The History of the DSM's Classification of Sex

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OVERVIEW

> "Where this would lead us has been shown by the purely medicalclinical approach of Krafft-Ebing, ...his predecessors and successors, some of whom believed they had enriched science when they had only coined new foreign sounding terms."(Bloch 1912)

The purpose of this paper is to examine the history of sexual mental disorders, as seen through the lens of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, by reviewing the DSM I through the DSM IV. The idea for this inquiry came out of a lecture given in the late 1990's by Dr. Charles Moser on the DSM-IV. Dr. Moser discussed how the DSM could be used in legal affairs (such as child custody) and the need to modify a future DSM to lessen its detrimental effects on individuals. At the time I felt that an exploration of the development of the DSM regarding sexual issues would reveal useful patterns.

Reading the various revisions of the DSM revealed a mishmash of classifications that shifted with each version of the manual. A review of other writings about the DSM revealed considerable political maneuvering. These other writings assert that there is little empirical data to justify the diagnosis, a lack of consistency on the part of psychiatrist to diagnose the same disorder in any given client, and no relationship between the ability to diagnose and the ability to assist the client. It is also asserted that

the DSM and the APA contribute to medicalizing everyone. If everyone is crazy, the APA gets lots of business.

It is the intent of this paper to restrict the evaluation of the DSM's history and impact to comparing revisions of the DSM. There continues to be considerable disagreement over the DSM, both from within the American Psychiatric Association and from without. Two excellent sources of insider information are: The Selling of DSM, The Rhetoric of Science in Psychiatry, Stuart A. Kirk & Herb Kutchins, Aldine de Gruyter, 1992; and They Say Your're Crazy, How the World's Most Powerful Psychiatrists Decide Who's Normal, Paula J. Caplan, Addison-Wesley Publishing, 1995.

This paper has four parts: this Overview, the Summary of Classifications and Coding, the Detailed History of the DSM Revisions, and the Summary. I believe the evaluation of the DSM revisions is sufficient to make the case of the arbitrariness of the DSM. My comments and critiques contained in this paper are in italics.

SUMMARY OF CLASSIFICATION AND CODING OF SEXUAL ISSUES

The DSM I was an outgrowth of government efforts to track Morbidity and Mortality (classifications of illness and death) for mental hospitals. Each year the hospitals reported the classifications of admissions, discharges, deaths, and current residents. The DSM II was a revision of the DSM I with an attempt to align with the ICD, a growing international standard for Morbidity and Mortality.

The DSM III signaled a major change in intent of the DSM. The intent was to create a diagnostic tool for mental health practitioners, particularly Psychiatrists. The document was also intended to be a method of defining mental illness for third-party payers. Effectively, the DSM became an elaborate scheme to categorize individuals. Although attempts were made within the DSM to avoid stigmatizing individuals, negative labeling was a forgone conclusion.

Some of the complaints made against the DSM include: its use in labeling individuals; arbitrary and politically motivated categories; misuse of scientific

evidence (and sometimes no evidence) in creation of the categories; the inability of psychiatrists, when faced with the same cases, to be consistent in categorization of the cases; no relationship between categories and any standard of care or effective treatment; and the misuse of the DSM for legal disputes, for discrimination by health and life insurance companies, discrimination by employers, and as a tool for coercion of individuals by spouse, family, and social organizations. Thomas Szasz observed that "the notion of mental illness is used today chiefly to obscure and 'explain away' problems in personal and social relationships, just as the notion of witchcraft was used for the same purpose from the early Middle Ages until well past the Renaissance." (Caplan p 41)

The general classification of Sexual Behaviors shifts throughout the revisions. *It is apparent from the shifts in the classifications that the DSM is derived from cultural values and not necessarily scientific systems.*

1952: In the DSM I Sexual Behaviors are classified under Sociopathic Personality Disturbance, which also included Dyssocial Reaction, a condition of being out of harmony with the larger society. *Multi-culturalism was not recognized.*

1968: In the DSM II Sexual Deviations was listed under Personality Disorders and certain other Non-Psychotic Mental Disorders, which also included addictions and antisocial personality types. *People with Sexual Behaviors issues could be accused of guilt by association with other mental disorder classifications.*

1980: In the DSM III, Psychosexual Disorders was made its own classification. Gender Identity Disorders and Psychosexual Dysfunctions were considered for the first time. The term "Paraphilia" was introduced. *John Money, who popularized the term, was on the committee to prepare this revision.*

1984: In the DSM III-R, Gender Identity Disorders were broken out from the other sexual issues and included in Disorders Usually First Evident in Infancy, Childhood or Adolescence.

1994: By the DSM-IV, Gender Identity Disorders were rejoined with the other sexual issues under Sexual and Gender Identify Disorders. Also added were a series of

codes in the new classification: Sexual Dysfunction Due to a General Medical Condition.

The coding numbers also shifted over time.

The DSM-II was the first revision to use ICD codes, and we will pick up our trail from there. In the beginning there were two classes of other sexual disorders, 302.8 Other Sexual Deviations, and, 302.9 Unspecified sexual deviations. In the DSM-III the 302.8 disappears, while the 302.9 mutates into 302.89 Psychosexual disorder not elsewhere classified, which resurfaces back in the DSM-III-R and DSM-IV as 302.9 and is now labeled Sexual Disorder Not Otherwise Specified (NOS).

In the DSM-II, the code for Sexual Sadism, 302.6, becomes Gender Identity Disorder of Childhood in the DSM-III and DSM-III-R, only to become both Gender Identity Disorder in Children and Gender Identity Disorder NOS in the DSM-IV.

Sexual Sadism (302.6 in the DSM-II) becomes coded as 302.84 in the DSM-III.

Zoophilia (302.10) makes a brief appearance in the DSM-III, only to be buried in Paraphilia NOS (302.9) in the DSM-III-R. *We have to remember that Money participated in the DSM-III, so there is no surprise that this revision contains extra paraphilias.*

Next I will review the labeling of special cases highlights the arbitrariness of the system.

