Paraphilia NOS (nonconsenting) and antisocial personality disorder

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Analysis of the diagnostic criteria and text in the current Diagnostic and Statistical Manual for Mental Disorders, Fourth edition, Text Revision (DSM-IV-TR) leads the author to conclude that (1) personality disorders and paraphilias are separate, independent diagnoses, (2) deviant sexuality need not be either obligatory or exclusive for a person to meet criteria for a diagnosis of paraphilia not otherwise specified (NOS) (nonconsenting), (3) either antisocial personality disorder or paraphilia NOS could serve as the qualifying disorder for civil commitment of a sexually violent predator (SVP), and (4) whether a person meets criteria for civil commitment as an SVP must be determined on a case-by-case basis rather than by cursorily considering the person's psychiatric diagnosis.

KEY WORDS: *Paraphilia, paraphilia NOS, paraphilia NOS (nonconsenting), sexually violent predator, civil commitment, sex offender, DSM-IV-TR, personality disorder, personality disorder NOS, psychiatric diagnosis*

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In a recent case involving the civil commitment of a man alleged to be a sexually violent predator, two issues predominated. One issue was whether he met DSM-IV-TR criteria for Paraphilia. The other issue was whether a person who does not meet the diagnostic criteria for Paraphilia should ever be considered to meet legal criteria for civil commitment as an SVP. Although conceptually quite distinct, these two issues may often arise together in civil commitment cases, so it makes sense to consider both issues in one article. First we consider a legal question: Is it conceptually wrong to think that antisocial personality disorder could be a qualifying disorder for civil commitment as an SVP? Second, we consider diagnostic issues regarding Paraphilia Not Otherwise Specified (NOS). Third and last, we consider legal questions arising from the diagnostic explorations regarding Paraphilia NOS.

Is civil commitment just for paraphiles?

Vognsen and Phenix (2004) replied to a portion of an article by Sreenivasan, Weinberger, and Garrick (2003), which was prompted by this sentence in the U.S. Supreme Court case *Kansas v. Crane* (2002, p. 413): "The psychiatric diagnosis, and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sex offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case." In delivering the opinion of the Court, Justice Breyer wrote that *Crane* "concerns the constitutional requirements substantively limiting the civil commitment of a dangerous sexual offender" (p. 409).

The Court previously upheld the Kansas Sexually Violent Predator Act (which addresses civil commitment of sex offenders) in *Kansas v. Hendricks* (1997):

In doing so, the Court characterized the confinement issue as civil, not criminal, confinement. And it held that the statutory criterion for confinement embodied in the statute's words "mental abnormality or Personality Disorder" satisfied "substantive due process requirements." In reaching its conclusion, the Court's opinion pointed out that "States have in certain narrow circumstances provided for the forcible civil detainment of people who are unable to control their behavior and who thereby pose a danger to the public health and safety." It said that "we have consistently upheld such involuntary commitment statutes" when (1) "the confinement takes place pursuant to proper procedures and evidentiary standards," (2) there is a finding of "dangerousness either to one's self or to others," and (3) proof of dangerousness is "coupled ... with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.'" It noted that the Kansas "Act unambiguously requires a finding of dangerousness either to one's self or to others," and then "links that finding to the existence of a 'mental abnormality' or 'personality disorder' that makes it difficult, if not impossible, for the person to control his dangerous behavior." And the Court ultimately determined that the statute's "requirement of a 'mental abnormality' or 'personality disorder' is consistent with the requirements of ... other statutes that we have upheld in that it narrows the class of persons eligible for confinement to those who are unable to control their dangerousness" (*Crane,* pp. 409-410, citing *Hendricks,* citations omitted).

In *Crane,* the Court did not specify how states must narrow the class of persons eligible for confinement under the various sexually violent predator acts. The *Crane* Court clarified that to meet civil commitment criteria a person need not evidence total lack of control: "It is enough to say that there must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis, and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case" (p. 413).

