual Desire Disorder, Erectile Disorder, Early Ejaculation, Delayed Ejaculation, Female Sexual Interest/Arousal Disorder, Female Orgasmic Disorder Genito-Pelvic Pain/Penetration Disorder

Gender Dysphoria

DSM-IV

Sleep Disorders

Sexual Dysfunctions
(within Sexual Disorders)

Gender Identity Disorder
(within Sexual Disorders)

DSM-5 “Metastructure” - VI

DSM-5/ICD-11

Disruptive, Impulse Control, and Conduct Disorders

Includes ODD, Conduct Disorder, Antisocial PD, Pyromania, Kleptomania, Intermittent Explosive Disorder

Substance Use and Addictive Disorders

Includes Substance Use, Substance-Induced, Intoxication, Withdrawal, Gambling Disorder

DSM-IV

Disruptive Behavior

ODD, Conduct(in Childhood)

Impulse Control Disorder

Pyromania, Kleptomania, IED

Antisocial PD

in personality disorders

Substance-Related Disorders

PG in Impulse Control Disorders

DSM-5 “Metastructure” - VII

DSM-5

Neurocognitive Disorders

Includes Delirium, Major Neurocognitive Disorder, Mild Neurocognitive Disorder

Personality Disorders

Paraphilias

DSM-IV

Delirium, Dementia, Amnesic and Other Cognitive Disorders

Personality Disorders

Paraphilias (within Sexual Disorders)

DSM-5 and Dimensions

“We have decided that one, if not the major, difference between DSM-IV and DSM-V will be the more prominent use of dimensional measures in DSM-V”

**-- Regier et al., Am J Psychiatry
166:6, June 2009**

Dimensions vs. Categories

- Although most patient data is dimensional (e.g., blood pressure, laboratory values, severity of depression), all classification systems in medicine are categorical (e.g., hypertension, Major Depressive Disorder) reflecting nature of medical decisions.

- Dimensions most useful for

- Documenting subthreshold symptoms
- Indicating and monitoring of disorder severity
- Communicating dimensional nature of syndromes

DSM-5 moves towards dimensionality - I

- Combining categories with lower and higher severities into single broad categories with dimensional severity indicators

- Autistic Disorder (more severe) and Asperger's disorder (less severe) combined into Autism Spectrum Disorder
- Substance Dependence (more severe) and Substance Abuse (less severe) combined into Substance Use Disorder

DSM-5 Moves Towards Dimensionality - II

- Reconceptualization of Neurocognitive Disorders on a dimensional continuum
 - Major Neurocognitive Disorder: significant cognitive decline that interferes with independence in everyday activities
 - Mild Neurocognitive Disorder: modest cognitive decline that does not interfere with capacity for independence but requires greater effort, compensatory strategies, or accommodation

DSM-5 and Dimensionality - III

- Original plan for radical change in classification of personality disorders to a trait model dividing personality into five domains: Negative Affectivity, Detachment, Antagonism, Disinhibition, and Psychoticism
- Ultimately rejected because of concerns about complexity, validity, reliability, and clinical utility
- Placed in Section III ("Emerging Measures and Models")

DSM-5 and Dimensionality - IV

- Original plan to include cross-cutting symptom measures, a disability scale, plus 150+ disorder severity measures as an official part of DSM-5
- With three exceptions (severity of intellectual disability, autism spectrum disorder, and psychotic disorders), all were relegated Section III
- Only three included in print version of DSM-5; remainder available in free on-line supplement (www.psych.org/dsm5)
- Were developed for paraphilic disorders, but not on-line now
- Contrast with DSM-IV-TR where every disorder could be characterized as mild, moderate, or severe

Concerns about adding Dimensional Measures to DSM-5

- No evidence that adding dimensions improves patient management or outcome
- No validation
- No evidence for feasibility of use of dimensions in typical psychiatric settings
- None of proposed DSM-5 dimensions are codable and thus information cannot be indicated to payors
- Many are extremely complex (e.g., 8 dimensions for psychosis, each rated 0 to 4)
- Could be co-opted by insurers to limit care (see GAF, Axis II)

