DSM-5 and the Medicalization of Criminalized Risks

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Abstract: This paper explores three controversial diagnoses that were proposed (and rejected) for DSM-5, each of which deals with an intersection of medicine and the law. Pedohebephilia would extend the diagnosis of pedophilia (a paraphilic disorder) to those who are attracted to teenagers, potentially expanding the group of individuals potentially subject to civil commitment procedures. Coercive paraphilia would medicalize the act of rape. Parental alienation syndrome would introduce the psychiatric concepts of psychosis and delusion into already charged family court proceedings. I contend that all three diagnoses were designed more for the courtroom than the clinic. I investigate the controversies surrounding each diagnosis and the arguments that ultimately succeeded in preventing these diagnoses from becoming explicitly institutionalized in DSM-5, and I discuss the rhetorical and legal implications of the decisions that were made. I argue that while the impetus for these proposed diagnostic innovations is the institutional management of risk, their ultimate disposition turned on arguments about the risks these diagnoses posed to civil liberties.

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More than a decade of techo-scientific deliberation about how best to classify mental illness culminated in the May 2013 publication of the American Psychiatric Association's [APA] fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-5], "one the most anticipated events in the mental health field" (American Psychiatric Association, 2010a).[1] More than a decade in the making, its development attracted considerable interest from scientists, mental health professionals, professional societies, patients, and other publics, and has ignited a controversy that sits at the intersection of the public, technical, and personal spheres of argument (Goodnight, 1982). As historian Hannah Decker has noted, "rarely has the medical world—and the general public, for that matter—been witness to an open drama such has taken place... in response to a medical association's [decision] to revise its diagnostic categories" (Decker, 2010, para. 1). In 2010, amidst concerns about transparency and openness, the APA published preliminary draft revisions, along with notes and other details from the DSM-5 Task Force and Work Groups, on the Internet (dsm5.org), and solicited public comment over a two and a half month period. During this time, more than 500,000 people visited the website, and the APA received almost 9,000 responses (Moyer, 2010). The high level of interest DSM-5 has garnered reflects the controversial nature of its subject matter and the scope of its influence: "The power of DSM throughout the world should not be underestimated, and it is the problem for all the psychiatrists of the future—at least until the DSM-6 is written" (Fink, 2010, p. 6).

This paper explores three controversial diagnoses that were proposed for DSM-5,

1 The first four editions of the DSM are distinguished by Roman numerals (e.g., DSM-IV). In a move somewhat reminiscent of Catholic Church's decision to abandon the exclusive use of Latin in its liturgical celebrations in order "to adapt more suitably to the needs of our own times those institutions which are subject to change" (Paul VI, 1963, sec. 1) the APA has eschewed this practice for DSM-5, explaining that "in the 21st century, when technology allows immediate electronic dissemination of information worldwide, Roman numerals are especially limiting" (American Psychiatric Association, 2010b). I believe the decision should be understood in light of the criticisms—in which the fifth edition is almost always referred to as 'DSM-V,' incidentally—proffered by individuals closely associated with the development of DSM-III and DSM-IV. This is supported by the timing of the decision: the APA referred to the revision as 'DSM-V' for more than eight years, choosing to change the name after significant criticism from the former editors appeared. Though minor, the change supports the position that the older editions contain a nosology that is limiting, especially given recent scientific and technological developments.

each of which deals with an intersection of medicine and the law. Pedohebephilia would extend the diagnosis of pedophilia (a paraphilic disorder) to those who are attracted to teenagers, potentially expanding the group of individuals potentially subject to civil commitment procedures. Coercive paraphilia would medicalize the act of rape. Parental alienation syndrome would introduce the psychiatric concepts of psychosis and delusion into already charged family court proceedings. I contend that all three diagnoses were designed more for the courtroom than the clinic. I investigate the controversies surrounding each diagnosis and the arguments that ultimately succeeded in preventing these diagnoses from becoming explicitly institutionalized in DSM-5, and I discuss the rhetorical and legal implications of the decisions that were made. I argue that while the impetus for these proposed diagnostic innovations is the institutional management of risk, their ultimate disposition turned on arguments about the risks these diagnoses posed to civil liberties.