The *Crane* Court took note of a study by Moran (1999) who reported that although the prevalence of antisocial personality

disorder in community samples may be about 2 to 3%, it may be around 40 to 60% among male prisoners. By sheer numbers, the mere presence of antisocial personality disorder might not be considered "sufficient to distinguish the dangerous sex offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case." Sreenivasan and colleagues (2003) described their opinion that some people without an additional psychiatric diagnosis could nevertheless be distinguished from typical recidivists. Vognsen and Phenix (2004, p. 442) disagreed, and expressed this opinion:

> Sreenivasan *et al.* are correct that statutory and case law do not exclude antisocial personality disorder from being a qualifying condition for [civil commitment as a sexually violent predator]. Indeed, statutory and case law do not preclude diagnoses such as caffeine related disorders from being considered in an ... assessment [in these cases]. However, reliance on such diagnoses alone is not clinically appropriate. Paraphilias are the diagnostic conditions that cause a person to experience serious emotional or volitional difficulty predisposing the commission of criminal sexual acts.
>
> In summary, careful consideration of the activities with which the forensic mental health expert is concerned indicates that a diagnosis of antisocial personality disorder alone is not enough to [find that a person meets criteria for civil commitment as a sexually violent predator].

Although I agree with some of Vognsen and Phenix's (2004) analysis, I disagree with their conclusion. To paraphrase a popular slogan, psychiatric disorders do not engage in acts of sexual violence; people do. In my opinion, it is just as wrong to state that an antisocial personality disorder could never make a person likely to commit acts of sexual violence as it would be to say that a paraphilia always makes a person likely to engage in sexual violence. According to DSM-IV-TR:

> The essential feature of antisocial personality disorder is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood. ... Individuals with antisocial personality disorder fail

to conform to social norms with respect to lawful behavior. They may repeatedly perform acts that are grounds for arrest (whether they are arrested or not). … Persons with this disorder disregard the wishes, rights, or feelings of others. They are frequently deceitful and manipulative in order to gain personal profit or pleasure (e.g., to obtain money, sex, or power). They may repeatedly lie, use an alias, con others, or malinger. A pattern of impulsivity may be manifested by a failure to plan ahead. Decisions are made on the spur of the moment, without forethought, and without consideration for the consequences to self or others. Individuals with antisocial personality disorder tend to be irritable and aggressive and may repeatedly get into physical fights or commit acts of physical assault (including spouse beating or child beating) … These individuals also display a reckless disregard for the safety of themselves or others. … They may engage in sexual behavior or substance use that has a high risk for harmful consequences. … Individuals with antisocial personality disorder also tend to be consistently and extremely irresponsible. … Individuals with antisocial personality disorder show little remorse for the consequences of their acts. They may be indifferent to, or provide a superficial rationalization for, having hurt, mistreated, or stolen from someone (*e.g.,* … "[she had it coming anyway"). These individuals may blame the victims for being foolish, helpless, or deserving their fate; they may minimize the harmful consequences of their actions; or they may simply indicate complete indifference. They generally fail to compensate or make amends for their behavior (pp. 701-702).

As I understand the sexually violent predator laws, no person who meets criteria for antisocial personality disorder but has never committed a sexually violent act (as defined in the various statutes) meets criteria for civil commitment as a sexually violent predator. But in those states that use "mental abnormality or personality disorder" to describe the qualifying condition, I see nothing conceptually inconsistent with using a diagnosis of antisocial personality disorder as one – or the sole – qualifying disorder. On a case-by-case basis, some people who show a pervasive pattern of violating the rights of others, repeatedly performing sexual acts that are grounds for arrest, disregarding the rights of others involved in their sexual acts, displaying reckless disregard for the safety of others involved in their sexual acts, engaging

in nonconsensual sex without forethought or consideration of consequences, and being indifferent to the rights and feelings of others involved in their sexual acts, may meet criteria for civil commitment as sexually violent predators.

Again, I see nothing conceptually inconsistent with using a diagnosis of antisocial personality disorder as one – or the sole – qualifying disorder for determining whether a person meets criteria for civil commitment as a sexually violent predator. On a case-by-case basis, the question for the trier of fact is whether a particular person meets the legal criteria in the relevant legal jurisdiction.