SEXUAL HARM DISORDER

1. During the past two weeks, how often did you feel a sexual urge to cause physical pain or injury, fear, or humiliation to an unwilling stranger or other nonconsenting person?
 - a. Never
 - b. Once
 - c. About once a week
 - d. Several times a week
 - e. About every day
2. During the past two weeks, how often did you feel sexually aroused while imagining (or remembering) yourself causing physical pain or injury, fear, or humiliation to a nonconsenting person?
 - a. Never
 - b. Once
 - c. About once a week
 - d. Several times a week
 - e. About every day
3. During the past two weeks, how sexually exciting was the idea of causing physical pain or injury, fear, or humiliation to an unwilling stranger or other nonconsenting person?
 - a. Not at all exciting
 - b. Slightly exciting
 - c. Moderately exciting
 - d. Strongly exciting
 - e. Extremely exciting
4. During the past two weeks, how many nonconsenting people did you cause physical pain or injury, fear, or humiliation?
 - a. 0
 - b. 1
 - c. 2
 - d. 3
 - e. 4 or more
5. Over the course of your life, excluding the past two weeks, how many nonconsenting people did you cause physical pain or injury, fear, or humiliation?
 - a. 0
 - b. 1
 - c. 2
 - d. 3-50
 - e. More than 50

DSM-IV-TR Sexual and Gender Identity Disorders

- Sexual Dysfunctions**
- Paraphilias**
- Gender Identity Disorder**
- Sexual Disorder Not Otherwise Specified**

Provided category to diagnosis Hypersexual Disorder, with example of "Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used."

DSM-5 Succeeding Categories

- Sexual Dysfunctions
- Gender Dysphoria
- Paraphilic Disorders
- Unspecified Mental Disorder

DSM-5 Paraphilic Disorders

Voyeuristic Disorder

Exhibitionistic Disorder

Specify whether: Sexually aroused by exposing genitals to prepubertal children, Sexually aroused by exposing genitals to physically mature individuals, Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals

Frotteuristic Disorder

Sexual Masochism Disorder

Specify if: With asphyxophilia

Sexual Sadism Disorder

Pedophilic Disorder

Specify whether: Exclusive type, Nonexclusive type
Specify if: Sexually attracted to males, Sexually attracted to females, Sexually attracted to both
Specify if: Limited to incest

DSM-5 Paraphilic Disorders

Pedophilic Disorder

Specify whether: Exclusive type, Nonexclusive type
Specify if: Sexually attracted to males, Sexually attracted to females, Sexually attracted to both
Specify if: Limited to incest

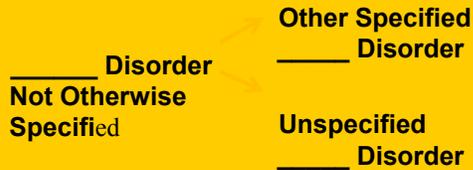
Fetishistic Disorder

Specify: Body part(s), Nonliving object(s), Other

Transvestic Disorder

Specify if: With fetishism, With autogynephilia

NOS Split Into Two Categories in DSM-5



DSM-5 Paraphilic Disorders

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 used in situations in which the clinician choose to communicate the specific reason that the presentation does not meet the criteria for any specific paraphilic disorder. This is done by recording "other specified paraphilic disorder" followed by the specific reasons (e.g. zoophilia).

DSM-5 Paraphilic Disorders

Unspecified 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. The unspecified paraphilic disorder category is used in situations in which the clinician chooses not to specify the reasons that the criteria are not met for a specific paraphilic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis.

DSM-IV-TR and DSM-5 Structure of Paraphilic Disorders

DSM-IV-TR Diagnostic criteria for Sexual Sadism

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.
- B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

DSM-5 Diagnostic criteria for Sexual Sadism Disorder

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors.
- B. 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.

DSM-IV-TR and DSM-5 Structure of Pedophilia

DSM-IV-TR Diagnostic criteria for Pedophilia

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years 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 16 years and at least 5 years older than the child or children in Criterion A.

DSM-5 Diagnostic criteria for Pedophilic Disorder

- A. Over a period of at least 6 months, recurrent, intense sexually arousing prepubescent child or children (generally age 13 years of younger).
- B. The individual has acted on these sexual urges, or the sexual urges of fantasies cause marked distress or interpersonal difficulty.
- C. The person is at least 16 years and at least 5 years older than the child or children in Criterion A.

DSM-5 New Specifiers

For all paraphilias in DSM-5:

Specify if:

- In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in sadistic sexual behavior are restricted.
- In full remission: The individual has not acted on the urges with nonconsenting 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.

