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LETTER TO THE EDITOR

DSM5: Pandora Replies to Dr Frances

By Kenneth J. Zucker, PhD | February 22, 2010

Dr Zucker is chair of the DSM5 Workgroup on Sexual and Gender Identity Disorders. He is psychologist-in-chief at the Centre for Addiction and Mental Health (CAMH) and the head, Gender Identity Service, Child, Youth, and Family Program at CAMH. He is a professor in the department of psychiatry, University of Toronto.

In his recent David Letterman-like **Top-19 list of DSM5 issues**, Dr Allen Frances targeted a proposed revision of the *DSM-IV* diagnosis of Pedophilia, and 2 proposed new diagnoses: Hypersexual Disorder and Paraphilic Coercive Disorder. He protests the inclusion of pubescent teenagers in the definition of the proposed revision of Pedophilia (including the renaming of it as Pedohebephilic Disorder) and criticizes the quality of writing of these criteria.[1] As the chair of the DSM5 workgroup responsible for those draft criteria, I need to address his poorly reasoned claims.

If Dr Frances were a thoughtful critic of the **DSM5**, he could at least have studied the detailed literature reviews and the stated rationales for the changes—easily accessible along with the proposed diagnostic criteria in the **APA's Web site**. He could then submit his concerns as a Letter to the Editor to the Archives of Sexual Behavior, where all but one of the paraphilic reviews have been published online since the fall of 2009, or to the work group directly, through the Comments section of the Web site. He has ignored my invitation to do so,[2] and instead has chosen to fire off criticisms as quickly as his grandchildren might tweet to their friends.

I also doubt that he has read Dr Blanchard's[3] lengthy report on the serious problems with the *DSM-IV-TR* diagnostic criteria for Pedophilia, which were detailed in his published report to the DSM5 Paraphilias Subworkgroup, a report that can be downloaded for free at **www.dsm5.org**, thanks to a shared copyright agreement between Springer (the publisher of *Archives of Sexual Behavior*) and the **APA**. I have worked professionally with Dr Blanchard for almost 30 years, and he is the most careful writer I know. That Dr Frances would characterize Dr Blanchard's proposed diagnostic criteria as poorly written is, to expropriate an adjective from my friend and colleague, Bob Spitzer, "absurd." The Paraphilias subworkgroup has labored for months and for several hundred hours on their proposed products, and I am dumbfounded by Dr Frances' characterizations.

In his commentary, Dr Frances (who was the editor of the *DSM-IV*) fails to mention the epistemological problems he created by clumsily implementing the requirement of distress and/or impairment to diagnosis a paraphilia. In the versions of the DSM prepared under Dr Frances' supervision, a person cannot *have* a paraphilia unless he is distressed by that paraphilia or he is harming other people because of it. A distinct but harmless paraphilia cannot exist, *by definition.* A man cannot be a fetishist, for example, even if he masturbates into rubber boots on a regular basis, unless he is bothered by this behavior or is impaired in his psychosocial functioning. In *DSM-IV-TR,* there is no such thing as a well-adjusted paraphile; they are defined out of existence.

It is ironic that Dr Frances criticizes the wording of the proposed diagnostic criteria for the paraphilias, when the criteria

prepared under his supervision contained such logical absurdities. He has often and ominously warned of future, possible "unintended consequences" of the wording details of the diagnostic criteria, but he has been strangely silent about clear errors in diagnostic criteria that should have been obvious in the *DSM-IV*. In order to correct this problem, the Paraphilias Subworkgroup has introduced the proposed distinction between ascertaining a Paraphilia versus diagnosing a Paraphilic Disorder. In my view, this is an extremely creative distinction that might do well in distinguishing people who have paraphilic behavior from those who have a paraphilic disorder. He had his kick at the paraphilic can and missed it.

Regarding the proposed new diagnoses of Hypersexual Disorder (HD) and Paraphilic Coercive Disorder, Dr Frances ignores the detailed literature review by Kafka[4] regarding the former and the advisor reports on the latter.[5-7] Regarding HD, all he can muster is an oversimplified morality lecture: "[HD] would be a gift to false positive excuse seekers..." For thoughtful readers of *Psychiatric Times,* the Paraphilias Subworkgroup welcomes detailed feedback on its proposed diagnoses and diagnostic revisions. That is, after all, the purpose of the **DSM5 Web site**, which is arguably the most transparent forum for feedback in the history of medicine.

-Kenneth J. Zucker, PhD, CPsych

DR FRANCES RESPONDS

I thank Dr Zucker for accurately stating **my position** and then illustrating it with a particularly vivid and well-chosen example. I continue to find no reason to label as mental disorder sexual urges, fantasies, or behaviors that are harmless to others and cause no distress or impairment to the individual. As psychiatrists, we have our hands full taking care of the suffering and distress caused by real mental disorders. There is no need for us to expand our purview to cover sexual thoughts and behaviors that are private and harmless.

The behaviors captured by "paraphilic coercion" and "hypersexuality" are anything but private or harmless—but that does not make them mental disorders. There is no infallible definition guiding what should, and what should not, be included in the official manual of mental disorders.

