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LETTER TO THE EDITOR

The Proposed Diagnosis of Hypersexual Disorder for Inclusion in DSM-5: Unnecessary and Harmful

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The intent of this Letter is to discuss one of the "Criteria for Change in the Current Diagnostic Classification" (as stipulated in the *Guidelines for Making Changes to DSM-5*) that is lacking in the Sexual and Gender Identity Disorders Work Group's rationale for its proposed diagnostic category "Hypersexual Disorder" (with one of seven possible specifiers: Masturbation, Pornography, Sexual Behavior With Consenting Adults, Cybersex, Telephone Sex, Strip Clubs, or Other) (see Kafka, 2010). The criterion that is lacking in the rationale is: "A discussion of possible unintended negative effects of its proposed change, if it is made, and a consideration of arguments against making the change should also be included."

Let me start by asserting that specifically medicalizing (psychiatrizing) an aberrant sexual activity when there already exists a number of DSM diagnoses that more than adequately cover the subject is inimical to the best interests of the persons who experience the "disorder" and, more important, to society itself.

He (almost all "hypersexual" individuals are male) gets involved with a mental health therapist when he (1) becomes depressed because of any number of reasons (e.g., contracting AIDS, charged with a crime, heavily addicted to a narcotic, etc.); (2) seeks help for a compulsive disorder, having frequently failed to resist the urge to engage in sexual activity; (3) is hospitalized for treatment of a psychotic disorder or is in prison for having committed a serious crime (the treatment being sought would be for hypersexual conduct prior to the institutionalization because, obviously, hypersexual activity, at least with the opposite sex, is not ordinarily possible in these settings). A diagnosis of "Hypersexual Disorder" is entirely unnecessary because the criteria for the diagnoses mentioned are correctly met in any particular case.

Thus, hypersexually behaving persons are not "a distinct group of people who need appropriate clinical attention." In other words, "Hypersexual Disorder" is not "sufficiently distinct from other diagnoses to warrant being considered a separate diagnosis." It does not contribute to "better conceptualization of diagnoses or to better assessment and treatment."

The Work Group's rationale states: "There is a significant research-associated need to consolidate an operational definition for such a condition so that research from varying theoretical perspectives can coalesce with a common set of criteria." The Work Group also asserts that "A DSM-V-based empirically derived definition should significantly enhance research efforts to explore some of the additional diagnostic validators for which there are no current data." Having had very little involvement in research, I discussed the Work Group's position with an experienced research psychiatrist at Harvard Medical School. I asked: Can meaningful research be undertaken without varying theoretical perspectives coalescing with a common set of criteria? Can studies (by intelligent, ethical, well-trained, and experienced researchers) to explore some additional diagnostic validators be undertaken without a DSM-5-based empirically derived definition? My consultant found no basis for the Work Group's assertions that the special conditions are necessary to conduct research on hypersexuality. He emphasized that research that the Work Group deems necessary and important can be undertaken on the basis of hypotheses developed for research on psychological or psychiatric disorders, indeed for research in any field.

Although I am not suggesting that hypersexuality is even remotely as serious a problem as some of the sexual disorders described in DSM-IV-TR, I would like to remind the DSM-5 Work Group of the controversies in the American Psychiatric Association (APA) during the Fall and Winter of 1985 when

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"Sexual Assault Disorder," "Paraphilic Rapism," and "Paraphilic Coercive Disorder" were successively under consideration (by the Work Group to Revise DSM-III) for inclusion in the Paraphilias section of the chapter on Sexual Disorders**.** I do so because the type of problems that I believed would have occurred had a diagnosis such as "Sexual Assault Disorder" been included in the DSM would, without doubt, in my opinion, be experienced if the diagnosis of "Hypersexual Disorder" were included in DSM-5.

Much earlier, in the first draft of DSM-III in March 1976, it was proposed (by the APA Task Force on Nomenclature and Statistics) that the rapist be officially recognized as a patient suffering from a mental disorder. The following operational (diagnostic) criteria for "Sexual Assault Disorder" were listed: (A) The fantasy of sexual assault is erotically exciting. (B) There is significant motivation to translate the exciting fantasy into action. The individual *has* committed an act of sexual assault, or inevitably *will* in the near future. If the act has been committed in the past, there is significant motivation to repeat it.

A DSM-III Conference was organized to review the proposals of the APA Task Force on Nomenclature and Statistics. The meeting was held on June 10–11, 1976, in St. Louis, Missouri, under the auspices of the Department of Psychiatry of the University of Missouri-Columbia School of Medicine. At this conference, as a representative of the American Academy of Psychiatry and the Law, I pointed out during the brief period allocated for a discussion of the proposed "Sexual Assault Disorder" diagnosis that we were then facing a countrywide movement to stop the holding of the victim of rape as responsible for the crime and to focus instead on the criminal. I said that while at first blush the introduction of the classification of rape as being due to a "Sexual Assault Disorder" might seem harmless, it could be considered by some as a move on the part of the American Psychiatric Association to foster the decriminalization of rape. In the statement I submitted prior to the Conference, I wrote that classifying sexually assaultive behavior under a specific psychiatric diagnosis would have the effect of minimizing the wrongfulness of the perpetrator's conduct and would open the door to even more widespread misuse of psychiatry than existed at that time. Prosecutors would seek to hospitalize offenders when there was insufficient evidence to convict, and defense attorneys would seek to hospitalize offenders when there was overwhelming evidence making conviction otherwise inevitable. Sexual assault, I pointed out, is not a disorder—it is a crime; DSM-III is a classification of mental disorders, not a classification of criminal conduct.

I recommended that "Sexual Assault Disorder" be excluded from DSM-III. In this recommendation, I was joined by women's groups throughout the country. Subsequent drafts of DSM-III (April 15, 1977, and January 15, 1978) did not include the diagnosis of "Sexual Assault Disorder," and, of course, it did not appear in the 1980 edition of DSM-III.

The DSM-5 Sexual and Gender Identity Disorders Work Group appears to be unaware that competent lawyers would have no problem advancing "Hypersexual Disorder" as a mitigating factor in the defense of a "hypersexual" felonious criminal defendant. More specifically, however, I believe that the proposed diagnoses of "Hypersexual Disorder" (with specifier Pornography) and "Hypersexual Disorder" (with specifier Cybersex) have ominous implications for forensic psychiatry and the criminal justice system. Were the diagnosis of "Hypersexual Disorder" included in DSM-5, arrestees charged with having committed violations of laws prohibiting either child pornography or cybersex involving solicitation of sex with a minor, and facing long periods of imprisonment, could easily be coached to claim that they "suffer" from at least four of the symptoms listed in Criterion A of the diagnoses "Hypersexual Disorder" (with specifier Pornography) or "Hypersexual Disorder" (with specifier Cybersex), respectively.

A "Cautionary Statement" (such as DSM-IV-TR's "The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency" (p. xxxvii)) is certain to be included in DSM-V. As has been the case with prior DSMs, such a cautionary statement would be totally disregarded by lawyers and judges—they would use DSM-5 as the primary (more likely, only) authority in psychiatry (the "Bible" of psychiatry).

In conclusion, I believe that specifically medicalizing, psychologizing, or psychiatrizing an aberrant sexual activity (hypersexuality) in addition to the diagnostic categories already adopted and generally accepted by the psychiatric and psychological professions all over the world is, at best, a useless redundancy and, at worst, an invitation to the anti-psychiatry movement, and others, to scorn and ridicule the American Psychiatric Association.

Reference

Kafka, M. P. (2010). Hypersexual disorder: A proposed diagnosis for DSM-V. *Archives of Sexual Behavior, 39*, 377–400.