

Non-Consensuality Pathologised: Analysing Non-Consensuality as a Determiner for Paraphilic Disorders

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Abstract

The fifth text-revised iteration of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) defines paraphilia as “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners”. Paraphilic *disorders* specifically denote a paraphilia that is “currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others”. A diagnosis of paraphilic disorder either demands the personal distress and/or impairment of function that is caused by the atypical sexual urges and fantasies to be present, or the status of non-consent of the other person that these sexual fantasies and urges are directed towards when acted upon by the patient. This paper discusses how consent not only becomes the standard for permissible and legal sexual activity with other persons, but also, when the diagnostic criteria are taken at face-value, for sexual pathology in the DSM-5-TR when the patient acts on their sexual urges. After a close investigation of various possible interpretations of the element of non-consensuality in the diagnostic criteria for paraphilic disorders, this paper concludes that the DSM-5-TR does not offer a clarifying explanation on how mental health professionals should understand its approach to diagnosing paraphilic disorders, leaving us with an ambiguous, unclear and unsettled conceptualisation of what it would mean to fulfil its diagnostic criteria.

About the author

Shirah Theron has just submitted her Philosophy MA thesis, titled “Pornography Conceptualised as an Addictive Substance”, for examination at Stellenbosch University is already working on her PhD proposal. Her general research focuses on sexual ethics and philosophy of sex, and she wishes to do further research in the fields of psychology and sexology. She serves as the President of the philosophy department’s student society, as well as the Editor-in-Chief for the departmental academic journal, the Stellenbosch Socratic Journal. Shirah strives to make a worthwhile change in her community, particularly relating to advocating Krav Maga techniques for the purposes of self-defence with the mindset: “We work together to empower each other”. Furthermore, she still absolutely adores cats.

1. Introduction

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is widely acknowledged as the “leading clinical manual of contemporary psychiatry” (Adriaens, 2015: 160), and is utilised by mental health professionals as a guide to diagnose and treat mental disorders. Its latest edition (DSM-5-TR) was published in May of 2022 (with its original fifth edition published nine years ago in 2013) and has been amended multiple times leading up to this revised fifth release. This resulted in the continued expansion of the concept of ‘mental disorder’ (Boysen and Ebersole, 2014), including the latest diagnostic criteria for paraphilia and paraphilic disorders. According to the DSM-5-TR (American Psychiatric Association, 2022), paraphilia refers to “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners”, whereas paraphilic disorders specifically denote a paraphilia that is “currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others”.

But what exactly is being pathologised in paraphilic disorders? In other words, what exactly is it *about* paraphilic disorders that make them mental disorders rather than merely deviations of societal norms?¹ The DSM definition of mental disorder emphasises that discrepancies between the individual and societal norms are not to be considered disorders, as the “symptoms must be caused by a dysfunction in the individual to constitute a disorder” (Wakefield, 2011: 198). This paper discusses the conceptualisation of mental disorders and focuses on the diagnostic

criteria for paraphilic disorders in the DSM-5-TR (APA, 2022). As I will show, consent not only becomes the standard for permissible and legal sexual activity with other persons, but also, when the diagnostic criteria are taken at face-value, for sexual pathology in the DSM-5-TR when the patient acts on their sexual urges.

A diagnosis of paraphilic disorder is either based on the personal distress and/or impairment of function that is caused by the atypical sexual urges and fantasies, or based on the status of non-consent of the other person that these sexual fantasies and urges are directed towards when acted upon by the patient. This paper aims to specifically investigate and identify various possible interpretations of the element of non-consensuality in the diagnostic criteria for paraphilic disorders. I will conclude that the DSM-5-TR does not offer a clarifying explanation on how mental health professionals should understand its approach to diagnosing paraphilic disorders, leaving us with an ambiguous, unclear and unsettled conceptualisation of what it would mean to fulfil its diagnostic criteria.

