An Overview

As I was preparing revisions for the 11th edition of *Sexuality Today* (due for publication in December), I had to rely on published papers reflecting various opinions about possible sex-related changes to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* or *DSM-5*. Many of these papers were published in the *Archives of Sexual Behavior*, and there was also a good deal of discussion on various professional listserves. When the finished manual was published in late May, I was able to put the final touches on my own book.

The American Psychiatric Association’s revision process took 12 years, beginning with an evaluation of the strengths and weaknesses of the DSM that was coordinated with the World Health Organization Division of Mental Health, the World Psychiatric Association, and the National Institute of Mental Health. This was followed by the development of a research agenda for the new edition and 13 international planning conferences to review the world literature. In 2006, the DSM-5 Task Force was formed, establishing 13 diagnostic work groups that ultimately involved several hundred advisors and group members. Drafts of various diagnostic criteria were published for public comment and field trials were conducted. The final version has received harsh criticism, as any politically-charged effort will, but I think it is quite thorough and consistent with current research. It has left open numerous “Conditions for Further Study,” and “Other Conditions that May Be a Focus of Clinical Attention,” a gesture that seems well-advised in the face of continuing controversies.


Here are some of the most important points about the new organizational structure of the *DSM-5*:

- The multiaxial system of assessment has been dropped, so no longer will we need to make distinctions among the Axis I, II, III, etc. disorders.

- The former DSM-IV Global Assessment of Functioning (GAF) Scale (Axis V) has also been dropped for lack of clarity and questionable psychometrics.

- It is more culturally competent, organizing cultural issues into: *Cultural syndrome*, found in specific cultural groups with features that may be recognized by outside observers; *Cultural idiom of distress*, that describes particular ways in which members of a culture communicate about the essential features of distress; and *Cultural explanation or perceived cause* with which members of a culture label and conceive the cause of symptoms, something that may be critical to understanding classifications of disease used by laypersons or healers in the culture.

- It recognizes that there may be potential differences in the ways women and men express mental illness, naming *sex differences*, attributable to variant sex organs and chromosome complements, and *gender differences* that result from both biology and individual self-representation.

- It has further developed the dimensional concept of severity with regard to many disorders, and the spectrum approach to disorders such as autism and schizophrenia. This has meant that some of the sub-classifications of these disorders have been replaced by notations of severity.
Defining Mental Disorders

After defining a “disorder” as being characterized by a significant disturbance in cognition, emotional regulation, or behavior, and reaffirming that in most cases this must be associated with “significant distress or disability” in the individual, the manual sensibly goes on to distinguish this from the kind of social and ethical complexities that often plague attempts at defining sex-related diagnostic categories:

“Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders (italics mine) unless the deviance or conflict results from a dysfunction in the individual as described above.” (p. 20)

The *DSM-5* has organized its compendium of mental disorders into 22 different diagnostic criteria, of which these three relate directly to sexuality:

- Sexual Dysfunctions
- Gender Dysphoria (replacing the term Gender Identity Disorder)
- Paraphilic Disorders

A few sex-related “conditions” are mentioned in passing in other sections of the manual, and some seem simply to have either disappeared or been excluded from the psychiatric lexicon altogether. For example, I had read that *hypersexual disorder* or *compulsive hypersexuality* might appear in this edition, but it does not seem to have made the cut and perhaps with good reason. In the section on differential diagnosis for obsessive-compulsive disorder, there are a couple of sentences on “other compulsive-like behaviors,” including sexual behaviors (as in paraphilias) (p. 241). They are distinguished from OCD by the fact that they usually produce pleasure for the person and may be resisted only because of potential negative consequences. Similarly I had read that *sex addiction* might be added as a behavioral addiction, much as gambling disorder has been listed as a Non-Substance-Related Disorder, but it is nowhere to be found. Probably just as well since it is such an amorphous category without well-researched treatment.

*Child sexual abuse* and *spouse, partner, or non-partner sexual violence* appear as categories in the section titled Other Conditions that May Be a Focus of Clinical Attention, and there are differing specifiers for confirmed and suspected cases, types of offenders, and the circumstances under which the activity took place.

*Body dysmorphic disorder* (BDD), a preoccupation with parts of the body that are misperceived to be somehow flawed, is no longer considered to be a somatic disorder and is instead classified as an *obsessive-compulsive-related disorder*. Apparently a preoccupation with thinking that one’s body build is too small or insufficiently muscular, called *muscle dysmorphia*, is quite common with BDD and is specified with it if present. The severity of BDD is specified on the basis of how much insight into the problem the individual has.

