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LETTER TO THE EDITOR

What's Wrong With Sex?

Patrick Singy

Several psychiatrists and psychologists have recently made important criticisms of specific diagnostic innovations proposed by the *DSM-5*'s Sexual and Gender Identity Disorders Work Group (DeClue, 2009; Frances, 2010; Green, 2010; O'Donohue, 2010). As a historian and philosopher of science, my goal here is more general: I want to show that what this Work Group is trying to accomplish undermines the definitions of "paraphilia" and "mental disorder" that have been operative since the *DSM-III*. If the revisions proposed by the Work Group are implemented, the *DSM-5* will be closer to the *DSM-I* and *DSM-II* than to their successors. In order to understand why this is so, we need first to take a short historical detour and to look at how "mental disorder" and "paraphilias" have traditionally been defined. Only then will we be in a position to grasp the magnitude of what the *DSM-5* is trying to accomplish.

As is well known, the *DSM-I* (American Psychiatric Association, 1952) and *DSM-II* (American Psychiatric Association, 1968) did not define "mental disorder." In the *DSM-II*, the paraphilias (called "sexual deviations") were simply described as sexual interests directed "primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstance" (American Psychiatric Association, 1968, p. 44). Needless to say, it is rather bizarre to use "bizarre" as a nosological criterion, and probably not the best way to make psychiatry look like a serious science. In 1973, however, psychiatrists voted to remove homosexuality from the *DSM*, and at that point the need arose to spell out what a mental disorder is.

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According to the *DSM-III* (American Psychiatric Association, 1980), a mental disorder must meet two criteria: (1) it must cause harm, either to oneself (in the form of distress or disability) or to others; (2) it must be a dysfunction. The fact that both criteria have to be met is a guarantee that doctors cannot transform every problem into a disease. Childbirth, for instance, is not a disease even when it causes harm, because it is not dysfunctional. Nor is homosexuality a disease since, even if it were dysfunctional (as some have claimed), it is not harmful.

The weakness of this understanding of mental disorder hinges mostly on the idea of dysfunction, which, as long as it is not better defined, can easily be interpreted in sociocultural terms. The following example clearly illustrates how this can have troublesome consequences. In 1851, Dr. Samuel A. Cartwright described a condition that he called "drapetomania," a disease that made slaves try to flee captivity (Cartwright, 1851). Is "drapetomania" a real disease? If we apply the *DSM-III* definition of mental disorder and use a sociocultural understanding of function, the answer must be "yes": slaves who try to escape from their masters indeed do not "function" in a racist society (and they harm their masters by depriving them of their property).

"Function" must therefore be clearly distinguished from sociocultural values, lest psychiatry be exactly what anti-psychiatrists have for decades accused it of being: a mere instrument of social control. This is why some of the psychiatrists who in the past have been in charge of the *DSM*, such as Robert L. Spitzer and Michael B. First, have recently pushed for a narrower understanding of "function" (Spitzer, 1999; Wakefield & First, 2003). They want to make psychiatry into a science whose job would not be to mirror and to fuel social prejudices, but to cure genuine diseases. They have usually relied on the influential work of Wakefield (1992).

According to Wakefield, a function should be understood as an internal mechanism selected by evolution. The theory of

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evolution grounds the concept of "mental disorder" in biological and psychological science, and thus makes it less directly dependent on sociocultural values. Now we can say, for instance, that Cartwright's "drapetomania" is not only revolting by modern cultural standards (we hope) but also scientifically wrong. From an evolutionary point of view, trying to run away from an oppressor is certainly not dysfunctional.

So how will the *DSM-5* be different from its predecessors? The recent papers published by the Sexual and Gender Identity Disorders Work Group betray an ambition to weaken drastically, if not to dismantle altogether, both the "dysfunction" and the "harm" criteria.

Let's look at "dysfunction" first. The Work Group is perfectly content to turn its back on efforts to make the criterion of "dysfunction" independent of cultural values. For instance, Thornton, an official advisor to the *DSM-5*, claims that a paraphilia is "an abnormal sexual interest," adding matter-of-factly that "what counts as 'abnormal' is culturally relative" (Thornton, 2010, p. 411).

Blanchard (2010), the Chair of the Paraphilias Subwork Group, defines a paraphilia as "any powerful and persistent sexual interest other than sexual interest in copulatory or precopulatory behavior with phenotypically normal, consenting adult human partners" (p. 367). Although it is difficult to make sense of this hodgepodge definition, one thing seems clear: some kind of cultural norm must be the glue that holds together the odd conjunction of copulation (a behavior), consent (a legal concept), and phenotypical normality (whatever that means).

The official *DSM-5* website (www.dsm5.org) confirms the reduction of perversions to cultural abnormality. No definition of "paraphilia" is actually given in the paraphilia section of the website, where one would naturally expect to find it. But under the "Rationale" heading explaining the addition of the disease of "hypersexuality," this new (non-paraphilic) disease is contrasted with paraphilias, which are said to be "characterized by persistent, socially anomalous or deviant sexual arousal."

