

Deconstructing the DSM-5

By Jason H. King

Assessment and diagnosis of sexual and gender-related disorders

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) presents a new conceptualization and organization of sexual dysfunctions, gender identity disorder and the paraphilias. Each of these diagnostic classifications is now carved out as an independent chapter and contains important language changes and symptom descriptions.

According to Elizabeth Boskey's article, "Sexuality in the DSM 5," that appeared in the August 2013 issue of *Contemporary Sexuality*, the new manual does a reasonable job of reflecting changing public and scientific opinions. A number of positive changes in the new manual will please many involved in sexuality counseling, research and activism.

The DSM-5 makes it much clearer that a broad range of sexuality and gender expressions should be considered normal and healthy, while streamlining the diagnosis of sexual dysfunction for both men and women. Furthermore, it includes an expanded sexual abuse section with definitions that give clearer descriptions of the broad range of acts that providers and the legal system should consider problematic.

Sexual dysfunctions

The sexual dysfunctions chapter in the DSM-5 contains 10 diagnoses, reduced from 17 in the DSM-IV-TR. For example, the highly comorbid and difficult to distinguish sexual pain disorders vaginismus and dyspareunia are merged into genito-pelvic pain/penetration disorder. This includes expanded symptom descriptions of marked difficulty having vaginal intercourse/penetration; marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts; marked fear or anxiety about vulvovaginal or pelvic pain either in anticipation of, during or as a result of vaginal penetration; and marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration.

Hypoactive sexual desire disorder and female sexual arousal disorder are combined into female sexual interest/arousal disorder. Sexual aversion disorder has been removed due to a lack of supporting research. In other changes, male orgasmic disorder has been renamed delayed ejaculation, male erectile disorder is now erectile disorder, and "early" has been added to premature (early) ejaculation.

The DSM-5 retains the lifelong, acquired, generalized and situational DSM-IV-TR subtypes and now designates them as specifiers for all sexual dysfunction diagnoses. New to the manual is important language indicating that:

- A "desire discrepancy" between sexual partners is not sufficient to diagnose a sexual dysfunction

- Clinical judgment should be used in determining whether sexual difficulties are the result of inadequate sexual stimulation or if cultural factors are present that may influence expectations or engender prohibitions about the experience of sexual pleasure
- Symptom duration for all sexual dysfunctions must be a minimum six months (the DSM-IV-TR did not contain symptom duration time frames, opening the door for potential overdiagnosis)
- Sexual dysfunctions must be experienced on most or all occasions (75 percent to 100 percent) of partnered sexual activity

The DSM-5 removes language that portrayed sexual dysfunctions as disorders of the sexual response cycle related to desire (fantasies about sexual activity), excitement (subjective sense of sexual pleasure and accompanying psychological changes), orgasm (peaking of sexual pleasure with release of sexual tensions and rhythmic contraction) or resolution (muscular relaxation and general well-being).

Sexual dysfunctions are now understood to have requisite biological underpinnings that are influenced by intrapersonal, interpersonal, cultural and psychological factors. For example, the DSM-5 requires consideration of the following factors during assessment and diagnosis of all sexual dysfunctions:

- Partner (partner's sexual problems, partner's health status)
- Relationship (poor communication, discrepancies in desire for sexual activity)
- Individual vulnerability (poor body image, history of sexual or emotional abuse)
- Psychiatric comorbidity (depression, anxiety)
- Stressors (job loss, bereavement)
- Cultural/religious factors (inhibitions related to prohibitions against sexual activity or pleasure, attitudes toward sexuality)
- Medical factors relevant to prognosis, course or treatment

The DSM-5 also emphasizes that a diagnosis of sexual dysfunction is not to be made if severe relationship distress, partner violence or significant stressors better explain the sexual difficulties. However, an appropriate V or Z code for the relationship problem or stressor may be listed. Some of these V or Z codes, properly designated as "Other Conditions That May Be a Focus of Clinical Attention," include the following (see DSM-5 pages 715-727):

- High expressed emotion level within family (for example, hostility, emotional overinvolvement or criticisms directed toward a family member who is an identified patient)

