

Reports from the DSM-V Work Group on Sexual and Gender Identity Disorders

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DSM Prolegomena

Since the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* was published in 1952 by the American Psychiatric Association (APA), the manual has gone through a series of revisions: DSM-II in 1968, DSM-III in 1980, DSM-III-R in 1987, DSM-IV in 1994, and a text revision to the DSM-IV in 2000. For those with a sharp eye, one will note that, subsequent to DSM-I, the manual has had a slightly different name: *Diagnostic and Statistical Manual of Mental Disorders*.

Any clinician, researcher, or policy maker with an interest in psychiatric nosology is keenly aware that the publication of the DSM-III in 1980 was a watershed moment in contemporary psychiatry. By that time, the intellectual and institutional hegemony of psychoanalysis that had dominated the psychiatric landscape had lost some, if not most, of its grip (see Grob, 1991; Paris, 2005; Wilson, 1993). Sketchy psychoanalytic models of at least some psychiatric disorders that were described in the DSM-I and DSM-II were abandoned. The rather vague diagnostic descriptors were replaced by more detailed criteria and, for the majority of conditions described in the DSM-III, an atheoretical approach predominated. As noted in the Introduction to the DSM-III:

For most of the DSM-III disorders...the etiology is unknown.... The approach taken in DSM-III is atheoretical with regard to etiology or pathophysiological process except for those disorders for which this is well established and therefore included in the definition of disorder.... The major justification for the generally atheoretical approach

taken in DSM-III with regard to etiology is that the inclusion of etiological theories would be an obstacle to use of the manual by clinicians of varying theoretical orientations, since it would not be possible to present all reasonable etiological theories of each disorder.... Because DSM-III is generally atheoretical with regard to etiology, it attempts to describe comprehensively what the manifestations of the mental disorders are, and only rarely attempts to account for *how* the disturbances come about... This approach can be said to be “descriptive” in that the definitions of the disorders generally consist of descriptions of the clinical features of the disorders. (American Psychiatric Association, 1980, pp. 6–7)

A psychiatric nosology that was, by and large, agnostic with regard to underlying causal mechanisms was deemed preferable to a theoretical model that was no longer satisfying to many researchers and practitioners. Advances in biological psychiatry, the emergence of competing psychologic models of development and disorder, and the increasing availability of alternative approaches to therapeutics all contributed to a paradigm crisis in the discipline’s nosological manual. Since 1980, one overarching vision was that the manual, if organized around descriptively neutral diagnostic criteria, could be utilized by a diverse array of clinicians and researchers from many disciplines. A common and transparent language, so it has been held, should facilitate communication in a rapidly developing field (see Spitzer & Klein, 1978).

There was also another very crucial issue that served as a backdrop to the substantive changes that occurred with the publication of DSM-III, namely the concern that the prior manuals lacked sufficient detail to produce reliable and valid diagnostic categories. This was already apparent in the 1960s (e.g., Spitzer, Cohen, Fleiss, & Endicott, 1967; Spitzer, Fleiss, Burdock, & Hardesty, 1964; Stoller & Geertsma, 1963), but was

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brought to the fore by the seminal work by a team of psychiatrists at Washington University in St. Louis (e.g., Feighner et al., 1972; Goodwin & Guze, 1979; Robins & Guze, 1970). The importance of reliability and validity has remained a central concern in all of the post-DSM-III manuals (see, e.g., Blashfield, Sprock, & Fuller, 1990; Nelson-Gray, 1991; Pincus, Frances, Davis, First, & Widiger, 1992; Tsuang, 1993; Widiger, Frances, Pincus, & Davis, 1990; Widiger, Frances, Pincus, Davis, & First, 1991) and will continue to do so with the publication of DSM-V.

For the last 30 years, it would be very reasonable to state the obvious: the DSM has had an enormous (international) impact on clinical training, the delivery of clinical care, and programs of research (both basic and applied). It has also served as a springboard for continued and considered reflection on the contemporary concept of mental disorder (see, e.g., Decker, 2007; Fabrega, 1994, 2006, 2007; Horwitz, 2002; Horwitz & Wakefield, 2007; Houts, 2002; Jablensky, 2007; Jensen, Knapp, & Mrazek, 2006; Kendell, 2001, 2002; Kendell & Jablensky, 2003; Kendler, 1999; Lane, 2007; Lewis, 2006; Lilienfeld & Marino, 1995; Luhmann, 2001; McNally, 2001; Paris, 2008; Scotti, Morris, McNeil, & Hawkins, 1996; Silk, Nath, Siegel, & Kendall, 2000; Spitzer, 1999; Spitzer & Endicott, 1978; Wakefield, 1992a, 1992b, 1993, 1997; Widiger & Clark, 2000; Zachar & Kendler, 2007). At the time of completing this Editorial (August 30, 2009), the simple search term “DSM” in PubMed yielded a mere 28,223 entries!

