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Paraphilias: A Survey of Experts

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Abstract

There is limited research examining the processes utilized when making diagnoses in sexual offender civil commitment (SVP) evaluations. The purpose of this research was to examine mental health professionals' (MHPs) opinions towards, and use of, paraphilic diagnoses in SVP evaluations. In particular, other-specified (OS) paraphilic diagnoses of hebephilia and nonconsent were examined. Results indicate a lack of understanding among MHPs regarding how to recognize and apply OS paraphilic diagnoses. Findings also provide insight into how and why MHPs choose to diagnose OS paraphilias, demonstrating a high level of reliance on documentation. Results indicate the existence of an adversarial allegiance among MHPs diagnosing paraphilias in SVP evaluations. These findings advance our understanding of how OS paraphilias are understood by MHPs and provide insight into the diagnostic processes utilized in SVP evaluations. Policy implications and suggestions for future research are explored.

Introduction

Sexual offender civil commitment legislation (here after referred to as Sexually Violent Predator (SVP) legislation) is controversial given the associated ethical dilemmas (Sreenivasan, Frances, & Weinberger, 2010) and reliability issues with commonly used diagnoses (Levenson, 2004; Perillo, Spada, Calkins, & Jeglic, 2014). Paraphilias make up a majority of the diagnoses assigned to those being evaluated for indefinite civil commitment (Becker, Stinson, Tromp, & Messer, 2003; Levenson & Morin, 2006**;** McLawsen, Scalora, & Darrow, 2012). However, the empirical basis of this diagnostic category has long been debated due to insufficient reliability, questionable validity, and a lack of field studies (Balon, 2013; Levenson, 2004; Perillo et al., 2014).

The use of other specified (OS) labels as paraphilic diagnoses, specifically hebephilia and nonconsent, has also been debated. The application of these concepts as psychiatric diagnoses has elicited both opposition (Baxter, Marshall, Barbaree, Davidson, & Malcolm, 1984; Brown, Gray, & Snowden, 2009; Frances, Sreenivasan, & Weinberger, 2008; Good & Burstein, 2012; Prentky & Barbaree, 2011; Wakefield, 2012) and support (Blanchard, 2008, Blanchard, 2009; O' Donohue, 2010; Stern, 2010; Thornton, 2010) in the literature. Despite these issues, OS paraphilias remain one of the most commonly used diagnoses in SVP proceedings (Becker et al., 2003; Levenson, 2004; Perillo et al., 2014). This is concerning given the lack of established criteria and resultant low levels of inter-rater reliability that have been observed when utilizing these diagnoses (Levenson, 2004; Perillo et al., 2014), especially given that the consequences of these labels can result in indefinite civil commitment.

Jackson and Hess (2007) attempted to address this issue, finding that clinicians followed relatively similar evaluative processes when applying diagnoses in SVP evaluations. Jackson and

Hess (2007) did not, however, indicate if any differences were found for those diagnosing OS paraphilias as compared to paraphilias with more established criteria (e.g., pedophilia). The researchers also noted an important limitation regarding the possibility of an unrepresentative sample in their study; a majority of their evaluators were state retained, and may have, therefore, differed from those typically hired by the defense (Jackson & Hess, 2007). This concept of an "adversarial allegiance" has been addressed in other areas of SVP civil commitment (Murrie, Boccaccini, Johnson, & Janke, 2008; Murrie, Boccaccini, Guarnera, & Rufino, 2013) but to our knowledge, no research has examined its impact when diagnosing paraphilias.

Evidently, little is known about how clinicians decide to apply diagnoses in SVP proceedings. Therefore, the current study will address this question by (1) asking MHPs to indicate their familiarity with and understanding of hebephilia and nonconsent; (2) exploring the diagnostic process of MHPs assigning hebephilia and nonconsent diagnoses; (3) analyzing the frequency and settings in which these specifiers are utilized when comparing state and defense contracted MHPs and (4) examining the differences in attitudes towards these diagnoses based on legal affiliation.

Paraphilias and Sexually Violent Predator (SVP) Legislation

The concept of paraphilias was first introduced as a subset of psychosexual disorders in the DSM-III (American Psychiatric Association [APA], 1980). Controversy has surrounded this diagnostic category since its advent, with Money (1984) arguing that paraphilias were incorrectly designated as atypical, and included in the DSM not because of their pathology or therapeutic need, but rather for forensic applications.

The use of paraphilias in forensic settings has been seen in the SVP context, which allows for the indefinite civil commitment of sexual offenders deemed to be of risk to society (Perillo et

al., 2014). Although some state-by-state variation exists, eligibility requirements for SVP status typically include the following four criteria: (1) previous criminal sexual behavior; (2) a mental abnormality; (3) risk for future harmful sexual acts; and (4) a connection between the mental abnormality and risk (Janus, 2000). Researchers have identified that paraphilias are the most commonly used diagnostic category in SVP civil commitment cases (Becker et al., 2003; Levenson & Morin, 2006**;** McLawsen et al., 2012). In fact, some scholars have argued that because the mental abnormality diagnosed must predispose the individual to sexual offending specifically, a paraphilic diagnosis should be required (Becker & Murphy, 1998).

First (2010) proposed that SVP legislation has led to an increase in the rate of false positive paraphilic diagnoses. First (2010) attributed this change to the fact that clinicians began misapplying diagnostic criteria in order to provide evidence for the mental abnormality prong of SVP civil commitment. He argued that this was likely due to the DSM-IV's ambiguous language. Researchers have noted additional issues with the diagnostic criteria, including a lack of reliability and validity data due to a failure to conduct field studies **(**Balon, 2013). These concerns have been supported with researchers identifying poor inter-rater reliability for various paraphilic diagnoses (Levenson, 2004; Perillo et al., 2014). Despite this evidence, no changes were made in the DSM-5's diagnostic criteria for paraphilias (APA, 2013). These issues are of particular concern when considering the OS and unspecified categories of the DSM-5 [previously known as "not otherwise specified (NOS)"].

Research has identified that issues of diagnostic reliability and validity are especially prominent for OS paraphilic diagnoses. Levenson (2004) studied this issue, examining the interrater reliability between two independent MHPs regarding diagnostic decisions for sexual offenders evaluated for civil commitment in Florida between July 1, 2000 and June 30, 2001.

Findings indicated that OS diagnoses had "poor" inter-rater reliability (kappa= .36), compared to "fair" inter-rater reliability for pedophilia (kappa= .65), a diagnosis with more established criteria (Levenson, 2004).[1] Perillo et al. (2014) similarly found that OS paraphilias had "poor" inter-rater reliability (kappa= .35). More recently, these findings have been replicated with researchers finding that evaluators diagnosing OS paraphilias demonstrated poor agreement (kappa = .21) compared to good agreement for pedophilia (kappa = .78; Graham, 2019). These concerns are particularly troublesome when one considers that after pedophilia, OS paraphilias have been identified as the most commonly used diagnoses in the SVP context (Becker et al., 2003; Levenson, 2004; Perillo et al., 2014). Two of the more commonly used OS diagnostic specifiers are hebephilia and nonconsent.

Hebephilia

Although definitions vary, hebephilia is a term often used to describe those who are preferentially sexually attracted to pubescent individuals; that is, those who show emerging signs of puberty. More specifically, hebephilia refers to individuals attracted to those in Tanner's stages 2-3 who are beginning to show some secondary sex characteristics (Graham, 2019). Blanchard et al. (2008) most recently defined the concept as "the erotic preference for pubescent children (roughly, ages 11 or 12–14)" (p. 335). Controversy exists in the literature regarding whether or not this sexual preference should be considered a diagnosable disorder (e.g., Blanchard et al., 2008; Prentky & Barbaree, 2011). Proponents of its inclusion argue that those with hebephilic preferences show a distinct pattern of arousal (Brown et al., 2009; Blanchard,

[1] It should be noted that other established diagnoses (e.g., sadism, exhibitionism) also demonstrated poor inter-rater reliability in the aforementioned research (Levenson, 2004; Perillo et al., 2014), and pedophilia may, therefore, be an exception rather than a difference attributable to established guidelines.

2008, Blanchard, 2009; O' Donohue, 2010). Others, however, have refuted these claims, stating that hebephilic preferences are not distinguishable from other proposed sexually deviant interests [i.e., rape (Baxter et al., 1984) and pedophilia (Good & Burstein, 2012; Prentky & Barbaree, 2011)]. Rather, they argue that studies identifying such a distinction used flawed methodology such as sampling from extreme groups and excluding intermediate data points, resulting in erroneous conclusions (Wollert & Cramer, 2011). Many cite the evolutionary benefits of hebephilia as evidence that this preference is one that has been made into a disorder by societal standards and should, therefore, not be diagnosed in clinical contexts (Franklin, 2009; Rind & Yuill, 2012).

Scholars report that although the concept of hebephilia has been in existence for generations, it was not proposed for inclusion in the DSM until the advent of SVP legislation (Frances & First, 2011; Franklin, 2009). Although rejected from inclusion in the DSM-5 as a distinct diagnostic category, unease remains prevalent among researchers due to the ability for hebephilia to be used as an OS diagnosis (First, 2009; First, 2014). As the OS category has historically been the most commonly used for diagnosing in SVP proceedings (Becker et al., 2003; Levenson, 2004; Perillo et al., 2014), this concern appears valid.

Nonconsent

Another common OS specifier that has given rise to controversy is nonconsent [also known as paraphilic coercive disorder (PCD)]. In considering the inclusion of nonconsent as a diagnosis in the DSM-5, the APA defined what they referred to as PCD as "recurrent, and intense sexual arousal from sexual coercion, as manifested by fantasies, urges, or behaviors" resulting in distress, impairment, or forceful sexual behavior (APA, 2011 as cited in Zonana, 2011). Proposals for the inclusion of nonconsent as a diagnosable disorder were also made for

the DSM-III-R and DSM-IV; however, the concept has continually been rejected due to its lack of validity, reliability, and potential for misuse in forensic settings (Frances et al., 2008).

Despite its exclusion from the manual, the use of nonconsent has continued to increase significantly, a trend seen only in populations of sexual offenders, almost exclusively in the SVP context (King, Wylie, Bran, & Heilbrun, 2014). In fact, researchers have identified OS nonconsent as the most commonly observed paraphilic diagnosis in SVP cases (65.5%; McLawsen et al., 2012). This has an immense impact on offenders, with findings indicating that a diagnosis of OS nonconsent increased the chances of being civilly committed under SVP legislation by an odds ratio of 106.78 (Levenson & Morin, 2006).

Those who support the inclusion of nonconsent as a diagnosis in the DSM argue that this would provide clear standards on which evaluators could base their decisions, thereby decreasing variability in diagnoses (Stern, 2010; Thornton, 2010). However, critics note that distinguishing "simple criminals" (i.e., the majority) who commit rape from a subset of those who have paraphilic interests would be extremely challenging (Screenivasan et al., 2008; Frances & First, 2011). For example, distinguishing between personality disordered behavior and paraphilic interests, and differentiating between opportunistic criminal acts and those resultant from paraphilic urges and fantasies, would require substantial evidence and examination (Screenivasan et al., 2008). Considering these challenges in accordance with the commonality of OS diagnoses in SVP proceedings raises the question of how exactly MHPs decide to apply these diagnoses.

Diagnosis of Paraphilias in Legal Contexts

There appears to be a lack of consensus regarding how one should assess an individual for mental abnormality in the SVP context. To our knowledge, only two groups have

publications providing counsel on this matter. The Association for the Treatment of Sexual Abusers (ATSA) guidelines recommend that when determining mental abnormality in SVP proceedings, clinicians should: (1) identify the existence of a psychiatric disorder, one which is "generally defined" by the DSM, and (2) assess for risk (ATSA, 1997 as cited in Miller et al., 2005). More recently, Witt and Conroy (2009) published a guide outlining best practices for MHP's conducting evaluations with sexually violent predators. They state that evaluators should first assess for mental abnormality using records and collateral documentation; however, they assert that many of the decisions made regarding how to assess for mental abnormalities should be based on the evaluator's discretion (Witt & Conroy, 2009).

Despite ATSA's recommendation that clinicians apply disorders defined in the DSM, some of the most commonly applied diagnoses in SVP proceedings (i.e., hebephilia and nonconsent) are not in the manual, indicating MHPs may not adhere to these guidelines. This fact, coupled with the ambiguous language utilized in both of the publications providing counsel on this matter, fails to provide clarification on how MHPs conduct diagnostic assessments related to sexual offender civil commitment. These issues can be attributed, in part, to the lack of available methods for paraphilic assessment.