2. The DSM's contribution to understanding mental disorders

There is robust consensus among philosophers and mental health professionals that the concept of mental disorder is at the foundation of psychiatry (Varga, 2011: 1). Due to a variety of socio-political factors, many psychiatrists believe that only a completely objective and value-free definition of mental disorder is truly apt in making a successful diagnosis (ibid.).² Questioning the nature of mental disorders is crucial, since there is a real possibility of wrongfully classifying

¹ Jerome Wakefield explains this using the example of adultery. Adultery is “negatively socially valued”, but the fact that it deviates from some societal norm does not *make* it a disorder. He adds that, “the desires underlying adultery, while disapproved, are conceded to be within the normal range of human biological design and not a dysfunction of sexual desire” (2011: 198).

² What makes some definitions of mental disorders more objective than others lies beyond the scope of this paper, as this paper focuses on the element of non-consensuality in the diagnostic criteria of paraphilic disorders in the DSM-5 and DSM-5-TR (APA, 2013, 2022). However, I do not deny the importance of questioning the objectivity of medical definitions that change through time and society.

various kinds of social deviance or behavioural variations as a 'disorder'. However, these deviances and variations may be "better conceptualised using other categories, such as 'non-pathological individual differences', 'lifestyle choice', or 'crime'" (Stein, Palk & Kendler, 2021: 1).

The Diagnostic and Statistical Manual of Mental Disorders is used to better understand the concept of mental disorder, which is fundamental for mental health professionals to correctly diagnose their patients. Even at the time of the most recent publication of the DSM-5-TR in 2022, the question of whether and how the DSM should define a mental disorder "remains as controversial as ever" (Bingham & Banner, 2014: 537). There have been grave consequences of the misapplication (and misuse) of the concept of 'disorder'. A "crucial controversy", as Adriaens terms it, of the DSM-1 and DSM-2 was the pathologisation and classification of homosexuality as a mental disorder (2015: 164-167). This is a pivotal example of how culture-relative notions have greatly influenced how far 'mental disorder' can expand over its conceptual plane. Only in the late 1970s, was it understood that it is a *homophobic* society that "transforms homosexuality into a disease" (Adriaens, 2015: 166).

As seen in the example above, it is of great importance to understand the concept of mental disorder appropriately, as it is crucial for "constructing 'conceptually valid' criteria that are good discriminators between disorder and non-disorder" (Wakefield, 1992: 373-374). This is to say that each mental disorder listed and described in the DSM must "satisfy the definition of mental disorder" (First & Wakefield, 2013: 663). Each mental disorder must have one or more elements of dysfunction and harm present. These dysfunction and harm-components are key in determining the presence of a mental disorder in the patient, because almost all symptoms and characteristics of the mental disorders listed in the DSM can occur under some

circumstances in a normally functioning individual (ibid., 665).

Furthermore, if the diagnostic criteria of mental disorders are not carefully evaluated and revised when considering new neuroscientific findings or novel medical conceptualisations, the potential for diagnostic false positives will increase (First & Wakefield, 2013: 665). As previously mentioned, both the harm-component and dysfunction-component must necessarily be present to meet the requirements for a mental disorder and a successful diagnosis thereof. The mental disorder's definition refers to the dysfunction-component as the "failure of biologically designed functioning of psychological mechanisms or processes" (ibid., 664). In addition to this, it is the dysfunction that must also cause harm to the patient, usually in the form of "distress or social role impairment that is sufficiently serious to warrant clinical attention" (ibid.).

The DSM has been expanded to include more disorders,³ but in doing so has left much open to interpretation. The concept of dysfunction, for example, is extremely difficult to define. Stein, Palk and Kendler (2021: 7) posit that "[s]ymptom severity, excessiveness, and duration" may be very helpful in categorising the dysfunction of mental disorders and assist in diagnosis. The DSM does attempt to be somewhat specific in its diagnostic criteria with regards to a mental disorder's indicators, but it is also crucial to remember that "biological difference does not point to dysfunction" (ibid.). This leaves the possibility that, despite the availability of particular factors that categorise dysfunction, the true nature of dysfunction is not clear-cut and remains very demanding to delineate.

