DSM-IV-TR and the Paraphilias: An Argument for Removal

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SUMMARY. The *DSM-IV-TR* (2000) sets its own standards for inclusion of diagnoses and for changes in its text. The Paraphilia section is analyzed from the perspective of how well the *DSM* meets those standards. The concept of Paraphilias as psychopathology was analyzed and assessed critically to determine if it meets the definition of a mental disorder presented in the *DSM*; it does not. The Paraphilia diagnostic category was critiqued for logic, consistency, clarity, and whether it constitutes a distinct mental disorder. The *DSM* presents "facts" to substantiate various points made in the text. The veracity of these "facts" was scrutinized. Little evidence was found in their support. Problems with the tradition of equating particular sexual interests with psychopathology

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were highlighted. It was concluded that the Paraphilia section is so severely flawed that its removal from the *DSM* is advocated. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]*

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All societies attempt to control the sexual behavior of their members. One mechanism of exercising this control is to define a specific sexual interest as pathognomonic for a mental disorder. Historically and cross-culturally, even an accusation of interest in specific sexual practices could result in death, imprisonment, loss of civil rights, and other social sanctions. Similarly, being classified as mentally ill could result in death, imprisonment, loss of civil rights, and other social sanctions. Thus, the confounding of mental illness with unusual sexual desires is understandable.

Which sexual interests are proscribed often changes; masturbation, oral sex, anal sex, and homosexuality were once considered mental disorders or symptoms of other mental disorders but are now typically accepted as part of the spectrum of healthy sexual expression. Similarly there are conditions that were accepted as "normal" in the past, but are now classified as mental disorders (e.g., hypoactive sexual desire, sexual aversion disorder, and female orgasmic disorder). It is exceedingly difficult to eliminate historical and cultural factors from the assessment of unusual sexual interests. Empirically based, scientific definitions of healthy and pathological sexual behavior continue to elude us.

Cross-culturally, sexual activity considered "acceptable" in the United States is viewed as "stigmatized" in other cultures; similarly, sexual activity considered "unacceptable" in other countries is not "stigmatized" in the United States. For example, non-marital coitus is accepted in the US, but is stigmatized harshly in many Moslem countries; topless sunbathing among women at public beaches is accepted in Western Europe, but illegal and condemned in most of the United States. Violation of these cultural norms often results in strong negative reactions. Given the socio-cultural context in which such beliefs are embedded, it is not surprising that the lay public and even many sex ex-

perts cannot understand how unusual sexual interests can signify anything but mental disorders. Nevertheless, it is the assumption that unusual sexual interests constitute symptoms of or are mental disorders per se, that we are questioning.

The American Psychiatric Association (APA) publishes the *Diagnostic and Statistical Manual* (*DSM*); it describes the diagnostic criteria and defining features of all formally recognized mental disorders. It serves as a definitive resource for mental health professionals. Although its primary influence is in the United States, its impact is global. A psychiatric diagnosis is more than shorthand to facilitate communication among professionals or to standardize research parameters. Psychiatric diagnoses affect child custody decisions, self-esteem, whether individuals are hired or fired, receive security clearances, or have other rights and privileges curtailed. Criminals may find that their sentences are either mitigated or enhanced as a direct result of their diagnoses. The equating of unusual sexual interests with psychiatric diagnoses has been used to justify the oppression of sexual minorities and to serve political agendas. A review of this area is not only a scientific issue, but also a human rights issue. The power and impact of the *DSM* should not be underestimated.

The *DSM* is revised at regular intervals. Diagnoses can be added or eliminated, and diagnostic criteria reformulated with each new edition. There have been six editions to date (APA, 1952, 1968, 1980, 1987, 1994, 2000). The current edition is designated *DSM-IV-TR* (APA, 2000) and will be the focus of this paper.

With the publication of *DSM-III* (1980), the focus of the *DSM* changed from a theoretically based, psychoanalytic model of illness to an evidence-based and descriptive model. The *DSM* is currently intended " . . . to be neutral with respect to theories of etiology" (APA, 2000, p. xxvi), based on objective observation, and able to support its statements with empirical research. With this transition, the nomenclature of these disorders changed from "Sexual deviation" to "Paraphilia," a supposedly atheoretical, non-pejorative descriptor.