Assessment of Paraphilias

Unlike many diagnosable mental health conditions, there is a lack of standardized methods that can be used when diagnosing paraphilias (Miller et al., 2005). One method of assessment frequently cited in the literature as being an acceptable measure of paraphilic interests is the penile plethysmograph (i.e., a measurement of blood flow to the penis). Although empirical evidence has established the measures ability to identify deviant sexual interests (Lalumière & Harris, 1998; Miller et al., 2005), this instrument is not without its limitations.

Researchers have noted concerns regarding the possibility of offenders "faking" plethysmograph results, as well as issues with generalizability across studies due to varied stimuli presentation (Miller et al., 2005). Further, no structured or semi-structured interviews have been developed to assist with the diagnostic process (Miller et al., 2005). Likely due to the lack of available measures, MHPs most commonly utilize unstructured interviews and file information when diagnosing mental abnormality (Jackson & Hess, 2007). The limited instrumentation available to MHPs diagnosing paraphilias highlights the need to understand how clinicians are reaching their diagnostic decisions in SVP proceedings.

Jackson and Hess (2007), who aimed to identify how MHPs make diagnostic decisions when conducting SVP evaluations, constructed a survey modeled after measures that address professionals who conduct forensic evaluations (Borum & Grisso, 1995; Ryba**,** Cooper, & Zapf, 2003). Forty-one experts with experience in this area were surveyed to determine what practices were typically utilized (Jackson & Hess, 2007). MHPs were asked to rank how often they utilized various tools, and/or assessed specific domains, and to rate the importance of each. The authors found that documentation (e.g., police reports, pre-sentence evaluations, and institutional records) was the core method utilized by MHPs when diagnosing mental abnormality. These results support those identified by Schoop, Scalora, and Pearce (1999), who concluded that heavy reliance on documentation might be explained by a fear that offenders are dishonest in self-reports. Jackson and Hess (2007) also noted that 97.6% of respondents considered assessment of paraphilias an essential aspect in the evaluation, yet only 80.5% reported that they "always" assessed for a paraphilia. The authors hypothesized that the difference between the importance attributed to assessing for paraphilias and the actual number who consistently evaluated paraphilias may have been the result of reliance on documentation (Jackson & Hess,

2007), which is concerning considering the poor inter-rater reliability of this diagnostic category. Although the research conducted by Jackson and Hess (2007) provided an important advancement in our understanding of MHPs diagnostic processes, the unbalanced sample in their study, which favored state hired respondents, may have confounded their conclusions.

Adversarial Allegiance

Jackson and Hess (2007) noted that because a majority (70%) of their sample consisted of MHPs who worked for the state, they might have differed in some significant way from those who typically work for the defense. They are not the first researchers to note this potential bias. Murrie and colleagues (2008) sought to examine if differences in clinician ratings of psychopathy, another commonly examined diagnosis in SVP evaluations (Levenson & Morin, 2006; Perillo et al., 2014), existed between those affiliated with opposing legal teams. The researchers found that when utilizing the Hare Psychopathy Checklist-Revised (PCL-R) to measure psychopathic symptomology, individuals retained by the state gave considerably higher scores on the measure (i.e., indicating psychopathy was evident) compared to those working for the defense. They concluded that this was indicative of an "adversarial allegiance," meaning that the MHPs opinions tended to support the goals held by the individuals for whom they worked (Murrie et al., 2008). Murrie and colleagues (2013) expanded on these findings by instituting an experimental design to analyze the presence of adversarial allegiance among clinicians. Participants were led to believe that they had been hired by the state or the defense and were then presented with case files and asked to score the alleged offenders on the PCL-R and Static-99R (Murrie et al., 2013). Results indicated that those who believed that they were working for the state assigned higher scores than those led to believe they had been hired by the defense. (Murrie et al., 2013). As King and colleagues (2014) note that more weight is typically given to the

opinions of experts testifying on behalf of the state, the issue of adversarial allegiance may add an additional layer of partiality for defendants.

Prentky and Barbaree (2011) argued that similar results would be found with paraphilic diagnoses, stating that those who typically work for the state would approve the admissibility of OS paraphilias (e.g., hebephilia and nonconsent), while those who primarily work for the defense would oppose use of these disorders. Although the idea of adversarial bias has been identified in assessing symptoms of psychopathy and risk (Murrie et al., 2008; Murrie et al., 2013), to our knowledge, no such research has examined if these findings generalize to paraphilic diagnoses.

Study Overview

There is a lack of research examining the application of paraphilic diagnoses, specifically OS paraphilias, in the SVP context. Considering the immense weight of such decisions, coupled with the controversy regarding the use of hebephilia and nonconsent as valid diagnostic categories in SVP evaluations, more research is needed to advance the understanding of MHPs knowledge, use, and application of these labels. The current study will, therefore, aim to address five questions related to diagnosing OS paraphilias in SVP proceedings.

Question One: Do MHPs understand OS paraphilic diagnoses?

Hypothesis One: Based on the literature which indicates low levels of inter-rater reliability among clinicians diagnosing OS paraphilias (Graham, 2019; Levenson, 2004; Perillo et al., 2014), it is hypothesized that MHPs lack an understanding of what these disorders are and, therefore, differences in the definitions provided will be apparent. Fewer differences will be seen among MHPs defining pedophilia.

Question Two: Are MHPs who conduct SVP evaluations more familiar with OS paraphilic diagnoses than those who have never conducted SVP evaluations?

Hypothesis Two: Based on the literature that indicates OS diagnoses such as nonconsent are used almost exclusively in SVP evaluations (King et al., 2014), it is hypothesized that MHPs who have not conducted SVP evaluations will be less familiar with nonconsent and hebephilia, as compared to those who have experience conducting SVP evaluations. No differences in familiarity are expected for pedophilia as this is an established diagnosis.

Question Three: Do MHPs use consistent methodology to diagnose OS paraphilias?

Hypothesis Three: There will be less consensus in the methodology utilized by SVP evaluators to diagnose hebephilia and nonconsent when compared with pedophilia, due to the fact that these diagnoses have no established definitions and lack a set of criteria.

Question Four: How often, and in which settings, do MHPs utilized OS specifiers? Does an adversarial allegiance exist among MHPs diagnosing paraphilias in SVP evaluations?

Hypothesis Four: Based on the previous research (Murrie et al., 2008), it is hypothesized that SVP evaluators who typically work with the state will have diagnosed pedophilia, hebephilia, and nonconsent significantly more than those who work for the defense. As prior research has indicated that OS specifiers such as nonconsent are used almost exclusively in SVP evaluations (King et al., 2014), it is hypothesized that those who have not conducted civil commitment evaluations will have applied these diagnoses less frequently.

Question Five: Are state affiliated MHPs more supportive of OS specifiers than defense retained MHPs?

Hypothesis Five: Based on the previous research (Murrie et al., 2008), it is hypothesized that SVP evaluators who typically work with the state will be significantly more supportive of hebephilia and nonconsent (i.e., their use in SVP settings and their inclusion in the DSM). No such differences between state-retained and defense-retained MHPs will be seen for pedophilia.

Method

Research Design

The current study used a cross-sectional design to compare MHPs use of and agreement with the application of hebephilia and nonconsent as specifiers for OS diagnoses. Pedophilia was included to compare results with an established paraphilic diagnosis. A mock diagnosis, "statutory rape," was also included to control for acquiescence bias, and identify if MHPs tend to agree with any proposed OS specifier. Specifically, the variables of interest included level of agreement, frequency and setting of use, and legal affiliation (i.e., defense or state). Diagnostic measures utilized and rationales provided by MHPs were examined to expand the understanding of diagnostic processes. Definitions provided by MHPs for hebephilia, nonconsent, and pedophilia were also studied to gain insight into MHPs understanding of these diagnoses.

Participants

Twenty-nine participants responded to the survey. Seven individuals were excluded due to incomplete data, for a final sample size of 22 participants. Nine respondents (39.13%) had conducted sexual offender civil commitment evaluations. The number of SVP evaluations conducted by these participants ranged from two to 200, with an average of 90.11. Six respondents had conducted SVP evaluations exclusively for the state. One evaluator had been hired by both the state and defense. This respondent had worked with the defense in 65% of his cases and was, therefore, grouped with the one other respondent who had worked exclusively with the defense. MHPs who worked with sexual offenders but had not conducted SVP evaluations (n=13; 59.09%) were also included in order to identify any between group differences in level of support, understanding, and use of OS diagnoses in non-SVP settings.

In order to control for any gender, race, or age effects, demographic data was collected. A slight majority of the sample was female (54.55%; *n*=12) with a mean age of 52.10 years (range of 24-72). Approximately 90.91% (*n*=20) identified as White and 9.09% (*n*=2) as Hispanic. To ensure that professional experience did not influence the results, information was collected on participants' degree and number of years conducting evaluations. The most prominent degrees held by participants were PhDs (27.27%; *n*=6), and PsyDs (27.27%; *n*=6), followed by M.As (13.64%; *n*=3). Other degrees held by participants included MSW (9.09%; *n*=2), MS (4.55%; *n*=1), LMH (4.55%; *n*=1), and D.O (4.55%; *n*=1). Responses given by 9.09% (*n*=2) were unclear. On average, participants had spent 15.48 years (*SD*=13.56; range=0-41) conducting sex offender evaluations, and 7.09 years (*SD*=9.32; range=0-30) conducting civil commitment evaluations.

Procedures and Materials

Potential participants were identified by contacting state chapters of ATSA. States that had SVP civil commitment laws and ATSA chapters (*n*=15) were chosen. An e-mail containing a description of the research and link to the survey was sent to each state chapter (*n*=15) who then forwarded the information to their members (see Appendix A). Responses were received from: Florida, Illinois, New Jersey, and Washington. The survey was administered using Survey Monkey's online software. At the beginning of the study, participants were presented with a consent form describing the research (see Appendix B). In order to access the survey and communicate voluntary participation, respondents were required to click "agree" on the consent form. After selecting "agree" and clicking next, participants were taken to the first page of the survey. For their participation, respondents were asked to choose from one of four organizations (Red Cross, American Cancer Society, Alzheimer's Association, American Society for the Prevention of Cruelty to Animals) to which they would like two dollars donated on their behalf.

Measure

A survey containing three sections was developed for the current research. A copy of the survey can be found in Appendix C.

Section I. The first section was created to address MHPs: understanding of, diagnostic process for, agreement with, and frequency of use for nonconsent and hebephilia diagnoses. The same questions were asked of pedophilia to provide a comparison with an established paraphilic diagnosis, and for the mock diagnosis, statutory rape, to control for acquiescence bias. Open-ended (e.g., "In your own words, provide a definition for hebephilia") and close-ended (e.g., "Have you ever applied a diagnosis of hebephilia?") questions were included. If a participant indicated they had never heard of a diagnosis, the survey automatically skipped to the next disorder. For example, if a participant indicated they had never heard of nonconsent, they would not answer any additional questions pertaining to this diagnostic label.

Section II. Section II was modeled after Jackson and Hess' (2007) survey of MHPs conducting SVP evaluations. This section employed close-ended questions (e.g., "How frequently do you assess for substance abuse in sexual offender civil commitment evaluations?") to assess procedures utilized when diagnosing in SVP evaluations. Section II also asked questions regarding legal affiliation to allow for examination of adversarial allegiance. As section II of the survey addressed procedures utilized during SVP evaluations specifically, those who indicated they did not have experience in this area automatically skipped to section III.

Section III. Section III collected demographic and professional practice information using open-ended and close-ended questions.

Results

Part One: MHPs Familiarity with Diagnoses[2]

Pedophilia. All (*N*=22) respondents in the current study acknowledged having heard of the diagnosis of pedophilia. While significance could not be determined due to the small sample size, SVP evaluators tended to report being more familiar with the pedophilia diagnosis than non-evaluators, although both groups reported high levels of familiarity (see Appendix E).

Hebephilia. All (*N*=22) respondents in the current study had heard of hebephilia. SVP evaluators tended to report being more familiar with the hebephilia diagnosis than non-evaluators, although both groups reported similarly high levels of familiarity (see Appendix E). However, significance could not be determined due to the small sample size.

Nonconsent. Eighteen respondents (81.82%) in the current study had heard of nonconsent, while four (18.18%) had not heard of the diagnosis. Of those who had not heard of nonconsent (*n*=4), none had experience conducting SVP evaluations. SVP evaluators tended to report being more familiar with the nonconsent specifier than non-evaluators, although significance could not be determined (see Appendix E).