Determining an internal dysfunction is particularly challenging, due to our lack of access to objective

³ For more on this, see Boysen and Ebersole (2014).

biomarkers for dysfunction. We are not⁴ (yet!) able to uncover objective evidence of brain and neurological dysfunction in a laboratory that points towards psychological and mental disturbance – as if the symptoms that are observed in the laboratory themselves constitute the disorder (First & Wakefield, 2013: 665). Due to the absence of such clear biomarkers, the dysfunction must instead be “inferred from the symptomatic presentation *together* with the contextual circumstances” (ibid., 665, own emphasis). And again, given that almost every psychiatric symptom that is characteristic of a mental disorder can occur in some context of a normally functioning person, the criteria based on the symptoms of the mental disorder must be constructed in such a way as to indicate that the symptom “cannot reasonably be considered normal”,⁵ so that mental health professionals can better distinguish and identify the dysfunctions from what is considered normal functioning.

3. Questioning what it means to fulfil the diagnostic criteria of paraphilic disorders in the DSM-5-TR

Paraphilia is constructed from two Greek roots: *para* meaning beyond and *philia* meaning love, reflecting that paraphilias are construed not only as sexual disorders but as “disorders of loving” (Zinik & Padilla, 2016: 45). In the DSM-5-TR (APA, 2022), there are eight listed paraphilic disorders, along with “other specified paraphilic disorder” and “unspecified paraphilic disorder”.⁶ These eight disorders are “voyeuristic disorder”, “exhibitionistic disorder”, “frotteuristic disorder”,

“sexual masochism disorder”, “sexual sadism disorder”, “pedophilic disorder”, “fetishistic disorder” and “transvestic disorder” (APA, 2022: 779-802). The DSM-5-TR distinguishes between paraphilia and paraphilic disorder. Paraphilia refers to “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners”,⁷ whereas a paraphilic disorder specifically denotes a paraphilia that is “currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others” (APA, 2022: 780). All eight of these disorders satisfy at least one of Criterion A and Criterion B.

In the diagnostic criteria for each of the listed paraphilic disorders in the DSM-5-TR (APA, 2022), Criterion A specifies the “qualitative nature” of the paraphilia, such as an erotic focus on inanimate objects or a focus on exposing the genitals to unsuspecting strangers. This criterion usually stipulates a timeframe of about six months. Criterion B specifies the “negative consequences” of the paraphilia, such as the harm it causes others or the impairment and distress it causes to the patient (ibid.). According to the DSM-5-TR, fulfilling Criterion A denotes a paraphilia, but only when the patient fulfils *both* Criteria A and B can they be diagnosed with the paraphilic *disorder*. It is thus Criterion B that contains the dysfunction-component and harm-component which turns the paraphilia into a paraphilic disorder. Furthermore, Charles Moser notes that, “[o]nce the distress or impairment

⁴ First and Wakefield also mention that such “diagnostically specific abnormal brain imaging findings known to be the result of brain pathology, would obviate the need for inference, but such tests are unavailable at this time” (2013: 665).

⁵ With regards to non-consensuality, as its presence in Criterion B is the focus of this paper, none of the possible interpretations discussed in this paper is particularly typical, but the issue remains that the DSM-5-TR (APA, 2022) does not specify which one (or more) of these three interpretations we should take on when working on diagnosing a paraphilic disorder in a patient.

⁶ I wish to add that Wakefield mentions: “Many other paraphilias, from asphyxophilia to zoophilia, can be diagnosed within a ‘wastebasket’ category of ‘paraphilia not otherwise specified’ (paraphilia NOS) that encompasses any condition judged by the clinician to be a paraphilia that does not fall under any of the specific categories provided by the DSM” (2011: 195).

⁷ Colloquially, we have come to refer to these as sexual ‘kinks’ and/or ‘fetishes’.

resolves, then the DSM-5[/DSM-5-TR] would label the symptom-free individual with the paraphilic disorder diagnosis for *five more years!* After 5 years, the symptom-free individual may be classified as having a paraphilic disorder in full remission, never reverting back to a paraphilia per se” (2019: 683, own emphasis). Therefore, if the distress and/or impairment caused by the paraphilic disorder is resolved (for whatever reason), the patient will remain diagnosed with the paraphilic disorder (for at least five years).