Homosexuality transformed throughout the process. In the DSM-I and DSM-II (1968), homosexuality was listed as one of the sexually based mental disorders. In 1973, homosexuality was revised to be Sexual Orientation Disturbance. This classification required that the individual be "disturbed by, in conflict with, or wish to change their sexual orientation." *(In 1973, given the general social attitudes about homosexuality, if one were homosexual-identified, it would be difficult to be fully comfortable about it–so the new wording may have continued to include most homosexual–identified individuals.)*

When working on the DSM-III in 1980, the APA was met with considerable resistance to classification of homosexuality as a mental illness. The protesters and gay psychiatrists had their effect. In the DSM-III, homosexuality maintained the same coding but was now called Ego-Dystonic Homosexuality. This classification was created by vote. This was very upsetting to the more conservative psychiatrists who felt that the process for this diagnosis was purely political. In the DSM-III-R, homosexuality moved as one phrase in the Sexual Disorder NOS classification. *It seemed the APA couldn't let go of the homosexual classification.*

What would later be called paraphilias started simply as a list of conditions in the DSM-I. They were listed as a class in the DSM-III, called "bizarre" and required to be either, 1. preferred usage of nonhuman objects, 2. repetitive sexual activity with humans involving real or simulated suffering, or 3. repetitive sexual activity with nonconsenting partners (children were classified as not able to give consent). The client had to have done the activity to qualify. In the DSM-III-R, the classification criteria was expanded to included having fantasies for six months or having done the activity. *Fantasies, even enjoyable ones, would now get you classified.*

The DSM-IV changed the criteria to having done the activity for six months and, with the exception of pedophilia, that the fantasies or behaviors caused clinically significant distress or impairment in social, occupational, or other important areas of functioning. The opening verbiage of the DSM-IV states that "these individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with sexual partners or society."(p 523 DSM-IV) *There are two issues here. First, there appears to be evidence that there are many individuals who have the specified sexual interests and do not have a problem. In which case, the problem for those individuals do come into conflict with society may be other than the so-called paraphilia. Second, it remains to be seen as to who can press charges of impairment – the individual, the therapist, the insurance company, or the spouse.*

Although not always directly involved with sexual issues, women were also faced with a number of challenges to changing DSM classifications. Classifications such as

Masochistic Personality Disorder and Premenstrual Dysphoric Disorder specifically targeted women. The renaming convention also occurs here. Masochistic Personality Disorder became Self-Defeating Personality Disorder *(also known as the Good Wife Syndrome by critics).* Premenstrual Dysphoric Disorder became Perilutieal Phase Dysphoric Disorder, which became Late Luteal Phase Dysphoric Disorder in the DSM-III-R, and back to Premenstrual Dysphoric Disorder in the DSM-IV. *Are we sure these guys (and it is largely older white guys, according to two sources) know what they are doing? Or do they know exactly what they are doing, and use arcane words to obscure? There seems to be a huge amount of room in the process for cultural and personal bias in creating the various classifications.*

The criteria for the Sexual Dysfunctions have been expanded so that what took three simple sentences in the DSM-I expanded to 47 dense pages in the DSM-VI. My own efforts to make sense of the various criteria revealed little consistency and a landscape of changing terminology and codes. *My question: is anyone better off? I see a parallel to Krafft-Ebing when he attempted to provide examples of every bizarre case he could find, or of Money who invented new terminology at a prolific rate. It appears that we are seeing a Delusional Naming Disorder at work.*

One of the phenomena that is prevalent when studying the history of Sexology is the human trait to make up constructs, and then believe the construct even in the face of evidence to the contrary. While this goes on in every area of life, sex is an area we work hard to avoid looking at. Critical thinking gets turned over to authority figures. When we do shine the light on reality, the constructs can appear ludicrous.

It is apparent from this rather simple examination that psychiatry falls into the same area of human exploration. No one wants to look at the possibility of mental illness, so unquestioned constructs are turned over to authority figures.

HISTORY OF THE DSM REVISIONS

The Statistical Manual for the Use of Hospitals for Mental Diseases, first published in 1917 by the Committee on Statistics of the American Medico-psychological Association (now the American Psychiatric Association [APA]), was the prevailing document for statistical classifications, primarily for the purposes of setting up a uniform basis of collecting statistics of admissions, discharges, and deaths in mental institutions (Morbidity and Mortality). In 1927 the New York Academy of Medicine, in an effort to develop a uniform nomenclature of disease in the U.S., spearheaded a movement towards a nationally accepted standard nomenclature of disease, resulting in the 1933 publication of the Standard Classified Nomenclature of Disease. The Statistical Manual took up the nomenclature of the Standard.

With the events of World War II, the military psychiatrists were seeing numerous mental cases, only about 10% of which were classified in the Statistical Manual. There was a need to account accurately for all causes of morbidity, and a variety of classifications were created by the various types of doctors in the field. In 1944 the Navy made a partial revision of its nomenclature, in 1945 the Army made a much more sweeping revision of its nomenclature, which was mostly adapted by the Veterans Administration in 1946. In 1948 a revised International Statistical Classification was adopted. Doctors exiting the military after WWII came from the mix of government standards of nomenclature, and did not want to return to the current civilian standards. (pvii, DSM-I)

DSM-I - 1952

The American Psychiatric Association assumed responsibility for future publication of the manual, and retitled it. The first Diagnostic and Statistical Manual of Mental Disorders (1952) (DSM-I) was part of an effort to standardize the classifications primarily for the purposes of setting up a uniform basis of collecting statistics of admissions, discharges and deaths in mental institutions. (p v, vi)

The DSM-I "classifications reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors."(p. 1, DSM-III) "This was the first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories."(p. xviii, DSM IIIR)

In the DSM-I sexual issues shows up primarily under chronic organic brain syndromes relating to syphilis. Under this heading, detailed classifications are given for a number of syphilis-based conditions.

Sexual behaviors are classified under Sociopathic Personality Disturbance, which included Antisocial reaction, Dyssocial reaction, Sexual Deviation, and Addiction. Dyssocial reaction applied to individuals who "manifest disregard for the usual social codes, and often come in conflict with them, as the result of having lived all their lives in an abnormal moral environment." "These individuals typically do not show significant personality deviations other than those implied by adherence to the values or code of their own ... social group." [1]

The entire section on Sexual Deviation reads:

> This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenic and obsessional reactions. The term includes most of the cases formerly classed as "psychopathic personality with pathologic sexuality." The diagnosis will specify the type of the pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation.)