- Spouse or partner abuse, psychological (berating or humiliating the victim, interrogating the victim, threatening the victim with sexual assault or physical harm, isolating the victim from family, friend or social support resources)
- Other problem related to employment (unemployment, recent job change, threat of job loss, job dissatisfaction, stressful work schedule, sexual harassment on the job, hostile work environment)
- Phase of life problem (entering or completing school, leaving parental control, getting married, starting a new career, becoming a parent, children leaving home, retiring)
- Social exclusion or rejection (being bullied, teased, intimidated, verbally abused and humiliated or purposefully excluded from activities of workmates)
- Target of (perceived) adverse discrimination or persecution (resulting from gender identity, race, ethnicity, religion, sexual orientation, country of origin, political beliefs, disability status, social status, weight, physical appearance)
- Problem related to lifestyle (lack of physical exercise, inappropriate diet, high-risk sexual behavior, poor sleep hygiene)
- Sex counseling (counseling related to sex education, sexual behavior, sexual attitudes such as embarrassment/timidity, others' sexual behavior or orientation, sexual enjoyment or any other sex-related issue)

Gender dysphoria

In the DSM-5, gender identity disorder (GID) has been changed to gender dysphoria (GD). Use of the word dysphoria properly conveys the intense feelings of depression and discontent that individuals experience when their physical body is incongruent with their manifest gender identification, as opposed to having psychological confusion regarding their gender identification (as suggested by the diagnosis title of gender identity disorder).

In her article, Boskey reported that during the revision process, activists from the transgender community were vocal on both sides of the question of how gender identity should be addressed in the DSM-5.

While some advocated for the removal of gender identity disorder from the manual to signal the normalization of nonbinary gender identities within today's society, others fought to retain it, concerned that securing insurance coverage for gender confirmation surgery (also known as gender reassignment surgery) would be even more difficult if the disorder was no longer diagnosable by mental health professionals.

According to Jack Drescher, a member of the Sexual and Gender Identity Disorders Work Group for the DSM-5, a central tension in discussions about the diagnosis was between the possibly stigmatizing effect of retaining a category for gender conflicts among a list of

mental disorders and the need to maintain access to care for individuals who experience distress or impairment in function related to gender conflicts. “We decided the access-to-care issue was very important,” Drescher said. “If you take out the diagnosis, you don’t have a code for treatment.”

Additional highlights of changes to the former gender identity disorder in the DSM-5 include:

- The presence of clinically significant distress for longer than six months (the DSM-IV-TR had no duration time frame)
- Emphases on “gender incongruence” rather than cross-gender identification per se
- Definition of sexual and gender-related terms such as cross-sex, gender assignment, gender-atypical, gender-nonconforming, gender reassignment, gender dysphoria, gender identity, transgender and transsexual
- Merging DSM-IV-TR’s Criterion A “cross-gender identification” and Criterion B “aversion toward one’s gender” because factor analytic studies did not support keeping the two separate
- “The other sex” (DSM-IV-TR) is replaced by “some alternative gender”
- “Strong desire to be of the other gender” replaces “repeatedly stated desire” because children in a coercive environment may not verbalize the desire

The DSM-5 now recognizes separate diagnostic criteria for children (ages 10 and younger), with six of the following eight symptoms required for a diagnosis:

- Aversive attitudes: 1) desire to be of other gender, 2) dislike of anatomy, 3) desire to have other sex characteristics
- Aversive behaviors: 4) cross-dressing, 5) cross-gender fantasy, 6) cross-gender play, 7) cross-gender playmates, 8) rejection of toys, games and activities typically associated with their gender

In contrast, adolescents (age 11 and older) and adults (age 18 and older) only need to meet two of the following six symptoms for a diagnosis:

- Mental fixation: 1) incongruence, 2) conviction that one possesses feelings of the other gender
- Strong desires: 3) to change, 4) to have sex characteristics of the other gender, 5) to be the other gender, 6) to be treated as the other gender

The DSM-5 provides a thorough discussion regarding the differences between early-onset gender dysphoria and late-onset gender dysphoria. Additionally, and importantly, the gender dysphoria criteria eliminate the sexual orientation specifiers found in the DSM-IV-

TR's definition of gender identity disorder. This reflects a growing understanding that gender identity and sexual orientation are not inherently intertwined.

Boskey noted that the language used in the gender dysphoria criteria in the DSM-5 reflects both a more modern understanding of gender identity and the input of stakeholders. This can be seen quite clearly in the post-transition specifier, which looks at dysphoria that continues after an individual has transitioned to full-time living in the desired gender and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen.

