"Depathologize!": A follow-up.

If I had to pick the top theme that sexologists and sexuality interest groups were discussing in the lead up to the proposed DSM changes, that would be it: *Depathologize, depathologize, depathologize.* From blogs to letters to editors of research journals, there have been demands that the DSM declare as officially *normal* various sexual phenomena, ranging from purely consensual situations (like transsexualism and BDSM) to those that motivate sexual offenses (such as pedophilia and hebephilia). With the release of the DSM5 proposals from their various workgroups, I thought it was worth revisiting. I was actually quite surprised by which of the DSM committees did and did not remove the label *mental illness* and from whom:

1. Despite being under the most pressure (probably) to remove the diagnosis of *Gender Identity Disorder* (GID), the gender committee of the DSM (composed of Drs. Jack Drescher, Heino F. L. Meyer-Bahlburg, and Friedemann Pfäfflin and chaired by Dr. Peggy Cohen-Kettenis) has, in effect, *widened* that diagnosis. In the DSM5 proposal, *Gender Incongruence* (the new name) also includes people born with physical *Disorders of Sex Development* (DSD)—such as people who are born with ambiguous genitalia and who dislike the gender to which they were assigned at birth. In the old DSM (DSM-IV-TR), people with DSD were specifically *excluded* from being diagnosed with GID. (Although they rarely received any DSM diagnosis in practice, they could be diagnosed under what amounted to an "other" category.)

2. In contrast, the paraphilias committee of the DSM (Drs. Martin Kafka, Richard B. Krueger, and Niklas Långström, and chaired by Dr. Ray Blanchard) greatly *narrowed* the range of what is deemed a mental illness. In the DSM5 proposal, people with atypical—but otherwise consensual and unproblematic—sexual activities such as cross-dressing and BDSM would no longer be diagnosed with a disorder at all.

3. The remaining depathologization discussions have pertained to paraphilias associated with *nonconsensual* behaviors. Although there have been people at the extremes, writing that even the sexual preference for children should be deemed normal by removing it from the DSM, the paraphilias committee kept the basic scope roughly the same as before, but repaired contradictory criteria that were in DSM-IV-TR. Whereas DSM-IV-TR used the diagnosis *Pedophilia* very broadly (applying it to people whose sexual preference is for children up to age ~13), the DSM5 proposal uses more homogeneous groups: *Pedophilia* (the sexual preference for *prepubescent* children, up to age 10) and *Hebephilia* (the sexual preference for *pubescent* children, ages ~11–14), bringing it into line with the definitions most often used in current research studies.*

So, some diagnoses were widened, some narrowed, and some left the same.

To me, the most surprising of these changes was the expansion made by the gender committee, widening *Gender Identity Disorder* to include people with *Disorders of Sex Development* (called *Intersexes* in DSM-IV-TR). The life experiences of people with DSD are very different from those of transsexuals. Transsexuals struggle terribly trying to convince society of their compelling need to

transsexuals. Transsexuals struggle terribly trying to *convince society* of their compelling need to change their bodies, despite having no visible evidence of a physical disorder. People with DSD, however, suffer the very opposite: Born with very clear evidence of a physical disorder, *society compels them* to change their bodies, even before the infants grow to an age to express what those changes should be (if any). Combining very different situations decreases rather than increases the precision of the manual's terminology.

In the years leading up to the DSM5, the primary arguments for removing versus retaining transsexualism have been: (for removal) that being listed in the DSM conveys an unnecessary stigma; and (for retention) that medical insurance will cover only medically necessary treatments, and in the absence of physical evidence of a physical pathology, recognizing transsexualism in the DSM establishes it as a bone fide medical condition with a bone bide medical resolution (hormonal and surgical sex reassignment), despite the lack of physical evidence. The gender committee's proposal suggests that they believe transsexuals indeed receive greater benefit by remaining in the DSM.

Obviously, the gender committee felt that *Disorders of Sex Development* merited reclassification, but it is less clear why it would be reclassified rather than entirely depathologized. Unlike with *Gender Identity Disorder,* no medical care becomes available to people with DSD from being in the DSM that is not already available to them under their physical diagnosis (e.g., *Congenital Adrenal Hyperplasia,* etc.). No government-issued identification or other document becomes changeable that could not already have been changed on the basis of the physical diagnosis. To me, having DSD in the DSM is all cost and no benefit. Rather than *depathologize* DSD, however, the gender committee is elevating the status of DSD from one of several possibilities in a DSM "other" category, up to a specifier of the primary diagnosis.

