Commentary

Does heterosexuality belong in the DSM?

Charles Moser & Peggy J. Kleinplatz

A NUMBER OF RECENT articles have criticised the *DSM* (American Psychiatric Association [APA], 1994; APA, 2000) sex and gender diagnoses in general and the paraphilia section in particular (Davis, 1998; Gert, 1992; Moser; 2001, Moser, 2002; Moser & Kleinplatz, 2002; Moser & Kleinplatz, in press). These classifications have been criticised for being based on social convention rather than upon a foundation of empirical data contrary to the stated agenda in the *DSM*. In the *DSM* it is written that, 'the utility and credibility of the *DSM-IV* require that it ... be supported by an extensive empirical foundation' (APA, 2000, p.xxiii).

The diagnostic process is unduly influenced by clinical, personal and social bias, rather than by objective parameters. If in fact the diagnostic process can be demonstrated to be subjective or arbitrary, then it calls into question the utility of the *DSM* diagnostic nosology. The purpose of this paper is to scrutinise the criteria of the *DSM* paraphilia section by applying them to a common sexual phenomenon, not currently listed in the *DSM*, and not considered to be a mental disorder but associated with distress and dysfunction as will be discussed below.

This paper argues that the strict application of these *DSM* criteria leads to the conclusion that heterosexuality is a mental disorder. Similar reasoning was used to argue against inclusion of proposed diagnostic criteria for sexual addiction, by showing that newlywed heterosexuals met those criteria (see Goodman, 1992; Moser, 1992). If heterosexuality fits the diagnostic criteria for a mental disorder and specifically for a paraphilia, the validity of all the other paraphilia diagnoses is called into even further question.

Every human society has attempted to regulate the sexuality of its members. Obviously conventional forms of sexuality in any given society are not likely to be deemed sinful, criminal, or pathological, but the characteristics of the dominant form change from society to society and from time to time. Although societal attempts to control the sexuality of its members are usually ineffective, these efforts can cause incredible hardships to those unfortunate enough to have their activities exposed.

Questioning whether the diagnostic criteria are logically consistent is not an academic exercise; what is and is not a mental disorder has significant legal, social, and political ramifications, in addition to implications for psychiatric practice. The *DSM* is used by the courts, insurance companies, other mental health disciplines, government, other psychiatric diagnostic nosologies (i.e. ICD), among other entities. If the logic and science which underpins the *DSM* is faulty, then the editors have done a disservice to their patients, their colleagues, medicine, society, and science.

About 250 years ago, medicine and especially psychiatry were responsible for transforming masturbation from sin to pathology (Bullough & Bullough, 1977). Rationales provided by early psychiatrists led to draconian measures to prevent children from touching their genitals. The persecution of homosexuals was condoned and justified for decades by the listing of homosexuality in the *DSM*. Other psychiatric follies concerning sexuality from the past include involutional melancholia, promiscuity, oral sex, nymphomania, frigidity, to name just a few. Relying on the clinicians' own behaviour and experiences to guide

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assessment – rather than upon objective criteria – has led to a conspicuous pattern of diagnoses: 'too much masturbation' has been deemed excessive; 'too many partners' demonstrates 'promiscuity'; 'too frequent sex' has been diagnosed as nymphomania or satyriasis; 'too little response' is judged as an arousal disorder; 'too little desire' is labelled inhibition; 'too few orgasms' were considered frigidity and 'too different' sex is called perverted or paraphilic.

Is heterosexuality a mental disorder?

The following are the diagnostic criteria of the proposed, new diagnosis of heterosexuality. The wording is borrowed directly from the diagnostic criteria describing other paraphilias.

Diagnostic criteria for 302.1 Heterosexuality

A. Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with an adult of the other sex.

B. The person has acted on these sexual urges with a non-consenting person, or the fantasies, sexual urges, or behavior cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The *DSM* definition of a mental disorder is: '... a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom ... Neither deviant behavior (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders ...' (APA, 2000, p.xxxi).

Heterosexuality is obviously a clinically significant behavioural and psychological pattern. Heterosexuality is not deviant behaviour nor does it qualify as a conflict between the individual and society, so it does not meet that *DSM* exclusion criterion.

The question then becomes, is heterosexuality associated with present distress or disability? The paraphilia section of the DSM is concerned with specific sexual interests and activities. The diagnostic criteria for all the paraphilias include a criterion that the sexual interest leads to distress or impairment (disability). Meeting the distress and impairment criteria for a paraphilia would satisfy the requirement that heterosexuality also meets these criteria for a mental disorder. Thus the question is reduced to, Does heterosexuality meet the diagnostic criteria for a paraphilia?