The 1952 DSM-I was created in parallel with the International Statistical Classification of Disease, Injuries, and Causes of Death (ICD). Efforts were made to translate between the definitions of the two documents. (p 87) The coding system of the DSM-I was different than used by the ICD, and cross referencing between the two coding systems was included.

[1] many of the pages of the DSM-I were not numbered and therefore not documented here

The bulk of the DSM-I is dedicated to statistical reporting and numerical classifications of mental disease, complete with sample charting techniques. Twelve states are listed in the appendix as having state mental hospitals with statistical offices.

The DSM-I and the ICD-6 had many incompatibilities, which caused problems with compiling statistics and for indexing medical records in psychiatric treatment facilities. In 1961, work started between individuals at the APA and at the World Health Organization. (p xiv, DSM-II)

DSM-II - 1968

The second edition (DSM-II) was published in 1968. Its foreword starts with the intent to reflect the classifications listed in the International Classification of Diseases (ICD-8, 1968), published by the World Health Organization in 1966. (p vii) There is not total agreement between the two documents as to nomenclature. The coding system of the ICD-8 was used, with additional codes added for the U.S. in the DSM-II.

Sexual behavior disorders are listed under the classification of Personality disorders and certain other non-psychotic mental disorders, which includes, Antisocial personality, Sexual deviations, Alcoholism, and Drug dependence.

The entire section on Sexual deviations is:

> This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them.

The DSM-II then lists Homosexuality, Fetishism, Pedophilia, Transvestitism, Exhibitionism, Voyeurism, Sadism, Masochism, Other sexual deviation, and Unspecified sexual deviation. No definitions of these terms were given. (Note: the

classifications of Voyeurism, Sadism, Masochism were added to the ICD-8 for the U.S. only. The classification, Unspecified sexual deviation, was included for other countries using the ICD-8 and is not to be used in the U.S.) (p 44)

The DSM-II provided more rationale for the sexual behavior classifications and removed rape and violent acts from the classification.

DSM-III - 1980

The Introduction of the DSM-III starts with the acknowledgment that the DSM is shifting from just a statistical / classification tool to include uses as a diagnostic tool, and includes diagnostic criteria and "much-expanded descriptions of the disorders." (p. 1) For the first time the document mentions the usage of the coding system by third-party payers. (p. 5) Breaking with the format for the DSM-II which followed the ICD-8, in writing the DSM-III it was felt that the ICD-9 was not detailed enough in its classifications and contained some classifications that would not be suitable for use in the U.S. (p.2) It was acknowledged that

> Since in DSM-I, DSM-II, and ICD-9 explicit criteria are not provided, the clinician is largely on his or her own in defining the content and boundaries of the diagnostic categories. In contrast, DSM-III provides specific diagnostic criteria as guides for making each diagnosis since such criteria enhances interjudge diagnostic reliability. It should be understood, however, that for most of the categories the diagnostic criteria are based on clinical judgment, and have not yet been fully validated by data. (p. 8)

In other words, the categories of mental disorders are not necessarily valid or correct, but psychiatrists using the new categories are more likely to be consistent among themselves in putting patients into the same categories.

> In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In

addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is limited to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.) (p. 6)

A change from the DSM-I. Just being different was no longer a mental condition, at least according to the previous passage.

The DSM-III does attempt to make a distinction between individuals and the disorders they may have.

> A common misconception is that a classification of mental disorders classifies individuals, when actually what are being classified are disorders that individuals have. (p.6)

The DSM-III goes out of its way to say that the etiology of any mental disorder is largely unknown, and generally the classification is low on inference as to its origin. An exception is made, however, for Personality Disorders, where criteria includes such inferences as disturbance manifested by uncertainty about issues such as gender identity. (p. 7)

The DSM-III, for the first time, listed an advisory committee for psychosexual disorders. This committee included Drs. Paul Gebhard, Richard Green, Helen Kaplan, John Money, and others.

The classification of Psychosexual Disorders fall into the groupings of Gender identity disorders, Paraphilias, Psychosexual Dysfunctions, and Other Psychosexual Disorders. (p. 18)

Gender Identity Disorders include the incongruity between anatomic sex and gender identity. The gender identity is the internal experience, the gender role is the external demonstration.

Transsexualism is a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish to live as a member of the other sex. The diagnosis

is made only if the disturbance has been continuous for at least two years and is not due to another mental disorder or physical condition. "Frequently there is considerable anxiety and depression, which the individual may attribute to inability to live in the role of the desired sex." (p. 262) "Transsexualism seems always to develop in the context of a disturbed parent-child relationship." (p. 263) The classification is further codified regarding the sexual interest of the individual, with homosexual and heterosexual referring to the anatomic sex. (p. 264)

Gender Identity Disorder of Childhood is "a persistent feeling of discomfort and inappropriateness in a child about his or her anatomic sex and the desire to be, or insistence that he or she is, of the other sex." "The majority of the boys with this disorder begin to develop it before their fourth birthday." "Some of these children, particularly girls, show no other signs of psychopathology." (p. 264) A significant percentage of children with this diagnosis become aware of a homosexual orientation during adolescence.

"**Paraphilias:** The essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement. Such imagery or acts tend to be insistently and involuntarily repetitive and generally involve either: (1) preference for use of a nonhuman object for sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation, or (3) repetitive sexual activity with nonconsenting partners." (p. 266)

> Since paraphiliac imagery is necessary for erotic arousal, it must be included in masturbatory or coital fantasies. ...In the absence of paraphiliac imagery there is no relief from nonerotic tension, and sexual excitement or orgasm is not attained. ...Individuals with these disorders tend not to regard themselves as ill, and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with society ...Frequently these individuals assert that the behavior causes them no distress and that their only problem is the reaction of others to their behavior. Others admit to guilt, shame, and depression at having to engage in an unusual sexual activity that is socially

unacceptable. There is often impairment in the capacity for reciprocal affectionate sexual activity, and psychosexual dysfunctions are common." "Social and sexual relationships may suffer if others, such as a spouse (many of these individuals are married), become aware of the unusual sexual behavior. In addition, if the individual engages in sexual activity with a partner who refuses to cooperate in the unusual behavior, such as fetishistic or sadistic behavior, sexual excitement may be inhibited and the relationship may suffer." (p. 267) [2]

...Virtually all reported cases have been in males, with the exception of Sexual Sadism and Sexual Masochism, which, however, occur far more commonly in males."

