Arch Sex Behav (2010) 39:1235–1237
DOI 10.1007/s10508-010-9654-8

LETTER TO THE EDITOR

Disregarding Science, Clinical Utility, and the DSM's Definition of Mental Disorder: The Case of Exhibitionism, Voyeurism, and Frotteurism

Andrew C. Hinderliter

Published online: 12 August 2010

In Långström's (2010) methodology section, he says that he "carefully read prior versions of the DSM diagnostic criteria for these paraphilias from the DSM-III to DSM-IV-TR" (p. 317), but his review makes some serious errors. Långström writes:

> In the DSM-III-R (American Psychiatric Association, 1987), the core criterion (A) for Exhibitionism (Over a period of at least 6 months, recurrent, intense sexual urges and sexually arousing fantasies involving intense sexual arousal from exposing one's genitals to an unsuspecting stranger) remained the same as in DSM-III (American Psychiatric Association, 1980). However, a qualifying diagnostic B criterion was added, as were [sic] true for all paraphilia diagnoses. This criterion was added to emphasize that psychiatric disorders or diagnoses had to include acting out against others or substantial distress. (p. 317)

Here is what DSM-III's (American Psychiatric Association, 1980) diagnostic criteria for Exhibitionism said: "Repetitive acts of exposing the genitals to an unsuspecting stranger for the purpose of achieving sexual excitement, with no attempt at further sexual activity with the stranger" (p. 272). Unlike DSM-III-R, DSM-III made no reference to sexual fantasies or sexual urges—the focus was on sexual behaviors. His analysis of Voyeurism in DSM-III is even more problematic.

> In the DSM-III-R, the core criterion for Voyeurism (Over a period of at least 6 months, recurrent, intense sexual urges and sexually arousing fantasies, involving the observation of an unsuspecting person who is naked, disrobing, or engaging in sexual activity) remained the same as in DSM-III. (Långström, 2010, p. 320)

What DSM-III says:

> A. The individual repeatedly observes unsuspecting people who are naked, in the act of disrobing, or engaging in sexual activity and no sexual activity with the observed people is sought.
> B. The observing is the repeatedly preferred or exclusive method of achieving sexual excitement. (p. 273)

The focus is on sexual *behaviors*, and—unlike DSM-III-R—DSM-III required these to be preferred to other sexual interests. Also, DSM-III-R did not require that "no sexual activity with the observed person is sought." These errors are more than inattention to detail. They suggest that the entire review process is seriously flawed and that previous criticisms of the Paraphilias have been ignored—it is often critics of the Paraphilias who give the closest analysis of their text.

These factual errors aside, Långström (2010) gives compelling reason for removing exhibitionism, voyeurism, and frotteurism from the DSM, but fails to draw this conclusion. In an article of eight pages, he reviews *three* diagnoses; given that his methodology indicates he did a thorough literature search, this must mean that there is only scant empirical work to support these diagnoses—implying that only the thinnest of scientific foundation exists. Regarding frotteurism, Långström acknowledges that it "has not been a subject of much clinical or scientific interest" (p. 320). Essentially, he admits that this diagnosis has minimal scientific foundation, minimal clinical value, and has resulted in minimal research.

Långström cites a number of studies indicating that voyeuristic behavior (and interest) is extremely common, but notes that, overall, there is not much research on prevalence. He suggests this is because "voyeurism is relatively easy to relate to for many

A. C. Hinderliter (✉)
Department of Linguistics, University of Illinois, 4080 Foreign Languages Building, Urbana, IL 61801, USA
e-mail: ahinder2@illinois.edu

individuals and, therefore, does not elicit the same strong negative emotions as do some of the other paraphilias" (p. 319). Here, he implies that the basis for classifying the paraphilias as disorders is prejudice–and then acknowledges that there is not even much prejudice against this paraphilia!