Back to the Future

On April 13, 2006, the APA announced the appointments of David J. Kupfer, M.D., as chair, and Darrel A. Regier, M.D., M.P.H., as vice chair, of the DSM-V Task Force (American Psychiatric Association, 2006). And on May 1, 2008, the APA announced the appointments of the entire ensemble of the DSM-V Task Force (American Psychiatric Association, 2008), including the 13 Work Group Chairs for the current groupings of psychiatric disorders in the DSM-IV, its cross-cutting Work Groups, other members of the Task Force, and so on. Since then, many advisors have been nominated and approved by the Task Force to consult with the Work Groups, resulting in an even larger cast. The anticipated publication of the DSM-V is 2012, five years later than predicted by Blashfield and Fuller (1996). For further information on the DSM-V, the reader is encouraged to consult www.dsm5.org.

The DSM-V Task Force has, as its mission, a number of major tasks. These include, but are not limited to, the following: (1) literature reviews of current diagnostic entities; (2) literature reviews of proposed new diagnostic categories; (3) incorporation of feedback from advisors and the scientific community at large, as well as other interested stakeholders; (4) examination of relevant secondary data sets; (5) proposals

for field trials to test revised diagnostic criteria; and (6) revision to the text that accompanies each diagnosis.

In addition, the Task Force will examine some other major issues: (1) the meta-structure of the manual, i.e., disorder groupings; (2) measurement of distress and impairment; (3) the possible inclusion of dimensional diagnosis as a complement to categorical diagnosis; (4) the possible inclusion of common dimensional assessment that will be used across different diagnostic categories; (5) further consideration of developmental parameters for diagnosis; and (6) further consideration of cultural factors and gender vis-à-vis diagnosis. For these issues, the interested reader can consult the following: Andrews, Charney, Sirovatka, and Reiger (2009), Beach et al. (2006), Dimsdale et al. (2009), Helzer and Hudziak (2002), Helzer et al. (2008), Hyman (2007), Kraemer (2007), Krueger, Skodol, Livesley, Shrout, and Huang (2007), Kupfer, First, and Regier (2002), Kupfer, Regier, and Kuhl (2008), Narrow, First, Sirovatka, and Regier (2007), Phillips, First, and Pincus (2003), Regier, Narrow, First, and Marshall (2002), Regier, Narrow, Kuhl, and Kupfer (2009), and Tackett, Balsis, Oltmanns, and Krueger (2009).

The Sexual and Gender Identity Disorders Work Group

It was an honor and privilege for me to be appointed as Chair of this Work Group by the DSM-V Task Force and the American Psychiatric Association. My first task was to consult with the Task Force regarding candidates for the Work Group. There was, of course, a restriction on how many members could be appointed to the Work Group. Vetting nominees is a time-consuming process. It also costs money, as does participation in face-to-face meetings and conference calls. Thus, for our Work Group, as for others, it was impossible to consider all qualified candidates. Apart from consideration of scholarly qualifications, it was also important to adhere to the conflict of interest guidelines set forth by the Task Force, including a ceiling set on the amount of personal income received from the pharmaceutical industry (see Cosgrove, Krinsky, Vijayaraghavan, & Schneider, 2006), an issue that was particularly relevant for our Sexual Dysfunctions subworkgroup. The Work Group that materialized included the following individuals: For the Sexual Dysfunctions subworkgroup, R. Taylor Segraves (Chair), Yitzchak M. Binik, Lori A. Brotto, and Cynthia Graham; for the Paraphilias subworkgroup, Ray Blanchard (Chair), Martin P. Kafka, Richard Krueger, and Niklas Långström; for the Gender Identity Disorders subworkgroup, Peggy T. Cohen-Kettenis (Chair), Jack Drescher, Heino F. L. Meyer-Bahlburg, and Friedemann Pfäfflin. Members of each Work Group nominated a number of advisors, many of whom are acknowledged in the literature reviews that are part of this Special Section of *Archives*.

In this issue (and already available via advance online publication), the reader will find a total of 16 reviews written by our Work Group. Reviews by Taylor Segraves on the male sexual

dysfunctions will be published in the *Journal of Sexual Medicine*. Most of the reviews focus on a critical appraisal of the relevant diagnoses that appeared in the DSM-IV (or earlier), with proposed suggestions for reform and revision. There is also one review that considers the addition of a new diagnosis (Hypersexuality) and two reviews on gender identity disorder consider conceptual and sociopolitical/historical parameters. Each review was subject to internal feedback by the Work Group and, in some cases, from feedback by advisors. It should be made clear that the recommendations and options embedded in these reviews are just that. In no way should the reviews be considered the “final product.” The final product is a multi-layered process that will involve additional feedback and certainly will be influenced by the results from field trials.

Publishing these reviews in the *Archives* is part of the transparency process that is of critical importance to the DSM-V Task Force. It allows interested members of the scientific community and other stakeholders to scrutinize the thinking of our Work Group and to provide feedback. In our post-modern era, where a micro-thought is just a twitter away, the scientific periodical is, I hope, still a useful forum for reflection, critique, and dialogue.

Commentaries that are no more than 1500 words in length will be considered for subsequent publication in the *Archives*. Commentaries should be submitted to Kenneth J. Zucker, Ph.D., Editor, *Archives of Sexual Behavior* at Ken_Zucker@camh.net. The commentary should be submitted as an e-mail attachment using WORD, should contain a brief title, the author’s complete mailing address, and the use of the reference style of the American Psychological Association.

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