Paraphilias: DSM and ICD

1. Included in DSM in DSM-1-1952 "Sexual Deviation"
2. DSM-II-1973-homosexuality removed
3. DSM-III had criteria for various paraphilias, with requirement for some being preferential
4. DSM-IV removed preferential criterion
5. WHO-ICD-6 became the first version with mental disorders in 1948; there was a category of Sexual Deviation, including exhibitionism, fetishism, homosexuality, pathologic sexuality, sadism, other sexual deviations

Paraphilias: DSM and ICD

1. DSM-IV-TR for all paraphilic disorders differentiates between "A" criteria (which define an atypical pattern of sexual arousal) and the "B" criteria, which involves distress or dysfunction. For those with a victim the "B" criteria additionally contain the specification of acting involving a non-consenting person.
2. The ICD does not; if an individual has a paraphilia as a preferential pattern, regardless of whether they have distress, dysfunction, or have acted on it, they receive the diagnosis.
3. Thus, ICD-10 diagnosed vastly more individuals with paraphilias than did DSM-IV or DSM-IV-TR

ICD

DSM

Produced by global health agency of UN	Produced by single national professional association
Free and open resource to advance public good	Provides large proportion of APA revenue
For: 1) countries; and 2) front-line service providers	For psychiatrists
Global, multidisciplinary, multilingual development	Dominated by US, Anglophone perspective
Approved by World Health Assembly	Approved by APA Board of Trustees
Covers all health conditions	Covers only mental disorders

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 direct physiological effects of exogenous substances (e.g., drugs of abuse or medications) or to Manic Episodes.

D. The person is at least 18 years of age.

Stable-2007

Item 10: Sexual Pre-occupations/Sex Drive

The basic concept: In contrast to romantic attraction or infatuation, sexual pre-occupation focuses on recurrent sexual thoughts and behavior that are not directed to a current romantic partner. The degree of casual or impersonal sexual activity may interfere with other pro-social goals (e.g., in debt due to costs of prostitutes) or be perceived as intrusive or excessive by the offender. However, high levels of sexual pre-occupation should be considered problematic even if the offender sees little wrong with his behavior. Offenders with a history of prostituting themselves would be considered to have problems in this area. Also included in this category are offenders who are continually struggling to control their sexual thoughts or activities, for example, offenders who view all sexual activity as sinful/wrong/degenerate and to be completely avoided. These offenders give sexual expression a value that it does not warrant.

Stable-2007

Examples of sexual pre-occupations

Masturbation (excessive=most days for 2+month, or 15+ times a month)

Indicators of impersonal sexual activity

A history of multiple sexual partners (e.g., 30 or more)

Regular use of prostitutes, strip bars, massage parlours, phone-sex

Sex-oriented internet use, such as sexually explicit sites, chat rooms, excessive downloading of pornography

Pornography collection (videos, magazines) (or, parent/baby magazines)

Cruising for impersonal sex

Excessive sexual content in typical conversations

Psychic pre-occupation

Self-report of difficulty controlling sexual impulses

Any disturbing sexual thoughts/dreams

DSM-5 Other Specified Disruptive, Impulse-Control, and Conduct Disorder

This category applies to presentations in which symptoms characteristic of a disruptive, impulse-control, and conduct 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. . . . The other specified disruptive, impulse-control, and conduct disorder category 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 impulse control . . . disorder. This is done by recording "other specified disruptive, impulse-control, and conduct disorder" followed by the specific reasons (e.g. recurrent behavioral outbursts of insufficient frequency").

Unspecified Disruptive, Impulse-Control and Conduct Disorders

This category applies to presentations in which symptoms characteristic of a disruptive, impulse-control, and conduct 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 disruptive, impulse-control and conduct disorder diagnostic class. The unspecified disruptive, impulse-control, and conduct disorder category is used in situations in which the clinician chooses not to specify the reasons that the criteria are not met for a specific disruptive, impulse-control, and conduct disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g. in emergency room settings [and perhaps forensic settings]).

Other Specified Mental Disorder

For presentations in which the clinician has fully characterized the presentation but does not meet full criteria for existing disorders or for syndromes not included in the DSM-5 Clinician writes in the reason why criteria are not met, e.g., "Other Specified Mental Disorder: Hypersexual Disorder. Patient's symptoms do not make criteria for paraphilia or addictive disorder."