A Corollary

An essential corollary to Vognsen and Phenix's (2004) argument that antisocial personality disorder should never be considered to be a satisfactory qualifying disorder is their "contention that individuals who have serious difficulty controlling their emotions and volition in such a manner that they repeatedly commit criminal sexual acts must undoubtedly have a Paraphilia" (p. 441). If this statement were true, then it would seem that every person who meets criteria for a diagnosis of antisocial personality disorder and who repeatedly commits criminal sexual acts would also have a Paraphilia. But taken literally this sweeping statement is not true. The falsity of the statement becomes clear when we consider that in some jurisdictions "criminal sexual acts" include adultery, fornication, prostitution, oral sex, anal sex, normative sex play among preschoolers, or two 15-year-olds feeling each other up or having sexual intercourse using birth control. Clearly, a person could repeatedly engage in such sexual activity without meeting criteria for a paraphilia. Although such sexual actions are illegal in some jurisdictions, they are not symptoms of a mental disorder. Rather than trying to tweak Vognsen and Phenix's (2004) statement quoted above, I suggest that we use accepted diagnostic criteria,

which currently is the DSM-IV-TR, to determine whether a particular person meets criteria for a Paraphilia.

Is callous indifference enough for a diagnosis of paraphilia?

The case that sparked this article involved a man who had a pattern of engaging in nonconsensual sex, and who also had a pattern of exerting power and control, often including physical violence, toward women, including his paramours. Vognsen and Phenix (2004, pp. 441-442) consider such men: "The offender who poses more of a diagnostic challenge for forensic experts is the antisocial person who takes what he wants when he pleases, not an uncommon scenario for those who rape. … Repeated coercive sex most often indicates a specific arousal to forced sexual assault, over and above simply a search for sexual gratification. … If an offender sexually assaults women as an expression of a pattern of hostility and desire to control women and this is coupled with distinct sexual arousal to forced sex, then the offender has a Paraphilia." That passage proved useful in the case that sparked this article, but, generally, I believe Vognsen & Phenix are wrong to consider the diagnostic question to be *whether* a person's behavior reflects antisocial personality disorder *or* a paraphilia.

Generally, with some sensible exceptions, the authors of DSM-IV-TR recommend that if a person meets criteria for more than one disorder, both diagnoses are assigned. We do not have to decide whether a person shows a dependency to alcohol *or* tobacco *or* meets criteria for a mood disorder *or* has a learning disability. Any or all may be present. Some disorders subsume other disorders; thus a diagnosis of antisocial personality disorder subsumes a diagnosis of conduct disorder. And in some instances, one diagnosis may supplant another diagnosis. For example, if careful assessment reveals that the symptoms of female orgasmic

disorder are due to the direct physiological effects of a substance such as an antidepressant or an antihypertensive, then the diagnosis of female orgasmic disorder is supplanted by the diagnosis of substance-Induced sexual dysfunction.

Within DSM-IV-TR I find no directions for subsuming or excluding regarding antisocial personality disorder and Paraphilia. In fact, the only mention of "antisocial personality disorder" I found in the entire section on sexual and gender identity disorders (where paraphilias are classified) is "When sexual sadism is severe, and especially when it is associated with antisocial personality disorder, individuals with sexual sadism may seriously injure or kill their victims" (p. 574). I found just one other mention of "personality disorder" in a section describing mental disorders that are associated with Paraphilias: "Personality disturbances are also frequent and may be severe enough to warrant a diagnosis of a personality disorder" (p. 567). In context, this is a direction to diagnose both conditions if both are present. Similarly, I found no instance of "paraphilia" or any other "philia" in the DSM-IV-TR section on Personality Disorders. I found no recommendation in DSM-IV-TR that a diagnostician should grapple with the question of whether a person meets criteria for a personality disorder or a paraphilia. These are two separate, independent diagnostic questions.

Freed from the burden of trying to decide whether a person has a Personality Disorder *or* a Paraphilia, we can focus on guidelines regarding when to diagnose a Paraphilia in cases in which a person repeatedly engages in sex with nonconsenting persons. This is the second of the three major issues addressed in this article, and the focus now is on proper diagnosis according to DSM-IV-TR, not on any legal issue.

Vognsen and Phenix (p. 442) expressed the opinion that to meet criteria for a diagnosis of Paraphilia NOS (nonconsenting) the person must show evidence of something more than just repetitive sexual behavior with nonconsenting persons,

something like a preference for coercive sex, compared to consensual sex: "In the case where several acts of rape have occurred over only a limited span of time and/or have occurred in concert with other offenses such as burglary, those acts of rape must exhibit a clear and special lust for the aggressive taking of sex to indicate an ongoing desire for such activity. Again, an ongoing clear and special lust for the aggressive taking of sex, or a sexualized hostility toward women,[4] leads to a diagnosis of Paraphilia." That is their opinion. But is that how Paraphilias are diagnosed in DSM-IV-TR? Let us take a look, Paraphilia by Paraphilia, starting with those Paraphilias specifically described in DSM-IV-TR and ending with the Not Otherwise Specified group at the end of the Paraphilia section.