All these statements point in the same disturbing direction: the *DSM-5* is ready, and perhaps even eager, to crack a moral whip and to make psychiatrists into the guardians of cultural values. The pathological would simply be whatever society deems bizarre and morally unacceptable. In this respect, the *DSM-5* would more closely resemble the *DSM-I* and *DSM-II* than later editions.

But it gets worse. As if reducing the "dysfunction" criterion to cultural disapproval were not problematic enough (both scientifically and ethically), the Work Group is also trying to undermine the critical importance of the "harm" criterion. If it succeeds, a "harmless paraphilia" would indeed no longer be an oxymoron: people who enjoy sex in a way that harms no one, yet happens to be outside the cultural norm, would now have a paraphilia and would find their place in the *DSM-5* (Blanchard, 2010, p. 367; Zucker, 2010; www.dsm5.org). By contrast, from the *DSM-III* to the current *DSM-IV-TR*, such people have not been considered paraphiliacs and have been left alone.

Strictly speaking, the *DSM-5* claims that paraphilias, unlike paraphilic disorders, are not actual disorders, precisely because they are not harmful. But, obviously, neither are paraphilias completely unrelated to paraphilic disorders; otherwise, they would not even be mentioned in the *DSM*. It is, in fact, easy to predict that the distinction between paraphilias and paraphilic disorders will quickly crumble under relentless pressure from sex therapists and the pharmaceutical industry. Sure, the Work Group claims that "a paraphilia by itself would not automatically justify or require psychiatric intervention" (www.dsm5.org). But as a preventive measure, wouldn't it be safer to deal with a paraphilia now, when it is still benign, rather than later, when it will have grown into a full-blown paraphilic disorder? After all, if your doctor were to discover an unsuspected cancerous tumor in your body, would you wait until it causes painful symptoms to treat it? There is no reason to think that psychiatrists would not use the same kind of reasoning with paraphilias.

The *DSM* is taking a turn for the worse. If the Sexual and Gender Identity Disorders Work Group gets its way, it won't be long before those who don't copulate the straight and narrow way are bombarded with advertisements for pills and encouraged to start therapy before it's too late, weeping on talk shows as they share with us their painful struggles with abnormality. We are heading toward the creation of an epidemic of perverts—not because more people will engage in bizarre sexual behaviors as a result of the publication of the *DSM-5*, of course, but because a much wider range of sexual behaviors will be deemed pathological.

Obviously, sexual minorities should be especially upset about the direction taken by the *DSM-5*. What is needed is a new wave of powerful activism that would finish the job started in 1973 and force psychiatrists to remove not just one perversion from the *DSM*, but all of them. The law is sufficient to deal with those who engage in illegal sexual activities, and religious and cultural norms do not need the help of psychiatry to normalize harmless erotic quirks.

But psychiatrists themselves should also be concerned about the innovations of some of their colleagues. Historically, the scientific status of psychiatry has always been fragile. Tainted by accusations of racism, misogyny, and homophobia, it has been at pains to establish itself as a science worthy of the name. If the *DSM-5* does not quickly go through a radical revision, its publication will be yet another blow to the scientific reputation of psychiatry.

References

American Psychiatric Association. (1952). *Diagnostic and statistical manua: Mental disorders*. Washington, DC: Author.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

Blanchard, R. (2010). The DSM diagnostic criteria for Transvestic Fetishism. *Archives of Sexual Behavior, 39*, 363–372.

Cartwright, S. (1851). Report on the diseases and physical peculiarities of the Negro race. *The New-Orleans Medical and Surgical Journal, 7*, 691–715.

DeClue, G. (2009). Should hebephilia be a mental disorder? A reply to Blanchard et al. (2008) [Letter to the Editor]. *Archives of Sexual Behavior, 38*, 317–318.

Frances, A. (2010, March 17). DSM5 and sexual disorders—Just say no. *Psychiatric Times.*

Green, R. (2010). Sexual preference for 14-year-olds as a mental disorder: You can't be serious!! [Letter to the Editor]. *Archives of Sexual Behavior, 39*, 585–586.

O'Donohue, W. (2010). A critique of the proposed DSM-V diagnosis of pedophilia [Letter to the Editor]. *Archives of Sexual Behavior, 39*, 587–590.

Spitzer, R. L. (1999). Harmful dysfunction and the DSM definition of mental disorder. *Journal of Abnormal Psychology, 108*, 430–432.

Thornton, D. (2010). Evidence regarding the need for a diagnostic category for a coercive paraphilia. *Archives of Sexual Behavior, 39*, 411–418.

Wakefield, J. C. (1992). Disorder as harmful dysfunction: A conceptual critique of DSM-III- R's definition of mental disorder. *Psychological Review, 99*, 232–247.

Wakefield, J. C., & First, M. B. (2003). Clarifying the distinction between disorder and nondisorder. In K. A. Phillips, M. B. First, & H. A. Pincus (Eds.), *Advancing DSM: Dilemmas in psychiatric diagnosis* (pp. 23–55). Arlington, VA: American Psychiatric Association.

Zucker, K. J. (2010, February 22). DSM5: Pandora replies to Dr Frances. *Psychiatric Times.*