Unspecified Mental Disorder

For presentations in which symptoms characteristic of a mental disorder that cause clinically significant distress or impairment in social, occupational, or other important area of functioning predominate but do not meet the full criteria for any mental disorder. The clinician chooses not to specify the reason that the criteria are not met. "Unspecified Mental Disorder"

Compulsive Sexual Behavior Disorder

1. Compulsive sexual behavior disorder is characterized by the presence of intense, repetitive sexual impulses or urges that are experienced as irresistible or uncontrollable, leading to repetitive sexual behavior.
2. ICD-10 F52.7 Excessive sexual drive
Both men and women may occasionally complain of excessive sexual drive as a problem in its own right, usually during late teenage or early adulthood. When the excessive sexual drive is secondary to an affective disorder (F30-F39) or when it occurs during the early stages of dementia (F00-F03), the underlying disorder should be coded.
Includes: nymphomania
satyriasis

**Compulsive Sexual Behavior Disorder
Tentative Definition ICD-11**

Compulsive sexual behaviour disorder is characterized by the presence of intense, repetitive sexual impulses or urges that are experienced as irresistible or uncontrollable, leading to repetitive sexual behaviour. In addition, in order for compulsive sexual behaviour disorder to be diagnosed, the individual must be markedly distressed by these repetitive sexual impulses or behaviour, or have experienced significant impairment in social, occupational or other important areas of functioning as a result of the sexual impulses or behaviours. Compulsive sexual behaviour disorder cannot be diagnosed based solely on distress and/or impairment in functioning related to real or feared social disapproval of sexual impulses or behaviours.

**Forensic Use of Other Specified/
Unspecified Categories**

- Forensic utility of Other Specified/Unspecified categories is considerably less than specific categories
- Lack of operationalized criteria make them inherently unreliable
- Residual and idiosyncratic nature renders them outside of what is generally accepted by the field as a reliable and valid psychiatric disorder; subject to potential admissibility challenge
- Unable to draw on body of empirical evidence about condition to allow for other prediction
- But, in span of 23 years, number of paraphilic terms has increased from a list of 125 words (Money, 1986) to 547 named paraphilias (Aggrawal, 2009)

**DSM-5: Separate “Forensic Use”
section eliminated but Cautionary
Statement Expanded (DSM-5 p. 25)**

The text acknowledges use in forensic settings
“although designed for clinicians...DSM-5 is also used as a reference for the courts and attorneys in assessing the consequences of mental disorders.”

Then continues with caution regarding definition of mental disorder:
“ . . . the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and researcher investigators rather than all of the technical needs of the courts and legal professionals.”

**DSM-5 Cautionary
Statement- II-DSM-5 p. 25**

The text goes on to acknowledge several sources of potential forensic utility: “When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations.”

Value of Accompanying Literature

- Review of literature may facilitate legal decision makers' understanding of the relevant characteristics of mental disorders"
- Psychiatric literature (journal articles, practice guidelines, textbooks) for past 30 years have been geared to DSM definitions of mental disorders.
- If client has DSM diagnoses, can access the large body of literature for information that might be relevant to the case

DSM-5 Other Controversies

- Paraphilic coercive disorder
- Hebephilia, pedohebephilia, and ephebophilia
- Diagnosing paraphilic disorders in nonforthcoming individuals
- Additions in the descriptive text

ICD-9-CM - I

- Diagnostic codes range from 001.0 Cholera due to Vibrio cholera to 999.9 Other and Unspecified complications of medical care, not elsewhere classified
- Also a supplementary classification of "Factors Influencing Health Care and Contact With Health Services" ranging from V01.0 Contact with cholera to V82.9 Special screening for unspecified condition

DSM-5 and Diagnostic Coding

- Because DSM-5 is being published during the time in which ICD-9-CM is still in effect, all DSM-5 disorders have ICD-9-CM codes assigned to them
- Because DSM-5 will be used on October 1, 2014 and beyond, ICD-10-CM codes are also assigned
- Codes are listed side-by-side, with ICD-10-CM code in gray ink and parenthesis, e.g., 300.4 (F34.1)
- Printings of DSM-5 after ICD-10 is adopted in the United States will only contain ICD-10-CM codes