Since this paper focuses on paraphilic disorders in the DSM-5-TR, I look at both Criteria A and B – but specifically Criterion B, since this criterion must be present (or fulfilled) for a paraphilic disorder to be diagnosed. Criterion B for voyeuristic disorder (spying on others in private activities), exhibitionistic disorder (exposing the genitals), frotteuristic disorder (touching or rubbing against a non-consenting person) and sexual sadism disorder (inflicting humiliation, bondage, or suffering) states the following: “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” (APA, 2022: 780, 783, 785, 790). It is understandable that Criterion B for sexual masochism disorder (undergoing humiliation, bondage, or suffering), pedophilic disorder (sexual focus on children), fetishistic disorder (using non-living objects or having a highly specific focus on non-genital body parts) and transvestic disorder (engaging in sexually arousing cross-dressing)⁸ differs from the Criterion B for voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder and sexual sadism disorder and does not include the explicit factor in Criterion B of acting on sexual urges with a non-

consenting person. This latter set of paraphilic disorders (when acting on the sexual urges) require an active approach to another person. The first set of paraphilic disorders (when acting on the sexual urges) involve either being on the receiving end of the sexual approach (such as with sexual masochism disorder), or by definition involve non-consenting persons (such as with pedophilic disorder, for children are unable to grant valid consent), or do not usually involve another person altogether (such as with fetishistic disorder and transvestic disorder).

I now focus on the first section of Criterion B, namely that the “individual has acted on these sexual urges with a non-consenting⁹ person”. I interpret this as a section of Criterion B that can stand alone, since it is placed before an ‘or’. Criterion B can therefore be fulfilled either in the case of the patient acting on their sexual urges with a non-consenting person, *or* in the case in which the patient has not acted on their sexual urges, but the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Either one or both have to be present in order to fulfil Criterion B. Granted, if this is not how the writers of the DSM-5-TR (APA, 2022) wished Criterion B to be interpreted, it would mean that more clarification is needed for Criterion B in the next iteration of the DSM.

Wakefield states that he is aware of several possible answers to the question of what role non-consensuality plays in judgments and diagnoses of paraphilic disorders (2011: 207). He notes that non-consensuality is a form of harm that fulfils the “harm” criterion for disorder, but that this is independent of whether there is a dysfunction in the desires aimed at the non-

⁸ I wish to make clear that dressing as the opposite gender does not constitute a mental disorder. In the case of transvestic disorder, it specifically pertains to cross-dressing that involves sexual arousal and that those feelings, urges, and behaviours cause impaired functioning and clinically significant distress/harm to the patient’s life.

⁹ It is possible that the idea of using non-consensuality as a sufficient criterion for a paraphilic disorder may have come about due to a misinterpretation of the DSM’s text. For more on this, see Frances, A., Sreenivasan, S., & Weinberger, L. E. (2008), and Frances, A., & First, M. B. (2011).

consenting person: “Non-consent would then be seen as a moral and legal concern, but not by itself a determinant of whether a psychiatric disorder exists” (Wakefield, 2011: 207). This is, however, only one possible interpretation of Criterion B, since the DSM never stipulates that non-consensuality is not itself a determinant of a paraphilic disorder diagnosis. Matters involving sexuality are controversial, but as Hinderliter points out, the importance of “careful wording in drafting definitions and diagnostic criteria in the DSM should *not* be [controversial]” (2011: 27, own emphasis). Wakefield further notes that in the context of paraphilic disorders, “activity with non-consenting partners could easily be seen as a fundamental category of paraphilia, although according to Frances and First it was never conceived or intended that way” (2011: 207). However, this explanation has not been stipulated as such in the DSM-5-TR (APA, 2022) either, and thus remains open to interpretation. In the following section, I argue that since the DSM is not specific enough in its conceptualisation of including the element of non-consensuality in Criterion B, it leaves a lot of confusion and uncertainty about how to diagnose a paraphilic disorder when the patient acts on their sexual urges.

4. Interpreting non-consensuality and acting on sexual urges in Criterion B

The first problem that arises when one involves a non-consenting person as part of a criterion in paraphilic disorders, is the concept of non-consent itself. What does it mean to be a ‘non-consenting person’ during a sexual act? Anderson points out this potential ambiguity: “Is it sex for which consent has been explicitly declined, or sex that has not received explicit consent (which includes the former)?” (2016: 60). The standard for consensual sex (i.e., whether affirmative and/or explicit consent is necessary or not), has followed

various trends in societal history. We would hopefully view “respect for a person’s non-consent as essential to fostering people’s sexual integrity” when determining the standard for consensual sex (ibid., 59). Essentially, if we do not act according to this view, we commit sexual assault and/or rape.