Statutory Rape. Eight respondents (36.36%) in the current study stated that they had heard of the mock diagnosis of statutory rape, while fourteen (63.64%) had not heard of this diagnosis. Three (37.50%) of the individuals who stated they had heard of the mock diagnosis had conducted SVP evaluations in the past. While significance could not be determined due to the small sample size, SVP evaluators tended to report being slightly less familiar with the

[2] Although the sample size was insufficient and assumptions were violated, chi-square tests were conducted for thesis purposes only to identify the existence of any emerging patterns in level of familiarity with these diagnoses (see appendix D).

statutory rape diagnostic specifier than non-evaluators, although both groups reported low levels of familiarity (see Appendix E).

Part Two: MHPs Understanding of Diagnoses

A coding manual was developed following a preliminary line-by-line analysis of the definitions provided by respondents for pedophilia, hebephilia, nonconsent, and statutory rape.

Pedophilia. Of the participants who provided a definition for pedophilia (*n*=21), 90% (*n*=18) included information about the attraction being towards a "minor," or "child," with ten respondents (50%) specifying the attraction would be towards "pre-pubescent" individuals. Of the six individuals who provided an age range, four (66.67%) indicated that pedophilia applies to those with victims "13 and under." One respondent specified an age range of "under 12", and another gave the range of "under the age of 11…or so." Other information in the definitions provided included: duration of at least six months (25%; *n*=5), distress or impairment to offender (30%; *n*=6), acting on urges (10%; *n*=2), persistence (25%; *n*=5), and age of the offender (10%; *n*=2). See appendix F for a list of all definitions provided for pedophilia.

Hebephilia. Of the participants who provided a definition for hebephilia, 38.09% (*n*=8) included information about the victim being "pubescent,"14.29% (*n*=3) stated that the individual would be "post-pubescent," and 4.76% (*n*=1) stated they would be "pre-pubescent." Two individuals also noted aspects of legality in their definitions (e.g., "not the age of consent"). Five different age ranges were provided: 11-14 (*n*=2), 11-15 (*n*=1), 12-15 (*n*=1), up to 16 (*n*=1), and up to 18 (*n*=2). Other information in the definitions included: distress/impairment (14.28%; *n*=3), duration (4.76%; *n*=1), persistence (19.05%; *n*=4), and presence of secondary sex characteristics (9.52%; *n*=2). See appendix F for a list of all definitions provided for hebephilia.

Nonconsent. Of the participants who provided a definition for nonconsent, 56.25% (*n*=9) indicated that non-consent would be defined by a lack of consent. Four individuals (25%) included that force, violence, or intimidation would be seen. One participant described diagnosing a client after they stated, "Doc, I'm just not turned on unless the woman is frightened." Other information in the definitions included: persistence (31.25%; *n*=5), distress/impairment (12.50%; *n*=2), duration (12.50%; *n*=2), partner age/ characteristics (12.50%; *n*=2), and coercion (6.25%; *n*=1). One individual defined the diagnosis of nonconsent as "rape, sexual assault." See appendix F for a list of all definitions provided for nonconsent.

Statutory rape. Of the participants who provided a definition for the diagnosis of statutory rape (*n*=8), 50% (*n*=4) indicated the victim would be "underage" or a "minor." Five respondents included terms such as "rape," "assault," "force," "no consent," or "coercion" in their definitions. While two individuals specifically noted a lack of consent, one stated that the individual would have consented. One participant provided the same definition for nonconsent and statutory rape. See appendix F for a list of all definitions provided for statutory rape.

Part Three: MHPs Diagnostic Decisions

A coding manual was developed following a preliminary line-by-line analysis of the reasons provided by MHPs for having diagnosed or not diagnosed pedophilia, hebephilia, nonconsent, and statutory rape.

Diagnostic rationale: Pedophilia. Four individuals provided a reason as to why they had not diagnosed pedophilia. These responses included information about being unable to determine the truth (*n*=1), not having been exposed to an individual meeting the criteria (*n*=1), having others provide diagnoses (*n*=1), and never being "called upon" to give a diagnosis (*n*=1). See appendix G for a complete list of explanations provided for never having diagnosed pedophilia.

Eighteen individuals provided explanations as to why they had diagnosed pedophilia. Eight (44.44%) stated that they had applied this diagnosis based on evidence of past behavior or records. Seven (38.89%) indicated that their decision was influenced by self-reported attraction to young children. Additional explanations noted the inclusion of pedophilia in the DSM (27.78%; *n*=5), and the results of other assessment measures (e.g., psychological testing; 11.11%; *n*=2). One individual (5.57%; *n*=1) indicated they had diagnosed pedophilia for treatment planning. Another MHP specified that they would not diagnose pedophilia if the individual had "urges or impulses to have sexual contact with children but has not acted on them." One MHP equated this diagnosis with criminal behavior when they stated "they were pedophiles – specifically, sexual offenders." See appendix H for a complete list of explanations provided for having diagnosed pedophilia.

Diagnostic rationale: Hebephilia. Eleven individuals provided a reason for never having diagnosed hebephilia. Four (36.36%) of these respondents explained that they had not diagnosed hebephilia because it was not accepted, not in the DSM, or not supported by research. Other explanations included that hebephilia had not been applicable to their clients (18.18%; *n*=2), that they used "unspecified" in these situations (18.18%; *n*=2), and that they had not been asked to give a diagnosis (9.09%; *n*=1). One respondent (9.09%; *n*=1) stated "the court did not want to hear it – for legal reasons as compared to clinical ones." See appendix G for a complete list of explanations provided for never having diagnosed hebephilia.

Nine individuals provided explanations as to why they had diagnosed hebephilia. Four (44.44%) stated that they had applied this diagnosis based on evidence of past behavior or records. Other explanations included that their decisions were influenced by self-reported attraction (22.22%; *n*=2), attraction to those 14-17 who are "fully developed sexually" (11.11%;

n=1), or attraction to pubescent individuals (11.11%; *n*=1). One respondent (11.11%; *n*=1) specified that they diagnosed hebephilia because they were "asked to do so." See appendix H for a complete list of explanations provided for having diagnosed hebephilia.

Diagnostic rationale: Nonconsent. Eight individuals provided reasons as to why they had never diagnosed nonconsent. Three (37.50%) of these respondents explained that they had not diagnosed nonconsent because it was not accepted, not in the DSM, or not supported by research. Other explanations included that nonconsent had not been applicable to their clients (12.50%; *n*=1), and that they were not asked to give a diagnosis, or do not diagnose (37.5%; *n*=3). One respondent attributed not diagnosing in part to legal issues, when they stated, "a defense attorney will naturally challenge this diagnosis." See appendix G for a complete list of explanations provided for never having diagnosed nonconsent.

Nine individuals provided reasons for having diagnosed nonconsent. Six (66.67%) stated that they had applied this diagnosis based on evidence of past behavior or records. Other reasons included self-reported attraction to nonconsent/ force (22.22%; *n*=2), and results of other assessment measures (e.g., psychological testing; 22.22%; *n*=2). One respondent specified that they diagnosed nonconsent because "It was early in my career when I was prone to making such idiotic mistakes." Another noted, "…just because politically the DSM does not include various specific paraphilic diagnoses, the reasons for these decisions do not in my opinion indicate that the disorder itself does not exist, but that caution should be used in applying the diagnosis." See appendix H for a complete list of explanations provided for having diagnosed nonconsent.

Diagnostic rationale: Statutory rape. Six individuals provided a reason for never having diagnosed statutory rape. Three (50%) of these respondents explained that they had not diagnosed statutory rape because it was not accepted, not in the DSM, or not supported by

research. Other explanations included: that statutory rape had not been applicable to their clients (16.67%; *n*=1), they have used "unspecified" in these situations instead (16.67%; *n*=1), and that they had not been asked to give a diagnosis, or do not diagnose (33.33%; *n*=2). One respondent attributed not diagnosing in part to legal issues, when they stated, "Too controversial, more than likely to be challenged by defense counsel." See appendix G for a complete list of explanations provided for never having diagnosed statutory rape.

One individual endorsed having diagnosed statutory rape. They indicated that this decision was based on "interview, victim statements."

Diagnostic methods. When diagnosing pedophilia, MHPs used an average of 4.83 methods. Ten respondents (58.82%) indicated documentation was the most important method for diagnosing pedophilia. An average of 6 methods were used by MHPs when diagnosing hebephilia. Four participants (40%) indicated that structured/semi-structured interviews were the most important method for diagnosing hebephilia. When diagnosing nonconsent, an average of 4.4 methods were utilized. Eight of the nine individuals who had diagnosed nonconsent (88.89%) indicated documentation was the most important method they used. Table 5 provides information on the methodology ranked as most important in diagnosing pedophilia, hebephilia, and nonconsent. Table 6 provides information on the number of participants utilizing each method in their evaluations.

Table 5

Frequency of Methods Ranked as Most Important by Mental Health Professionals When Diagnosing Pedophilia, Hebephilia, and Nonconsent

Method	Diagnostic Category		
	Pedophilia (*n*=18)	Hebephilia (*n*=9)	Nonconsent (*n*=9)
Documents	55.56% (10)	22.22% (2)	88.89% (8)
Historical			
Psychiatric	11.11% (2)	11.11% (1)	0% (0)
Structured/ Semi-Structured Interviews	33.33% (6)	44.44% (4)	0% (0)
Unstructured Interviews	0% (0)	11.11% (1)	0% (0)
Phallometric Testing	0% (0)	0% (0)	0% (0)
IQ/ Neurological Tests	0% (0)	0% (0)	0% (0)
Multi-Scale Inventories	0% (0)	0% (0)	0% (0)
Personality Tests	0% (0)	11.11% (1)	0% (0)
Other	0% (0)	11.11% (1)	11.11% (1)
Documents	55.56% (10)	22.22% (2)	88.89% (8)
Historical			
Psychiatric	11.11% (2)	11.11% (1)	0% (0)
Structured/ Semi-Structured Interviews	33.33% (6)	44.44% (4)	0% (0)
Unstructured Interviews	0% (0)	11.11% (1)	0% (0)
Phallometric Testing	0% (0)	0% (0)	0% (0)
IQ/ Neurological Tests	0% (0)	0% (0)	0% (0)
Multi-Scale Inventories	0% (0)	0% (0)	0% (0)
Personality Tests	0% (0)	11.11% (1)	0% (0)
Other	0% (0)	11.11% (1)	11.11% (1)

Table 6

Methods Utilized by MHPs When Diagnosing Pedophilia, Hebephilia, and Nonconsent

Method	Diagnostic Category		
	Pedophilia (*n*=18)	Hebephilia (*n*=9)	Nonconsent (*n*=9)
Documents	100% (18)	100% (9)	100% (9)
Historical Psychiatric	88.89% (16)	77.78% (7)	77.78% (7)
Structured/ Semi-Structured Interviews	94.44% (17)	100% (9)	100% (9)
Unstructured Interviews	50.00% (9)	66.67% (6)	55.56% (5)
Phallometric Testing	27.78% (5)	22.22% (2)	N/A
IQ/ Neurological Tests	22.22% (4)	55.56% (5)	11.11% (1)
Multi-Scale Inventories	44.44% (8)	77.76% (7)	33.33% (3)
Personality Tests	33.33% (6)	77.76% (7)	22.22% (2)
Other	22.22% (4)	22.22% (2)	44.44% (4)
Documents	100% (18)	100% (9)	100% (9)
Historical Psychiatric	88.89% (16)	77.78% (7)	77.78% (7)
Structured/ Semi-Structured Interviews	94.44% (17)	100% (9)	100% (9)
Unstructured Interviews	50.00% (9)	66.67% (6)	55.56% (5)
Phallometric Testing	27.78% (5)	22.22% (2)	N/A
IQ/ Neurological Tests	22.22% (4)	55.56% (5)	11.11% (1)
Multi-Scale Inventories	44.44% (8)	77.76% (7)	33.33% (3)
Personality Tests	33.33% (6)	77.76% (7)	22.22% (2)
Other	22.22% (4)	22.22% (2)	44.44% (4)

Diagnostic processes in SVP evaluations. Respondents who had conducted SVP evaluations (*n*=9) were asked to report the frequency at which they assess for and apply various diagnoses in these settings. Information regarding the assessment of various categories is reported in Appendix I. The most frequently assessed diagnostic categories, indicated as being used "always," were substance abuse (88.89%; *n*=8) and paraphilias (88.89%; *n*=8). Frequency of diagnoses applied in SVP evaluations are detailed in Appendix J. Paraphilias were the most common diagnosis to be applied in 100% of cases.