Medicalization itself is a risk phenomenon, and the medicalization of risk is a phenomenon in the very image of reflexive modernity. Ivan Illich (1976) famously described the situation that gives rise to the question of whether some problem by its nature belongs to the domain of health: "Each civilization defines its own diseases. What is sickness in one might be chromosomal abnormality, crime, holiness, or sin in another" (p. 37). Once formulated as a health concern and pathologized, a putative disease entity is on course to fall under the technical gaze of expertise, which will occur when acceptable subjective and objective criteria are developed and institutionalized.

The concept of medicalization is relatively recent—the term entered discourse in the 1960s, and first appeared in a dictionary (of jargon) in 1987 (Aronson, 2002). Medicalization has been defined as "a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and

disorders" (Conrad, 2007, p. 4). Fairly recent examples include baldness (alopecia), bad breath (halitosis), impotence (erectile dysfunction), overactive bladder (detrusor instability), shyness (social anxiety), too much plastic surgery (body dysmorphic disorder), to name just a few (Conrad, 2005, 2010; Conrad & Leiter, 2004; Conrad & Schneider, 1992; Ghigi, 2009; Lane, 2007; Maturo, 2009; Payer, 1992). There are two primary pathways to medicalization, "the pathologizing of normal biological or social variation and... the portrayal of the presence of risk factors for disease as a disease state itself" (Heath, 2006, p. e146). Some examples of diseases constructed from risk factors, sometimes called "prediseases" or "pre-conditions... a medical label [for] people who are at risk of being at risk," include 'high' blood pressure, 'high' cholesterol, menopause, obesity, pre-diabetes, and pre-osteoporosis (Gambrill, 2012; Moynihan, 2010, p. 485). The process is in part driven by market dynamics, which exert a downward pressure on the severity thresholds of the newly medicalized phenomena:

> Due to the shape of the typical disease bell curve, lowering the severity threshold at which people think they have a 'real' disease and need drug treatment typically expands the potential market by a factor of ten or more. It is only with a low severity threshold that a PR firm can whip up a proper scare campaign about a hidden epidemic of disease that affects ten, twenty, or fifty million people. (Brody, 2008, p. 241)

Industry is only one side of the issue—the neo-liberal structuring of academia encourages researchers to carve out new pet conditions and promote them to the public (Moynihan, 2011). The rampant medicalization of the problems and risks of modern life has left us increasingly intolerant of relatively mild complaints and increasingly anxious about risk (Barsky & Borus, 1995; Conrad, Mackie, & Mehrotra, 2010; McCormick, 1996).

In the domain of sexual crimes, judicial appeals to psychiatric diagnosis are made, with some controversy, to deny civil liberties traditionally afforded to all citizens. These kinds of crimes are considered so evil, so abnormally deviant, so

unthinkable for a normal, rational citizen, that anyone who commits one of these crimes is forever held under suspicion, even after their 'debt to society' has been paid. People who have been found guilty of rape are more likely than the average citizen to commit another act of rape; prudence demands that we take steps to control this controllable risk. Hence, sex offender registries and the strange paradoxes of sexual crime control, e.g., children who 'sext' one another are being prosecuted for distributing child pornography (Lee, Crofts, Salter, Milivojevic, & McGovern, 2013), and that in some cases one can receive a larger penalty for passively viewing child pornography than for actually raping a child (Crary, 2012; Jauregui, 2014).