I put forward the act of rape as the classic paradigm of the violation of consent. Today, rape continues to refer to the act of sexual penetration of any person, without their consent (Bryden, 2000; Plaut, 2006; Danaher, 2018). There are simple and complex cases when it comes to conceptualising sexual consent. Theories of consent and what it means to give consent extend over giving sexual consent explicitly, voluntarily, affirmatively and/or non-verbally (Dougherty, 2015). Alan Soble, for example, investigates the sufficiency of sexual consent based on the notion of free¹⁰ and informed¹¹ consent as derived from the central principle in the practice of Western medicine (2022: 1-3). He argues that the satisfaction of the free and informed consent principle requires that “each person knows their own reasons for the sexual encounter and the reasons of the other person(s)” (2022: 8), and that we should not overlook the importance of reflecting on *why* we wish to engage sexually with someone.

Others question whether it is, in fact, non-consent that should determine a case of rape, or whether rape should be conceptualised on the basis of coercion – as coerced sex (Anderson, 2016). Anderson argues for the (re)conceptualising of rape as coerced sex, for it can, according to him, “replace both the force and non-consent elements” of rape, since those elements “fail to capture what is distinctively problematic about rape for women and why rape is pivotal in supporting women’s gender oppression”. I would argue, however, that the non-consent and/or force element of rape is indeed problematic and harmful *enough* and that non-consent therefore serves as the marker for rape and

¹⁰ As in, “voluntary, uncoerced”.

¹¹ As in, “knowledgeable understanding; the absence of lies, fraud, deception; no important information withheld”.

sexual assault. Further, if one takes Anderson's suggestion seriously, it would mean that rape could not be uncoerced in any scenario.¹²

This still leaves the questions regarding consent unanswered. If a person were coerced into having sex, does that mean that they *appeared* to consent to having sex, but since the consent was not voluntarily given, the consent becomes invalid? For consent to be considered valid, it must be given voluntarily and "without undue influence or coercion" (Nair, 2016: 762). Or, if a person is not coerced into having sex and they do not give consent, but sex is forced upon them regardless, is this not rape? Virtually all modern scholars contributing to the literature on rape want to "modify or abolish the force requirement as an element of rape" (Bryden, 2000: 322). This paper maintains that rape is a violent act that does not require physical force, physical or verbal resistance from the victim, nor the use of a weapon (Easteal, 2011). It nevertheless remains crucial to understand non-consent *and/or* force as elements of rape in order to apply the concept of rape. The DSM-5-TR (APA, 2022) does not elaborate on the exact meaning of its authors' stipulation in Criterion B when specifying that patients act on their sexual urges with *non-consenting* persons. In other words, it is unclear what exactly a non-consenting person would look like. To avoid ongoing confusion, the authors of the future iteration of the DSM will need to provide conceptual clarity regarding these matters.

Even if it is unclear exactly what is meant by 'non-consenting person' in the DSM-5-TR (APA, 2022), more questions arise regarding its applicability to certain scenarios when diagnosing paraphilic disorders. Can

we assume that, since "acting on sexual urges with a non-consenting person" is grouped under Criterion B, the patient experiences sexual arousal specifically due to the non-consenting state of the person? Is it the case that if the person were *not* a non-consenting person, the patient (unless the patient experiences clinically significant distress as stated in the second section of Criterion B) *cannot* be diagnosed with the paraphilic disorder? In such a case, it would mean that the element of a non-consenting person is arousing to the patient (when acting on sexual urges), and it is this arousal of non-consent in the patient's acting on their sexual urges that converts the paraphilia to a paraphilic disorder. That is to interpret the patient's actions not only as 'seeking out' non-consent¹³ in persons when acting on their sexual urges, but also to conceptualise their actions as rape and/or sexual assault.