Revisions to the Sexual Dysfunctions Section

The desire dysfunctions have taken on some gender differences. *Female sexual interest/arousal disorder* combines those two formerly separate problems, leaving only *male hypoactive sexual desire disorder* which is still considered to be distinct from *erectile disorder*. Difficulty reaching orgasm in males is now called *delayed ejaculation*, but women still can have *female orgasmic disorder*. Males who reach orgasm too rapidly now have *premature (early) ejaculation*, which seems a bit redundant. Its severity is specified by the number of seconds after vaginal penetration that ejaculation occurs.
The former separate problems of vaginismus and dyspareunia have been merged to form genito-pelvic pain/penetration disorder because of their typical comorbidity and apparent difficulty in distinguishing between them. I suspect this newly morphed category may raise some professional hackles. I always thought the term dyspareunia could be applied to men as well, but there is apparently no distinct diagnostic category now for male sexual pain.

Except for substance/medication-induced sexual dysfunction, all of these problems require a minimum of six months duration for formal diagnosis, and there are only two subtypes now available: lifelong versus acquired and generalized versus situational.

Revisions to the Gender Dysphoria Section

The identifier gender dysphoria is meant to be a more inclusive term describing any form of gender incongruence, not just identification with the “other” gender. Transgender activists are probably not happy with this new term either, although it perhaps has a slightly less negative connotation than gender identity disorder, which they have long despised. The bottom line is that the APA still classifies transgender states as pathologies rather than normal variants, although it does require that the condition be associated with significant clinical distress. On the other hand, if one is uncomfortable within one’s own body, I can’t imagine how this would not cause distress. There will surely be further debate about this.

There are two separate sets of symptom criteria, one for children and another for adolescents and adults. Sexual orientation was formerly part of subtyping the disorder, but has been dropped because it was not clinically useful. There is a new posttransition specifier indicating that the individual has already begun some sort of medical intervention in support of a new gender assignment.

Revisions to the Paraphilic Disorders Section

The diagnostic criteria for these disorders have not changed markedly, but all paraphilic disorders may now be specified as occurring in a controlled environment, applying mostly to institutional settings where the behavior would be more restricted, or in full remission, meaning that the individual has not acted on the sexual urges with a nonconsenting person within an uncontrolled environment for at least five years. The DSM-5 strongly emphasizes that the unusual sexual interests represented by the paraphilias do not necessarily rise to the diagnosis of a paraphilic disorder unless two diagnostic criteria are met, listed as A and B for each category. Criterion A details that the recurrent and intense sexual arousal to the unusual stimulus has occurred over a period of at least 6 months, as manifested by fantasies, urges, or behaviors. If only this criterion is satisfied the individual may be said to have this paraphilia. However, if criterion B is also met, specifying that the individual has acted on the sexual urges with a nonconsenting person or the urges or fantasies have caused significant clinical distress or impairment, the individual is diagnosed with a paraphilic disorder.

The specific disorders included in the manual are essentially the same as in the past: voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, sexual masochism disorder, sexual sadism disorder, pedophilic disorder, fetishistic disorder, and transvestic disorder. There is another catch-all category called other specified paraphilic disorder that may be used to designate paraphilic symptoms including, “but not limited to” telephone scatology, necrophilia, zoophilia, coprophilia, urophilia, or klismaphilia (enemas). These attractions are far less researched than the others, but if you cannot find an individual’s kinky arousal on any of the lists, there is also the unspecified paraphilic disorder category that may be used.

I think it is safe to say that the paraphilic disorders have been among the most controversial and difficult to sort out for this new edition. I know that some sexologists advocated for use of the term hebephilia to
describe recurrent and intense sexual arousal toward post-pubescent adolescents, but it was not adopted. This means that pedophilia is limited quite specifically to fantasies, urges, or behaviors with prepubescent children, “generally age 13 years or younger.” The manual specifies that to meet the disordered diagnosis, the individual must be at least 16-years-old and at least 5 years older than the child, and it specifically excludes “an individual in late adolescence involved in an ongoing relationship with a 12- or 13-year-old” (p. 697). There is concern on the part of some observers that this allows for a fair amount of subjectivity when it comes to diagnosing pedophilic disorder, but it also seems to leave some of the complexities of defining the ethical dimensions of sexual encounters involving adolescents to legal and social interpretation and regulation rather than psychiatric diagnosis. Perhaps this is the more sensible approach as we continue to wrestle with the realities of normative adolescent sexual behavior.

*Ken Zucker, Editor of Archives of Sexual Behavior, has just published an editorial that not only carefully documents the many publications behind the sex-related decisions that went into the DSM-5, but has invited further commentary. The editorial is titled DSM-5: Call for Commentaries on Gender Dysphoria, Sexual Dysfunctions, and Paraphilic Disorders, and it may be accessed by clicking on the link: http://www.mhhe.com/hssl/newsletter/humansexuality/docs/KenZuckereditorial.pdf