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LETTER TO THE EDITOR

Problems with Ascertainment

Charles Moser

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The Paraphilias subworkgroup (PSWG; see Zucker, 2010) has proposed a number of revisions for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), to be published by the American Psychiatric Association (APA). One supposedly new proposal is the recognition that the paraphilias are not *ipso facto* psychiatric disorders, but the existence of nonpathological unusual sexual interests was explicit and identical in both DSM-IV and DSM-IV-TR:

> A Paraphilia must be distinguished from the nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement in individuals without a Paraphilia. Fantasies, behaviors, or objects are paraphilic only when they lead to clinically significant distress or impairment (e.g., are obligatory, result in sexual dysfunction, require participation of nonconsenting individuals, lead to legal complications, interfere with social relationships). (APA, 1994, p. 525; APA, 2000, p. 568; boldfacing in both originals removed)

In practice, the distinction between pathological and nonpathological unusual sexual interests has been ignored.[1] The "pathological" criteria often describe individuals with normophilic sexual interests and do not distinguish normophilic individuals from individuals with a paraphilia (Moser & Kleinplatz, 2005a, 2005b).

The above differential diagnosis language was adopted after a similar attempt to distinguish a nonstandard sexual interest from a mental disorder characterized by distress related to that interest was abandoned. The diagnosis of "Ego-dystonic Homosexuality" (APA, 1980) referred to individuals who were distressed by their homosexual arousal pattern, but a homosexual arousal pattern was not (and is not) considered a mental disorder. This diagnosis, which did not meet "the definition of a disorder" (Drescher, 2010, p. 435) was removed from the next edition of the DSM (see APA, 1987, p. 426), and thus "the APA implicitly accepted a normal variant view of homosexuality" (Drescher, 2010, p. 435).

One of the arguments supporting the removal of Ego-dystonic Homosexuality from the DSM was that its existence implied that other types of ego-dystonic characteristics were also mental disorders. Distress or impairment related to one's race, height, or normophilic sexual interests (e.g., ego-dystonic masturbation) could lead inappropriately to the creation of new psychiatric disorders (see Drescher, 2010). It is not clear why the DSM editors have not recognized that this argument also applies to the Paraphilias.

Despite these problems, the PSWG seems intent on trying to perpetuate the distinction between the interest versus the disorder which results from the interest yet again. According to this proposal, individuals are to be ascertained with a paraphilia, which is not a mental disorder. If the ascertained paraphilia "causes" distress or impairment, then the individual would be diagnosed with a paraphilic disorder (see Blanchard, 2010), which would be classified as a mental disorder.

The specific types of distress and impairment associated with paraphilic disorders have not been delineated (Moser, 2009). Apparently, the PSWG believes the distress must result from the sexual interest itself. Classifying a disorder according to the precipitant of the distress, rather than the characteristics of the

C. Moser (✉)
Department of Sexual Medicine,
Institute for Advanced Study of Human Sexuality,
45 Castro Street, #125, San Francisco, CA 94114, USA
e-mail: Docx2@ix.netcom.com

[1] This Letter focuses on the non-criminal paraphilias (fetishism, partialism, sexual masochism, consensual sexual sadism, and transvestism). The reader should not construe the present Letter to support the decriminalization of any sex crime.

distress produced, confuses the meaning of a mental disorder; it focuses the treatment away from the distress to whatever precipitated the distress. Becoming unemployed may result in distress for many individuals, but "unemployment disorder" is not a mental disorder.

Assuming the distress or impairment resolves, would the individual's status revert to paraphilic ascertainment, a paraphilic disorder in remission, or continue with the paraphilic disorder diagnosis? An update on the DSM-5 website suggests that the PSWG is leaning towards the "In Remission" option (APA, 2010), which confuses the goals of treatment. Is it the remission of the ascertained paraphilia or remission of the distress or impairment associated with the paraphilic disorder? Usually, the "In Remission" specifier is applied to mental disorders with characteristic relapsing courses, but which aspect of diagnosis is expected to relapse (the ascertained interest or the diagnosed distress or impairment)?