In one discussion among professionals on the proposed changes, Dr. Randall Ehrbar, a clinical psychologist and openly trans man, saw an ideological overtone to the combining of transsexualism and DSD. "I agree that the addition of the DSD specifier is a mistake....Because many trans people and providers strongly believe that being trans is *per se* reflective of a neurological intersex condition, I fear the use of this specifier would reflect the ideology of providers rather than the presenting concerns of clients."

Another critic of the proposed change is Dr. Allen Frances, who was the head of the prior DSM. Although I disagree with other things he has written on the DSM5, I believe his comment regarding the new *Gender Incongruence* criteria was quite apt:

> The writing here is especially unclear, but there appears to be an ill conceived suggestion to remove the requirement for clinically significant distress or impairment. Presumably everyone with an unorthodox gender identity would now get a diagnosis of mental disorder—even if they are happy and functioning well. [The previous] approach seems best—i.e., to recognize that gender incongruence becomes a mental disorder only when it is causing significant problems. [Ref1]

I have not yet seen any reaction from DSD community or family groups about the proposed changes. I suspect that they have been caught by surprise (as have I). Although transgender and other groups have been following the DSM discussions very closely for many years, the widening of the primary gender-related diagnosis was not discussed by DSD groups. The issues of interest to DSD advocates usually pertain to how infants are treated, what sex they should be raised as, and whether any surgeries should be conducted in infancy or later in life, when the persons are able to make decisions for themselves. This change to the DSM seems (to me) to have come out of nowhere. It will be very interesting to see what the DSD communities' responses will be, as they organize their reactions.

The change to the criteria for paraphilias involving *consenting* sexual behaviors, such as cross-dressing and BDSM (e.g., bondage/discipline), provides a clear split: Persons who sexually prefer such activities may be said to have a "paraphilia" but would *not* be diagnosed with a mental illness (now called a "paraphilic disorder") when those activities cause no harm or distress. This change has garnered explicit community support. According to the *National Coalition for Sexual Freedom:*

> In the new proposals for the DSM-V, alternative sexual behavior has been

depathologized….NCSF has worked very hard with its DSM Revision Project to make sure these changes take place, and will continue to strongly advocate for clear language of what exactly constitutes a mental disorder. [Ref2]

The proposed changes to the diagnoses about having sexual preferences towards children appear to have been structural only. Although there have been individual authors—such as Karen Franklin [Ref3] advocating for the depathologization of *Hebephilia* (the sexual preference for 11–14 year old children), and Richard Green [Ref4], for the depathologiziation of *Pedophilia* (the sexual preference for children under 11)—the criteria have been "cleaned up" rather than broadened or narrowed. The DSM-IV-TR said on the one hand that pedophilia was a sexual attraction towards prepubescent children, but it nonetheless used age 13 (which is long after the mean onset of puberty in the U.S. and Canada) as the guideline.

The DSM5 criteria resolve that inconsistency: The term *Pedohebephilia* will refer to sexual attraction to pubescent or prepubescent children generally, with *"pedophilic type"* used for those whose sexual interests are limited to *prepubescent* children (Tanner Stage 1 of physical development, usually under age 11), *"hebephilic type"* used for those whose sexual interests are limited to *pubescent* children (Tanner Stage 2 or 3, usually ages 11–14), and *"pedohebephilic type"* for those whose interests span both stages of development.

There has been little community input on this aspect of the DSM5. Although there exist groups advocating for increasingly punitive reactions to sex offenders against children, there has been little discussion (that has reached my own desk, anyway) about what the general community believes would be the optimal cut-off for how young a sexual interest has to be before one might consider it a mental illness (if at all). In fact, that would make for an interesting, if overdue, survey.

Given the many expressions that the DSM should pathologize less, I would certainly have predicted that the sex and gender workgroups would reduce the range of situations receiving a diagnosis. I would not have predicted, however, that it would be *the paraphilias committee* rather than the gender committee which actually did so the most.

For those interested, the full text of the proposed DSM5 diagnostic criteria are available from the website of the American Psychiatric Association, and they are requesting public input:

DSM5 Criteria for the Sexual and Gender Identity Disorders (proposed)

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*In the interests of full disclosure, I should point out that I am a co-author or lead author on many of the published studies that explicitly included a group of hebephiles. Although there are writers who inaccurately refer to hebephilia as a sexual interest in "teenagers" (ages 13–19) or "adolescents" (approx. ages 11 to early 20's), the work from my own team is very specific in referring to the sexual preference in *pubescent* children, ages 11–14.

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