Part Four: Diagnostic Frequency and Settings

Pedophilia. Eighteen **(**81.81%) participants had applied a diagnosis of pedophilia in the past. MHPs with no experience conducting SVP evaluations who had diagnosed pedophilia (*n*=9) applied the diagnosis in approximately 8.47% of their cases. MHPs with a history of diagnosing pedophilia and conducting SVP evaluations (*n*=9) diagnosed pedophilia in approximately 18.82% of their work. Differences were seen in that those working for the state (*n*=7) reported diagnosing pedophilia in SVP evaluations in approximately 15% of cases; while MHPs who had worked primarily for the defense (*n*=2) endorsed diagnosing pedophilia in these settings .02% of the time.

All SVP evaluators (*n*=9) had diagnosed pedophilia in SVP evaluations. Those who endorsed diagnosing pedophilia in SVP evaluations had also diagnosed the disorder in forensic treatment settings (*n*=5), general evaluations (*n*=4), and non-forensic treatment settings (*n*=4). Of the MHPs who had diagnosed pedophilia (*n*=18), 66.67% (*n*=12) endorsed applying the label in forensic treatment settings. Ten respondents (55.56%) stated they had diagnosed pedophilia in general evaluative settings. Approximately 39% (*n*=7) of MHPs had diagnosed pedophilia in non-forensic treatment settings.

Hebephilia. Ten (43.48%) participants had applied a diagnosis of hebephilia in the past. MHPs with no experience conducting SVP evaluations who had diagnosed hebephilia (*n*=5) had applied this as a diagnosis in approximately 20.26% of cases. Two of these individuals reported having diagnosed hebephilia in 50% of their cases, which may have skewed these results. MHPs with a history of diagnosing hebephilia and conducting SVP evaluations (*n*=4) had diagnosed hebephilia in approximately 18.78% of their work. Differences were seen in that those working for the state (*n*=3) reported having diagnosed hebephilia in SVP evaluations in approximately 13.67% of cases while the respondent working primarily for the defense (*n*=1) reported never having diagnosed hebephilia in these settings.

Five (55.56%) SVP evaluators endorsed having diagnosed hebephilia in SVP evaluations. Two (40%) of these individuals endorsed diagnosing hebephilia exclusively in SVP settings. SVP evaluators had also diagnosed the disorder in forensic treatment settings (*n*=3), general evaluations (*n*=3), and non-forensic treatment settings (*n*=3). Hebephilia was endorsed as being diagnosed in forensic treatment settings by seven (77.78%) respondents. Six respondents (66.67%) stated they had diagnosed hebephilia in general evaluative settings. Three (33.33%) of the MHPs who diagnosed hebephilia endorsed doing so in non-forensic treatment settings.

Nonconsent. Nine **(**39.13%) participants had applied a diagnosis of nonconsent in the past. MHPs with no experience conducting SVP evaluations (*n*=3) applied a diagnosis of non-consent in approximately 6.9% of their cases. MHPs with a history of diagnosing nonconsent and conducting SVP evaluations (*n*=6) had diagnosed nonconsent in approximately 21.91% of their work. Differences were seen in that those working for the state (*n*=4) had diagnosed nonconsent in SVP evaluations in approximately 25.59% of their cases; those working primarily for the defense (*n*=2) endorsed diagnosing nonconsent in these settings .05% of the time.

Six (66.67%) SVP evaluators endorsed having diagnosed nonconsent in SVP evaluations. Five (83.33%) of these individuals endorsed diagnosing nonconsent exclusively in SVP evaluations. The one respondent who had used this diagnosis in SVP evaluations had also diagnosed the disorder in forensic treatment settings (*n*=1). Nonconsent was endorsed as being diagnosed in forensic treatment settings by three (33.33%) respondents. Two respondents (22.22%) stated they had diagnosed nonconsent in general evaluations, and endorsed doing so in this setting 80% and 100% of the times in which they applied this diagnosis. No respondents had diagnosed nonconsent in non-forensic treatment settings.

Statutory rape. Only one participant stated they had applied a diagnosis of statutory rape in the past. They stated they had provided this diagnosis in 10% of their cases in a forensic treatment setting, based on interviews and victim statements.

Part Five: Level of Support for Diagnoses

One-way between subjects ANOVA's were conducted to compare legal affiliation (i.e., state, defense, or neither) and support for pedophilia, hebephilia, nonconsent, and statutory rape diagnoses. Level of support was measured by agreement with various statements on a 6-point Likert scale, with 6 indicating the MHP "strongly agreed" with the use of the diagnosis (1) as a mental disorder, (2) in the DSM, (3) in SVP evaluations, and (4) in non-forensic treatment settings.

Pedophilia. The mean level of support for pedophilia as a 'mental disorder' was 5.36 on a 6-point Likert scale, indicating a high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support for pedophilia as a mental disorder (F= 2, 19) = 1.80, p = .192). The mean level of support for the inclusion of pedophilia in the DSM was 5.45,

signifying a high level of support. No significant differences between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense were identified (F= 1.32, 162) = 1.32, $p < .001$). The mean level of support for the use of pedophilia as a diagnosis in SVP evaluations was 5.18, corresponding with a high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support for the use of pedophilia as a diagnosis in SVP evaluations (F= 2, 19) = 1.33, $p = .289$). The mean level of support for pedophilia as a diagnosis for use in non-forensic treatment settings was 4.82, indicating a moderately high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of pedophilia for use in non-forensic treatment settings (F= 2, 19) = 1.329, $p < .288$). Mean levels of support for pedophilia based on legal affiliation can be found in Appendix K.

Hebephilia. The mean level of support for hebephilia as a 'mental disorder' was 4.43 on a 6-point Likert scale, corresponding with a moderately high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of hebephilia as a mental disorder (F= 2, 18) = .529 $p = .598$). The mean level of support for inclusion of hebephilia in the DSM was 4.38, signifying a moderately high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of hebephilia's inclusion in the DSM (F= 2, 18) = .693 $p = .513$). The mean level of support for the use of hebephilia as a diagnosis in SVP evaluations was 4.52, indicating a moderately high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the

defense regarding support of using hebephilia as a diagnosis in SVP evaluations (F= 2, 18) = 2.189 p = .141). The mean level of support for hebephilia as a diagnosis for use in non-forensic treatment settings was 4.43, corresponding with a moderately high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense (F= 2, 18) = .831 p = .189). Mean levels of support for hebephilia based on legal affiliation can be found in Appendix K.

Nonconsent. The mean level of support for nonconsent as a 'mental disorder' was 4.22 on a 6-point Likert scale, indicating a moderately high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of nonconsent as a mental disorder (F= 2, 15) = .529 p = .07). However, post-hoc comparisons using Tukey's HSD indicated that mean level of support for nonconsent as a mental disorder reported by those affiliated with the state (M=5.14, SD=1.22) differed significantly from the mean level of support reported by those affiliated with the defense (M=2.50, SD= .71). The mean level of support for the inclusion of nonconsent in the DSM was 4.28, corresponding with a moderately high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support for the inclusion of nonconsent in the DSM (F= 2, 15) = 3.60 p = .053). However, post-hoc comparisons using Tukey's LSD indicated that mean level of support for the inclusion of nonconsent in the DSM as reported by those affiliated with the state (M=5.29, SD=1.49) differed significantly from mean level of support reported by those affiliated with the defense (M=2.50, SD= 2.12). The mean level of support for the use of nonconsent as a diagnosis in SVP evaluations was 4.72, indicating a moderately high level of support. No significant differences were identified between MHPs

with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of using nonconsent as a diagnosis in SVP evaluations (F= 2, 15) = 2.137 p = .153). The mean level of support for the use of nonconsent in non-forensic treatment settings was 4.22, signifying a moderately high level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of nonconsent in non-forensic treatment settings (F= 2, 15) = .664 p = .529). Mean levels of support for nonconsent based on legal affiliation can be found in Appendix K.

Statutory rape. The mean level of support for statutory rape as a 'mental disorder' was 3.00 on a 6-point Likert scale, indicating a moderate level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of statutory rape as a mental disorder (F= 2, 5) = 1.127 p = .394). The mean level of support for statutory rape in the DSM was 3.00, corresponding with a moderate level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of statutory rape's inclusion in the DSM (F= 2, 5) = 1.624 p = .286). The mean level of support for the use of statutory rape as a diagnosis in SVP evaluations was 2.75, signifying a moderately low level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state, and those affiliated with the defense regarding support of using statutory rape as a diagnosis in SVP evaluations (F= 2, 5) = 2.527 p = .620). The mean level of support for statutory rape as a diagnosis for use in non-forensic treatment settings was 3.63, indicating a moderate level of support. No significant differences were identified between MHPs with no legal affiliation, those affiliated with the state,

and those affiliated with the defense regarding support of statutory rape in non-forensic treatment settings (F= 2, 5) = 1.053, p = .415). Mean levels of support for statutory rape based on legal affiliation can be found in Appendix K.

Discussion

The aim of the current study was to provide insight into MHPs knowledge, use, and application of the hebephilia and nonconsent diagnostic specifiers. We explored this issue in five parts. First, we addressed level of familiarity with various paraphilic labels. Next, we examined definitions provided for these diagnoses to gain insight into whether there was a shared understanding of hebephilia and nonconsent labels. We then analyzed diagnostic rationale and processes utilized in applying paraphilic diagnoses in SVP evaluations. We also examined MHPs support for these diagnoses, as well as the frequency and settings in which they were applied, to determine if an adversarial allegiance was present.

Part One: MHPs Familiarity with Diagnoses

All (100%; n=22) of the respondents in the current study reported having heard of pedophilia. One hundred percent (n=22) reported having heard of hebephilia and some 80% (n=18; 81.82%) had heard of nonconsent. Although sample size was insufficient and assumptions were violated, chi-square tests were conducted for thesis purposes to identify the existence of any emerging patterns in level of familiarity with these diagnoses (see appendix D). Contrary to our hypothesis, these tests failed to identify any significant differences in levels of familiarity for hebephilia, and nonconsent between those who had conducted SVP evaluations and those who had not. This suggests that prior literature asserting that these diagnoses were used almost exclusively in SVP contexts (King et al., 2014) may have been incorrect. However,

further research with a larger sample size is needed to make accurate conclusions regarding any differences in familiarity that may exist in relation to experience conducting SVP evaluations.

Part Two: MHPs Understanding of Diagnoses

Based on the definitions provided by MHPs, issues with diagnostic agreement were identified for hebephilia and nonconsent; however, it is important to note that issues with inter-rater agreement are not exclusive to OS paraphilic diagnoses, or paraphilic diagnoses generally. Literature indicates that even with medical diagnoses that have evidence based biological testing, ideal kappa values tend to fall between .6 and .8, with .4 to .2 being deemed acceptable (Kraemer et al., 2012). As such, it is important that expectations regarding DSM diagnoses are not set unrealistically high (Kraemer et al., 2012). Therefore, the present findings should be considered in light of the fact that low inter-rater reliability is generally deemed acceptable.

Pedophilia. Definitions of pedophilia provided by MHPs indicate consistency with the DSM-5, which defines pedophilia as being attracted to "pre-pubescent" individuals below age 13 (APA, 2013b). While the consistency in definitions supported our hypothesis, only one respondent provided a definition for pedophilia that included all three criteria outlined in the DSM-5 (APA, 2013b). This indicates that despite inclusion in the DSM, MHPs may still lack knowledge of the diagnostic criteria for paraphilic diagnoses. This further refutes claims proposed by researchers that inclusion of nonconsent and hebephilia in the DSM would increase diagnostic reliability (Stern, 2010; Thornton, 2010). However, as we asked MHPs not to utilize external sources when providing definitions, it is possible that clinicians who indicated incorrect age ranges or omitted certain criteria followed our instructions, but in practice would reference the DSM-5 to avoid making inaccurate diagnoses.

Hebephilia. While there are no formally established guidelines for diagnosing hebephilia, a recent definition proposed by Blanchard and colleagues (2008) stated that hebephilia is "the erotic preference for pubescent children," ages 11 or 12 to 14. Using this as a baseline of understanding, we identified that of those who included a stage of pubescence in their definition (*n*=12), 66.67% (*n*=8) stated that the attraction would be towards "pubescent" individuals. Of those who provided an age range in their definition (*n*=7), only 28.57% (*n*=2) provided the range of 11-14, as suggested by Blanchard and colleagues definition. Some 4.76% *(n*=1) provided a range of 11-15, 4.76% (*n*=1) provided a range of 12-15, and 43.56% (*n*=3) stated that hebephilia would apply to those attracted to individuals up to the age of 16 or 18. These concepts represent distinct stages of sexual development (Tanner, 1981) and suggest a lack of common understanding regarding how to define and recognize hebephilic interests. The lack of commonality in the definitions provided for hebephilia suggests insufficient inter-clinician understanding. Indeed, previous literature has identified poor inter-rater reliability among those diagnosing NOS paraphilias (Levenson, 2004; Perillo et al, 2014).