In the text of the latest edition of the *DSM*, it is asserted that a "comprehensive and systematic" (APA, 2000, p. xxvi) review of the literature was conducted in preparation of the *DSM*. "The utility and credibility of the DSM-IV require that it . . . be supported by an extensive empirical foundation" (APA, 2000, p. xxiii). The text indicates, " . . . the majority of paragraphs in the DSM-IV have not been revised, indicating that, even after the literature review, most of the information in the original text remains up-to-date" (APA, 2000, p. 829). Our own,

extensive review found no literature to support most of the assertions made in the Paraphilia section of the *DSM* and several studies were found that contradict the text (discussed below). Objective data to support the classification of the Paraphilias as mental disorders is lacking.

When the APA removed homosexuality from the *DSM* approximately 30 years ago, some observers thought that the other Paraphilias would also be removed from subsequent editions. The argument for removal of homosexuality was bolstered by the lack of objective research supporting its inclusion and research that failed to support the theory that homosexuals fit specific psychiatric stereotypes. Nevertheless, some observers believe the removal of homosexuality was primarily a political act (Bayer, 1981). The situation of the Paraphilias at present parallels that of homosexuality in the early 1970s. Without the support or political astuteness of those who fought for the removal of homosexuality, the Paraphilias continue to be listed in the *DSM*.

The term "paraphilia" will be employed here in keeping with its use in the literature, even though we have serious reservations about the validity of the diagnosis and the applicability of this term. The rationale for the inclusion of the Paraphilia diagnostic category as it is constituted in the *DSM-IV-TR* (APA, 2000) will be addressed and challenged. We will suggest that the construct of the Paraphilias is ambiguous and does not describe a diagnosable, distinct mental disorder. A review of the scientific literature does not support the inclusion of this diagnostic category in the *DSM*.

ARE THE PARAPHILIAS MENTAL DISORDERS?

The concept that unconventional sexual interests are mental illnesses or crimes (religious or societal) predates both the *DSM* and modern psychiatry. Sanctions against individuals who engage in proscribed sexual behavior have changed over time. At first, it was considered a sin to be governed by penitentials and religious courts. Over time, civil laws were used to "control" the unacceptable behavior. In the 19th century the medical model was applied to transform these "sins" or "crimes" into "pathology" (Bullough & Bullough, 1977).

The assumption that Paraphilias are a form of psychopathology has been questioned and each subsequent edition has attempted to address some of the perceived weaknesses in this diagnostic category. Nevertheless, the bulk of serious criticism (Davis, 1996; McConaghy, 1999;

Rubin, 1992; Silverstein, 1984; Suppe, 1984) has not been addressed fully.

In the *DSM*, it is indicated that it is difficult to define a mental disorder as well as mental health. Nonetheless, the text defines a mental disorder as being " . . . associated with present distress . . . or disability . . . or significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (APA, 2000, p. xxxi). Individuals who engage in many common activities (scuba divers, gun owners, mountain climbers, inhabitants of many large cities, and criminals) also incur increased risks of death, pain, disability, or loss of freedom, but are not diagnosed with mental disorders. This apparent contradiction demonstrates that social context can affect the application of this definition.

To clarify the definition, the *DSM* further states, "Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above" (2000, p. xxxi). There is concern that psychiatric diagnoses can be used inappropriately to discredit dissenters; at least in some venues, criminals have more rights and credibility than psychiatric patients do. The above statement was added to protect the labeling of unpopular or illegal activities as mental illnesses, but the last clause allows the clinician to disregard this distinction.

The *DSM* does not define healthy sexuality, much less healthy mood, thoughts, or personalities. Unfortunately, the range of "healthy" human sexual behavior is not known, thus creating potential pitfalls in the diagnostic process. The *DSM* is meant to be interpreted by an experienced and objective clinician. Without consensus from the scientific literature, however, clinicians are often forced to rely on their own subjective evaluations.