The issue with conceptualising the sexual acts committed by a patient diagnosed with a paraphilic disorder as rape and/or sexual assault, is that, "[t]here has never been a diagnostic category in any edition of the Diagnostic and Statistical Manual of Mental Disorders (APA, 1952, 1968, 1980, 1987, 1994, 2000, 2013) that describes an individual who is persistently aroused by coercive sex and repeatedly commits acts of rape" (Zinik & Padilla, 2016: 45). In other words, the conceptualisation of such a disorder would attempt to turn rape into a mental disorder. Richard Wollert strongly argues that "[r]ape is a crime and prison is the proper placement for rapists", and that paraphilic coercive disorder (PCD) "does not belong in the Appendix or anywhere else in DSM-5" (2011: 1098). I feel compelled to argue hypocrisy on the part of the authors of the

¹² If we take it that coercion in this case refers to the use of force and/or intimidation to obtain compliance, one can imagine an example where Person A does not consent to have sex with Person B, but B proceeds to sexually penetrate A without using any force or intimidation. This is still an example of rape since consent was violated.

¹³ Even though the role of morality and the law in cases of paraphilic disorders and/or sexual crimes lies beyond the scope of this paper, I also wish to add here that Moser states: "Technically,

exhibitionism, frotteurism, and voyeurism are paraphilias only if the individual has eroticized the non-consensual aspect of the activity. An interaction with a non-consenting individual, when the perpetrator is not aroused by the non-consensual aspect of activity, is a crime, but does not appear to satisfy the diagnostic criteria of a paraphilic disorder and should not be diagnosed. The same behaviour with a consenting individual is not indicative of a paraphilia and should not be used to support a paraphilic disorder diagnosis" (2019: 684).

DSM in rejecting the proposals for paraphilic rape and PCD, but including non-consensuality as an element for a diagnosis of paraphilic disorder. If mental disorder diagnoses for rapists have been denied on the grounds that it would “have serious potential for misuse” (Knight, 2010), it follows that non-consensuality cannot be used to diagnose paraphilic disorders.

If the argument could be made that the above interpretation of ‘seeking out’ non-consent is a *mis*interpretation of “acting on sexual urges with a non-consenting person” as stipulated in Criterion B, and it is rather the case that the patient is *not* specifically sexually aroused by the person’s state of non-consent, it can then be interpreted as the patient not caring for the status of consent of the person. Whether the person consents or not is not important to the patient, and it is then this indifference and apathy (and not the experience of arousal and ‘seeking out’ of a non-consenting person specifically when acting on their sexual urges) that causes a paraphilia (when acting on sexual urges) to convert to a paraphilic disorder in the patient. Unfortunately, the DSM does not make this explicit, so we are left to speculate. Wakefield makes the point that, “...the failure to be turned off by a partner’s non-consent does not appear to be a paraphilia. At most, it would seem that some individuals are less affected than others by a victim’s protests and may lack the empathy and moral sense that overrides sexual assertion in most individuals. They may be terrible, unempathic, immoral people, but that is *not* a paraphilic disorder” (2011: 207, own emphasis). If it is the case that these patients are merely acting immorally and not due to a paraphilic disorder, the future iteration of the DSM must, once again, make this point clear. The potential difficulty with interpreting Criterion B’s element of non-consensuality as the patient’s *disregard* for consent, is that if the person *just so happens* to consent, the patient cannot be diagnosed with a paraphilic disorder when acting on their sexual urges (Moser, 2019: 684). The result is that we are only able to look back in retrospect at the status of consent of the person. That is to say that, again, it is not the person’s non-consent that forms part of the criterion that

must be fulfilled in order to diagnose disorder in the patient, but rather a different interpretation of the element of non-consensuality.

Referring to the interpretation regarding the patient’s disregard for consent, I argue that, if *that* is what the authors meant, they should rather state that the element of non-consensuality concerns the indifference and disregard for status of consent of the person by the patient, and not the ‘non-consenting person’ itself that converts the paraphilia to a paraphilic disorder, for there is a difference between these two interpretations. As Wakefield posits, “[a]rousal by coerciveness is not clearly distinguished here from arousal despite coerciveness, or arousal enhanced by coerciveness” (2011: 207). Another similar interpretation would be to read that it is not exactly the indifference or disregard for status of consent of the person by the patient, but that the element of non-consent does not interrupt or stop the patient from experiencing sexual arousal (Knight, 2010: 423). Nonetheless, the DSM does not stipulate these details and it therefore, again, remain open to various readings and interpretations.