Nonconsent. While there are no formally established guidelines for diagnosing nonconsent, recent criteria proposed by the APA prior to the release of the DSM-5 stated that nonconsent/PCD involves sexual arousal *from* sexual coercion, resulting in distress, impairment, or forceful sexual behavior (APA, 2011 as cited in Zonana, 2011). Using this as a baseline of understanding, we identified that only one individual (6.25%) included aspects of coercion in their definition, and merely 12.50% (*n*=2) included aspects of distress or associated difficulties. Nine (56.25%) MHPs definitions included that the sexual attraction/activity would be "nonconsensual." The circularity of these definitions could imply that the diagnostic title itself allows clinicians to infer what nonconsent may mean, despite lacking an actual understanding of

the concept. Such circularity has been seen in definitions provided in the literature (e.g., King et al., 2014), and is concerning as it fails to differentiate "simple criminals" who commit rape from those who commit rape and have a nonconsent paraphilia (i.e., arousal resultant from force/coercion; Frances & First, 2011).

Statutory rape. Surprisingly, 36.36% (*n*=8) of MHPs in this sample indicated knowledge of "paraphilia other specified: statutory rape" and provided definitions for this mock diagnosis. However, five (62.50%) of these individuals included terms such as "rape," "no consent," and "force" in their definitions. Additionally, one individual provided the same definition for nonconsent and statutory rape, indicating that respondents may have conflated these terms, and/or confused legal terminology for a diagnostic specifier. Regardless, the endorsement of this specifier is concerning considering that it is a legal term and has never been proposed or considered as a diagnostic category. This may provide evidence that individuals are overly liberal in applying specifiers in evaluative settings. Future research should work towards establishing if this is an accurate interpretation of the results by proposing mock diagnoses that do not sound similar to legal terminology and identifying clinician response.

Part Three: MHPs Diagnostic Decisions

Diagnostic rationale. The most common reason for diagnosing pedophilia was use of historical behaviors and/or records (*n*=8). Rationale for diagnosing OS disorders yielded similar results, with four individuals citing the use of historical behaviors and/or records when diagnosing hebephilia, and six endorsing use of these materials when applying a label of nonconsent. These results support previous findings by Jackson and Hess (2007) that identified documentation as the most commonly utilized method for diagnosing mental abnormality in SVP

evaluations, and suggests that their results may generalize to OS paraphilias and diagnostic processes used in non-SVP related settings.

Of the 11 MHPs who had not diagnosed hebephilia, 36.36% (*n*=4) indicated that they had refrained from using this diagnosis because it was not accepted and/or not in the DSM. Similarly, 37.50% (*n*=3) stated they had not used the nonconsent specifier for this reason. These findings suggest that some MHPs refrained from applying diagnoses of hebephilia and nonconsent due to their exclusion from the DSM-5. Adding these disorders to the DSM may, therefore, increase their application in clinical settings, further pathologizing criminal behavior (Frances & First, 2011). Considering these results in light of previous findings noting issues with reliability, validity, and a lack of field studies (Balon, 2013; Levenson, 2004; Perillo et al., 2014), we are in agreement with previous decisions to exclude OS specifiers of nonconsent and hebephilia from the DSM.

Diagnostic methods. Results for pedophilia and nonconsent replicated previous findings (Jackson & Hess, 2007) in that documentation was considered the most important method utilized by clinicians applying these diagnostic labels. Our operationalization of documentation helped provide clarity regarding exactly which materials MHPs use when employing this methodology. By separating the construct of documentation previously used in the literature (i.e., Jackson & Hess, 2007) into two categories, "documentation (e.g., police records, victim statements)" and "historical psychiatric records," our findings were able to identify that the documents being utilized seem to focus on legal materials. This supports prior research that has suggested that nonconsent has been adopted to pathologize criminal behavior (Frances & First, 2011), suggesting issues with the diagnostic process in that labels are being applied based on criminal behaviors. Future research should obtain qualitative responses regarding the use of this

method to gain a better understanding of why legal materials are highly valued in diagnostic settings.

Our hypothesis was supported for hebephilia in that compared to pedophilia, a high number of methods on average (*n*=6) were used when making this diagnostic decision. These findings indicate that hebephilia may be less understood and/or more difficult to identify; or it may be that clinicians are more careful when using diagnoses that have not been formally established. However, our hypothesis was not supported when examining the methodology utilized for diagnosing nonconsent, as an average of only 4.4 methods were applied. The low number of methods used on average for nonconsent may be the result of the importance attributed to documentation.

Diagnostic processes in SVP evaluations. Assessment of substance abuse and paraphilias in SVP evaluations were found to be of equal importance in this sample, with 88.89% indicating they assess for these diagnoses in 100% of cases. These findings are similar to those identified by Jackson and Hess (2007), who found that 80.5% of their sample "always" assessed for paraphilias. Despite the high frequency at which MHPs are assessing for paraphilias, this diagnostic category was only applied "always" when evaluating for SVP civil commitment by 22.22% of evaluators. This is surprising considering that in order to meet commitment criteria, the mental abnormality applied must be linked to risk of sexual recidivism (Janus, 2000). This could mean one of two things. First, it could be that individuals are rarely assigning any diagnosis in SVP evaluations, concluding that the clients do not meet the criteria to be civilly committed. Second, it could implicate the use of various other diagnoses (e.g., personality disorders). Future research should determine in what percent of SVP evaluations MHPs are assigning a diagnosis to help clarify this relationship.

Part Four: Diagnostic Frequency and Settings

Frequency. As anticipated, SVP evaluators working for the state utilized OS diagnoses more than those working primarily for the defense. State evaluators were more likely to diagnose hebephilia, nonconsent, and the established diagnosis of pedophilia. Of the two evaluators in our study who indicated working primarily for the defense, neither had applied a diagnosis of hebephilia. While sample size was insufficient in establishing statistical significance, the numbers do appear to differ greatly (e.g., 25.59% of cases for state-retained versus .05% for defense-retained MHPs diagnosing nonconsent). These findings provide additional evidence for the theory of adversarial allegiance, suggesting that MHPs opinions tend to support the goals of the individuals for whom they work (Murrie et al., 2008; Murrie et al., 2013). This advances the literature, which previously focused on psychopathy and risk (e.g., Murrie et al., 2008; Murrie et al., 2013) by discovering a similar pattern among those diagnosing paraphilias.

Evidently, these findings have implications for MHPs working in SVP evaluations. The role of MHPs in this setting is to be impartial in identifying if an offender meets criteria for indefinite civil commitment (APA, Committee on Ethical Guidelines for Forensic Psychologists, 2010). However, the current findings suggest that MHPs hold biases based on the legal affiliation with whom they work. This adversarial allegiance has the ability to significantly impact those being evaluated. It may be that those working with the defense withhold applicable diagnoses in order to satiate their hiring party. Or, state affiliated MHPs may feel pressure to assign a diagnosis and if the client does not qualify for an established paraphilia (e.g., pedophilia), they may alter results, or be more willing to utilize OS diagnoses so the individual meets SVP criteria. This possibility has been supported in the literature by First (2010) who attributed the increased rate of false positive paraphilic diagnoses to misapplication of diagnostic criteria so that MHPs

could provide evidence for SVP civil commitment. These findings are further concerning when one considers that prior literature has identified state expert opinions are typically given more weight by legal decision makers (King et al., 2014).

Settings. Contrary to expectations, hebephilia had been diagnosed by MHPs in general sex offender evaluations, and forensic and non-forensic treatment settings. Similarly, nonconsent had been diagnosed in general sex offender evaluation and forensic treatment settings. These results contradict previous literature, which suggested that nonconsent was utilized almost exclusively in SVP contexts (King et al., 2014), and indicates that use of these controversial labels may be more widespread than previously assumed. However, it is also possible that the evaluations and forensic treatment settings were related to SVP contexts (e.g., risk assessments, in-prison/in-commitment treatment). Therefore, future research should clarify these uncertainties by asking the specific context of the setting in which OS specifiers are being applied.

Part Five: Level of Support for Diagnoses

Those who worked for the state tended to be more supportive of pedophilia, hebephilia, nonconsent, and statutory rape (i.e., as a mental disorder, inclusion in the DSM, use in SVP evaluations, and use in non-forensic treatment settings), but these findings were not statistically significant. The lack of significant differences identified in support of these diagnostic labels may be due to the small sample size; or it could be that biases based on legal affiliation are unconscious. That is, MHPs may be aware that they should be neutral in evaluations, but because of perceived pressure, unconsciously alter their findings to support the hiring party. If this were an unconscious process, level of support for the diagnoses would not be different based on legal affiliation. Future research employing experimental designs in which MHPs are led to believe

they have been hired by each legal party (i.e., defense and state) in different cases may be of use in clarifying this relationship.

Limitations and Directions for Further Research

Although the results of the current study provide important advancements in understanding how MHPs view and apply diagnoses, the strength of the findings are limited by the small sample size and unequivalent groups; particularly the fact that only two individuals had worked primarily for the defense. This is an issue that has been seen in previous research (Jackson & Hess, 2007), and may therefore implicate the existence of self-selection bias related to legal affiliation. Further, the inclusion of a MHP who had worked for both the state and defense may have impacted results. We assigned this respondent to a category based on self-report as to which legal affiliation they had most often worked (i.e., the defense). However, this self-report may have been inaccurate, and inclusion of a MHP with experience working for both sides of the system may have decreased significance in the results. Future studies may control for this possibility by analyzing data collected for MHPs who have worked solely with one legal affiliation.

Future research should also expand on the qualitative results identified in the current study. While this data provided important insights into MHPs understanding of paraphilic diagnoses, conducting in-depth interviews may be an effective way to clarify ambiguous responses and further enhance our knowledge of diagnostic processes and reasons for the application of paraphilic labels.

Additionally, as current findings support the existence of an adversarial allegiance in SVP evaluations, future research should address this problem by examining if there are methods, such as education about biases, that could be utilized to mitigate the impact of this effect.

Increasing the accuracy of MHPs diagnostic decisions in SVP evaluations would benefit offenders and the public alike by? ensuring individuals are receiving the appropriate amount of treatment and restrictions based on their risk to society. Policy makers should also examine this area to implement measures aimed at eliminating the impact of MHP biases to restore impartiality in legal proceedings. The existence of an adversarial allegiance may also be important for consideration in other areas of forensic psychology in which MHPs are assumed to be impartial experts (e.g., competency evaluations, custody battles). Future research should examine how the current findings generalize to these other areas of practice.

Conclusion

The purpose of the current study was to provide insight into MHPs knowledge, use, and application of hebephilia and nonconsent diagnostic labels. Inter-clinician inconsistencies and deviations from descriptions suggested in the literature indicated that MHPs are unclear regarding how hebephilia and nonconsent should be operationalized. The lack of understanding communicated by these results has implications for the applicability of these diagnoses, suggesting that MHPs may apply these labels in a subjective manner. Therefore, high rates of false positive diagnoses may be found among those evaluated for SVP civil commitment (First, 2010). Considering the consequences of receiving such a sentence (Perillo et al., 2014), these findings imply that MHPs considering diagnoses of hebephilia and nonconsent in SVP evaluations should exercise extreme caution until there is evidence of a communal understanding.

Further, the importance attributed to documentation (e.g., police records, victim statements) demonstrated a reliance on legal materials by MHPs diagnosing pedophilia and nonconsent, and may support the pathologization of “simple criminal” behaviors (Frances &

First, 2011). This suggests the need for guidelines in diagnostic evaluations to ensure reliable conclusions are reached based on accurate predictors of risk.

The current study also yielded results regarding MHPs biases based on their legal affiliation. In line with previous research (Murrie et al., 2008; Murrie et al., 2013), findings identified the existence of an adversarial allegiance, in that those who worked for the state utilized diagnoses of hebephilia, nonconsent, and pedophilia more often than those who worked primarily for the defense. This suggests that biases influence diagnostic decisions in SVP evaluations, which may lead to negative consequences for defendants, particularly when one considers that the literature has noted more weight is typically given to state-retained expert opinions (King et al., 2014).

