Proposed New Psychiatric Diagnoses Raise Charges of Gender Bias

Revisions of a key manual of psychiatric diagnoses have prompted a dispute among mental health professionals

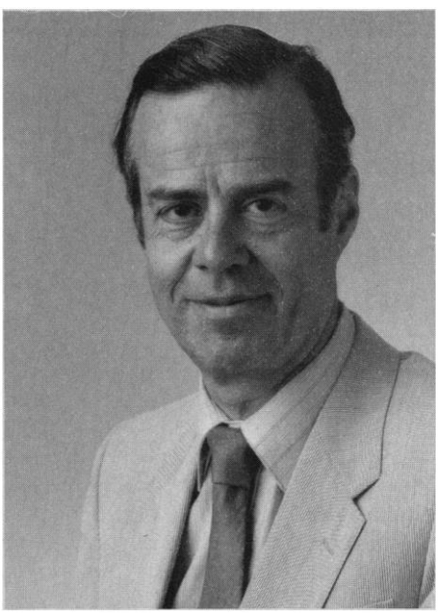
A debate has been simmering in the psychiatric community in the past few months over proposals that would result in widespread recognition of three new mental disorders. Feminist psychiatrists and psychologists, and groups concerned with the victims of sexual abuse, contend that the proposals could contribute to sexual inequality and legitimize attempts to "blame the victim" in some cases of assault.

The dispute centers on the proposed inclusion of the three new diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-III. The manual, which is published by the American Psychiatric Association (APA), is the basic reference book for mental health clinicians. It is generally regarded as representing the consensus of the psychiatric profession on diagnoses of disorders, and it also provides standardized diagnostic criteria used by insurance carriers.

The controversial categories proposed for inclusion in a revised version (DSM-III-R), to be published in 1987, are: "premenstrual dysphoric disorder," a version of premenstrual syndrome (PMS) that emphasizes the accompanying mood and behavioral changes; "paraphilic coercive disorder," designed to identify a subset of sexual offenders who are sexually aroused by the coercive nature of the act; and "self-defeating personality," a broad category of personality disorders characterized by masochistic and self-destructive behavior. A fourth new category is "sadistic personality disorder," characterizing persons whose common mode of relating to people is through violence, humiliation, and intimidation.

The manual is revised periodically in the light of clinical experience. The changes can have an important impact on treatment—for example, the recognition (encoded in the 1980 version) that some schizophrenia-like behaviors are actually attributable to mania or other disorders has probably contributed to the decline in diagnoses of schizophrenia. While the characterizations of most syndromes have remained fairly stable, the manual is not immune to changes in cultural attitudes, the chief contemporary example being the decision to discontinue listing homosexuality as a behavioral disorder.

According to psychiatrist Robert L. Spitzer of the New York Psychiatric Institute, who heads the working group on the revision, the strongest objections to the new diagnoses have come from people outside the relevant fields. He says persons espousing the feminist viewpoint have been included on advisory committees, but they represent only a small minority of informed opinion. Spitzer respects the feminist view that any diagnosis that is seen more commonly in one sex should be viewed with "great suspicion and caution." However, he says, "we don't accept the basic principle that concentration in one sex equals bias."



Robert L. Spitzer

Heads working group drafting the revisions.

Some feminist mental health professionals are, however, not only critical of the new categories but also contend that Spitzer's committee displayed considerable political naïvete by omitting the systematic consideration of gender bias in diagnoses. They say they did not even learn of the proposed diagnoses until last September, when they were presented more or less as a fait accompli to the APA board.

Following protests from the women's committees of both the APA and the American Psychological Association as well as from a number of other groups, alterations were made in both the diagnostic criteria and nomenclature, which were finally approved in December. Nonetheless, according to Renee Garfinkel, director of the Women's Program Office of the psychological association, critics are still unhappy with the conceptual bases of the diagnoses and regard the whole process as intellectually "slipshod."

With regard to premenstrual dysphoric disorder, Spitzer says the diagnosis is justified in view of the fact that the majority of women who complain to their doctors are more distressed about the psychological than the physical symptoms. In addition to physical symptoms including swelling, tenderness, headaches, and so forth, the disorder is marked by sharp changes in mood, weepiness, depression, irritability, lassitude, food cravings, sleep problems, and difficulty in concentration for about a week before and during the first few days of menstruation. A diagnosis of dysphoric disorder is only made if it constitutes a recurrent and serious disruption in a woman's life and if the behavior does not represent an exacerbation of an underlying problem such as depression.

Feminist critics do not deny the existence of a premenstrual syndrome but contend that it should remain only a gynecological diagnosis, and that its inclusion in the psychiatric lexicon contributes to the stigmatization of normal women. Psychiatrist Jean Hamilton of the National Coalition for Women's Health says the diagnosis "puts the cart before the horse" because there is no solid evidence linking the psychological changes with biological ones. Critics say it reinforces the idea that being a woman puts one at additional risk for psychiatric disor-

ders; that it appears to pathologize normal endocrinological events; and that no good purpose is served by listing it when the etiology is unknown and there is no sure cure. The diagnosis is "many steps beyond what is actually known about the menstrual cycle," says Garfinkel.