In particular, the full specifier includes language describing gender reassignment surgery as "confirming the desired gender." Many transgender individuals and activists prefer the term "gender confirmation surgery" over "sex reassignment surgery." The term is seen as more accurately reflecting a construct in which gender is internal and inherent (the body can be changed to match it) rather than an external construct determined by the presence of a particular set of genitalia.

As a whole, changes to the previous gender identity disorder in the DSM-5 make the gender dysphoria diagnosis more restrictive and conservative. As Drescher notes, "It takes psychiatrists out of the business of labeling children or others simply because they show gender-atypical behavior."

Paraphilic disorders

In the DSM-5, paraphilias are now called paraphilic disorders. A paraphilia is necessary but not a sufficient condition in and of itself for having a paraphilic disorder. The DSM-5 requires subjective distress manifest in either of the following: The paraphilia involves another person's psychological distress, injury or death, or it involves a desire for sexual behaviors with unwilling persons or persons unable to give legal consent.

This two-pronged nature of diagnosing requires counselor-rated or self-rated measures and severity assessments that address the strength of the paraphilia itself or the seriousness of its consequences. Counselors should keep in mind that it is not rare for an individual to manifest two or more paraphilias.

The paraphilias also receive new classification schemas, or groupings, based on common expressions. Voyeuristic disorder, exhibitionistic disorder and frotteuristic disorder are known as anomalous activity preference courtship disorders. Sexual masochism disorder and sexual sadism disorder are known as anomalous activity preference algolagnic disorders. Pedophilic disorder, fetishistic disorder and transvestic disorder are known as anomalous target preference disorders.

The DSM-IV-TR limited transvestic disorder behavior to heterosexual males; the DSM-5 has no such restrictions. To enhance specification of the respective diagnosis, all paraphilic disorders can be coded as "in a controlled environment" (institutional or other setting) and "in full remission" (being symptom free for a minimum of five years).

Hypersexual disorder

Not included in the final publication of the DSM-5, but tested in the clinical field trials, was hypersexual disorder (sexual addiction). It included the following proposed symptomology.

A) Over a period of at least six months, recurrent and intense sexual fantasies, sexual urges or sexual behaviors in association with three or more of the following criteria:

- Time consumed by sexual fantasies, urges or behaviors repetitively interferes with other important (nonsexual) goals, activities and obligations
- Repetitively engaging in sexual fantasies, urges or behaviors in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability)
- Repetitively engaging in sexual fantasies, urges or behaviors in response to stressful life events
- Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviors
- Repetitively engaging in sexual behaviors while disregarding the risk for physical or emotional harm to self or others.

B) There is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges or behaviors.

C) These sexual fantasies, urges or behaviors are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication)

Specify if:

- Masturbation
- Pornography
- Sexual behavior with consenting adults
- Cybersex
- Telephone sex
- Strip clubs
- Other
- Clinical diagnostic

As Martin P. Kafka wrote in a 2009 paper called “Hypersexual Disorder: A Proposed Diagnosis for DSM-V,” the “sexual addiction literature, while rich in description of individual sex addicts and possible treatments, has lacked a coherent codification for the specific hypersexual behaviors that are reliably or consistently reported in clinical or research reports.” Hence, the disorder is not included as a formal diagnosis in the DSM-5.

For those counselors needing a diagnosis to account for sexually addictive behavior in clients, I suggest ruling out borderline personality disorder and histrionic personality disorder even though hypersexuality is characteristic of both disorders. Counselors must also remember that hypersexuality is core to manic and hypomanic episodes, so proficient ruling out for bipolar I or II disorders is strongly encouraged.

For example, as detailed in the DSM-5, manic/hypomanic episodes are characterized by “goal-directed, excessive involvement, high potential for painful consequences, poor judgment, loss of insight; hyperactivity related to sexuality and sexual indiscretions; increased sexual drive, fantasies and behavior; disregard for the risk of sexually transmitted disease or interpersonal consequences.”

Until next month, be well!

Bio

Jason H. King is core faculty in the CACREP-accredited mental health counseling program at Walden University. He is a state-licensed and national board certified clinical mental health counselor and an AMHCA diplomate and clinical mental health specialist in substance abuse and co-occurring disorders counseling. He received the 2012 AMHCA Mental Health Counselor of the Year Award. He provides face-to-face and video trainings on the DSM-5. Visit him at mellivoragroup.com.
Letters to the editor: ct@counseling.org