302.4 Exhibitionism

A person gets a diagnosis of Exhibitionism if the following criteria are satisfied: (a) over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger, and (b) the person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. "In some cases, the individual is aware of a desire to surprise or shock the observer. In other cases, the individual has the sexually arousing fantasy that the observer will become sexually aroused" (p. 569). Now imagine that your task is to decide whether a particular man[1] meets criteria for this diagnosis. Available evidence clearly shows that this man repeatedly exposes himself to other people, is sexually excited by people watching him, and masturbates to orgasm most of the time unless he is interrupted.[2] That would appear to satisfy diagnostic criteria, would it not?

Does the man "lose" the diagnosis of exhibitionism if he also enjoys exposing his penis and masturbating while being

observed by his wife, male lover, or next-door neighbor who is a willing, enthusiastic observer? No, provided that he is repeatedly exposing his penis to unsuspecting strangers, the fact that he also exposes his penis and masturbates in the willing presence of paramours or friends does not negate the diagnosis.

302.81 Fetishism

A person gets a diagnosis of Fetishism if the following criteria are satisfied: (a) over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments), (b) the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, and (c) the fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator). A man who derives sexual pleasure from shoes and who frequently disturbs the peace by rubbing or licking the shoes of nonconsenting women he meets in public would likely be considered to meet criteria for that diagnosis, even if he and his wife both enjoy making love while she wears high-heeled shoes. The fact that he also enjoys consensual fetishistic acts does not negate the diagnosis for a man who repeatedly engages in fetishistic acts with nonconsenting persons.

302.89 Froteurism

A person gets a diagnosis of Froteurism if the following criteria are satisfied: (a) over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person, and (b) the person has acted on these urges, or the sexual urges or fantasies cause marked distress

or interpersonal difficulty. Now consider a man who persists in frequenting crowded places such as bus terminals or queues at sporting events or concerts and derives sexual pleasure by rubbing against strangers, even though he has been punched by annoyed people and has been arrested several times. Would he be any less likely to meet criteria for a diagnosis of froteurism if he engages in the just-mentioned behavior and at other times he and his wife or lover derive sexual pleasure from him sneaking up behind her and rubbing her buttocks? I think not.

302.2 Pedophilia

A person gets a diagnosis of pedophilia if the following criteria are satisfied: (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 or younger) and (b) the person has acted on these urges, or the sexual urges or fantasies cause distress or interpersonal difficulty, and (c) the person is at least 16 years of age and at least 5 years older than the child or children (but do not include an individual in late adolescence involved in an ongoing relationship with a 12- or 13-year-old child). DSM-IV-TR recommends that the diagnostician specify whether a person who meets criteria for Pedophilia is exclusively attracted to children or not. In either case, the diagnosis of Pedophilia is assigned. A person who enjoys sex with young children and who also enjoys sex with adults would be diagnosed with Pedophilia, nonexclusive type.

302.82 Sexual Masochism

A person gets a diagnosis of Sexual Masochism if the following criteria are satisfied: (a) over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not

simulated) of being humiliated, beaten, bound, or otherwise made to suffer, and (b) the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. A person who was in danger of being fired due to often missing work days due to injuries incurred during masochistic sexual encounters would likely meet criteria for this disorder even if she or he also derived enjoyment from gentle lovemaking on other occasions.

302.84 Sexual Sadism

A person gets a diagnosis of Sexual Sadism if the following criteria are satisfied: (a) over a period of at least six 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, and (b) the person has acted on these urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. What about a person who enjoys inflicting pain on another person during sexual acts whether the other person consents or not? If a person is indifferent to the other person's wishes and engages in acts of sexual sadism simply to please himself, it would appear that criteria for a diagnosis of Sexual Sadism are met. What about a person who enjoys sex while inflicting pain on nonconsenting persons sometimes – and does so – and other times enjoys gentle, loving sex. Would that person not meet criteria for sexual sadism?