Not only does Långström (2010) tacitly admit that these three diagnoses have minimal scientific support, he recognizes that they can harm patients: "Seen from an overall perspective of DSM psychiatric nosology, [the issue of false-negatives] may be a particular problem for the potentially criminal paraphilias since shame, social stigma, and *negative legal consequences* prevent people from being open about their symptoms" (p. 232, emphasis added). If diagnosis of a Paraphilia can harm patients, the imperative to Do No Harm demands the deletion of these diagnoses unless it can be shown that their benefit considerably outweighs this harm. Furthermore, if these diagnoses discourage patients from being honest with clinicians, their clinical value is seriously drawn into question.

Långström's criticism of Sweden's decision to remove several of the Disorders of Sexual Preference from the ICD is especially telling in this regard: "[Now] clinicians in Sweden need to find other ways to diagnose *and occasionally treat* individuals with several of the deleted, but arguably still existing, disorders" (p. 322, emphasis added). The use of *occasionally* to modify *treat* but not *diagnose* suggests that the primary purpose of these diagnoses is not therapeutic. Is it punitive?

For frotteurism, Långström (2010) speculates that it was "its relevance to decision-making in criminal justice rather than in clinical settings that motivated its emergence as a specified paraphilia" (p. 321). Basically, he acknowledges that it is in the DSM simply because the associated act is illegal. With this type of reasoning, perhaps "Embezzlement Disorder" and "Insider Trading Disorder" should be added to the DSM? First and Frances (2008) emphasize the importance of not "blur[ing] the distinction between mental disorder and ordinary criminality" (p. 1240), which has been especially problematic in the diagnosis of the paraphilias.

From DSM-III to the present, all versions of the DSM have explicitly stated in their definitions of mental disorder that social deviance, whether commendable or not, is not itself a mental disorder. According to Spitzer and Williams (1982), this statement "was added to express indignation at the abuse of psychiatry as when, in the Soviet Union, political dissidents without sign of mental illness [were] labeled as having mental disorders and under that guise incarcerated in mental hospitals" (p. 21). In the U.S., 20 states and the Federal Government have Sexually Violent Predator laws that permit the (often lifelong) civil commitment of sex offenders *after* completing their sentences, including offenders with "no real mental disorder" (Frances, 2009), a situation which has been supported by a misreading of DSM-IV-TR's (American Psychiatric Association, 2000) phrase "sexually arousing fantasies, sexual urges, or behaviors" in the definition of Paraphilia. This has been used to diagnosis people with a Paraphilia on the basis of behavior alone. Långström rejects First and Frances' (2008) plea to remove "or behaviors" from the Paraphilias, which they say was a mistake to begin with. Practically, this means he endorses regarding *deviant sexual behavior alone*—without corresponding sexual fantasies or urges—as mental disorder. (That is what *or* means.) Combined with Långström's tacit acceptance of his speculation about why frotteurism was added to the DSM, this amounts to a rejection of the DSM's claim that social deviance itself is not a mental disorder.

Långström justifies rejecting First and Frances' plea saying, "I am not convinced that psychiatric nosology should change primarily because of the potential or actual misuse of diagnoses in the judicial system" (p. 323), which raises the controversial issue of what role legal consequences should play in nosological debates. Some authors (e.g., Stern, 2010) argue that ideological and political issues should have no role in what (supposedly) should be an entirely scientific issue. Besides suggesting a serious case of what Spitzer, tongue in cheek, called Politics Science-Dichotomy Syndrome (Spitzer, 1985), this assumes that whether something is a disorder is entirely an objective, scientific issue, a position many disagree with (e.g., Sedgwick, 1982; Spitzer, 1981; Wakefield, 1992). Here are many values involved in psychiatric nosology, some scientific and some not (Sadler, 2005). Indeed, the primary purpose of the helping professions is to help people, not to be "scientifically objective" in a way that disregards the consequences diagnostic decisions will have on real people, as though that were somehow a virtue. The primary purpose of the DSM is to help them do this. As Pincus and McQueen (2002) state: "The goals of the DSM-IV can be divided into four main categories: clinical, research, educational, and information management. The clinical goals of the DSM-IV were paramount because the book is used primarily by clinicians" (p. 9).

