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A Rejoinder to Carpenter and Krueger: It is about Clarity and Consistency

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A Rejoinder to Carpenter and Krueger: It is about Clarity *and* Consistency

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After reading Carpenter and Krueger's response I was somewhat perplexed, given their criticisms were addressed in my article. My second reaction is a bit more subtle and even ironic. I was criticized for being a consistent critic and for pointing out that the HD concept has been persistently inconsistent.

The HD proponents do not take me to task for faulty logic, misrepresenting the data, or taking the statements by its proponents out of context. Rather they suggest that I should "present a cogent case for how in most cases another condition can account for their distress or dysfunction." Actually, it is the responsibility of the HD proponents to demonstrate that another condition does *not* account for the presenting individuals' distress or dysfunction. It was the data from the studies published by the HD proponents that indicated treatment of the underlying conditions mitigates the symptoms of individuals they would diagnose with HD. In this regard, my article underscores the inconsistency between their conclusions and their own data.

Although Carpenter and Krueger indicate that the HD "criteria were subsequently clearly written such that HD could apply to . . . nonparaphilic or paraphilic [behavior]", they did not provide a citation as to where we can find these new clearly written criteria. A major point of my article was that we need a consistent conceptualization of HD and clarification about what HD is, and more importantly, what it is not.

The APA has rigorous scientific standards for incorporating a new mental disorder into the DSM. It was the DSM editors (not Moser) who rejected the HD proposal for inclusion in DSM-5 because the current body of literature failed to provide adequate empirical support for the construct. Even the principal investigator of the largest DSM-5 field trial on HD acknowledges there are limitations to our understanding of HD (Reid, this issue). My criticisms represent some of the issues that proponents of HD will need to

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address if the HD construct is to be given serious consideration by APA and the larger psychiatric community in the future.

For the record, I acknowledged some individuals have a problem controlling their sexual behavior. I never suggested what the content of treatment should or should not be as Carpenter and Krueger assert. It is true that I proudly believe that “sexual expression in itself is natural, regardless of its form and degree of difference from what might be considered typical or within normal limits.” Critics of this perspective may need to consider whether they have an underlying sex negative bias inappropriately influencing their opinion. Throughout the history of psychiatry the view that “we” know what is healthy and what is pathological has destroyed the lives of countless individuals who engaged in same sex behavior, masturbation, and a constellation of other harmless sexual behaviors. That was not the golden age of psychiatry and the primary point of my paper was to warn that the HD has the same potential for misuse and abuse.