Pedohebephilic Disorder

It is easy for certain social categories associated with systematic prejudice (e.g., race) to pervert the operation of putatively objective judgment producing institutions (Metzl, 2009). One of the successes of the civil rights movement was the enactment of reforms that somewhat standardized the prison sentences given for felonies, so that someone who formerly would have received an especially light or heavy sentence would now receive one closer to the average. One consequence of this diminished discretionary power of judges in assigning punishments is that criminals who for whatever reason seemed more likely to re-offend were given shorter prison sentences. The solution to this problem came in the form of a shift from 'need-for-treatment' to 'dangerousness' criteria as the standard for civil commitment (Testa & West, 2010). This lead to the creation of the “sexually violent predator” [SVP] as a juridical object of knowledge, an individual who could be made to undergo chemical castration or else be forcibly 'treated' for their sexual perversions in a mental hospital after the term of their prison sentence was complete (Frances, 2013, p. 165). This was preventive detention by another name

(since preventive detention straightforwardly violates the US constitution).[2]

A diagnosis of pedophilia, indicating a sexual preference or compulsion for prepubescent children, is one of the ways one could qualify for such treatment (Aviv, 2013). The failed proposal either to include the diagnosis of 'hebephilia'—a disorder first so named by Glueck (1955) characterized by feeling sexual attraction toward teenagers—or to expand pedophilic disorder into a broader 'pedohebephilic disorder,' first so named by Freund, Seeley, Marshall, and Glinfort (1972), would have dramatically widened this category. It was proposed by the Paraphilias Subworkgroup but rejected by the APA Board of Trustees for reasons that remain confidential. The leading argument against treating hebephilia as a paraphilia, as presented by Frances (lead editor of DSM-IV and chief critic of DSM-5), is that it is actually 'normal' for adults (men) to feel sexually attracted to pubescent[3] children:

> Numerous studies have proven the obvious—such attraction is common and completely within the range of normal male lust... The advertising industry, wise to the fact that many adults remain sexually attracted to adolescents, cynically exploits their interest by displaying young-looking models in provocative clothing and poses. The assertion that sexual urges stimulated by sexy teenagers denote mental disorder violates common sense, experience, and evidence from research. It is not a crime or a mental disorder to lust after the newly pubescent; it is human nature. But it is a very serious crime in our society to act on these impulses, one that deserves a long prison term. (Frances, 2013, pp. 201–202)

One source of possible ambiguity in the debate over hebephilia is that the category of disorders in question concern disordered appetites/desires, rather than disordered conduct.

Along these lines, after reminding his audience of the historical uses of the category of paraphilic disorders to control deviant and taboo 'perversions,' Wakefield sharply criticized the proposal, calling it the “most flawed and blatantly

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2 Unless the nation is at war (*Korematsu v. United States*, 1944).

3 More specifically, children developmentally in Tanner Stage 2 and Tanner Stage 3, generally aged 11-14 (Tanner, 1978).

over-pathologizing paraphilia proposal," and suggesting that the proposed diagnosis "violates the basic constraint that disorder judgments should not be determined by social disapproval. This is a case where crime and disorder are being hopelessly confused" (Wakefield, 2011, p. 206). In response to this kind of criticism, Ray Blanchard, the chief proponent of regarding hebephilia as a mental disorder, argued that if pedophilia is a mental disorder, it must follow that hebephilia is a mental disorder for the same reasons; any criticism of hebephilia along the lines offered by Wakefield or Frances should equally provide reason to exclude pedophilia. Attempts to distinguish between pedophilia and hebephilia on the basis of fecundity would imply that homosexuality is paraphilic, Blanchard contended.

Blanchard acknowledged that the diagnosis would have serious reliability problems, but did not find that to be a very compelling argument:

> But so what? Should there exist no diagnosis for men who say they are most attracted to pubescents, who have committed repeated sexual offenses against pubescents, and who respond most strongly to laboratory stimuli depicting pubescents just because there are other men who produce less consistent findings?[4] (Blanchard, 2009b, p. 332)

Furthermore, Blanchard argued that his critics missed the entire point—hebephilia as advanced by Blanchard only would apply to men who *exclusively* feel attraction for adolescents; a man who is attracted to teenagers as well as adults would not be regarded as a hebephile. While Blanchard is correct that his opponents do not address this, in all his protesting he never makes an argument for why it is actually relevant, and it relies on an alternative understanding of pedophilia than used by the DSM since DSM-III-R, which defined pedophilia in absolute rather than relative terms, as in the DSM-5 image of a pedophile as an adult who has "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children," regardless of whether they do or do not have equal or greater feelings of attraction to adults (American Psychiatric