302.3 Transvestic Fetishism

A person gets a diagnosis of transvestic fetishism if the following criteria are satisfied: (a) over a period of at least six months, in a heterosexual male, recurrent, intense

sexually arousing fantasies, sexual urges, or behaviors involving cross dressing, and (b) the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Consider the man who wears a flannel shirt and work boots one day and wears high heels and a bra the next. If the cross-dressing significantly interferes with his work as a lumberjack, he would likely meet criteria for transvestic fetishism even if he only wore women's clothes to work on some days, not every day.

302.82 Voyuerism

A person gets a diagnosis of voyeurism if the following criteria are satisfied: (a) over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, and (b) the person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. If a person frequently peeps in windows of unsuspecting strangers hoping to see them having sex, he is likely to meet criteria for a diagnosis of voyeurism even if he also likes to watch his wife undress to take a shower and if she appreciates the fact that he likes looking at her naked.

302.9 Paraphilia Not Otherwise Specified (NOS)

The following brief passage contains all of the text in DSM-IV-TR under the heading just above: "This category is included for coding paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia

(enemas), and urophilia (urine)" (p. 576). Would a man who worked in a mortuary and was equally sexually satisfied by sex at home and at the office not meet criteria for necrophilia? Would a man who had sex with the family dog only on nights when his wife had a headache not meet criteria for zoophilia? Would a man who engaged in explicit sex talk with his friends *and* with startled people he called at random not meet criteria for telephone scatalogia?

What about patterns of sex acts that would be normatively popular with consenting persons, but are inflicted on nonconsenting persons? There appears to be general acceptance among most psychiatrists, psychologists, and sexologists that a person can have a Paraphilia involving rape. For example, Money and Lamacz (1989, p. 48) write about "the clinical syndrome named raptophilia (the Latin derivative) or biastophilia (the Greek derivative). In the syndrome of raptophilia, the raptophile's genitoerotic arousal and, eventually the orgasm, are contingent on having a partner who, as a captive, is forced to yield sexually under condition of threat, assault, and injury."

Now consider a hypothetical case of a married couple voluntarily seeking treatment. A husband and wife walk into a sex therapist's office and describe a sex life wherein the man has sex with his wife whenever he wants to, regardless of her wishes. When she does not want to have sex with her husband she says no and resists, but he threatens her or uses sufficient physical force to get her to comply. She has not called the police (yet) due to financial, cultural, or personal reasons, but this repeated behavior is causing great strain on their marriage. He has become somewhat unhappy because his wife complains a great deal, but he feels no true empathy, compassion, or remorse about this.[3] Although he initially was convinced that their marital problems were caused by his wife's "friggin' frigidness," as they begin to participate in treatment, he accepts at an intellectual level that there is something wrong with him in that he repeatedly has sex with

a nonconsenting person and really enjoys sex just fine even though she is miserable. With gradually increasing insight and understanding, he participates in sex therapy to try to manage or change his behavior. The couple's health insurance includes coverage for treatment of mental or emotional disorders, and the sex therapist bills the insurance company, listing the man's diagnosis as Paraphilia NOS (nonconsenting).

Now we turn briefly to several more hypothetical cases. The first is the case of an unmarried man who enjoys sex with a woman whether she wants to have sex with him or not. If he goes on a date and pays for dinner and a movie, he expects sex in return, and if his date complies they have intercourse. If his date does not comply, he rapes her.

Another man is married. If he is in the mood and his wife is in the mood, they have consensual sex. If he is in the mood and she is not in the mood, he rapes her, orally, anally, vaginally – whatever he feels like doing at the time.

Another man is released from prison and he shows up at the door of his ex-girlfriend. If she invites him in and they have consensual sex, that is fine with him. If she refuses to let him in he breaks down the door and sexually assaults her.

If each of the men in the three paragraphs above repeatedly engage in sexual activities with nonconsenting persons, would they meet criteria for Paraphilia NOS (nonconsenting persons)? What if these men persisted in the behavior following repeated arrests and incarcerations? Assume that the available data do not clearly show one way or another whether the person experiences "clear and special lust for the aggressive taking of sex" or clear "sexualized hostility toward women."