The diagnosis requires acting on the sexual fantasy.

Fetishism: "The essential feature is the use of nonliving objects (fetishes) as a repeatedly preferred or exclusive method of achieving sexual excitement." Clothing used in cross dressing is excluded. (p. 268)

Transvestism: "The essential feature is recurrent and persistent cross-dressing by a heterosexual male that during at least the initial phase of the illness is for the purpose of sexual excitement" (p. 269) "In some individuals sexual arousal by the clothing tends to disappear, although the cross-dressing continues as an antidote to anxiety."

Transvestism is defined as a heterosexual male. Apparently a homosexual man crossdressing is considered normal, as is a woman who is "packing" (carrying a dildo in her pants).

Zoophilia: "The essential feature is the use of animals as a repeatedly preferred or exclusive method of achieving sexual excitement" (p. 270) The use of animals when suitable human partners are not available is not included in this diagnosis. *As I mentioned earlier, Money was involved in this draft. As I understand it, individuals who fantasize about animals or prefer animals over human partners (as different from individuals who have had sex with animals) are rare. This classification didn't make it to the next revision.*

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[2] Bringing the spouse into the diagnosis has ramifications. *"The suffering my client has experienced, Your Honor, ..."*

Pedophilia: "The act of fantasy of engaging in sexual activity with prepubertal children as a repeatedly preferred or exclusive method of achieving sexual excitement." (p. 271) "Heterosexually oriented males tend to prefer eight-to-ten year-old girls, the desired sexual activity usually being limited to looking or touching. Most incidents are initiated by adults who are in the intimate interpersonal environment of the child. Homosexually oriented males tend to prefer slightly older children." "The severity of the condition often fluctuates with psychosocial stress." "Isolated sexual acts with children do not warrant the diagnosis of Pedophilia. Such acts may be precipitated by marital discord, recent loss, or intense loneliness." The diagnosis includes: "If the individual is an adult, the prepubertal children are at least ten years younger than the individual. If the individual is a late adolescent, no precise age difference is required, and clinical judgment must take into account the age difference as well as the sexual maturity of the child."

By 1980 a lot of social attention was being focused on adult-child sexuality, so it is not surprising that a parallel focus would appear in the DSM.

Exhibitionism: is "the repetitive acts of exposing the genitals to an unsuspecting stranger for the purpose of achieving sexual excitement, with no attempt at further sexual activity with the stranger." (p. 272) There is often the desire to shock or surprise.

Voyeurism: "is repetitively looking at unsuspecting people, usually strangers, who are either naked, in the act of disrobing, or engaging in sexual activity, as the repeatedly preferred or exclusive method of achieving sexual excitement." (p. 272) No sexual activity with the person is sought. Orgasm, usually by masturbation, occurs during the activity or later in response to the memory.

Sexual Masochism: "is sexual excitement produced in an individual by his or her own suffering." (p. 273) This diagnosis if either, "(1) the preferred or exclusive mode of producing sexual excitement is to be humiliated, bound, beaten, or otherwise made to suffer, or (2) the individual has intentionally participated in an activity in which he or she was physically harmed or his or her life was threatened in order to produce sexual excitement, which did occur." The condition is likely to be present in childhood. The

condition may manifest at a finite level, or may increase in severity over time. Sexual fantasies without the act are not sufficient for the diagnosis.

Sexual Sadism:

> is the infliction of physical or psychological suffering on another person in order to achieve sexual excitement. (p. 274) …The diagnosis is warranted under any of three different conditions: (1) On a nonconsenting partner, the individual has repeatedly and intentionally inflicted psychological or physical suffering in order to achieve sexual excitement. (2) With a consenting partner a repeatedly preferred or exclusive mode of achieving sexual excitement combines humiliation with simulated or mildly injurious bodily suffering. (3) On a consenting partner bodily injury that is extensive, permanent, or possibly mortal is inflicted in order to achieve sexual excitement. …Sadistic sexual fantasies are likely to have been present in childhood. …The condition is usually chronic in its extreme form. …Some individuals with the disorder may for many years engage in sadistic acts without a need to increase the potential for inflicting serious physical damage. Others, however, …increase the severity of the sadistic acts over time or during periods of stress. When the disorder is severe, these individuals may rape, torture, or kill their victims. …It should not be assumed that all or even many rapists are motivated by Sexual Sadism. Often a rapist is not motivated by the prospect of inflicting suffering, and may even lose sexual desire as a consequence.

The criteria distinguishes between consensual and non-consensual partners, but provides the same diagnosis. The same diagnosis is also given without regard to the outcome of the activity: pleasure, pain, damage, or death. By grouping without distinctions, use of this diagnosis could be extremely harmful to those so labeled.

Atypical Paraphilia "includes: Coprophilia (feces); Frotteurism (rubbing); Klismaphilia (enema); Mysophilia (filth); Necrophilia (corpse); Telephone Scatologia (lewdness); and Urophilia (urine)." (p. 275) *These are conditions popularized by John Money, who was on the committee.*

Psychosexual Dysfunctions: Psychosexual dysfunction is the inhibition of the sexual response cycle, and may fall in any of the phases including Appetive, Excitement, Orgasm, or Resolution. (p. 277)

> Frequently there are no other obvious signs of disturbance. This is particularly the case in Inhibited Sexual Desire, since it does not necessarily involve impairment in performance. In other cases there may be a vague sense of not living up to some ill-defined concept of normality. …Almost invariably a fear of failure and the development of a "spectator" attitude (self-monitoring), with extreme sensitivity to the reaction of the sexual partner, are present. This may further impair performance and satisfaction and lead to secondary avoidance of sexual activity and impaired communication with the sexual partner.

Inhibited Sexual Desire: "A persistent and pervasive inhibition of sexual desire" "The disturbance is not caused exclusively by organic factors." (p. 278)

Inhibited Sexual Excitement: also termed frigidity or impotence. i.e. failure to attain or maintain erection in men, and failure to attain or maintain the lubrication-swelling response in women. (p. 279)

Inhibited Female Orgasm after sufficient stimulation is a judgment by the clinician. A lack of orgasm during coitus without manual clitoral stimulation may or may not be so classified.