Is heterosexuality a paraphilia?

'The essential features of a paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors ...' (APA, 2000, p.566); heterosexuality fits this description. The *DSM* then adds the following qualifier, '... generally involving: (1) non-human objects; (2) the suffering or humiliation of oneself or one's partner; or (3) children or other non-consenting persons that occur over a period of at least six months' (APA, 2000, p.566). These qualifiers do not necessarily exclude heterosexuality.

The *DSM* uses the following criteria to define the paraphilic pathological state, '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 non-consenting individuals, lead to legal complications, interfere with social relationships)' (APA. 2000, p.568). Do these 'distress or impairment' criteria apply to individuals with heterosexuality?

Distress

All the psychogenic sexual dysfunction diagnoses (i.e. those not caused by a general medical condition or by substance abuse) include the same diagnostic criterion: 'B. The disturbance causes marked distress

or interpersonal difficulty' (for example see, APA, 2000, p.541). Sexual dysfunctions are found among individuals across the entire spectrum of sexual interests, but the scientific literature focuses on reported sexual dysfunctions among heterosexuals, which can affect as much as 43 per cent of the women and 31 per cent of the men (Laumann *et al.*, 1999). Individuals who experience sexual dysfunctions do not always seek out sex therapy; this choice does not reveal whether or not these individuals are distressed. It is generally believed that embarrassment, lack of mental health coverage, cost, fear that they are beyond help, and resignation to living with their dysfunction are prime reasons for not seeking sex therapy.

Heterosexuals are also distressed about not having sex, not having enough sex, having too much sex, wanting sex too much, not wanting sex enough, and wanting the 'wrong' type of sex. Some of these concerns are vying for their own *DSM* diagnoses (see Kafka & Hennen, 1999), others have been classified as pathological in the past, and some are still listed as mental disorders. Without understanding what constitutes 'normal' sexuality, it difficult to discern what is 'abnormal' sexuality. It appears that social trends rather than empirical science have dictated what constitutes 'normal'; psychiatry has followed these trends rather than demanding objective scientific benchmarks.

Is heterosexual distress caused by the individual's unwanted (i.e. ego-dystonic) heterosexual arousal, rather than distress from conflict with social expectations? The *DSM-III* (APA, 1980) contained the analogous homosexual diagnosis, 'Ego-dystonic Homosexuality,' but it was removed from the next edition (*DSM-III-R*, APA, 1987). Therefore, it seems improbable that the editors would want to create an 'Ego-dystonic Heterosexuality' diagnosis. In addition, 'Persistent and marked distress about sexual orientation' is specifically included under Sexual Disorder Not Otherwise Specified (APA, 2000, p.582). Logically, there is no reason to have two diagnoses that describe the same mental disorder, so we must reject the idea that heterosexuality is diagnosable as a mental disorder only when it is ego-dystonic.

Attempts to reconcile one's own sexual interests with the norms of the entire society or segments of society (e.g. partners, family, religion, or other social groups) can eventuate in an ego-dystonic state. This leads to the philosophical question: Is it healthier to follow the social norm or to stand up for one's own beliefs (Reiss, 1990)? Choosing either option does not indicate the presence of a mental disorder and is another example of the confusion between science and subjective morality.

As described in the *DSM*, 'Many individuals with these disorders [paraphilias] assert that the behavior causes them no distress ...' (APA, 2000, p.567). 'These individuals are rarely self-referred ...' (APA, 2000, p.566). From these statements, one can conclude that personal distress severe enough to lead the patient to psychiatric consultation is rare. If the distress results from conflict between the individual and society, then the diagnosis conflicts with the *DSM* definition of a mental disorder, which specifically excludes '... conflicts that are primarily between the individual and society ...' (APA, 2000, p.xxxi). Given that American society approves of heterosexuality, personal distress from this sexual interest must be even rarer than what is seen with other paraphilias.

In summary, personal (ego-dystonic) distress is rare and already covered by another non-paraphilic diagnosis. Distress related to the internalisation of societal values is a conflict between the individual and society, which by definition, does not constitute a mental disorder. Logically, this would appear to preclude distress as a criterion for deciding if any unusual sexual behaviour is necessarily pathological.

Disability or impairment

Heterosexuals seek out therapists because they cannot find partners, they cannot find

the 'right' partners, they are not attracted to appropriate partners, etc. Doubts and insecurities about making or keeping relationship commitments and subsequent attempts to save damaged or dysfunctional relationships appear to be common problems among heterosexuals. 'The capacity for reciprocal, affectionate sexual activity' (APA, 200, p.567) is often quoted as a sign of healthy functioning, but more than half of all American heterosexual marriages end in divorce (National Center for Health Statistics, 2005). The usual anger and disdain which characterise partners' interactions during and after the divorce process are further signs of relationship dysfunction. Furthermore, many individuals suffer endlessly in heterosexual relationships whether or not they eventually terminate them.