Overall, the results of the current research provide advancements in our understanding of the contested diagnoses of hebephilia and nonconsent. Based on the lack of agreement amongst clinicians, coupled with the prevalence of bias in the decision making process, it can be concluded that the use of such labels contribute to unreliable results. Therefore, diagnoses of hebephilia and nonconsent should not be permissible in court until evidence of a concrete understanding can be obtained, and a method for controlling clinician bias can be implemented. Seeing as similar results of an adversarial allegiance were identified for pedophilia, policy makers should consider methods in which this tendency to favor the hiring party can be counteracted for all diagnoses, rather than focusing solely on OS specifiers.

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Appendix A

Recruitment E-mail

To Whom it May Concern:

My name is Cecilia Allan. I am a Master's student at John Jay College of Criminal Justice in New York City, NY. I am currently working with Dr. Cynthia Calkins to complete my thesis and we are hoping you could be of help. We are looking to examine how mental health professionals conduct sexual offender civil commitment evaluations, particularly how they assign paraphilic diagnoses. **We were hoping you would be kind enough to forward our survey (via Listerv) to members of your ATSA chapter or provide us with a list of emails so that we may reach out to professionals in your state.** I have attached a link to the survey and consent form should you be interested in learning more about the project. **The survey should take approximately 10-15 minutes to complete, and for their participation**, $2.00 will be donated to an organization of their choice. At the conclusion of the study, participants be asked to choose one of four organizations (Red Cross, American Cancer Society, Alzheimer's Association, American Society for the Prevention of Cruelty to Animals) to which they would like to donate.

https://www.surveymonkey.com/r/expertsurvey_p

I look forward to hearing from you soon.

Best Regards,
Cecilia Allan

Appendix B
Consent Form

THE CITY UNIVERSITY OF NEW YORK
John Jay College of Criminal Justice
Department of Psychology

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of Research Study: Paraphilias: A Survey of Experts

Principal Investigator: Cecilia Allan, B.A., Psychology

Faculty Advisor: Cynthia Calkins, PhD, Clinical Psychology, Professor

You are being asked to participate in this research study because you are a mental health professional working with individual's accused of, or with a criminal history of, sexual offending.

Purpose: The purpose of this research study is to examine mental health professional's opinions towards and use of paraphilic diagnoses.

Procedures: If you volunteer to participate in this research study, we will ask you to complete an online survey. You will be asked both open-ended and close-ended questions. We anticipate it will take you approximately 10-15 minutes to complete the survey.

Time Commitment: Your participation in this research study is expected to last for a total of 10-15 minutes.

Potential Risks or Discomforts: The foreseeable risks associated with participation in this study are minimal. There is a minimal chance of breaches in confidentiality. However, no directly identifiable information (i.e., name, birth date) will be collected, reducing the possibility that responses can be linked to the respondent. Research procedures described above may involve risks that cannot be anticipated at this time. If we learn of anything that may affect your willingness to participate, you will be notified in a timely manner.

Potential Benefits: You will receive no direct benefits from your participation. The results of this research may benefit society by increasing understanding of the diagnostic process for paraphilic disorders.

Payment for Participation: For your participation, $2.00 will be donated to an organization of your choice. At the conclusion of the study, you will be asked to choose from one of four organizations (Red Cross, American Cancer Society, Alzheimer's Association, American Society for the Prevention of Cruelty to Animals) to which you would like to donate.

Confidentiality: We will make our best efforts to maintain confidentiality of any information

that is collected during this research study, and that can identify you. We will disclose this information only with your permission or as required by law. To protect confidentiality, no identifying information will be requested, and links between participants and responses will not be retained. Data will be collected from Survey Monkey and downloaded on to a password-protected workbook and saved on a locked laptop. Only the principle investigator will have access to the workbook password and laptop. The workbook will be de-identified, as no identifying information will be attached to participant responses. IP addresses are automatically collected by Survey Monkey. While IP addresses can identify an individual, no other identifying information will be obtained. Additionally, this information will be deleted before saving the workbook, therefore, IP addresses will not be tracked or reported anywhere.
The research team, authorized CUNY staff, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information. Publications and/or presentations that result from this study will not identify you by name.

Participants' Rights: Your participation in this research study is entirely voluntary. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. You can decide to withdraw your consent and stop participating in the research at any time, without any penalty.

Questions, Comments or Concerns: If you have any questions, comments or concerns about the research, you can talk to one of the following researchers:

Cecilia Allan, cecilia.allan@jjay.cuny.edu
Cynthia Calkins, ccalkins@jjay.cuny.edu

If you have questions about your rights as a research participant, or you have comments or concerns that you would like to discuss with someone other than the researchers, please call the CUNY Research Compliance Administrator at 646-664-8918. Alternately, you can write to:

CUNY Office of the Vice Chancellor for Research
Attn: Research Compliance Administrator
205 East 42nd Street
New York, NY 10017

Consent of Participant: If you agree to participate in this research study, please select "agree" below to continue to the survey.

Appendix C

Survey Administered to Mental Health Professionals via Survey Monkey

Paraphilias: A Survey of Experts

Section I

Pedophilia

Have you heard of the diagnosis pedophilia? Yes No *(if no directed to Paraphilia Other Specified- Hebephilia)*

How familiar are you with the term Pedophilia?

Unfamiliar Somewhat Familiar Quite Familiar Very Familiar

In your own words, provide a definition for Pedophilia *(please do not use external resources to assist with your definition)*

_____
_____

Have you ever provided a diagnosis of Pedophilia? Yes No

If no, please provide your rationale for having never given the diagnosis of Pedophilia.

_____
_____

If yes, in approximately what percent of your cases have you provided this diagnosis? ____

If yes, what was your rationale for providing the diagnosis of Pedophilia?

_____
_____

If yes, using percentages, please estimate the frequency with which you have applied this diagnosis in each setting.
Note: *this should add up to 100% - e.g., if you have applied the diagnosis twice (once in a sexual offender civil commitment evaluation and once in non-forensic practice), each corresponding category would receive a value of 50%.*
Sexual offender civil commitment evaluations
Forensically oriented treatment settings *(e.g., mandated treatment, treatment provided in a correctional facility)*
General sex offender evaluation
Non-forensic therapeutic practice *(e.g., voluntary outpatient therapy)*
Other: **specify**

If yes, please select all the methods you utilize when diagnosing Pedophilia:

Documentation (e.g., police records, victim statement)
Historical psychiatric records (prior diagnoses)
Structured or semi-structured clinical interview
Unstructured clinical interview
IQ and neuropsychological testing
Objective and/or projective personality tests
Multi-scale inventories
Plethysmograph or preferential viewing time
Other: **specify**

Please rank the methods you utilize in order of importance.
** ranking system which provides list of items selected in previous question**

Please indicate your level of agreement or disagreement with the following statements:

1. Pedophilia is a mental disorder.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

2. Pedophilia is a mental disorder that should be included in the DSM.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

3. Pedophilia is an appropriate diagnosis for use in sexual offender civil commitment evaluations.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

4. Pedophilia is an appropriate diagnosis for use in non-forensic settings.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

Paraphilia Other Specified- Hebephilia

Have you heard of the diagnosis Paraphilia Other Specified- Hebephilia?

Yes No *(if no, directed to Paraphilia Other Specified- Nonconsent)*

How familiar are you with the term Paraphilia Other Specified- Hebephilia?

Unfamiliar Somewhat Familiar Quite Familiar Very Familiar

In your own words, provide a definition for Paraphilia Other Specified- Hebephilia?
(please do not use external resources to assist with your definition)

_____
_____

Have you ever provided a diagnosis of Paraphilia Other Specified- Hebephilia? Yes
No

If no, please provide your rationale for having never given the diagnosis of Paraphilia Other Specified- Hebephilia.

_____
_____

If yes, in approximately what percent of your cases have you provided this diagnosis? ____

If yes, what was your rationale for providing the diagnosis of Paraphilia Other Specified-Hebephilia?

_____
_____

If yes, using percentages, please estimate the frequency with which you have applied this diagnosis in each setting.
Note: *this should add up to 100% - e.g., if you have applied the diagnosis twice (once in an sexual offender civil commitment evaluation and once in non-forensic practice), each corresponding category would receive a value of 50%.*
Sexual offender civil commitment evaluations
Forensically oriented treatment settings *(e.g., mandated treatment, treatment provided in a correctional facility)*
General sex offender evaluation
Non-forensic therapeutic practice *(e.g., voluntary outpatient therapy)*
Other: **specify**

If yes, please select all the methods you utilize when diagnosing Paraphilia Other Specified-Hebephilia:

Documentation (e.g., police records, victim statement)
Historical psychiatric records (prior diagnoses)
Structured or semi-structured clinical interview
Unstructured clinical interview
IQ and neuropsychological testing
Objective and/or projective personality tests
Multi-scale inventories
Plethysmograph or preferential viewing time
Other: **specify**

Please rank the methods you utilize in order of importance.
** ranking system which provides list of items selected in previous question**

Please indicate your level of agreement or disagreement with the following statements:

1. Paraphilia Other Specified- Hebephilia is a mental disorder.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

2. Paraphilia Other Specified- Hebephilia is a mental disorder that should be included in the DSM.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

3. Paraphilia Other Specified- Hebephilia is an appropriate diagnosis for use in sexual offender civil commitment evaluations.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

4. Paraphilia Other Specified- Hebephilia is an appropriate diagnosis for use in non-forensic settings.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

Paraphilia Other Specified- Nonconsent

Have you heard of the diagnosis Paraphilia Other Specified- Nonconsent?

Yes No *(if no, directed to Paraphilia Other Specified- Statutory Rape)*

How familiar are you with the term Paraphilia Other Specified- Nonconsent?

Unfamiliar Somewhat Familiar Quite Familiar Very Familiar

In your own words, provide a definition for Paraphilia Other Specified- Nonconsent?
(please do not use external resources to assist with your definition)

_____

_____

Have you ever provided a diagnosis of Paraphilia Other Specified- Nonconsent? Yes No

If no, please provide your rationale for having never given the diagnosis of Paraphilia Other Specified- Nonconsent.

_____
_____

If yes, in approximately what percent of your cases have you provided this diagnosis? ____

If yes, what was your rationale for providing the diagnosis of Paraphilia Other Specified-Nonconsent?

_____
_____

If yes, using percentages, please estimate the frequency with which you have applied this diagnosis in each setting.
Note: *this should add up to 100% - e.g., if you have applied the diagnosis twice (once in an sexual offender civil commitment evaluation and once in non-forensic practice), each corresponding category would receive a value of 50%.*
Sexual offender civil commitment evaluations
Forensically oriented treatment settings *(e.g., mandated treatment, treatment provided in a correctional facility)*
General sex offender evaluation
Non-forensic therapeutic practice *(e.g., voluntary outpatient therapy)*
Other: **specify**

If yes, please select all the methods you utilize when diagnosing Paraphilia Other Specified-Nonconsent:

Documentation (e.g., police records, victim statement)
Historical psychiatric records (prior diagnoses)
Structured or semi-structured clinical interview
Unstructured clinical interview
IQ and neuropsychological testing
Objective and/or projective personality tests
Multi-scale inventories
Plethysmograph or preferential viewing time
Other: **specify**

Please rank the methods you utilize in order of importance.
** ranking system which provides list of items selected in previous question**

Please indicate your level of agreement or disagreement with the following statements:

1. Paraphilia Other Specified- Nonconsent is a mental disorder.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

2. Paraphilia Other Specified- Nonconsent is a mental disorder that should be included in the DSM.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

3. Paraphilia Other Specified- Nonconsent is an appropriate diagnosis for use in sexual offender civil commitment evaluations.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

4. Paraphilia Other Specified- Nonconsent is an appropriate diagnosis for use in non-forensic settings.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

Paraphilia Other Specified- Statutory Rape

Have you heard of the diagnosis Paraphilia Other Specified- Statutory Rape?

Yes No *(if no, directed to Section II)*

How familiar are you with the term Paraphilia Other Specified- Statutory Rape?

Unfamiliar Somewhat Familiar Quite Familiar Very Familiar

In your own words, provide a definition for Paraphilia Other Specified- Statutory Rape?

(please do not use external resources to assist with your definition)

_____

_____

Have you ever provided a diagnosis of Paraphilia Other Specified- Statutory Rape?

Yes No

If no, please provide your rationale for having never given the diagnosis of Paraphilia Other Specified- Statutory Rape.

_____

_____

If yes, in approximately what percent of your cases have you provided this diagnosis? ____

If yes, what was your rationale for providing the diagnosis of Paraphilia Other Specified- Statutory Rape?