Inhibited Male Orgasm is a delay in or absence of ejaculation following adequate phase of sexual excitement.

Premature Ejaculation is defined by ejaculation before the individual wishes it.

Functional Dyspareunia is coitus in association with recurrent and persistent genital pain (male or female) when not caused by the lack of lubrication.

Functional Vaginismus is a persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with coitus.

Other Psychosexual Disorders: Ego-dystonic Homosexuality is "a sustained pattern of overt homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress." (p, 281) "There is some evidence that in time many

individuals with this disorder give up the yearning to become heterosexual and accept themselves as homosexuals. This process is apparently facilitated by the presence of a supportive homosexual subculture." "The extent to which therapy is able to decrease homosexual arousal, increase heterosexual arousal, or help homosexuals become satisfied with their sexuality is disputed." "Homosexuality itself is not considered a mental disorder." Note: this classification was new to the DSM-III and was removed by the time of the publication of the DSM-III-R.

The classification of Ego-dystonic Homosexuality seems rather benign compared to the history of classifying homosexuality, per se, a disorder. Some of the critics of the DSM, however, state that this criteria is the remnant of the political fight within the APA between those who believed homosexuality to be a disorder, those that believe homosexuality to be within the variations of human sexuality, and gay activists (both within and without the APA) who protested, lobbied, and worked with APA committee members to get the classification changed.[3]

Psychosexual Disorder Not Elsewhere Classified has example including: inadequacy related to self-imposed standards of masculinity or femininity, impaired pleasure during normal physiological pelvic responses of orgasm, distress about a pattern of repeated sexual conquests, and confusion about preferred sexual orientation.

DSM-III-R - 1987

The committee on Sexual Disorders was further divided into two subcommittees. The subcommittee on Paraphilia included Dr. Park Dietz of the Attorney Generals

[3] p. 81-90, The selling of DSM, The Rhetoric of Science in Psychiatry, Stuart A. Kirk & Herb Kutchins, New York, 1992

Report on Pornography.[4] With the exception of Robert Spitzer, M.D.[5], none of the DSM-III committee members sat on the DSM-III-R Paraphilia subcommittee. The subcommittee on Sexual Dysfunctions included Dr. Helen Kaplan. Gender Identity Disorders was grouped under Disorders Usually First Evident in Infancy, Childhood or Adolescence.

The ICD-9 codes were expanded with a fifth digit in its classification codes, which allowed for parallel codes with the DSM-III. This expansion resulted in publication of the ICD-9-CM (for Clinical Modification.) (p. xix)

Gender Identity Disorders: These use substantially the same wording as the DSM-III. The revised manual includes verbiage that gender identity disturbances are on a continuum. (p. 71)

Gender Identity Disorder of Childhood uses almost the exact verbiage as the DSM-III, but with subtle differences. The older manual refers to the child feeling "discomfort and inappropriateness about (the) anatomic sex" (p. 264), while the revised manual refers to "incongruence between assigned sex and gender identity." (p. 71) The revised manual also states, "Whereas most adult people with Transsexualism report having had a gender identity problem during childhood, prospective studies of children with Gender Identity Disorder of Childhood indicate that very few develop Transsexualism in adolescence or adulthood." (p. 72) The predisposing factors between the two manuals are remarkably different. The older manual states: "Extreme, excessive, and prolonged physical and emotional closeness between the infant and the

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[4] In May of 1989 I was a witness for the defense in the porn trial: the United States of America, vs.. Steve Toushin, et al. Dr. Park Elliott Dietz was a witness for the prosecution. In the transcripts Dr. Dietz defined himself as a forensic psychiatrist with a history of evaluating the criminally insane, and a contributor to the DSM-III-R. "I was responsible for–the person principally responsible for writing the descriptions of sexual sadism and sexual masochism."
Q: Have you actually ever witnessed in life in person the type of behavior that was depicted in the movies we discussed (SM)?
A: Only theatrical portrayals of some of the behavior.
Q: But not actually people who were doing it because they wanted to do it for that scene? It is difficult to have somebody to invite you over to watch:
A: They have never invited me.

[5] Dr Spitzer's efforts are documented in The Selling of the DSM.

mother and a relative absence of the father during the earliest years may contribute to the development of this disorder in the male. Females who later develop this disorder have mothers who were apparently unavailable to them at a very early age, either psychologically or physically, because of illness or abandonment; the girl seems to make a compensatory identification with the father, which leads to the adoption of a male gender identity." (p. 265) The revised manual makes these same Freudian connections, but includes other factors such as weak reinforcement of normative gender-role behavior.

Transsexualism has the same split between the older DSM-III and the newer DSM-III-R manuals. The revised manual also notes that "even after sex reassignment, many people still have some physical features of their originally assigned sex that the alert observer can recognize." (p. 74) The revised manual adds: "Cross-culturally, the Hijra of India and the corresponding group in Burma may have conditions that, according to this manual, would be diagnosed as male-to-female Transsexualism. The Hijra, however, traditionally undergo castration, not hormonal and surgical feminization (creation of a vagina)." (p. 74)

The DSM-III-R added a third gender disorder: Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type is a recurrent discomfort and sense of inappropriateness about one's assigned sex, and recurrent cross-dressing in the role of the other sex, either in fantasy or in actuality, in a person who has reached puberty. (p. 76) It is not for the purpose of sexual excitement and there is no persistent preoccupation with getting rid of one's primary and secondary sex characteristics.

Sexual Disorders: are divided into two groups: Paraphilias and Sexual Dysfunctions.

Paraphilias: The new manual no longer uses the word "bizarre" when referring to these acts. "People with a Paraphilia commonly suffer from several varieties: in clinical settings that specialize in the treatment of Paraphilias, people with these disorders have an average of three to four different Paraphilias." (p. 280) The new manual also refines the criteria to having the fantasies for six months, or markedly distressed by the urges, or ever acting on them to qualify for the classification. At the same time, the criteria

has shifted so that a person can do the behavior while not having the paraphiliac imagery or fantasy to obtain sexual arousal, and qualify as having a paraphilic disorder. That individuals may collect specialized erotica is noted. While the old manual said that paraphilias were rare, the new manual said, "Judging from the large commercial market in paraphilic pornography and paraphernalia, the prevalence in the community is believed to be far higher than that indicated by statistics from clinical facilities. Because of the highly repetitive nature of paraphilic behavior, a large percentage of the population has been victimized by people with Paraphilias." (p. 281) For Sexual Masochism, the sex ratio is estimated to be 20 males for every female. For all other Paraphilias, there are virtually no females.