Guidance for diagnosticians regarding criteria for "other" Paraphilias coded as Paraphilia NOS comes from the discussion in the general Paraphilia section of DSM-IV-TR

and from recognizing patterns within directions for diagnosing the specific Paraphilias that are detailed in DSM-IV-TR.

Consider: "For some individuals, paraphilic fantasies or stimuli are obligatory for erotic arousal and are always included in sexual activity. In other cases, the paraphilic preferences occur only episodically (e.g., perhaps during periods of stress), whereas at other times the person is able to function sexually without paraphilic fantasies or stimuli" (p. 566). Clearly, a diagnosis of Paraphilia does not require that the paraphilic sexual behavior be the sole sexual outlet for the person. "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" (p. 566). Clearly, a diagnosis of Paraphilia does not require that the paraphilic sexual activity is the person's preferred sexual activity, at least when the person has (repeatedly)[5] engaged in the sexual activity with nonconsenting person(s).

Paraphilic imagery may be acted out with a nonconsenting partner in a way that may be injurious to the partner (as in sexual sadism or pedophilia). The individual may be subject to arrest and incarceration. … Social and sexual relationships may suffer if others find the unusual sexual behavior shameful or repugnant or if the individual's sexual partner refuses to cooperate in the unusual sexual preferences. In some instances, the unusual behavior (e.g., exhibitionistic acts or the collection of fetish objects) may become the major sexual activity in the individual's life. These individuals are

rarely self-referred and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with sexual partners or society (DSM-IV-TR, p. 566). Would it not be reasonable to use the same sentence structure in the preceding quote, substituting "nonconsensual" for "unusual" and making some minor wording changes? That yields:

> The individual may be subject to arrest and incarceration. … Sexual behavior with a nonconsenting person may be injurious to the other person. … Social and sexual relationships may suffer if others find the nonconsensual sexual behavior shameful or repugnant or if the individual's sexual partner refuses to cooperate in the nonconsensual sexual preferences. In some instances, the nonconsensual behavior may become the major sexual activity in the individual's life. These individuals are rarely self-referred and usually come to the attention of mental-health professionals only when their behavior has brought them into conflict with sexual partners or society.[6]

Every specific intrusive sexual act (including pedophilia, voyeurism, exhibitionism, frotteurism, and sexual sadism) described in the paraphilia section of DSM-IV-TR can be the qualifying act for a diagnosis of Paraphilia if the person repeatedly engages in the sexual act with nonconsenting persons, regardless of whether the person engages in the paraphilic behavior exclusively, preferentially, or indifferently (that is, with both consenting and nonconsenting partners). Therefore it would be inconsistent to expect that a person who engages in other sexual acts with nonconsenting persons would have to do so exclusively or preferentially to meet criteria for diagnoses such as telephone scatalogia, necrophilia, zoophilia, or for a pattern of engaging in otherwise normative sexual acts with nonconsenting persons.

DSM-IV-TR does not provide diagnostic criteria for any of the Paraphilias coded under paraphilias NOS, including the listed paraphilias such as telephone scatalogia, necrophilia, or zoophilia, or the unlisted paraphilias such as paraphilia NOS (nonconsenting). My reading of DSM-IV-TR suggests that paraphilia NOS (nonconsenting) should be diagnosed if the

following criteria are satisfied: (a) over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a nonconsenting person and (b) the person has acted on these urges, or the sexual urges or fantasies cause distress or interpersonal difficulty. In the absence of reliable data about a person's sexual fantasies and urges (or in spite of a person's claims that he has no sexual fantasies or urges to engage in sexual behavior with nonconsenting persons, the presence of Paraphilia NOS (nonconsenting) is evident if the person repeatedly engages in sexual behavior with nonconsenting persons over a period of at least six months.[7]

My reading of DSM-IV-TR is that repeatedly engaging in sexual behavior with nonconsenting person(s) over a period of at least 6 months is evidence of a Paraphilia, and that it is not necessary to prove that the person only engages in nonconsensual sex or that the person prefers nonconsensual sex to consensual sex.

Can a diagnosis of paraphilia NOS (nonconsenting) be a qualifying disorder for civil commitment as an SVP?