4 His critics would have no problem answering this rhetorical question with an emphatic 'no.'

Association, 2013, p. 697). The tone of his polemic is, perhaps appropriately, reminiscent of the manner in which teenagers argue with their parents, and is rather striking for scientific discourse. For example, he remarks that the validity of his position "should be obvious to anyone who has read our article" and comments on how "ironic" it was that his opponents cited a particular finding "when our laboratory was one of the first to report this," almost as if to declare ownership of the fact in question, the interpretation of which was not in dispute (Blanchard, 2009, p. 332).[5]

Coercive Paraphilia

The proposed diagnosis 'paraphilic coercive disorder' or 'coercive paraphilia' would have applied to anyone who has "sought sexual stimulation from forcing sex on three or more nonconsenting persons on separate occasions" (American Psychiatric Association, 2010c). This was not a new idea; in 1985 the DSM-III-R Workgroup proposed the diagnosis of 'paraphilic rapism,' "which was extensively criticized at the time" (Fuller, Fuller, & Blashfield, 1990; Krueger & Kaplan, 2012, p. 251). As explained in DSM-5, a paraphilia is sexual desire that is sufficiently deviant that it can almost be thought of as a kind of arousal psychosis:

> The term *paraphilia* denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners... [The] term *paraphilia* may be defined as any sexual interest greater than or equal to normophilic sexual interests. (American Psychiatric Association, 2013, p. 685, emphasis in the original)

Provoking reactions that range from outrage to humor, coercive paraphilia remains highly controversial, and most of the discussion about its inclusion was focused on

5 Ray Blanchard was a member of the DSM-5 Sexual and Gender Identity Disorders Work Group and chair of the Paraphilias Subworkgroup, and while the Board of Trustees of the APA voted not to accept the Subworkgroup's recommendations in favor of adopting Blanchard's view of hebephilia, he did succeed in his efforts to change the definition of a paraphilia adopted in the final manuscript so that it contrasts with what is 'phenotypically normal.' The approach in DSM-IV defined paraphilia by concatenation, enumerating a variety of paraphilic fantasies, urges, or behaviors; in contrast, the DSM-5 approach, which had been strongly advocated by Blanchard, defines paraphilia by exclusion, i.e., in terms of what it is not (Blanchard, 2009a).

the question of its status as a *medical* problem. Debate about this diagnostic category is not so much about whether a coercive sexual orientation is 'disordered,' but rather whether it is to be defined as a medical disorder, i.e., an illness, or as a legal disorder, i.e., a crime. On this point, Lombroso reminds us that "the distinction between crime and madness is something constructed not by nature but by society" (2006, pp. 83–84).

That the diagnosis seems designed as a risk management tool struck critics as too risky, in two opposing ways. On the one hand, there are concerns about the possible use by defense attorneys presenting an insanity or diminished capacity defense (Slovenko, 2011). In criticizing the disorder, Frances noted that the "construct 'paraphilic coercion' has already contributed significantly to a grave misuse of psychiatry by the legal system in the handling of sexually violent predator," and urged the DSM-5 Task Force to withstand the urge to "medicalize undesirable sexual behavior and thereby provide a psychiatric excuse helpful to those who are attempting to evade personal responsibility" (Frances, 2010a, pp. 3–4). On the other hand, critics alleged that coercive paraphilia was an "[invented] diagnosis for [the] civil commitment of rapists" (Zander, 2008, p. 459). Psychiatric diagnosis can be used for this basis, but " only if the offender's dangerousness is caused by a mental disorder and is not a manifestation of simple criminality... Being dangerous is not enough, since released criminals are also potentially dangerous" (Frances & First, 2011, p. 555).