_____

_____

If yes, using percentages, please estimate the frequency with which you have applied this diagnosis in each setting.
Note: *this should add up to 100% - e.g., if you have applied the diagnosis twice (once in an sexual offender civil commitment evaluation and once in non-forensic practice), each corresponding category would receive a value of 50%.*
Sexual offender civil commitment evaluations
Forensically oriented treatment settings *(e.g., mandated treatment, treatment provided in a correctional facility)*
General sex offender evaluation
Non-forensic therapeutic practice *(e.g., voluntary outpatient therapy)*
Other: **specify**

If yes, please select all the methods you utilize when diagnosing Paraphilia Other Specified- Statutory Rape:

Documentation (e.g., police records, victim statement)
Historical psychiatric records (prior diagnoses)
Structured or semi-structured clinical interview
Unstructured clinical interview
IQ and neuropsychological testing
Objective and/or projective personality tests
Multi-scale inventories
Plethysmograph or preferential viewing time
Other: **specify**

Please rank the methods you utilize in order of importance.
** ranking system which provides list of items selected in previous question**

Please indicate your level of agreement or disagreement with the following statements:

1. Paraphilia Other Specified- Statutory Rape is a mental disorder.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

2. Paraphilia Other Specified- Statutory Rape is a mental disorder that should be included in the DSM.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

3. Paraphilia Other Specified- Statutory Rape is an appropriate diagnosis for use in sexual offender civil commitment evaluations.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

4. Paraphilia Other Specified- Statutory Rape is an appropriate diagnosis for use in non-forensic settings.

Strongly Disagree Disagree Somewhat disagree

Somewhat agree Agree Strongly Agree

Section II

Have you ever conducted a sexual offender civil commitment evaluation pursuant to sexual offender civil commitment legislation?

Yes No *(if no, directed to Section III)*

When conducting sexual offender civil commitment evaluations, how frequently do you <u>assess for</u> the following diagnoses:

1. Substance Abuse

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%)

2. Paraphilias

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%)

3. Personality disorders

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%)

4. Developmental or cognitive disorders

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%)

5. Other DSM-5 disorders

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%)

When conducting sexual offender civil commitment evaluations, how frequently do you <u>apply</u> a diagnosis in the following categories:

1. Substance abuse

Never (0%) Rarely (1-10%) Sometimes (11-40%)

Frequently (41-80%) Most of the time (81-99%) Always (100%

2. Paraphilias

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%

3. Personality disorders

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%)

4. Developmental or cognitive disorders

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%

5. Other disorders

Never (0%) Rarely (1-10%) Sometimes (11-40%)
Frequently (41-80%) Most of the time (81-99%) Always (100%)

What is your primary method for assessing/diagnosing DSM-5 disorders (apart from paraphilias) in sexual offender civil commitment evaluations?

Documentation *(e.g., police records, victim statement)*
Historical psychiatric records *(e.g., prior diagnoses)*
Structure or semi-structured clinical interview
Unstructured interview
IQ and neuropsychological testing
Objective and/or projective personality tests
Multi-scale inventories
I don't routinely assess for DSM-5 diagnoses apart from paraphilias
Other: **specify**

In which jurisdictions have you conducted sex offender civil commitment evaluations? Please select all that apply.

Arizona
California
Florida
Illinois
Iowa
Kansas
Massachusetts
Minnesota
Missouri
Nebraska

New Hampshire
New Jersey
New York
North Dakota
Pennsylvania
South Carolina
Texas
Virginia
Washington
Wisconsin
District of Columbia
Federal (i.e., Bureau of Prisons)

Please indicate the number of sexual offender civil commitment evaluations you have conducted. _____

For whom have you typically been hired when conducting sexual offender civil commitment evaluations?
State-contracted Retained by the Prosecution
Retained by the Defense Other: **specify**

If you have been hired by multiple sources, please indicate for whom you have primarily worked: State-Contract Retained by the Prosecution
Retained by the Defense

If you have been hired by multiple sources, please indicate the approximate percentage of evaluations you have conducted for each.
State-Contracted: ____%
Retained by the Prosecution: ___%
Retained by the Defense: ___%

Section III: Demographic Information

In which of the following areas do you typically practice? Please select all that apply.
Research
Teaching
Treatment
Evaluation
Other: **specify**

Would you consider yourself someone who regularly teaches or does research in the field of sexual offending? Yes No

Would you consider yourself someone who regularly evaluates, diagnoses, or treats sex offenders? Yes No

What percent of your practice is diagnosing or treating sexual offenders? _____

How many years of experience do you have conducting sexual offender civil commitment evaluations pursuant to sexual offender civil commitment legislation? _____

How many years of experience do you have conducting forensic evaluations with sex offender populations that are unrelated to sexual offender civil commitment legislation *(e.g., risk assessments, parole eligibility, sentencing mitigation)*?
_____

What is your age? _____

With which gender do you identify? Male Female Other: **specify**

With which race do you identify? African American Asian Hispanic White Other: **specify**

Which, if any, degree(s) do you hold?
M.D
PhD
PsyD
J.D
Other: **specify**

Thank you for completing this survey!

For your participation, $2.00 will be donated to an organization of your choice. Please select which of the following three organizations to which you would like to donate:

Red Cross
American Cancer Society
Alzheimer's Association
American Society for the Prevention of Cruelty to Animals (ASPCA)

Appendix D

Chi Square Analysis for Level of Familiarity

Table 1

Mental Health Professionals Level of Familiarity with Pedophilia

	Reported Level of Familiarity			
Group	Unfamiliar	Somewhat Familiar	Quite Familiar	Very Familiar
SVP Evaluators (*n*= 9)	0	0	1	8
Non-Evaluators (*n*=13)	0	0	4	9

χ^2 (2) = 1.170, *p* = .279

Table 2

Mental Health Professionals Level of Familiarity with Hebephilia

	Reported Level of Familiarity			
Group	Unfamiliar	Somewhat Familiar	Quite Familiar	Very Familiar
SVP Evaluators (*n*= 9)	0	2	3	4
Non-Evaluators (*n*=13)	0	3	5	5

χ^2 (2) .087, *p* = .958

Table 3

Mental Health Professionals Level of Familiarity with Nonconsent

	Reported Level of Familiarity			
Group	Unfamiliar	Somewhat Familiar	Quite Familiar	Very Familiar
SVP Evaluators (*n*= 9)	1	1	2	5
Non-Evaluators (*n*=13)	5	2	1	5

χ^2 (3) = 2.695, *p* = .441

Table 4
Mental Health Professionals Level of Familiarity with Statutory Rape

	Reported Level of Familiarity			
Group	Unfamiliar	Somewhat Familiar	Quite Familiar	Very Familiar
SVP Evaluators (*n*= 9)	6	0	2	1
Non-Evaluators (*n*=13)	8	2	1	2

χ^2 (3) = 2.301, p = .512

Appendix E

Level of Familiarity with Diagnoses

Table 1

Level of Familiarity with Pedophilia Indicated by Mental Health Professionals

	Reported Level of Familiarity			
Group	Unfamiliar	Somewhat Familiar	Quite Familiar	Very Familiar
SVP Evaluators (*n*= 9)	0%(0)	0%(0)	11.11%(1)	88.89%(8)
Non-Evaluators (*n*=13)	0%(0)	0%(0)	30.76%(4)	69.23%(9)

Table 2

Level of Familiarity with Hebephilia Indicated by Mental Health Professionals

	Reported Level of Familiarity			
Group	Unfamiliar	Somewhat Familiar	Quite Familiar	Very Familiar
SVP Evaluators (*n*= 9)	0%(0)	22.22%(2)	33.33%(3)	44.44%(4)
Non-Evaluators (*n*=13)	0%(0)	23.1%(3)	38.5%(5)	38.5%(5)

Table 3

Level of Familiarity with Nonconsent Indicated by Mental Health Professionals

	Reported Level of Familiarity			
Group	Unfamiliar	Somewhat Familiar	Quite Familiar	Very Familiar
SVP Evaluators (*n*= 9)	11.11%(1)	11.11%(1)	22.22%(2)	55.56%(5)
Non-Evaluators (*n*=13)	38.46%(5)	15.38%(2)	7.69%(1)	38.46%(5)

Note: MHPs who reported that they had not heard of nonconsent were included in the "unfamiliar" category.

Table 4

Level of Familiarity with Statutory Rape Indicated by Mental Health Professionals

Group	Reported Level of Familiarity			
	Unfamiliar	Somewhat Familiar	Quite Familiar	Very Familiar
SVP Evaluators (*n*= 9)	66.67%(6)	0%(0)	22.22%(2)	11.11%(1)
Non-Evaluators (*n*=13)	61.54%(8)	15.38%(2)	7.69%(1)	15.38%(2)

Note: MHPs who reported that they had not heard of statutory rape were included in the "unfamiliar" category.

Appendix F

Definitions Provided by Mental Health Professional

Pedophilia

1. Sexual attraction to prepubescent individuals usually under 12yrs old. with the individual having the attraction being older then 16 and more then 5 yrs older if they act on it.
2. Sexual attraction to a minor child
3. Someone with a predominant sexual attraction to pre-pubescent children.
4. Sexual preoccupation with pre-pubescent minors
5. A pattern of recurrent, intensely arousing sexual urges, fantasies, and/or behaviors related to engaging in sex acts with prepubescent (generally age 13 or younger) children, lasting at least 6 months and having acted on this arousal
6. Acting out interest, attraction and arousal towards children under the age of 11 yrs old or so.
7. Primary attraction and sexual arousal to prepubescent children
8. Sexual urges or fantasies that cause impairment lasting for six months or more
9. Sexual attraction to prepubescent children.
10. This essentially describes sexual arousal to children.
11. Recurrent, intense sexual urges, sexually arousing fantasies, or behaviors involving sexual activity with a prepubescent child, usually 13 years or younger, over a 6-month period. Causes marked distress or interpersonal problems. Individual with the diagnosis is at least 16 and at least 5 years older than the child.
12. Abnormal sexual attraction towards pre-pubescent children.
13. Sexual gratification from children that causes life issues or suffering from person or those around him or her for a period of time.
14. Adults who experience sexual feelings or arousal toward children.
15. A person who is attracted to children, usually under the age of 13.
16. Intense and persistent sexual interest in children
17. A sexual attraction to children that causes an individual significant distress and that continues for at least 6 months
18. A recurring and persistent interest in sexual relationships with prepubescent children (typically 13 years of age and under). The individual has acted on these sexual urges or they cause distress to the individual.
19. Sexual arousal to stimuli involving pre-pubescent children, over a period of at least 6 months and which causes discomfort or adverse consequences
20. This refers to intense and persistent sexual interest with something other than a consenting, adult partner
21. Someone sexually attracted to children.

Hebephilia

1. Sexual attraction to individuals who have or are going through puberty but are not the age of consent.

2. Sexual attraction to early pubescent children (e.g. usually ages 11 to 14 or 15).
3. The individual has a predominant sexual attraction towards pubescent children generally ages 11 to 14
4. Sexual interest in pubescent children
5. A pattern of recurrent, intensely arousing urges, fantasies, behaviors related to sex acts with pubescent minors; having acted on and experienced distress or impaired functioning as a result of this pattern; typically with an attraction to the emergence of secondary sex characteristics
6. Interest attraction and arousal to someone between the age of 12 to 15
7. Sexual attraction/arousal to young teenagers
8. Preferential sexual attraction to teens causing impairment lasting six months or more
9. Sexual arousal to post pubescent MInors. This is not indicative Of psycho sexual Psychopathology.
10. This refers to arousal toward pubescent individuals - not children, not adults.
11. Recurrent, intense urges, sexually arousing fantasies, or behaviors involving sexual activity with pubescent children, generally up to 16 years old (age of consent in NJ). Causes marked distress or interpersonal problems.
12. Abnormal sexual attraction to teenagers. Legally underage, currently in or undergoing pubescence.
13. Attracted to post pubescent teens
14. When an individual is aroused and feels sexually toward pubescent children.
15. Saying that teen agers are the most sexually attractive
16. Attraction to prepubescent children
17. Intense and persistent sexual interest in children 11-14
18. A sexual attraction to post-pubescent children under the age of 18
19. Unable to provide a definition.
20. Same criteria as pedophilia, only involving pubescent (as opposed to pre-pubescent) children
21. Has to do with sexual urges toward persons under the age of 18 but who have secondary sex characteristics.
22. Sexually attracted to "pre-teens"

Nonconsent

1. The individual has a predominant sexual attraction to the use of force or violence during sex, generally with a non consenting partner or extremely passive or masocisitc partner .
2. A pattern of arousal to sex acts with individuals who, by virtue of age, force or intimidation, and/or infirmity or incapacity, are not willing or able to provide consent to the acts.
3. Interest attraction and arousal to anything/being without their consent that is not intended to be a mutual adult consenting sexual partner
4. Rape, sexual assault
5. Not accepted diagnosis
6. Sexual arousal to an unwilling partner being coerced to submit to sex.