In the occupational area, sexual harassment complaints against heterosexuals are all too common, unfortunately. One's emotional reactions to a new relationship, the ending of an existing relationship and not being able to find a relationship can cause profoundly deleterious effects on job performance.

There is little argument that heterosexuality tends to be obligatory; it is uncommon for heterosexual practitioners to seek other sexual outlets. Even when a heterosexual partner is not available, heterosexual fantasies typically accompany masturbatory behaviour or other sexual acts. The strict interpretation of this criterion suggests that limiting oneself exclusively to a particular sexual pattern (e.g. heterosexual) indicates impairment.

Given the high prevalence of sexual dysfunction among heterosexuals, discussed above, heterosexuality presumably is associated with sexual dysfunction; though it is not clear that heterosexuality or any other sexual interest actually causes sexual dysfunction as implied in the *DSM*. It is also not clear that the prevalence of sexual dysfunction among heterosexuals is higher than found among practitioners of other sexual interests.

Heterosexuality does not *require* the participation of a non-consenting individual, although the majority of sexual assaults are committed by heterosexuals. A non-consensual heterosexual act constitutes a sexual assault (or rape), which is a crime and, as such, is not specifically listed in the *DSM-IV-TR* (APA, 2000). Committing a sexual assault does not mean that the individual suffers from a mental disorder. The nature of the assault does not necessarily reveal anything about that individual's primary sexual interests.

There is another way of interpreting this 'non-consenting' part of the diagnostic criteria. If heterosexuality is a mental disorder, can an 'afflicted' individual freely provide informed consent to heterosexual acts? Does the mental disorder affect the individual's ability to make rational decisions or give informed consent? There are many examples of individuals making dangerous choices and acting in an unhealthy manner (e.g. exposing these individuals to the risks of sexually transmitted infections including HIV, unwanted pregnancies, date rape or other violent acts). Such behaviours cast doubt on the capacity for individuals with heterosexuality to make competent decisions.

Can heterosexuality lead to legal complications? Divorce is an excellent example of possible civil legal difficulties. Sexual harassment, breach of promise, and child custody are other common examples. Criminal legal difficulties include not only sexual assault, discussed above, but sex work (working in adult films, prostitution, 'strip' clubs), statutory rape, obscenity, indecency, and sodomy.

The final sign of impairment, 'interference with social relationships', is worthy of special attention. Aside from the problems facing heterosexuals within heterosexual relationships, it would appear that heterosexual proclivities can affect other social relationships: Social or work contact can tempt individuals to violate healthy boundaries and to engage in inappropriate sexual relationships (e.g. teacher-student, professional-client, employer-employee, adultery).

Concerns about the possibility of initiating this contact or the probable consequences of prospective contacts, has led to restrictions in social and occupational contact between heterosexual men and women.

These difficulties in one or more important areas of functioning thereby fit the disability criterion for a mental disorder. Examination of the popular literature suggests that few heterosexuals actually avoid these problems and concerns, but only a fraction of those affected seek treatment and would thus be subject to diagnosis.

Differential diagnosis

The *DSM* editors do recognise there is a difference between the arousal patterns of individuals with a paraphilia from '... the **non-pathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement** in individuals without a Paraphilia' (APA, 2000, p.568, boldened in the original). Unfortunately, the *DSM* provides no guidance for the clinician to make that distinction. If, however, the paraphilia diagnostic category can be construed to include all sexual interests, including heterosexuality, then the *DSM* distinction between 'paraphilic' and 'non-paraphilic' arousal becomes conceptually meaningless and clinically useless.

Is it the heterosexuality itself which is pathological? Or is this a case of correlation between heterosexuality and impairment rather than causation? Just because relationship and occupational problems are endemic among heterosexuals does not mean that the heterosexuality is the cause of these problems. Furthermore, it is improbable that 'converting' from a heterosexual arousal pattern to another sexual arousal pattern, would resolve these problems or impairments. Analogously, it is unclear if changing other paraphilic arousal patterns (even if that were possible), would resolve the distress or impairment from which those individuals reportedly suffer, except for potential legal complications inherent with paraphilias which involve illegal activities. It is hard to imagine that such a profound change would not cause new distress and disability symptoms.