David Rubinow, who does research on PMS at the National Institute of Mental Health (NIMH), is clearly sympathetic with feminist concerns, but he feels, contrary to their assertions, that "this is a gain for feminists." He points out that formalization of the diagnosis will make it clear that the great majority of women do not suffer from "raging hormones"; conversely, women who fear being stigmatized for mental problems will be less averse to seeking help if they can chalk up their distress to their endocrines.

"Self-defeating personality" is another diagnosis which feminist critics claim will be used against women. The original proposal was for "masochistic personality," which had them so upset that the National Coalition Against Domestic Violence was considering a lawsuit. According to Frederic Kass, director of adult psychiatry at Columbia-Presbyterian Medical Center, the term is associated with Freudian psychoanalytic concepts, and Freud applied it primarily to women. Kass says, however, that the category, although it is applied more often to women, is "probably one of the most common personality disorders that exists."

According to critics, this diagnosis reflects the distressing tendency on the part of clinicians to "blame the victim" in cases of abuse or battering and in cases where masochistic behavior may even be an adaptive response to being in a position of powerlessness. Hamilton says the original proposal was "appallingly naive about women's mental health." Garfinkel adds that the committee that sanctioned it (which is headed by Kass) was "totally unaware of research on victimization." Kass says there is a "large element of truth" to that charge, and that the feminists' critiques have been very helpful to the committee.

Garfinkel maintains nonetheless that even if the syndrome exists—and she doesn't think the research is there to back it up—it might better be called a situational reaction than a personality disorder. The DSM-III definition of personality disorder says it is a system of pervasively maladaptive traits that is "generally recognizable by adolescence or earlier." The diagnosis has implications for treatment because personality disorders are notoriously intractable, says Garfinkel, whereas brief intervention is often effective with victims of abuse.

Kass says, though, that battered women were by no means the population the committee had in mind when it proposed this diagnosis, and he acknowledges that most battered women, other than those with a pervasive and repetitive pattern of seeking abusive relationships, would not qualify. What the committee had in mind were several other types. One of the most familiar is the martyrish mother who always arranges to get the short end of the stick and whose manipulative, resentful, long-suffering manner reflects a profound lack of self-esteem. Another is the individual who always contrives to set himself up for failure, for example by turning down promotions or flunking an exam for which he was well prepared. Finally there are individuals, says Kass, who seem to be "hell-bent on suffering" through every available means—such as alcohol and drug abuse, auto accidents, masochistic relationships, and even deliberate self-infliction of pain. He says that in addition to extensive psychoanalytic literature on masochism, two recent empirical studies confirm the validity of the diagnosis.

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Critics are correct, though, in saying there is no systematic research on "sadistic personality disorder," which extends the concept of sadism beyond the traditional sexual meaning and can be applied to a person who inflicts pain and humiliation for its own end and usually also has a fascination for violence, torture, and the instruments thereof. Feminists claim that this diagnosis, which applies mainly to men, was thrown in as a counterbalance to the masochistic diagnosis, but Spitzer emphatically denies this, saying it is a category that has been called for by many forensic clinicians.

The final target of controversy is "paraphilic coercive disorder," applying to men who gain sexual pleasure from the coercive aspects of rape or sexual molestation (they are not, however, aroused by physical pain). According to Judith Becker, psychologist at Columbia-Presbyterian Medical Center, most rapists, such as the young man who performs a rape or two in the course of a burglary, can be diagnosed as antisocial personalities. But there is a subset of rapists—there are no statistics but she would put the proportion at about 20 percent—whose compulsion runs deeper. Many of these have no other criminal record and thus might be helped by therapy.

Feminists have voiced the concern that such a diagnosis will help get rapists and molesters off in court, a fear that seems to have little empirical justification. Hamilton and Garfinkel, however, say their real problem with the diagnosis is that it can be made solely on the basis of obsessional fantasies because the proposed definition says "the individual repeatedly acts on these urges or is markedly distressed by them." "Thoughts of rape are normative in this culture," says Garfinkel. She says she would be more comfortable if psychophysiological tests were required to confirm the diagnosis, but that it is more appropriately ranked among the obsessive-compulsive disorders.

The new diagnosis for sexual offenders reflects continuing efforts to refine definitions through differential diagnoses—that is, alternate explanations for sets of symptoms that have superficial similarity. In another area, the next revision of the manual will probably contain a new variety of depression called "seasonal affective disorder," which afflicts people as the days shorten. Spitzer says this will not be included in the DSM-III-R because research has only begun on it at NIMH.

In general, the diagnostic manual manages to keep controversy at a minimum by avoiding discussion of etiologies (except where they are definitely known) and treatment. However, political considerations invariably creep in in the case of disorders with no known biological substrate. As the APA continues to try to refine and differentiate diagnoses, there are increasingly implied assumptions about etiology. This year, for example, experts on child abuse tried (unsuccessfully) to get abuse-related diagnoses into the manual's secton on post-traumatic stress disorder. The feminists raise the interesting question of where the line should be drawn in the case of disorders whose prevalence is clearly influenced by the social environment. If indeed masochistic behavior is primarily perceived among women, Hamilton says she does not see a big difference between formal elaboration of this diagnosis and the creation of a special "low self-esteem" disorder for blacks.

The long and short of it is that critics seem to be operating from a somewhat different conceptual basis from the psychiatrists, one which emphasizes social factors in the etiology of mental disorders and overtly acknowledges the political role of psychiatry. It also reflects a less than unqualified faith in the wisdom of the individual clinician. ■ CONSTANCE HOLDEN