Many decisions can be tough calls. But it seems abundantly clear that these proposals from the Sexual Disorders Work Group have no place in **DSM5**. They offer little gain and would create significant problems. The construct "paraphilic coercion" has already contributed significantly to a grave misuse of psychiatry by the legal system in the handling of sexually violent predators—a misuse much opposed by the **APA** in a task force report and amicus brief to the Supreme Court.

Both constructs also medicalize undesirable sexual behavior and thereby provide a psychiatric excuse helpful to those who are attempting to evade personal responsibility. Such obviously risky proposals would deserve serious consideration only if they fill an important need; are supported by a wide, deep, and high quality base of scientific evidence; and would have containable blowback.

None of these conditions is met here. These proposals do not belong anywhere in **DSM5**—not even as Not Otherwise Specified examples.

Dr Zucker will no doubt respond that he is the expert on sexual disorders and that I don't know what I am talking about. This would miss the point that the official diagnostic system is too important to be left exclusively in the hands of the experts. Experts in any given area often have pet diagnoses that may have some value in their own hands but can cause unintended societal disasters when taken out of context and put to general use. Experts also tend to overvalue the quality and relevance of the scientific literature in their own field.

Every new diagnosis suggested for **DSM5** requires (but has not yet received) a searching risk/benefit analysis and a thorough forensic review. I am confident that none of the suggestions for new diagnoses made by the Sexual Disorders Work Group would stand up to such scrutiny.

-Allen Frances, MD

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by Richard Kramer | March 12, 2010 6:49 PM EST

One of the issues that has yet to be addressed is the fact that in regards to "pedohebephilia,"the DSM is currently being revised in the absence of data from representative samples of those people under consideration. If experts are right, there are hundreds of thousands of people (most experts estimate over a million) in the general population who are preferentially attracted to children or adolescents (emotionally and sexually). Yet, DSM revisions are being based on limited data only from unrepresentative correctional populations who cannot be honest with researchers. It is well-known among social scientists that data from such populations are highly biased and misleading. Such limited data hardly lead to "diverse perspectives" or to "a thorough, balanced review of scientific data" as specified by APA Statements regarding DSM revisions.

In fact, Dr. Blanchard writes that his proposed diagnostic criteria are based on the assumption that patients will be dishonest. Do other subworkgroups base their criteria on such assumptions? If one is interested in accurate diagnostic criteria, it would seem to be more effective to find solutions to this problem than to be content with misleading information and a situation where the only subjects are those who are encouraged to be dishonest while clinicians must outsmart them. It seems hard to believe that such an adversarial approach would result in accurate diagnosis or effective treatment.

This approach, along with the lack of accurate information, breeds fear both in society and among people who are attracted to minors. In my work with a non-profit organization (B4U-ACT) in Maryland, I have met many minor-attracted people not under the supervision of the correctional system, some of whom seek mental health services but are extremely feaful of condemnation solely for their feelings of attraction. I have also been contacted by teenagers who have engaged in cutting or attempted suicide due to their attraction to children. They do not feel safe contacting professionals or suicide hotlines. Fear forces minor-attracted people into hiding, making the gathering of accurate information even more difficult. Perpetuating this vicious cycle does not lead to reliable diagnostic criteria (nor to effective child protection policies). It renders the APA powerless to gather and disseminate accurate information.

There is a solution to this otherwise intractable problem. Our organization has facilitated communication and cooperation between mental health professionals and minor-attracted adults, and has proposed to establish in-person dialog with the paraphilias subworkgroup for the purpose of obtaining more accurate information. The ultimate goal is to reduce barriers between professionals and people who are attracted to minors for their benefit as well as the benefit of children and society in general.

So far, Dr. Blanchard has replied as follows:

1. He stated that members of the subworkgroup are too geographically scattered to meet with us. We replied by offering to meet with only one or two members.

2. He responded by saying that for the reason already given, the subworkgroup would not meet with us. He did not acknowledge the need for accurate information.

3. He wrote that his subworkgroup would never discourage minor-attracted people from seeking clinical assistance. We replied by noting that failing to include representation from patient and family groups as stipulated by APA policy seriously discourages them from receiving mental health care. The need to promote a cooperative relationship with clients is well known in the mental health field.

4. He wrote that to "ensure fair and equal treatment of all advocacy groups," APA policy precludes his subworkgroup from meeting with us. We replied that this was puzzling since the APA held a symposium at its 2009 Annual Meeting to "bring together transgender advocates and DSM-V group members," thus it was unclear how meeting with transgender advocates but not with us was fair and equal treatment. We also did not see how such a policy could be reconciled with the following APA statement: "To ensure that those involved in the revision process represent diverse perspectives, disciplines, and areas of expertise, the Task Force and work groups represent a variety of clinical and scientific disciplines, patient and family groups..." We wonder how minor-attracted patients or their families had been represented in his workgroup.

We fully support the APA's stated positions as cited above, but see evidence that the paraphilias subworkgroup may be reluctant to adhere to them.

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