The problem here is that engaging in "Paraphilic" behavior qualifies the participant a priori as a candidate for diagnosis. In addition, when individuals have unusual sexual interests, there is often speculation that any presenting problems are related to their sexuality. When a behavior per se signifies a diagnosis, then by definition the behavior is symptomatic of the disorder. This confound obscures the possibility that for at least some individuals, their specific sexual behaviors are healthy expressions of sexuality and beneficial to them. The fact that specific sexual behaviors are socially unacceptable or illegal is, and should be, irrelevant to the diagnostic process.

Historically, this was the situation that confronted homosexuals. When homosexual patients presented to a psychotherapist with any

problem, it was often assumed that the problem was caused or exacerbated by their homosexual interests.

The *DSM* has been organized with a "categorical" approach to classification of mental disorders since the third edition (APA, 1980). This approach works best " . . . when there are clear boundaries between classes, and when the different classes are mutually exclusive" (APA, 2000, p. xxxi). Although the text acknowledges problems with the categorical approach, these problems are particularly evident with the Paraphilias. The Paraphilia disorders do not have clear boundaries (Laws & O'Donohue, 1997). Non-clinical studies of individuals with unusual sexual interests demonstrate that these individuals are indistinguishable from those with "normophilic" (i.e., conventional) sexual interests (Brown et al., 1996; Wise, Fagan, Schmidt, Ponticas, & Costa, 1991). The clinical studies do not identify a discernible group who have anything more in common than their shared sexual interest. The existing empirical research does not distinguish individuals with Paraphilias from those with other mental disorders. That is, there is no demonstrable and distinct class of "paraphiliacs," except as created by defining specific sexual interests, a priori, as evidence of psychopathology. The inability to define "healthy" sexuality or to distinguish the characteristics of individuals with a paraphilia from those without one, suggests that the distinction does not exist and the category is invalid.

Individuals can and do experience psychiatric problems related to their sexual interests and behavior. Problems related to normophilic sexual interests or behaviors, associated with distress or dysfunctions, are dealt with differently and given non-sexual diagnoses. We can find no logical or scientific reason why some sexual behaviors and interests have been designated as Paraphilias and others have not.

THE DSM DEFINITION OF A PARAPHILIA

"The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors . . . that occur over a period of at least 6 months . . . " (APA, 2000, p. 566). The definition of intense is the issue; otherwise this statement in isolation describes healthy, sexually active individuals. The DSM already defines terms such as compulsive, impulsive, and obsessive; so intense in this situation must have a different implication. Even trained clinicians have difficulty distinguishing strong "unhealthy" sexual interests from strong "healthy" sexual interests, as demonstrated by previous, failed attempts

to define promiscuity (having more partners than the evaluator) and excessive masturbation (engaging in the act more often than the evaluator). Conversely, individuals lacking intense sexual arousal may be subject to diagnosis with a Sexual Arousal Disorder or Hypoactive Sexual Desire Disorder.

The editors further qualify their paraphilia definition by stating, " . . . generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's sex partner, or (3) children or other nonconsenting persons . . . " (p. 566). The implication is that the distinction between a mental disorder and a healthy sex interest is based in the nature of the specific sexual interest rather than in its intensity. The following statement found later in the text, reinforces that point: "Of course, for the specific diagnosis to be assigned, the particular pattern of paraphilic arousal must also be present" (p. 840). Although a less intense interest in the "unhealthy" behavior or an intense interest in a "healthy" behavior does not qualify for a paraphilia diagnosis, the distinction appears to be based upon the focus of the sexual interest rather than its intensity. An intense interest in conventional sexual behavior was once considered a criterion for a valid diagnosis. Nymphomania, satyriasias, and erotomania were not included in the current *DSM* for the same reasons that homosexuality was removed, i.e., the lack of data to support inclusion and the recognition that these diagnoses impose a cultural value judgment on the behavior, rather than comprising a diagnosable entity.