When critiquing the historical fight against masturbation, Hare states that one of the failures of medicine was that medical doctors never looked to see what portion of the population was doing it, and with what results.[6] *It would appear that the APA has had the same blindness.*

Fetishism and Frotteurism are moved from Atypical Paraphilia to their own classifications, while Zoophilia was moved into the Paraphilia Not Otherwise Specified classification, which also adds Partialism (exclusive focus on a part of the body). *This is really interesting, and inconsistent with the criteria established for paraphilias (see above). For example, foot worship involves humans, generally does not involve suffering, and can be quite consensual.*

The Pedophilia classification adds considerable verbiage. "People with this disorder who act on their urges with children may limit their activity to undressing the child and looking, exposing themselves, masturbating in the presence of the child, or gentle touching and fondling of the child. Others, however, perform fellatio or cunnilingus on the child or penetrate the child's vagina, mouth, or anus with their fingers, foreign

[6] Hare, E.H., "Masturbatory Insanity: The History of an Idea," The Journal of Mental Science [Published by Authority of the Royal Medico-Psychological Association], No. 452 Vol. 108, 1962

objects, or penis, and use a varying degrees of force to achieve these ends."[7] "Except in cases in which the disorder is associated with Sexual Sadism, the person may be generous and very attentive to the child's needs in all respects other than the sexual victimization in order to gain the child's affection, interest, and loyalty and to prevent the child from reporting the sexual activity." (p. 284) The diagnosis includes that the individual is at least 16 and at least 5 years older than the child.

The classification of Sexual Masochism is substantially expanded. The old manual simply lists "sexual excitement is to be humiliated, bound, beaten, or otherwise made to suffer." The new manual describes masochism to include solo acts as well as acts with a partner. The list includes self-bondage, electrical shocks, self-mutilation, restraint, blindfolds, paddling spanking, whipping, beating, cutting, piercing, and humiliation, scat and urine, forced cross-dressing, infantilism. A full paragraph is added describing auto erotic asphyxia (hypoxyphilia). (p. 286) The verbiage in the descriptive section says the individual must act on or be markedly distressed by the fantasies. The diagnostic criteria specifies having the fantasies for six months, and act on these urges or is markedly distressed by them. *This can be interpreted to mean that thinking about an activity plus either acting or being distressed qualifies – thinking about something that brings the individual pleasure will still get them qualified as having a disorder.*

The modifications for Sexual Sadism mirror those of Sexual Masochism. The description of the course of the disorder has been changed and now states: "Usually the severity of the sadistic acts increases over time." (p. 287) *This statement is a reflection of 18th century degeneracy theory. It would seem that the area of sex is so potent and forbidden in our society that it has been almost impossible to get rid of old myths and taboos.*

In regard to rape, the new manual states:

> Studies of rapists indicate that fewer than 10% have Sexual Sadism. Some rapist are apparently sexually aroused by coercing or forcing a nonconsenting

[7] The APA needs to be very careful when writing these descriptions. We have had accusations of "sex pervert" for individuals changing diapers or using a rectal thermometer. In theory, the above description would include pediatricians and pediatric dentists.

person to engage in intercourse and are able to maintain sexual arousal even while observing the victim's suffering. However, unlike the person with Sexual Sadism, such people do not find the victim's suffering sexually arousing. Sexual acts also occur in the absence of sexual arousal in a variety of crimes, in torture used to interrogate prisoners, in cult rituals, and in people with sadistic personality traits.

Transvestism has become Transvestic Fetishism. The words have changed, the intent remains the same with one exception. In the DSM-III the classification required that the individual be a heterosexual male. In the DSM-III-R the wording is, "This disorder has been described only in heterosexual males." *Again, women "packing" or use of typically male attire are being left out.*

Sexual Dysfunctions: The classification has been renamed from Psychosexual Dysfunction. The general description of the group of classifications is largely exactly the same as in the older manual, with only the order of a few words changed. The revised manual includes statistics of unspecified studies: "(I)n the young adult population, approximately 8% of the males have Male Erectile Disorder. It has been estimated that approximately 20% of the total population have Hypoactive Sexual Desire Disorder, 30% of the male population have Premature Ejaculation and that approximately 30% of the female population have Inhibited Female Orgasm." *Apparently, there is statistical evidence that a third of the population has sexual disorders. On the surface this appears highly self-serving. Declare a large percentage of the population to have a disorder, then offer the cure. Shades of John Kellogg.*

Inhibited Sexual Desire became Sexual Desire Disorders, with sub classifications of Hypoactive Sexual Desire Disorder (absence of sexual fantasies and desire) and Sexual Aversion Disorder (extreme aversion to, and avoidance of, all genital sexual contact with a sexual partner.) (p. 293)

Inhibited Sexual Excitement became two classifications, Female Sexual Arousal Disorder and Male Erectile Disorder (both classifications now includes "a subjective sense of sexual excitement and pleasure ...during sexual activity").

Inhibited Females Orgasm has been modified from "some" to "most" in describing that those women who climax with manual stimulation but not in coitus are within the normal variation of the female sexual response.

Inhibited Male Orgasm is the same as in the older manual with the addition: "This failure to achieve orgasm is usually restricted to an inability to reach orgasm in the vagina, with orgasm possible with other types of stimulation, such as masturbation."

Premature Ejaculation, with minor wording changes, remains the same.

Functional Dyspareunia is now Dyspareunia. Functional Vaginismus is now Vaginismus.

Other Sexual Disorders: The classification no longer has Ego-dystonic Homosexuality, and has moved to Sexual Disorder NOS.