This is the third of the three major issues addressed in this article, and the focus now is on a legal question, which is independent of the diagnostic question. My opinion here is similar to my opinion regarding the question of whether antisocial personality disorder can be a qualifying disorder for civil commitment as an SVP: Yes, it can be, and the question must be considered case by case. As with other paraphilias involving repeated acts of sexual behavior with nonconsenting persons, paraphilia NOS (nonconsenting) is a mental abnormality. It is not mentally normal to enjoy sexual behavior with nonconsenting persons. It is not mentally normal to prefer sexual behavior with nonconsenting persons, and it is not mentally normal to be indifferent to whether one's sexual partner/victim consents to sexual behavior or not. A

single instance of nonconsensual sexual behavior does not satisfy criteria for a diagnosis of Paraphilia NOS (non-consenting), but a repetitive pattern of sexual behavior with nonconsenting person(s) does. In some cases, including some legal cases, it may be impossible to distinguish whether a person has an obligatory or preferential paraphilia involving nonconsenting sex, such as Money and Lamacz's (1989) description of raptophilia/biastophilia, or the non-obligatory, nonpreferential paraphilia of Paraphilia NOS (nonconsenting).

In my opinion, a repetitive pattern of sexual behavior with nonconsenting persons is sufficient for the diagnosis of Paraphilia NOS (nonconsenting), which is a mental abnormality that in some cases could provide a qualifying diagnosis for meeting the criteria for civil commitment as an SVP. For a contrasting view, see Zander (2005). Zander argues against ever diagnosing a paraphilia on the basis of coercive sexual fantasies, urges, and/or behavior that, if not coercive, would not be considered paraphilic. Further information, including a detailed risk assessment, is necessary to determine on a case-by-case basis whether a particular person meets all the criteria for civil commitment as a sexually violent predator. As for convicted sex offenders with other diagnoses, to meet criteria for civil commitment, "there must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as … the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case" (*Kansas v. Crane,* p. 413).

Notes

1. Except for sexual masochism, most people who meet criteria for a diagnosis of paraphilia are males (DSM-IV-TR, p. 568). Here, the use of male examples and masculine pronouns reflect this finding.

2. Unless stated otherwise, assume that the people in the examples agree to be evaluated but choose not to discuss their sexual fantasies and urges. Their observed behavior provides the primare or sole data for diagnosis (which is comparable to mayn SVP evaluations).

3. For this particular example, assume that this man does not meet criteria for antisocial personality disorder. He does not habitually lie, steal, get in fights, etc., and in nonsexual parts of his life he shows empathy, remorse, etc.

4. As in Vognsen & Phenix (2004, p. 442).

5. *Repeated* paraphilic sexual *behavior* would be necessary for meeting criteria for the diagnosis unless additional data cleary showed the presence of paraphilic fantasios and/or urges. We continue the practice of relying solely on behavior for most of the diagnostic case examples.

6. Please note that I made this up. This is not a quote from DSM-IV-TR, but, I believe, is reasonably drawn from the general discussion about paraphilia and the discussion of the specific paraphilias detailed therein.

7. Again, please not that I made this up. Again, this is not a quote from DSM-IV-TR, but, I believe, is reasonably drawn from the general discussion about paraphilia and the discussion of the specific paraphilias detailed therein.

References

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).* Washington, DC: American Psychiatric Association.

Kansas v. Crane, 334 U.S. 407 (2002).

Kansas v. Hendricks, 521 U.S. 346 (1997).

Money, J. & Lamacz, M. (1989). *Vandalized lovemaps.* Buffalo, NY: Prometheus.

Moran, P. (1999). The epidemiology of antisocial personality disorder. *Social Psychiatry and Psychiatric Epidemiology, 34,* 231-242.

Sreenivasan, S., Weinberger, L. E. & Garrick, T. (2003). Expert testimony in sexually violent predatory commitments: conceptualizing legal standards of "mental disorder" and "likely to reoffend." *Journal of the American Academy of Psychiatry and the Law, 31,* 471-485.

Vognsen, J. & Phenix, A. (2004). Antisocial personality disorder is not enough: A reply to Sreenivasan, Weinberger, and Garrick. *Journal of the American Academy of Psychiatry and the Law, 32,* 440-442.

Zander, T. (2005). Civil commitment without psychosis: The law's reliance on the weakest links in psychodiagnosis. *Journal of Sexual Offender Civil Commitment, 1,* 17-82.