The tradition of identifying specific sexual behaviors as pathological predates the *DSM-I* (1952), possibly originating with Krafft-Ebing (1965/1886). It is a remnant of the reclassification of sexual sin to sexual pathology in the 19th century (Bullough & Bullough, 1977). The specifying of behaviors creates problems for at least six reasons:

1. A behavior in and of itself is not evidence of psychopathology. Even when a behavior is construed as a symptom of a mental disorder, we do not classify the mental disorder by the symptom or the behavior. Paranoia may be a symptom of several psychiatric diagnoses (e.g., schizophrenia, paranoid personality disorder, delusional disorder, psychoactive substance use, bipolar disorder), but paranoia by itself is not a diagnosis. Compulsive hand washing may be a symptom of obsessive-compulsive disorder, but it is not a hand-washing disorder.
2. The act of specifying particular, sexual behaviors as pathological leads to discrimination against all practitioners of those behaviors, even when their behavioral expressions are appropriate and be-

nign. Furthermore, at present, the urges may be construed as pathological even if one never acts upon them.

3. Specifying particular behaviors allows for the inference that other (i.e., unclassified) behaviors are unlikely to be the source of difficulties. As most practitioners in the field know, normative heterosexual behaviors can be problematic as well (cf., Kafka & Hennen, 1999).
4. Specifying the behavior focuses the evaluation and treatment on that behavior. Some individuals do experience problems related to their sexual interests and these may be an appropriate focus of therapy. However, the clinician may be diverted from any underlying concerns and attend unduly to controlling the specified behavior (Moser & Kleinplatz, 2002).
5. Social, political, religious and historical factors affect the inclination to see certain behaviors or sexual proclivities as pathological (Bullough, 1988; Davis, 1996, 1998). As acknowledged in the *DSM* (APA, 2000), these cultural values are a confounding influence and are contrary to the supposedly objective perspective of the *DSM*.
6. The therapist's own socialization or theoretical perspective is likely to affect judgments of health or pathology. This adds an unwelcome and inevitably, subjective component to an allegedly objective process.

CHANGES TO THE DIAGNOSTIC CRITERIA

It has been asserted that, " . . . all proposed changes were limited to the text sections . . . [and] no substantive changes in criteria were considered" (APA, 2000, p. xxix). This is patently false; the criteria for Exhibitionism, Frotteurism, Pedophilia, Sexual Sadism, and Voyeurism (i.e., "criminal" paraphilias) were changed and these changes were substantive. Of note, the Paraphilia section appears to be the only section of the *DSM-IV-TR* (APA, 2000) to which changes to the diagnostic criteria were made. The impetus for these changes is not stated. There are essentially two changes for each of the above diagnoses. Previously, the diagnosis was made *only* when the interest resulted in distress or dysfunction. Now acting on the urges alone is sufficient to make the diagnosis regardless of distress or dysfunction. This is a significant change, adding a new class of individuals to the diagnostic category. Whether this new class of individuals now diagnosed with Paraphilias meets the *DSM* definition of a mental disorder is even murkier. This change clearly confounds a "mental disorder" with a "crime."

The second change involves the wording of the "B" criterion. In the *DSM-IV* (APA, 1994), the "B" criterion for all paraphilias was identical. In the current *DSM* (APA, 2000), the "B" criterion for some, but not all, diagnoses has been changed. This involved the substitution of "marked distress" for "clinically significant distress" and "interpersonal difficulty" for "impairment in social, occupational, or other important areas of functioning." The rationale for these changes is not provided.

The inclusion of nonconsent is especially problematic in the case of Sexual Sadism. Although it is clearly possible for an individual with the diagnosis of Sexual Sadism to engage in nonconsensual acts, most "sadists" do not seek non-consenting partners (Moser, 1999; Weinberg, Williams, & Moser, 1984). Just as it is inappropriate to confuse rapists with those individuals interested in consensual sexual activities, the lumping of individuals interested in consensual sexual sadism with those who engage in non-consensual activities is similarly inappropriate (McConaghy, 1999). One can conclude the editors of the *DSM* appear to reject the possibility that anyone would engage willingly in these activities, despite a now sizeable professional and lay press which indicates just that. The application of the current *DSM* criteria may result in many rapists being diagnosed inappropriately with Sexual Sadism. The data suggest that the majority of rapists are not motivated by sadism (Groth & Hobson, 1983; Hucker, 1997); correspondingly, there is no data to suggest that rape is more common among practitioners of Sexual Sadism. It is noteworthy that "rape" was removed from the *DSM* with the publication of the second edition (1968). It is not clear why the concept is being reintroduced into the *DSM* at this time.