Dr. Park Dietz, in his testimony about the removal of homosexuality in the DSM-III-R as a participant in the writing of the DSM-III-R, testified, "If there had been a scientific body to review the evidence and decide, they may have reached the same result, but the procedure was a very political one in which gay and lesbian psychiatrists exerted a great deal of political pressure on the American Psychiatric Association to put it to a vote to the general membership. ...(T)hat is the one time in the history of, at least in American psychiatry, that a decision has been made politically rather than scientifically."[8] *Note: Caplan et al have presented considerable evidence for other such political decisions in the DSM process.*

Sexual Disorder Not Otherwise Specified no longer includes mention of impaired pleasure, adds "nonparaphilic sexual addiction," and changes "confusion about preferred sexual orientation" to "distress about one's sexual orientation." (p. 296)

[8] p. 85, transcripts, United States of America, vs. Steve Toushin, et al,. Defendants, May 25, 1989

DSM-IV - 1994

"The codes and terms provided in DSM-IV are fully compatible with both ICD-9-CM and ICD-10." (p. xxi) *This is not true.*[9]

> In DSM-IV, each of the mental disorders is conceptualized as 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 unless the deviance or conflict is a symptom of a dysfunction in the individual.

Multi-cultural values are now included. Of course, we are still left wondering who decides if there is a dysfunction.

In the DSM-IV, Sexual and Gender Identity Disorders are once again grouped together. The order of the listing is reversed, again, with Sexual Dysfunction listed first, followed by Paraphilias, then Gender Identity Disorders. (p. 493)

Sexual Dysfunctions: A Sexual Dysfunction is characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse. In evaluating the four phases of sexual response cycle, Appetitive is now reworded as Desire. Excitement has been simplified and the male Cowper's gland secretions are no longer mentioned. The Orgasm phase for the male still is defined as including the ejaculation of semen. *The APA needs to talk to a Sexologist or two if it cannot*

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[9] A review of the ICD-10 shows that the World Health Organization made a radical shift between the ICD-9 and ICD-10, when an entirely new coding scheme had been used - numbers that are not the same as the DSM-IV. Further, the groupings are different than the DSM. Sexual Dysfunction falls under Behavioral Syndromes Associated with Physiological Disturbances and Physical Factors. This category includes sleep and eating disorders. Note that Sexual Dysfunction includes a Excessive Sexual Drive category. Gender Identity Disorders and Disorders of Sexual Preference (paraphilias), fall under Disorders of Adult Personality and Behavior, a category that also includes Paranoia, Pathological Gambling, Edodystonic Sexual Orientation, et al.

get away from defining male orgasm as ejaculation. The female Orgasm is defined as contractions of the wall of the outer third of the vagina. Orgasm also mentions anal sphincter rhythmic contractions. The definition of the Resolution phase is unchanged. Sexual Dysfunctions may be subtyped as Lifelong Type or Acquired Type. Further subtyping includes Generalized Type vs. Situational Type. Finally, subtyping may include "Due to Psychological Factors" or "Due to Combined Factors." (p. 495)

New criteria is included:

> Clinical judgments about the presence of a Sexual Dysfunction should take into account the individual's ethnic, cultural, religious, and social background, which may influence sexual desire, expectations, and attitudes about performance. For example, in some societies, sexual desires on the part of the female are given less relevance (especially when fertility is the primary concern).

I gather from the above that if a woman from a society that discounts female orgasm has a complaint of being inorgasmic, she cannot get insurance compensation for treatment as she does not qualify for such a condition.

All the criteria for the Sexual Dysfunctions have been expanded so that what took less than 6 pages in the DSM-III-R requires 30 pages in the DSM-IV. Most of the added information is totally repetitive.

The criteria for Hypoactive Sexual Desire Disorder has grown considerably, from less than 1 1/2 inches of type in the DSM-III-R to two and a half pages, including qualifiers and causes. The criteria adds "the disturbance causes marked distress or interpersonal difficulty." This same clause is added to all of the Sexual Dysfunction classifications. (p. 496-515)

Sexual Aversion Disorder. "Some individuals with severe Sexual Aversion Disorder may experience Panic Attacks with extreme anxiety, feelings of terror, faintness, nausea,

palpitations, dizziness, and breathing difficulties." *Sounds like a list of the effects of onanism.*[10]

Female Sexual Arousal Disorder. "Limited evidence suggests that Female Sexual Arousal Disorder is often accompanied by Sexual Desire Disorders, and Female Orgasmic Disorder." Differential Diagnosis: "The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g. menopausal or postmenopausal reductions in estrogen levels, atrophic vaginitis, diabetes mellitus, radiotherapy of the pelvis)." (p. 501)

Male Erectile Disorder. "There are different patterns of erectile dysfunction. Some individuals will report the inability to obtain any erection from the outset of a sexual experience. Others will complain of first experiencing an adequate erection and then losing tumescence when attempting penetration. Still others will report that they have an erection that is sufficiently firm for penetration but that they then lose tumescence before or during thrusting. Masturbatory erections may be lost as well, but this is not common." (p. 502) "The erectile difficulties in Male Erectile Disorder are frequently associated with sexual anxiety, fear of failure, concerns about sexual performance, and a decreased subjective sense of sexual excitement and pleasure." (p. 503)

Female Orgasmic Disorder, formerly Inhibited Female Orgasm. "Because orgasmic capacity in females increases with age, Female Orgasmic Disorder may be more prevalent in younger women. Most female orgasmic disorders are lifelong rather than acquired. Once a female learns how to reach orgasm, it is uncommon for her to lose that capacity." (p. 505) *They are finally recognizing that "old ladies" can be sexy.*

Male Orgasmic Disorder, formerly Inhibited Male Orgasm. "In the most common form of Male Orgasmic Disorder, a male cannot reach orgasm during intercourse, although he can ejaculate from a partner's manual or oral stimulation. Some males

[10] In 1758, Tissot published the book: "Onanism, or a Treatise Upon the Disorders Produced by Masturbation".

with Male Orgasmic Disorder can reach coital orgasm but only after very prolonged intense noncoital stimulation. Some can ejaculate only from masturbation." (p. 507) "Many coitally inorgasmic males describe feeling aroused at the beginning of a sexual encounter but that thrusting gradually becomes a chore rather than a pleasure. A pattern of paraphiliac sexual arousal may be present." "Orgasm also can occur in the absence of emission of semen (e.g. when sympathetic ganglia are damaged by surgery or autonomic neuropathy). (p. 508) *Here we have an example of male orgasm without ejaculation. It would almost appear that different individuals wrote different sections of the classification and never cross-checked.*

Premature Ejaculation, no change.