Brotto's (2010) literature review for Sexual Aversion Disorder (SAD) notes that it is a diagnosis that was added in DSM-III-R with little empirical justification, likely because of one person's historical influence. Given the minimal clinical and research interest it has produced—and because what treatment has developed treats it as a specific phobia—Brotto regards maintaining the status quo for SAD as the least desirable of the options discusses. Brotto noted that "With DSM-V and the emphasis placed on any changes being based on empirical science, SAD clearly would not have made its way into the DSM" (p. 276). The same holds for the three diagnoses that Långström reviews (and likely a number of the other paraphilias as well). However, rather than suggest that the scientific and clinical merit of these diagnoses be subject to critical review, he supports maintaining the status quo with a single modification to reflect a proposal being made for all the potentially criminal paraphilias. How long must these diagnoses remain in the DSM without empirical support before an accounting of them is demanded?

Frances (2010), chair of the DSM-IV Task Force, titled an editorial that bluntly states his assessment of the work of the Sexual and Gender Identity Disorder Workgroup: "DSM-5 and Sexual Disorders—Just Say No." He writes:

> Each of the Work Group's suggestions is based on the thinnest of research support—usually a handful of studies often done by members of the committee making the suggestion. None has been subjected to, or could possibly survive, anything resembling a serious risk/benefit or forensic analysis.

Though he makes comments about the Gender Identity Disorder Subworkgroup, most of his criticism is reserved for the proposals of the Paraphilias Subworkgroup.[1] I would add that not only should all proposed changes to the DSM be subject to serious risk/benefit analysis, so should proposals to maintain the status quo. It is doubtful that Långström's proposal to maintain the status quo could survive a serious risk/benefit analysis. The DSM should be scientifically rooted, clinically useful, and socially responsible. Långström's literature reviews inspire little confidence that the Paraphilias Subworkgroup is taking any of these values seriously.

References

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

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Brotto, L. A. (2010). The DSM diagnostic criteria for Sexual Aversion Disorder. *Archives of Sexual Behavior, 39*, 271–277.

First, M. B., & Frances, A. (2008). Issues for DSM-V: Unintended consequences of small changes: The case of paraphilias [Editorial]. *American Journal of Psychiatry, 165*, 1240–1241.

Frances, A. (2009, June 26). A warning sign on the road to DSM-V: Beware of unintended consequences. *Psychiatric Times*. http://www.psychiatrictimes.com/dsm-5/content/article/10168/1425378.

Frances, A. (2010, March 17). DSM5 and sexual disorders—just say no. *Psychiatric Times*. http://www.psychiatrictimes.com/dsm-5/content/article/10168/1539921.

Långström, N. (2010). The DSM diagnostic criteria for exhibitionism, voyeurism, and frotteurism. *Archives of Sexual Behavior, 39*, 349–356.

Pincus, H. A., & McQueen, L. (2002). The limits of an evidence-based classification of mental disorders. In J. Z. Sadler (Ed.), *Descriptions and prescriptions: Values, mental disorders, and the DSMs* (pp. 9–24). Baltimore: The John Hopkins University Press.

Sadler, J. Z. (2005). *Values and psychiatric diagnosis*. Oxford: Oxford University Press.

Sedgwick, P. (1982). *Psycho politics*. New York: Harper & Row.

Spitzer, R. L. (1981). The diagnostic status of homosexuality in DSM-III: A reformulation of the issues. *American Journal of Psychiatry, 138*, 210–215.

Spitzer, R. L. (1985). DSM-III and the politics-science dichotomy syndrome: A response to Thomas E. Schacht's "DSM-III and the politics of truth". *American Psychologist, 40*, 522–526.

Spitzer, R. L., & Williams, J. B. W. (1982). The definition and diagnosis of mental disorder. In W. R. Gove (Ed.), *Deviance and mental illness* (pp. 15–31). Beverly Hills, CA: Sage.

Stern, P. (2010). Paraphilic coercive disorder in the DSM: The right diagnosis for the right reasons. *Archives of Sexual Behavior*. doi: 10.1007/s10508-010-9645-9.

Wakefield, J. C. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *American Psychologist, 47*, 373–388.

[1] Unfortunately, Francis fails to mention that none of his criticisms are about the Sexual Dysfunctions Subworkgroup's proposals.