301.9 (F60.9)	Unspecified Personality Disorder (684)
Paraphilic Disorders (685)	
<i>The following specifier applies to Paraphilic Disorders where indicated</i>	
<i>^aSpecify if: In a controlled environment, In full remission</i>	
302.82 (F65.3)	Voyeuristic Disorder ^a (686)
302.4 (F65.2)	Exhibitionistic Disorder ^a (689) <i>Specify whether: Sexually aroused by exposing children, Sexually aroused by exposing other individuals, Sexually aroused by exposing children and to physically mature individuals</i>
302.89 (F65.81)	Frotteuristic Disorder ^a (691)
302.83 (F65.51)	Sexual Masochism Disorder ^a (694) <i>Specify if: With asphyxiophilia</i>
302.84 (F65.52)	Sexual Sadism Disorder ^a (695)
302.2 (F65.4)	Pedophilic Disorder (697) <i>Specify whether: Exclusive type, Nonexclusive type</i> <i>Specify if: Sexually attracted to males, Sexually attracted to both</i> <i>Specify if: Limited to incest</i>
302.81 (F65.0)	Fetishistic Disorder ^a (700) <i>Specify: Body part(s), Nonliving object(s), Clothing</i>
302.3 (F65.1)	Transvestic Disorder ^a (702) <i>Specify if: With fetishism, With autogynephilia</i>
302.89 (F65.89)	Other Specified Paraphilic Disorder (703)
302.9 (F65.9)	Unspecified Paraphilic Disorder (705)

When Does DSM-5 Become "Official"?

Answer: Never

- The only official coding system is ICD-9-CM (until 10/1/14, when it will be ICD-10-CM)
- DSM-5 can be used immediately and will produce legal codes now (and after ICD-10 system is adopted)
- For most clinicians, its use is voluntary. One can meet legal requirements by using ICD-9-CM/ICD-10-CM codes.
- Some institutions may require use of DSM-5 and may establish a mandatory implementation date
- Generally advantageous to use DSM-5 in order to maintain effective communication with the vast majority of clinicians who will be using it

Living Document: DSM-5.x

- Rather than revising the entire DSM at certain intervals, sections will be revised and updated depending on scientific advances

For example, if biomarker is found for a diagnosis of Alzheimer's, then that section only might be revised

- Might reduce confusion of small changes that are inevitable with current method (i.e., temptation for workgroup members to leave their mark)

WHO Global Clinical Practice Network

1. WHO has Global Clinical Practice Network
2. Anyone who is licensed practitioner who treats mental illness, including psychiatrists, psychologists, nurses, primary care doctors, licensed counselors or therapists can join
3. 10,000 belong, many different countries and languages
4. There is a need for specialists in sexology & forensics
5. To register for WHO Global Clinical Practice Network, Google WHO Global Clinical Practice Network, or go to www.paraphilias.com
www.globalclinicalpractice.net

www.globalclinicalpractice.net

development.

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<p>DOUGLAS MARTINEZ, PhD</p> <p>PUBLICATIONS</p> <p>CONTACT</p> <p>HOME</p> <p>Interested professionals can find out more about the Global Clinical Practice Network and register to participate.</p> <p style="text-align: center;">Register</p> <p style="text-align: center;">BEHAVIORAL MEDICINE PROGRAM</p> <p style="text-align: center;">PROFESSIONAL SEXUAL MISCONDUCT</p>	<p style="text-align: center;">BACKGROUND</p> <p>Dr. Richard Krueger is a psychiatrist with an expertise in forensic psychiatry, addiction psychiatry, sexual offenders, professional sexual misconduct, and the psychopharmacological and behavioral treatment of paraphilias and sexual disorders. He is a graduate of Harvard Medical School and an Associate Clinical Professor of Psychiatry in the Department of Psychiatry, Columbia University, College of Physicians and Surgeons. He is also on the faculty of the Columbia-Cornell Fellowship Program in Psychiatry and the Law. He is Medical Director of the Sexual Behavior Clinic at New York State Psychiatric Institute and an attending psychiatrist at New York State Psychiatric Institute and at Columbia-Presbyterian Medical Center. Dr. Krueger is also a boardmember and Vice President of the New York State ATSA.</p> <p>For detailed information on Dr. Meg Kaplan's private practice, please see megkaplan.com.</p> <p>Dr. Meg Kaplan, is a psychologist who is an Associate Clinical Professor of Psychology in Psychiatry in the Department of Psychiatry, Columbia University, College of Physicians and Surgeons, and a Research Scientist at the New York State Psychiatric Institute, where she is Director of the Sexual Behavior Clinic. She is on the board of the New York State ATSA.</p>
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