Sexual Pain Disorders, AKA, "Dyspareunia". "(G)enital pain that is associated with sexual intercourse. Although it is most commonly experienced during coitus, it may also occur before or after intercourse. The disorder can occur in both males and females." (p. 511)

Vaginismus is the…involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted. …In some females, even the anticipation of vaginal insertion may result in muscle spasm." (p. 513) "Sexual responses may not be impaired unless penetration is attempted or anticipated." "Vaginismus occurs in some women during sexual activity but not during a gynecological examination. The disorder is more often found in younger than in older females, in females with negative attitudes toward sex, and in females who have a history of being sexually abused or traumatized."

New category: Sexual Dysfunction Due to a General Medical Condition is the presence of a clinically significant sexual dysfunction that is judged to be due exclusively to the direct physiological effects of a general medical condition.

New category: Substance-Induced Sexual Dysfunctions "a clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty."

Paraphilias: "Paraphilia (is the) recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman 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 6 months. For some individuals, paraphiliac fantasies or stimuli are obligatory for erotic arousal and are always included in sexual activity. In other cases, the paraphiliac preferences occur only episodically. ...The behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. ...Not uncommonly, individuals have more than one Paraphilia." (p. 523) *[This is interesting.*[11]*]* "Many individuals with these disorders assert that the behavior causes them no distress and that their only problem is social dysfunction as a result of the reaction of others to their behavior. *[But the definition says that one has to be distressed. Circular logic here.]* Others report extreme guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable or that they regard as immoral. *[With the APA's help I believe they would have more guilt, shame and depression.]* There is often impairment in the capacity for reciprocal, affectionate sexual activity." "The diagnosis of Paraphilias across cultures or religions is complicated by the fact that what is considered deviant in one cultural setting may be more acceptable in another setting. *Maybe, then, paraphilias are not an illness, but a social construct. This is reminiscent of the Dyssocial Reaction diagnosis from the DSM-I.* Except for Sexual Masochism, where the sex ratio is estimated to be 20 males for each female, the other Paraphilias are almost never diagnosed in females." (p. 524) "Although Paraphilias are rarely diagnosed in general clinical facilities, the large commercial market in paraphiliac pornography and paraphernalia suggest that its prevalence in the community is likely to be higher." "Certain of the fantasies and behaviors associated with Paraphilia may begin in childhood or early adolescence but become better defined and elaborated during adolescence and early adulthood.

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[11] It used to be that to have a paraphilia, one required the object or acts to be orgasmic. Now we can have many paraphilias. Does that mean that the individual must wear rubber while peeping, or that the individual must either wear rubber or peep to be orgasmic? The former is, I suspect, very rare. The latter states the individual has a choice. which is counter to the "must-have" quality to qualify for the classification. According to APA changing definitions, it sounds like people are just sexually exploring more.

Elaboration and revision of paraphiliac fantasies may continue over the lifetime of the individual."

All paraphiliac classifications (except pedophilia) require that the fantasies or behaviors are over a period of six months, and that the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. *As defined in the DSM's, there appears to be no medical difference between the so-called paraphilias. The issues that separate pedophilia from other paraphilias are legal and social values. Yet, the APA classifies pedophilia differently medically.*

The qualifying criteria for Exhibitionism,. Fetishism, Sexual Masochism, Sexual Sadism, Transvestism, Voyeurism, and Paraphilia Not Otherwise Specified are essentially unchanged from the DSM-III-R, except for the "behavior causing distress" clause.

Frotteurism has been modified. The DSM-III stated: "It is the touching, not the coercive nature of the act, that is sexually exciting." This is no longer mentioned in the DSM-IV.

Pedophilia. same definition. Added verbiage includes: "The recidivism rate for individuals with Pedophilia involving a preference for males is roughly twice that for those who prefer females." (p. 528) *I have found no supporting data. Is this accurate or is it subtly anti-homosexual?*

Gender Identity Disorders: Gender Identity Disorders have been redefined: "There must be evidence of a strong and persistent cross-gender identification (and) there must be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex." (p. 533) "The diagnosis is not made if the individual has a concurrent physical intersex condition." "To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning."

The description section discusses the difficulties of living as a gender other than one's appearances in this society (although not using those terms.)

The DSM-IV lists statistics: In children, there appears to be 5 boys for each girl referred. In adult clinic, men outnumber women about 2-3 to one. Data from Europe suggest that 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery. Referred children usually are between ages 2 and 4. Only a small number of children will continue to have symptoms that meet criteria for Gender Identity Disorder in later adolescence or adulthood. "By late adolescence or adulthood, about three-quarters of boys who had a childhood history of Gender Identity Disorder report a homosexual or bisexual orientation." *APA data suggests that we are dealing with a medical condition. If so, then these individuals do not have a mental disorder. These individuals need support and counseling to deal with a hostile and ignorant society, not therapy to fix their condition.*

Gender Identify Disorder Not Otherwise Specified: This classification includes intersex conditions, transient, stress-related cross-dressing, and persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex.

Sexual Disorder Not Otherwise Specified: This classification is used to include: feelings of inadequacy of sexual performance, distress about repeatedly objectifying sex partners, and distress about sexual orientation.

SUMMARY

I believe that the above analysis of the history of the DSM demonstrates an arbitrary and shifting set of standards with no reference to facts or academic studies.

The concepts of classification of mental disorders appear to have an arbitrary and highly culture-driven basis. Looking at issues of stress in our society and from reading the details of the above sexual behavior classifications, I would expect to see in the DSM classifications that specifically address the trauma of being left handed, a disorder for relationship issues caused by excessive workaholism, a disorder for dealing with obesity, a disorder of guilt of under achievement in the workplace. These conditions are at least

as prevalent. I suggest that the APA's focus on sex is much in the mind of the writers of the DSM.

Dealing with problems in doing the job of living life should not be classified as a disorder.[12] It appears to me that the best solution is to start by eliminating entirely Sexual Behaviors as a disorder, as well as any other classifications of disorders that are really a matter of counseling.

[12] Szazy, Caplan, et al