There remains one last possible interpretation of the element of non-consent in Criterion B. If it is neither the case that the patient experiences sexual arousal *specifically* with a non-consenting person, nor the case that it is the *indifference and disregard* for status of consent by the patient that leads to a paraphilic disorder diagnosis, nor the case that the element of non-consent does not *interrupt or stop* the patient from experiencing sexual arousal that leads to a paraphilic disorder diagnosis – then we are left to look elsewhere for what the element of non-consent actually refers to in Criterion B. The other option that has not yet been considered, is that the element of non-consensuality lies solely with the non-consenting person themselves. Perhaps the authors of Criterion B meant to state that paraphilic disorder diagnoses can be made purely based on the person’s state of consent – external to the patient. However, this would mean that when the patient acts on their sexual urges, it is the non-consenting person that would be the key player in diagnosing

a paraphilic disorder in the patient – and not anything in particular about the patient. Even though this is unlikely, it is worth noting that other mental disorders in the DSM can reach diagnosis even when the patient is unaware of personal harm or dysfunction, while persons around the patient are experiencing it. An example of such a diagnosis would be aphasics with anosognosia, where the patient is unaware that they are unable to communicate (Nikolinakos, 2004). Therefore, this interpretation of Criterion B is perhaps not completely far-fetched for the DSM.

Even though mental disorders are determined by both internal and external factors, the case mentioned above is far removed from the internal factors of the patient themselves. Such a diagnosis that hinges on the state of consent of the person can lead to false positive diagnoses and great misuse, since the diagnosis of the patient would be fully dependent on the person/victim's own recollection of their state of consent. Although it may intuitively seem that this interpretation is too far-fetched as it appears to struggle to reconcile with the necessary harm-element and dysfunction-element of mental disorder, I would argue that the non-consent and/or force element of rape and sexual assault is indeed problematic and harmful enough to contribute to the harm-element in a paraphilic disorder diagnosis. However, the widely held view remains that it is the dysfunction that must lead to harm for a diagnosis to be made. If we are to take up the above-mentioned external-view interpretation of non-consent in Criterion B, it would mean that the paraphilic disorder diagnosis needs to be made backwards – *via* the harm-element in order to identify the dysfunction-element. Such an interpretation would make for a shaky approach to diagnosing paraphilic disorders, because it would run the risk of arbitrarily attributing a dysfunction to the harmful component. Therefore, the conceptualisation of non-consensuality in Criterion B of paraphilic disorders remains ambiguous, unclear, and unsettled.

5. Conclusion

After considering all the possible ways a diagnosis of a paraphilic disorder can be reached, the conceptualisation and inclusion of the element of non-consensuality in Criterion B of paraphilic disorders in the DSM-5-TR (APA, 2022) remain open to various interpretations. With regards to non-consensuality, as its presence in Criterion B is the focus of this paper, determining whether non-consensuality itself is the key-factor in the dysfunction-component in some paraphilic disorders in the DSM-5-TR will depend on how the element of non-consent is conceptualised. Is it the seeking out of non-consensuality, or the disregard for status of consent, or the non-consensuality not inhibiting sexual arousal in the patient? Or are the paraphilic disorder diagnoses to be made purely based on the person's state of consent that these sexual fantasies and urges are directed towards – external to the patient? The DSM-5-TR does not specify which one (or more) of these interpretations we should use when diagnosing a paraphilic disorder.

Once aware of these various interpretations, it must be determined whether more than one of the interpretations need to be implemented in the sixth edition of the DSM to bring about more clarity about what needs to be the case to reach a successful diagnosis of a paraphilic disorder. Moreover, it must also be determined which of these interpretations can potentially be used simultaneously and which are contradictory. However, it remains the case that, due to the structure of Criterion B for paraphilic disorders, the element of non-consensuality is the *only* element that is mentioned and used as a marker for when the patient acts on their sexual urges. Therefore, it is crucial to understand how and when non-consensuality is applicable in determining successful paraphilic disorder diagnoses.