THE "B" CRITERION: DISTRESS AND DYSFUNCTION AND THE "PARAPHILIAS"

An essential criterion for making the diagnosis of paraphilia is that the behavior, urges, or fantasies cause distress or dysfunction. These two symptoms will be analyzed separately.

Distress

It is acknowledged in the *DSM* that, "These individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with

sexual partners or society" (APA, 2000, p. 566). Possibly for emphasis, the *DSM* includes the statement: "Many individuals with these disorders assert that the behavior causes them no distress and that their only problem is social dysfunction as a result of the reaction of others to their behavior" (p. 567). One must conclude that distress is rarely a problem for those individuals diagnosed with a paraphilia.

Consider the minority of individuals diagnosed with a paraphilia who are distressed because of their sexual interests. Although one's sexual interests "tend to be chronic and lifelong" (APA, 2000, p. 568), there is no indication that the distress is chronic. This distinction has been overlooked in the diagnostic criteria. If the distress can be mitigated, would these individuals cease to be diagnosable as having Paraphilias? Support groups can alleviate social stigma and isolation. Although they are helpful to mitigate this distress, they are rarely mentioned in the clinical literature in regard to the treatment of the Paraphilias (Moser, 1988; 1999). A strict reading of the definition of a mental disorder suggests that the distress must be "present distress" (APA, 2000, p. xxxi), which implies that if the distress is mitigated, the individual no longer meets the criteria for the diagnosis.

Some individuals sincerely wish to change their sexual interests and have not found solace from or are unwilling to attend support groups. These individuals should be treated in a similar fashion to those who are uncomfortable with their sexual orientation.

One may question why an individual with a paraphilia does not give up the sexual interest that results in adverse consequences. This has been interpreted as further evidence of the compulsive nature of these "disorders." Even if individuals exhibit compulsive fantasies, behaviors and urges, compulsivity is not included in the diagnostic criteria of the paraphilias, and should have no bearing on the diagnosis of a paraphilia. Furthermore, how many "normal" heterosexuals would be able to eliminate their interests if the laws suddenly changed? We wonder why individuals who refuse to change unpopular political or religious beliefs are not similarly diagnosed.

It is worth considering the possibility that unusual sexual interests might enhance one's quality of life rather than diminishing it. Proscribed fantasies, desires, and behaviors may not be pathological; healthy individuals resist giving up life-affirming and enhancing experiences, regardless of social mores. Historically, social and psychiatric sanctions have done little to decrease the incidence of other forbidden sex acts (bearing children outside of marriage, extramarital sex, and masturbation), but have caused the participants significant distress and

misery. It is important to distinguish carefully between having the integrity required to follow one's own sexual values, however unpopular, and having a mental disorder. The perseverance of gay rights activists in the face of the "diagnosis and treatment" of homosexuality provides an excellent example of this courage.

Discrimination can also lead to distress. It is difficult to argue that individuals suffer from mental disorders solely because they must deal with the consequences of discrimination. This would lead to diagnosing people for being homosexual, African-American, female, Communist, or Wiccan. When individuals in these "minority" groups present to therapists with problems related to the discrimination that they experience, "therapy" focuses on the development of coping strategies. Their minority status is not the diagnosis.

Dysfunction

The "B" criterion allows for the diagnosis if there is " . . . impairment in social, occupational, or other important areas of functioning" (APA, 2000, p. 566). The implication is that the dysfunction results from the paraphilia per se, rather than social reactions to the sexuality. Theoretically, the paraphilia diagnosis might be justified if the patient was fired for being habitually late as a result of engaging in the paraphilic behavior. However, if one is fired solely due to the discomfort of others, it does not signify dysfunction on the part of the employee.