The creation of the ascertainment category does not imply that the ascertained individual is healthy—only that the individual does not meet the definition of a mental disorder *yet*. Whether the "patient" indicates the sexual interest causes the distress or impairment is not germane to the diagnosis. It is the mental health professional who "ascertains" the diagnosis. Most people seek mental health treatment because they are experiencing distress or impairment in some form. It is difficult to imagine that unusual sexual interests, denigrated by society, would not add to the distress or impairment resulting from an unrelated problem. Thus, the distinction between ascertaining a paraphilic interest and diagnosing a disorder could be meaningless in practice.

Blanchard (2010) suggests that once an individual is ascertained with a paraphilia, then that ascertainment can continue even if the intense and recurrent sexual arousal is no longer present. If one can have a paraphilia without the requisite intense and recurrent sexual arousal, then a paraphilic disorder without *current* distress or impairment also may exist. The duration of the distress or impairment is not indicated and it is common for individuals with paraphilic (or homosexual) interests to experience some distress as part of the "coming out" process. A moment of angst could label someone as mentally disordered forever.

Societal discrimination against lesbians, gays, and bisexuals is known to increase the incidence of non-sexual psychiatric disorders in these individuals (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). Assuming societal discrimination has a similar effect on individuals ascertained with a paraphilia, one should not diagnose a paraphilic disorder in addition to non-sexual psychiatric diagnoses. If the revelation of someone's homosexual (or heterosexual) interests precipitates the dissolution of his or her primary relationship resulting in a clinical depression, most mental health professionals would diagnose just the clinical depression. If the dissolution was precipitated by the revelation of his or her paraphilic interests, it seems inappropriate to diagnose both clinical depression and a paraphilic disorder.

Those with paraphilic interests could also be disadvantaged even if they do not seek mental health treatment. For example, in a child custody proceeding, an estranged spouse could expose the other spouse's ascertained paraphilia to those evaluating parental fitness. The distress from the exposure of one's sexual interests, the impending divorce, or the fear of losing custody of the child may now satisfy the distress or impairment criterion for a paraphilic disorder. An individual with a diagnosed paraphilic disorder, or even an ascertained paraphilia, can be seen as a less suitable parent and lose custody (Klein & Moser, 2006).

It is reasonable to assume that those individuals whose distress or impairment is associated with their paraphilic interests have a mental disorder or might benefit from treatment, but this reintroduces the problems associated with the Ego-dystonic Homosexuality diagnosis. There is no proposal to ascertain homosexual (or heterosexual) interests. Individuals who have distress or impairment related to normophilic interests can be diagnosed with the less stigmatizing Adjustment Disorder, Identity Problem, or Sexual Disorder NOS, without specifying the problematic interest. No empirical evidence or rationale is given to support the different treatment of distress or impairment for normophilic versus paraphilic interests.

It can be argued that the option of ascertainment represents a political compromise between the status quo and the formal removal of the paraphilias from DSM-5, analogous to the compromise which replaced Homosexuality with Ego-dystonic Homosexuality (Drescher, 2010). Nevertheless, political compromises should not override the current state of the science. The DSM editors and PSWG should indicate clearly the data on which they base their decisions. If the data exist, they should be presented. If the data do not exist, that should be stated unambiguously. The lack of empirical data supporting the proposed changes or the continued pathologizing of the paraphilias in the DSM is a glaring omission in a supposedly scientific document.

I object strongly to PSWG member Långström's (2010) statement, "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). It clearly is psychiatry's responsibility to minimize the misuse of its diagnoses; a basic dictum of all medicine is "First, do no harm." The usefulness of the paraphilic disorder diagnoses (or ascertainments) must be weighed against the damage from their misuse to justify their continued listing in the DSM-5. Why should psychiatry be exempt from these risk–benefit analyses?

It is clear that the paraphilic disorder diagnoses have been misused (Klein & Moser, 2006; Kolmes, Stock, & Moser, 2006; Wright, 2006). The usefulness of these diagnoses is not apparent and the arguments defending their usefulness are egregiously absent. From a historical perspective, it is doubtful that the creation of the ascertainment category will prevent further misuse of these diagnoses. It appears the concept of ascertainment will

confuse rather than clarify the issues with these diagnoses. If psychiatry cannot create a clear nosology to minimize the misuse of these diagnoses and appropriately exclude misdiagnoses, then these diagnoses (and ascertainments) should be removed until they are able to accomplish that task (Moser & Kleinplatz, 2005a).

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