Bibliography

- Adriaens, P.R. 2015. Are Paraphilias Mental Disorders? The Case of the DSM. *Philosophy and Medicine*, 120, May: 159–178, doi:10.1007/978-94-017-9870-9_10
- American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 5th edition. *Encyclopedia of Applied Psychology, Three-Volume Set*. 5th edition, doi:10.1016/B0-12-657410-3/00457-8
- Anderson, S.A. 2016. Conceptualizing rape as coerced sex, *Ethics*, 127(1): 50–87, doi:10.1086/687332
- Bingham, R. and Banner, N. 2014. The definition of mental disorder: Evolving but dysfunctional?, *Journal of Medical Ethics*, 40(8): 537–542, doi:10.1136/medethics-2013-101661
- Boysen, G.A. and Ebersole, A. 2014. Expansion of the Concept of Mental Disorder in the DSM-5', *The Journal of Mind and Behavior*, 35(4): 225–243.
- Bryden, D.P. 2000. Redefining Rape, *Buffalo Criminal Law Review*, 3(2): 317–479, doi:10.1525/nclr.2000.3.2.317
- Danaher, J. 2018. Could There Ever be an App for that? Consent Apps and the Problem of Sexual Assault, *Criminal Law and Philosophy*, 12(1): 143–165, doi:10.1007/s11572-017-9417-x
- Dougherty, T. 2015. Yes Means Yes: Consent as Communication, *Philosophy & Public Affairs*, 43(3): 224–253.
- First, M.B. and Wakefield, J.C. 2013. Diagnostic criteria as dysfunction indicators: Bridging the chasm between the definition of mental disorder and diagnostic criteria for specific disorders, *Canadian Journal of Psychiatry*, 58(12): 663–669, doi:10.1177/070674371305801203
- Hinderliter, A. C. 2011. Defining Paraphilia in DSM-5: Do Not Disregard Grammar, *Journal of Sex & Marital Therapy*, 37: 17–31, doi:10.1080/0092623X.2011.533567
- Knight, R. A. 2010. Is a diagnostic category for paraphilic coercive disorder defensible?, *Archives of Sexual Behavior*, 39(2): 419–426, doi:10.1007/s10508-009-9571-x
- Moser, C. 2019. DSM 5, Paraphilias, and the Paraphilic Disorders: Confusion Reigns, *Archives of Sexual Behavior*, 48(3): 681–689, doi:10.1007/s10508-018-1356-7
- Nair, M. 2016. Pharmacotherapy for Sexual Offenders, in A. Phenix, and H. M. Hoberman, (eds.). *Sexual Offending: Predisposing Antecedents, Assessments and Management*. New York: Springer. 755–767.
- Plaut, S. M. 2006. Consent to Sexual Relations, *Archives of Sexual Behavior*, 35(1): 101–103, doi:10.1007/s10508-006-8999-5
- Soble, A. 2022. On the Sufficiency of Sexual Consent, *SSRN Electronic Journal*, January: 1–21, doi:10.2139/ssrn.4044729
- Stein, D. J., Palk, A. C. and Kendler, K. S. 2021. What is a mental disorder? An exemplar-focused approach, *Psychological Medicine*, 51(6): 894–901, doi:10.1017/S0033291721001185
- Varga, S. 2011. Defining mental disorder. Exploring the “natural function” approach, *Philosophy, Ethics, and Humanities in Medicine*, 6(1): 1, doi:10.1186/1747-5341-6-1
- Wakefield, J. C. 1992. The Concept of Mental Disorder: On the Boundary Between Biological Facts and Social Values, *American Psychologist*, 47(3): 373–388, doi:10.1037/0003-066X.47.3.373
- Wakefield, J. C. 2011. DSM-5 proposed diagnostic criteria for sexual paraphilias: Tensions between diagnostic validity and forensic utility, *International Journal of Law and Psychiatry*, 34: 195–209, doi:10.1016/j.ijlp.2011.04.012

- Wollert, R. 2011. Paraphilic Coercive Disorder Does Not Belong in DSM-5 for Statistical, Historical, Conceptual, and Practical Reasons, *Archives of Sexual Behavior*, 40: 1097–1098, doi:10.1007/s10508-011-9814-5
- Zinik, G. and Padilla, J. 2016. Rape and Paraphilic Coercive Disorders, in A. Phenix, and H. M. Hoberman, (eds.). *Sexual Offending: Predisposing Antecedents, Assessments and Management*. New York: Springer. 45–66, doi:10.1007/978-1-4939-2416-5_6