Suppose an individual is functioning in society without difficulty and also has an interest in a Paraphilia, thereby satisfying the "A" but not the "B" criterion. Theoretically, that person would not be diagnosed with a Paraphilia. Now assume that an employer, spouse, or parent discovers this interest. This revelation leads to termination of employment, discord in the couple or family, etc. Is it appropriate to conclude that the "paraphilia" is the cause of the "dysfunction" and the person now meets the diagnostic criteria? Is the distinction between health and psychopathology being able to keep unusual sexual interests hidden?

Whether the nature of the problem is a psychiatric dysfunction or practical difficulty is particularly murky. Social isolation may lead to depression; participating in support groups and in a subculture surrounding the specific sexual interest may lead to resolution of the alienation and associated depression without psychotherapy or anti- depressants.

It is indicated in the *DSM* (2000) that individuals with paraphilias may be sexually dysfunctional. Although it is true that an individual

with a paraphilia may be sexually dysfunctional, the *DSM* emphasizes causality (" . . . result in sexual dysfunction" [p. 568]); this statement lacks the requisite supporting empirical data. Our review of the literature did not uncover any references suggesting correlation between sexual dysfunction and a diagnosis of a paraphilia, much less causation. It is unclear if the incidence of sexual dysfunction is higher or lower among those with a paraphilia, but sexual dysfunctions are exceedingly common in the general population (Laumann, Paik, & Rosen, 1999). Brown et al. (1996) suggested that there is no difference between the sexual functioning of those diagnosed with a paraphilia compared to a "normal" sample. They reported that cross-dressers were indistinguishable from non-cross-dressers on the Derogatis Sexual Functioning Inventory (DSFI). In addition, Wise, Fagan, Schmidt, Ponticas and Costa (1991) found no significant difference in sexual functioning as measured by the DSFI between "transvestitic fetishists" and "other paraphilics."

Could individuals with Paraphilias have impaired sexual responses to "normative" sexual interests and manifest sexual dysfunctions when presented with non-paraphilic stimuli? Although this is a common belief, it too, is not supported by the data. Individuals diagnosed with Paraphilias apparently have a wide range of interests, including normative sexual interests (Langevin, Lang, & Curnoe, 1998). Conversely, "unusual" sexual interests are commonly found in the general population (Renaud & Byers, 1999; Sue, 1979).

The *DSM* contains the statement, "There is often impairment in the capacity for reciprocal, affectionate sexual activity" (APA, 2000, p. 567). The theme of reciprocal, affectionate sexual activity is repeated through several editions. In the *DSM-III* (1980), this phrase was used in conjunction with Ego-dystonic Homosexuality. Although this diagnosis was technically abandoned with the publication of *DSM-III-R* (1987), essentially the same wording remains in the description of Sex Disorder, Not Otherwise Specified in *DSM-III-R* (1987), *DSM-IV* (1994), and *DSM-IV-TR* (2000). The judgment of what constitutes reciprocal, affectionate sexual activity is clearly value laden and suggests an underlying, implicit, theoretical orientation. There are no data to suggest that individuals diagnosed with a paraphilia have any more difficulty maintaining relationships than "normal" heterosexuals, who have staggering divorce rates.

WHEN DO "PARAPHILIC" SEXUAL BEHAVIORS BECOME PATHOLOGICAL?

The *DSM* is intended to help the clinician distinguish between healthy functioning and mental disorders. The *DSM* cautions, "A paraphilia must be distinguished from the *nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement*" (APA, 2000, p. 568, emphasis in the original). The statement implies, but does not state explicitly that the stimuli can include the paraphilic "fantasies, behaviors, or objects." Guidance on how the clinician is to make this distinction is not given in the text.

In keeping with the *DSM* definition of a mental disorder, any sexual behavior can signify pathology if it interferes with the individual's functioning. However, the behavioral manifestations of a mental disorder should not be confused with the mental disorder or underlying problem itself. An individual with alcoholism may abuse other drugs if access to alcohol is limited. An individual with auditory hallucinations emanating from the radio may hear voices from other objects if the radio is removed. Similarly, an individual who cross-dresses to relieve anxiety after arguing with his wife may benefit from marital therapy rather than "treatment" targeting his transvestic fetishism. Stopping the "problematic" sexual behavior does not imply any problem has been treated or that subsequent sexual expression will be "healthy."