This raises the question of why any of the paraphilias are identified by their associated sexual behaviours. There is no indication that 'paraphilic' behaviours are related to the distress and disability symptoms required for the paraphilia diagnoses. Considering that not all practitioners of the identified behaviours meet the *DSM* diagnostic criteria, there must be 'healthy' individuals who exhibit 'paraphilic' behaviour and are inappropriately stigmatised by the association of their behaviour with a mental disorder.

The *DSM* provides no guidance on how to distinguish 'healthy' from 'unhealthy' individuals with a paraphilic interest. Clinicians need unambiguous diagnostic criteria to distinguish 'healthy' from 'unhealthy' individuals with all sexual interests or the present confusion will continue to be propagated.

Conclusions

This discussion leads inevitably to the conclusion that heterosexuality meets the *DSM-IV-TR* (APA, 2000) definitions of both a mental disorder and a paraphilia, at least as well as the other listed paraphilias. Previous literature has catalogued the problems in the *DSM* diagnostic criteria as applied to those with unusual sexual interests (Moser & Kleinplatz, in press). These same flawed criteria also lend themselves to diagnosing more common sexual interests, not usually believed to be mental disorders, and specifically, as paraphilias.

Diagnostic criteria that could include everyone or could be used to pathologise anyone, which cannot reliably and appropriately distinguish between those with a mental disorder from those without one, are fatally flawed and clinically useless. These diagnoses do not appear to be based on any objective scientific definition of disease; these criteria are not capable of distinguishing disease from normal variants. The obvious conclusion is that classification of

the 'paraphilias' as mental disorders appears to be an attempt at pathologising unusual sexual interests and provides a vehicle for social control. The act of specifically pathologising unusual (as opposed to the common, conventional and accepted) sexual interests obviously serves to regulate them.

The omission of heterosexuality exemplifies the underlying heterosexual bias which pervades the *DSM* nosology. The possibility that heterosexuality could be a mental disorder is not mentioned in the text and it appears no one even conceived of it as a possibility.

For the record, this is not a proposal to reclassify heterosexuality as a mental disorder or to include it in the next edition of the *DSM*. Concluding that heterosexuality is a mental disorder, according to the *DSM* criteria, does not imply that heterosexuality meets other definitions of a mental disorder. Similarly, the other paraphilias may or may not fit these other definitions.

Some might argue that it is important to keep the paraphilia section in the *DSM* because identifying perpetrators as 'sick' is necessary to keep 'sex crimes' illegal. We believe that criminal acts should be adjudicated in the criminal justice system and society should not use psychiatric diagnoses to justify criminalising unusual sexuality. The current *DSM* (APA, 2000) appropriately distinguishes crimes from psychiatric disorders; the paraphilia section confounds mental disorders with crimes. Any interpretation that this article supports any criminal behaviour is incorrect and misguided. Such allegations misconstrue our position and deflect attention from the substance of the arguments presented here.

This article asserts that diagnosing heterosexuality as a paraphilia according to the *DSM-IV-TR* (APA, 2000) criteria demonstrates that they are illogical, inconsistent, unworkable, conceptually unsound, and lack construct and discriminant validity – but no more so than using these criteria to pathologise other sexual proclivities. This expands upon previous criticism of the *DSM-IV-TR* (APA, 2000) diagnostic criteria by demonstrating their selective application and how general these criteria actually are. If the *DSM* is to be seen as a credible and clinically useful reference, its editors will have to demonstrate how the paraphilia diagnoses actually distinguish pathology from normal variations.

Correspondence

Charles Moser, PhD, MD, is Professor and Chair of the Department of Sexual Medicine, Institute for Advanced Study of Human Sexuality, San Francisco. He also maintains a private practice in Sexual Medicine and Internal Medicine, in San Francisco. His research focuses on BDSM, sexual minorities, classification of unusual sexual interests, and the practice of sexual medicine.

Dr Charles Moser
45 Castro Street, #125,
San Francisco, California, 94114, USA.
E-mail: docx2@ix.netcom.com

Peggy J. Kleinplatz, PhD, is a Clinical Psychologist, AASECT-certified sex therapist and sex educator. She teaches in the Faculty of Medicine and in the School of Psychology, University of Ottawa, Canada. Dr Kleinplatz has been teaching Human Sexuality since 1983 and was awarded the Prix d'Excellence by the University of Ottawa in 2000. Her work focuses on eroticism and transformation. Dr Kleinplatz is the editor of *New Directions in Sex Therapy: Innovations and Alternatives,* and with Dr Charles Moser of the forthcoming *Sadomasochism: Powerful Pleasures.*

Dr Peggy J. Kleinplatz
161 Frank Street,
Ottawa, Ontario, K2P 0X4, Canada.
E-mail: kleinpla@uottawa.ca

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