7. Some individuals have an erotic preference for sexual partners who are resisting the sexual interaction. As one of my clients once said "Doc, I'm just not turned on unless the woman is frightened".
8. Recurrent, intense urges, sexual fantasies, or behaviors involving non-consensual sexual activity over a 6-month period. Causes marked distress or interpersonal difficulty.
9. Paraphilic behaviors based upon an unwilling human or animal.
10. Self defining
11. Being aroused to sexual relations or interactions with other non consenting individuals
12. Someone acting without someone else's permission
13. n/A
14. Intense and persistent sexual interest in sexual contact with nonconsenting individuals
15. Recurrent and intense sexual arousal to a nonconsenting, physically mature individual. The person has acting on this sexual arousal.
16. Sexual arousal to stimuli involving forcing a person to engage in sex, over a period of at least 6 months and which causes distress or life problems
17. Sexual interests, urges, impulses regarding nonconsensual contact with an adult. The sexual interest is primarily about forcing sex on a nonconsenting adult, through verbal or physical threats, injury
18. Sexually offending an unwilling participant and being aroused to the person's non-consent.

Statutory Rape

1. We call it endangering the welfare of a minor in NYS but it indicates sexual activity with someone not old enough to consent to such.
2. An individual whose predominant sexual attraction involves luring women into romantic situations for the purpose of forcing them into sex
3. Forced sexual assault, aggravated sexual assualt with consent with someone
4. Adult who engages in sexual activity with older minor
5. Sexual arousal to minors Who are post pubescent.
6. A form of coercive statutory rape.
7. It's been written out of the laws.
8. It is a legal term for someone who rapes someone underage or without consent if it is someone of age.

Appendix G

Mental Health Professional Explanations for Not Providing Diagnostic Labels

Pedophilia

1. How can one honestly know all truths from anyone
2. I have only been in the field for one year. I have yet to meet a client who is exclusively attracted to children.
3. I leave that for Psychiatrists to do
4. While I have worked with clients who I recognized as having pedophilia, i have never been called upon to give a diagnosis, per se

Hebephilia

1. After it was dropped from the dsm 5 i no longer use it
2. I prefer the use of unspecified when I am limited on information
3. Not accepted diagnosis
4. Because it is not a mental disorder. It is not listed in any authoritative treat us including the DSM. Latest addition of the ICD does have something like this diagnosis. That will likely be problematic.
5. The court did not want to hear it - for legal reasons as compared to clinical ones
6. I try not to make the diagnosis of individuals. I work with those who are seeking treatment for their inappropriate sexual behaviors.
7. I have considered it in two cases, but found the majority of the victims either fell into the pedophilia category or older adolescents and only a few victims were 11-14 range.
8. I have not had the occasion to use this diagnosis.
9. Same as for pedophilia -- never been called upon to provide a diagnosis, per se
10. I would prefer to use Paraphilic Disorder, Not Otherwise Specified to describe the mental disorder
11. Not supported by enough research.

Nonconsent

1. Was not asked
2. Not accepted diagnosis
3. Again, if the court says it's not an acceptable diagnosis, I don't give it (but usually say what I think in the body of the report).
4. Too controversial at this time and not enough research literature to support its diagnosis therefore a defense attorney will naturally challenge this diagnosis.
5. Consent is not always black or white. Females change their mind after consent.
6. I have only been in the field for one year and have no met a client who was continuously aroused by this
7. I do not give diagnosis
8. n/a
9. Never been called upon to provide the diagnosis, per se

Statutory Rape

1. I am not familiar with it being an acceptable dx. I give the fall back unspecified.
2. I've never seen an individual where this was their predominant sexual attraction.
3. Was not asked
4. I may have made some idiotic mistakes but not this one. Any mental health professional who sells out their field with such a legalistic sounding diagnosis should reconsider their profession.
5. Too controversial, more than likely to be challenged by defense counsel.
6. NA
7. I don't do that

Appendix H

Mental Health Professionals Explanations for Applying Diagnostic Labels

Pedophilia

1. Having a victim under 12 or having acknowledged in court a victim under 12. In some cases a voluntary client may also be dx with this.
2. Reviewing arrest report(s), Child Protection Team interview reports, and DSM-5.
3. The individual admitted to having a predominant sexual attraction for prepubescent children.
4. Individuals with sexual preoccupation with children under the age of 12 either via content of pornographic materials or self-report
5. All cases were individuals who were convicted of sexual offenses, having repeatedly sexually abusing or assaulting young children, showed a preference for these acts (typically with no age-appropriate sexual interests or choosing this behavior over available age-appropriate partners), showed difficulty managing the urges (reoffending) despite the risk of detection and consequences, often with self-reports confirming this arousal pattern and its persistence (at times based on documented behaviors alone, but I do assign that diagnosis if it still seems appropriate in cases where there is an absence of self-report due to the individual's denial or refusing to speak with me about the arousal and behaviors)
6. They wanted one
7. Self-report, exclusive/excessive use of child pornography, details of criminal acts
8. Treatment planning
9. They have either demonstrated behaviorally a sexual attraction to children or have reported credibly a sexual attraction to children (prepubescent).
10. Examining the DSM-5 criteria and reviewing case material on the subject - and sometimes based on what the client states in our interview.
11. They were pedophiles - specifically, sexual offenders.
12. Per the diagnostic criteria for the DSM-5.
13. Use of the DSM 5
14. To clarify, I did not diagnose PEDOPHILIA, but PEDOPHILIC DISORDER. because they met the criteria in the DSM-5.
15. The individual either self reported a sexual attraction to pre-pubescent children or was diagnosed using the CASIC (C-PORT) and available documentation
16. The individual had a documented history of engaging in sexual relationships with young children over a period in excess of 6 months.
17. Evidence from the legal record, criminal histories, to include offender and survivor statements, data from penile plethysmograph, statements made during the course of treatment, or forensic interview. Polygraph information regarding masturbatory practices can also assist with determining whether a person meets criteria for Pedophilic Disorder. If someone has urges or impulses to have sexual contact with children but has not acted on them, then I would diagnose the person with Pedophiliia.

18. Convicted of, or having admitted to, sexually offending a minor.

Hebephilia

1. Sexual attraction to a female who is aged about 14 through 17, who physically present as fully-developed, sexually
2. The individual admits to this predominant sexual attraction.
3. The individuals repeatedly engaged in illegal sex acts with this age group of minors despite experiencing personal and legal consequences
4. Was asked to do so.
5. Self-report, attraction/behavior exclusively to young teens, records
6. Offenses against and sexual fantasies involving teenagers
7. Criminal behavior reflective of or self-disclosed documentation of attraction to young teenagers.
8. When clients have been exclusively attracted to pubescent children.
9. Interview, document review, psych testing, sex offender specific risk assessment tools

Nonconsent

1. The individual admitted to their predominant sexual attraction is that of force and/or violence.
2. Individuals who showed a repetitive pattern of interest/efforts in seeking out their victims, attacking individuals who were strangers or otherwise clearly unwilling participants in the acts, often along with documented or currently acknowledged arousal to rape such as in choices of pornography or role-play encounters that escalated into attacking actual victims, often occurring in spite of the availability of willing partners. In terms of needing a rationale per se, I also want to point out that, just because politically the DSM does not include various specific paraphilic diagnoses, the reasons for these decisions do not in my opinion indicate that the disorder itself does not exist, but that caution should be used in applying the diagnosis (e.g., a general mental health clinician automatically diagnosing a client they see who happens to admit they once raped someone) because of the impact it may have on that person's treatment or future, and that there were decisions made based on illogical fears that the designation of it as a mental disorder would reduce people's legal responsibility (irrational in that pedophilia remains a diagnosis and is not used for NGRI type defenses). Many reasons for the specific inclusion/exclusion of specific paraphilias could be debated in terms of rationale for/against the use of it in a particular case but, we see many individuals who clearly do have these disordered arousal patterns that perhaps the people making the political decisions do not see (or, they do but they fear less experienced individuals will improperly use the diagnosis) and in my opinion, that should not be the reason for attempting to eliminate diagnoses
3. Victim statements, police reports, clinical interview, psychological testing
4. It was early in my career when I was prone to making such idiotic mistakes.
5. Multiple rapes, arousal to rape and rape fantasies, preference for rape over consensual sex (including rough consensual sex).

6. The individuals had clear arousal patterns to the nonconseting aspect of the sexual activity (i.e., erection or ejaculation when victim said no or resisted or was unconscious or asleep or intoxicated, used threats or force or coercion repeatedly, reports more satisfaction from resisting sex than participating sex, etc.)
7. A documented history of engaging in sexual behaviors with a nonconsenting adult person.
8. Data from multiple sources. Evidence that the individual had access to a consenting partner(s) but chose to engage in forced sexual encounters.
9. Convicted of, or admitted to, intentionally sexually offending a victim against their will and being aroused to the non-consent.

Statutory Rape

1. Interview, victim statements

Appendix I

Frequency of Diagnostic Domains Assessed by Mental Health Professionals in SVP Evaluations

Method	Diagnostic Category					
	Never (0%)	Rarely (1-10%)	Sometimes (11-40%)	Frequently (41-80%)	Most of the time (81-99%)	A (1
Substance Abuse	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	11.11% (1)	88.8
Paraphilias	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	11.11% (1)	88.8
Personality Disorder	0.00% (0)	0.00% (0)	0.00% (0)	11.11% (1)	11.11% (1)	77.7
Developmental or Cognitive Disorder	0.00% (0)	0.00% (0)	11.11% (1)	11.11% (1)	44.44% (4)	33.3
Other DSM-5 Disorder	0.00% (0)	0.00% (0)	0.00% (0)	11.11% (1)	44.44% (4)	44.4

Appendix J

Frequency of Diagnoses Given by Mental Health Professionals in SVP Evaluations

Method	Diagnostic Category					
	Never (0%)	Rarely (1-10%)	Sometimes (11-40%)	Frequently (41-80%)	Most of the time (81-99%)	A (1
Substance Abuse	0.00% (0)	0.00% (0)	22.22% (2)	55.56% (5)	11.11% (1)	11.1
Paraphilias	0.00% (0)	11.11% (1)	11.11% (1)	11.11% (1)	44.44% (4)	22.2
Personality Disorder	0.00% (0)	0.00% (0)	11.11% (1)	33.33% (3)	55.56% (5)	0.0
Developmental or Cognitive Disorder	0.00% (0)	33.33% (3)	33.33% (3)	11.11% (1)	11.11% (1)	11.1

Appendix K

Mental Health Professional Levels of Support of Paraphilic Diagnoses Based on Legal Affiliation

Table 9

Mean Levels of Support for For Paraphilic Diagnoses to be Considered Mental Disorders as Indicated by Mental Health Professionals

	Diagnostic Category			
Legal Affiliation	Pedophilia	Hebephilia	Nonconsent	Statutory Rape
Neither (*n*=13)	5.23	4.67	3.89	3.20
State (*n*=7)	5.71	4.14	5.14	5.00
Defense (*n*=2)	5.00	4.00	2.50	1.50

Table 10

Mean Levels of Support for Inclusion of Paraphilic Diagnoses in the DSM as Indicated by Mental Health Professionals

	Diagnostic Category			
Legal Affiliation	Pedophilia	Hebephilia	Nonconsent	Statutory Rape
Neither (*n*=13)	5.31	4.67	3.89	3.40
State (*n*=7)	5.86	4.14	5.29	4.00
Defense (*n*=2)	5.00	3.50	2.50	1.50

Table 11

Mean Levels of Support for Use of Paraphilic Diagnoses in SVP Evaluations as Indicated by Mental Health Professionals

	Diagnostic Category

Legal Affiliation	Pedophilia	Hebephilia	Nonconsent	Statutory Rape
Neither (*n*=13)	5.00	4.92	4.22	2.80
State (*n*=7)	5.71	4.29	5.57	4.00
Defense (*n*=2)	4.50	3.00	4.00	2.00

Table 12

Mean Levels of Support for Use of Paraphilic Diagnoses in Non-Forensic Treatment Settings as Indicated by Mental Health Professionals

	Diagnostic Category			
Legal Affiliation	Pedophilia	Hebephilia	Nonconsent	Statutory Rape
Neither (*n*=13)	4.46	4.42	4.00	4.20
State (*n*=7)	5No.43	4.00	4.71	4.00
Defense (*n*=2)	5.00	2.50	3.50	2.00