STATEMENTS OF FACT?

The Paraphilia section contains a number of purportedly factual statements that do not appear to be supported by the research literature. For example, " . . . for Sexual Masochism . . . the sex ratio is estimated to be 20 males for each female" (APA, 2000, p. 568). No studies were found to support the 20:1 statement. Several studies were found that reported a significant number of women in the S/M subculture (Breslow, Evans, & Langley, 1985; Gosselin, Wilson, & Barrett, 1991; Levitt, Moser, & Jamison, 1994). By combining the data of Breslow et al. (1985) and Levitt et al. (1994), a ratio of four male masochists to each female masochist was found. Even if clinical samples are overwhelmingly male, no study supports the naming of a specific ratio.

The *DSM-IV-TR* states, "Approximately one-half of the individuals with Paraphilias seen clinically are married" (APA, 2000, p. 568). One study (Wise et al., 1991) appears to support that statement. That study

involved 50 men, comprised of 24 "transvestitic fetishists" and 26 "other paraphiliacs." The "other" types of paraphilias were not specified. However, only by combining the divorced, separated, and married category could one conclude that one-half the individuals were married. It is not clear if the "finding" that half are married is higher or lower than expected. Of interest, the Paraphilias were the only diagnostic section to include information about marital status. The rationale for inclusion of this poorly substantiated "fact" is not clear.

The purpose of many of the statements made in the Paraphilia section is nebulous. Some statements, while correct, are equally true for both those with a Paraphilia diagnosis as those judged to be normophilic. For example, "Frequent, unprotected sex may result in infection with, or transmission of, a sexually transmitted disease" (APA, 2000, p. 567) or, "The behaviors may increase . . . with increased opportunity" (p. 568). The implication is that those diagnosed with Paraphilias are more likely to have sexually transmitted diseases or difficulty engaging or refraining from their sexual interests than those with more conventional interests. Neither point is supported by data nor is the reason for their inclusion in the *DSM* apparent.

Another misleading statement is, "Sadistic or masochistic behaviors may lead to injuries ranging in extent from minor to life threatening" (APA, 2000, p. 567). Although any sexual activity can lead to injury, there is no data to suggest that the practitioners of "sadistic or masochistic behaviors" frequent emergency departments more often than practitioners of other sexual behaviors. A review of the sports medicine and emergency medicine literature reveals numerous studies of specific injuries related to various sports and other activities. If unusual sexual acts resulted in a significant number of injuries, presumably they, too, would appear prominently in the medical literature.

Another erroneous statement is evident in the confusion of hypoxyphilia with sexual masochism. The *DSM* contains the following statement: "One particularly dangerous form of Sexual Masochism, called 'hypoxyphilia,' involves sexual arousal from oxygen deprivation . . . " (APA, 2000, p. 572). In fact there is no empirical data correlating hypoxyphilia to masochism. In their study of 117 fatal cases of autoerotic asphyxia, Blanchard and Hucker conclude, "In contrast to transvestism, bondage during the fatal asphyxial episode was not differentially associated with any specific erotic object or interest that we examined, even bondage pornography" (1991, p. 375).

Some statements confuse rather than clarify the diagnostic process. For example, "For some individuals, paraphilic fantasies or stimuli are

obligatory. . . . In other cases, the paraphilic preferences occur only episodically . . . " (APA, 2000, p. 566). Analogously, heterosexual fantasies or stimuli are obligatory for some heterosexuals, but in other cases occur only episodically. Again, the purpose of the *DSM* statement is questionable.

THE SPECIAL CASE OF PEDOPHILIA

The politics and moral outage surrounding the diagnosis of pedophilia are so pervasive that specific comments about this sexual interest must be explicit. Pedophiles occupy a particularly odious position in our society and suggestions that these individuals do not suffer from a mental disorder may be interpreted as support for their activities. We wish to clarify that our suggestion to remove the paraphilias, which includes pedophilia, from the *DSM* does not mean that sexual acts with children are not crimes. We would argue that the removal of pedophilia from the *DSM* would focus attention on the criminal aspect of these acts, and not allow the perpetrators to claim mental illness as a defense or use it to mitigate responsibility for their crimes. Individuals convicted of these crimes should be punished as provided by the laws in the jurisdiction in which the crime occurred. Any interpretation of our work as supporting adult-child sexual interactions is misguided and wrong.

DISCUSSION

The Paraphilia section of the *DSM* (APA, 2000) does not meet the goals set forth in its text (i.e., "to correct any factual errors . . . to ensure that all of the information is still up-to-date . . . to reflect new information available. . . . all changes proposed . . . had to be supported by empirical data . . . [and] were limited to the text sections" [p. xxix]). Factual errors have not been corrected. The Paraphilia section does not reflect the current state of scientific knowledge nor does it reflect new information available. The diagnostic criteria were changed significantly and these changes were not supported by empirical data. The diagnosis focuses on particular sexual behaviors rather than the distress or dysfunction (or well being) that any sexual interest may promote.

The premise of the *DSM* is that diagnoses should be based upon objective science and not on political or social motivations. Therefore, objective research is needed to substantiate statements that some forms of

sexual expression are healthy and other forms constitute mental disorders. Although it may be tempting to generalize from one's clinical experiences, it is contrary to the premise and stated goals of the APA in the *DSM*. Without data to suggest that a behavior pattern is dysfunctional, one should either suspend judgment or assume the behavior pattern signifies a healthy, normal variation. Although that statement also has political ramifications, it is correct from a scientific perspective.

The *DSM* criteria for diagnosis of unusual sexual interests as pathological rests on a series of unproven and more importantly, untested assumptions. Given the explicit intent to produce an empirically valid document, the *DSM* must provide supporting documentation. Even if future research should verify their current assumptions, they have been inserted into the *DSM* inappropriately at this time. In the interim, these untested assumptions can be and are being misused.

The text of the *DSM* states, " . . . all changes proposed for the text had to be supported by empirical data" (2000, p. xxix). Although this goal is laudable, it can be interpreted as setting up an impossible burden for the removal of a diagnosis or category. If health cannot be defined, then it is impossible to prove that individuals currently subject to a specific diagnosis are actually "healthy" and not pathological. It is logically impossible to prove a negative. Diagnoses should be removed if they can not be shown to meet the definition of a mental disorder unambiguously and be substantiated by appropriate research. Failing that, the diagnosis in question should be either considered experimental or removed from the *DSM* completely.

CONCLUSION

The present critique did not explore every problem in the Paraphilia section. Many more were found than could be documented here. It is obvious that the present diagnostic category has not fulfilled the criteria for inclusion set out in its own text; its foundations are faulty, the criteria for diagnosis are not supported, and its applications subject to misuse and abuse. There are two possible solutions: A major revision of this section or the complete removal of this classification. Alternatives to the current paraphilia category have been proposed (see Moser, 2001, for one example), but a discussion of these alternatives is beyond the scope of the present paper.

If the editors of the *DSM* choose to revise this section, they will need to change the definition of a mental disorder or a paraphilia or both; cor-

rect the factual statements; adjust the criteria for inclusion of a diagnosis, and add safeguards to prevent the misuse of the diagnosis.

Although a radical solution, we now favor removal of the entire category from the *DSM* as the most appropriate remedy for the problems outlined. There are individuals now diagnosed with a paraphilia who seek psychotherapy. We believe that other psychological characteristics describe these individuals and their concerns more accurately than their sexual interests do. It is not their sexual interests, but the manner in which they are manifest that can be problematic at times and is a more appropriate focus for therapy.

A guiding principle in medicine is the dictum "First, do no harm." The confusion of variant sexual interests with psychopathology has led to discrimination against all "paraphiliacs." Individuals have lost jobs, custody of their children, security clearances, become victims of assault, etc., at least partially due to the association of their sexual behavior with psychopathology. This is not a new problem for psychiatry. Within the last 100 years, the labeling of other sexual behaviors as pathological (e.g., masturbation, "nymphomania," homosexuality) has caused untold misery. Judgments should be made on the basis of science, rather than the morality that is popular at the time of a given edition. It is time to reevaluate rigorously the Paraphilia section of the *DSM*.

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