It appears that Frances was just as concerned (if not more so) with this danger, because in *Saving Normal,* Frances argued that "we lose constitutional stability whenever we allow civil rights to be violated, even for those people we most detest" (Frances, 2013, p. 203). So as to prevent any ambiguity, Frances and First (who headed the DSM-IV Paraphilia Workgroup) stated their opposition unequivocally:

> The evaluators, prosecutors, public defenders, judges, and juries must all recognize that the act of being a rapist is almost always an aspect of simple criminality and that rapists should receive longer prison sentences, not psychiatric hospitalizations. (pp. 558-559)

At the 2010 annual conference of the American Academy of Psychiatry and the Law [AAPL], a group of forensic psychiatrists voted against endorsing 'paraphilic coercive disorder' by a vote of 31 to 2, citing "the dearth of scientific reliability or validity... [and] the potential for misuse by partisan advocates in the forensic arena, especially in civil commitment proceedings" (Franklin, 2011, p. 137).

This potential is not theoretical; even though the DSM-IV Paraphilia Workgroup "definitively rejected the claim that rape should be considered a mental disorder," and moreover the entire section on paraphilia in DSM-IV was written "before the issue of SVP [sexually violent predator] commitment arose and was written with clinicians, not forensic proceedings, in mind," Frances and First claim that "a misreading of the poorly worded paraphilia section allowed evaluators to form just the opposite impression," namely that rapists should be given the DSM-IV diagnosis of 'paraphilia, not otherwise specified [NOS]' (Frances & First, 2011, p. 556). As he often does when criticizing fellow psychiatrists, Frances concedes the intentions of his opponents are "well meaning and honorable," but argues that even "the best intended misuse of psychiatric diagnosis to curb risks to society is not worth the cost," reminding his audience that "mental health professionals in other countries have been turned into state-sponsored tools in the oppression of political dissidents" (p. 560).

Despite this ethotic concession of good faith, the criticism employs a tragic frame in which SVP evaluators, who are either acting "naively or purposefully," have in their *hubris* exceeded the appropriate limits of psychiatry (p. 559). Burke suggests that in tragedy, *hubris* is the "basic sin... [surrounded] with the connotations of crime," in "conflict with established values," yet at the same time

"tragedy deals *sympathetically* with crime," so that "we are made to feel that [the criminal's] offense is our offense," and ultimately the target of criticism is "admonished... to 'resign' himself to a sense of his limitations" (Burke, 1984, p. 39, emphasis in the original).

Critics of coercive paraphilia did not limit themselves to the tragic frame. In some cases, critics took to open mockery in the public sphere. While sometimes these criticisms aimed at a public audience retain the tragic character of the criticisms presented in expert forums, the turn to the public opens up space for the comedic frame. Both tragedy and comedy warn "against the dangers of pride," but in comedy, the

> emphasis shifts from *crime* to *stupidity*... The audience... chastened by dramatic irony... is admonished to remember that when intelligence means *wisdom* (in contrast with the modern tendency to look upon intelligence as merely a *coefficient of power* for heightening our ability to get things, be they good things or bad), it requires fear, resignation, [and] the sense of limits. (Burke, 1984, pp. 41–42, emphasis in the original).

In other words, comedy is an especially useful frame when one is urging for the exercise of practical wisdom over against expert expressions of technical rationality. Burke suggests that comedy used in this way "must develop logical forensic causality to its highest point," which he explains entails "completing the process of internal organization whereby each event is deduced 'syllogistically' from the premises of the informing situation" (p. 42).

For example, Karen Franklin, a forensic psychologist who presented at the 2010 AAPL conference, argued that if coercive paraphilia is a medical disorder, then apparent outbreaks should be treatable in the same manner that other contagious medical disorders can be treated:

> A shocking news story out of Australia makes me think that if Coercive Paraphilic Disorder exists, it must be contagious. Not just contagious, but virulently contagious in certain all-male environments. Of the 198 students at St Paul's College at the University of Sydney, a large proportion were

> apparently infected with a highly contagious form of the virus. If Paraphilic Coercive Disorder makes it into the next Diagnostic and Statistical Manual of Mental Disorders, St. Paul's will be Ground Zero for the epidemic. According to an article in today's Sydney Morning Herald, men at the elite, all-male college proudly set up a pro-rape Facebook group called "Define Statutory" that promoted sexual aggression against women. But the elite students did not stop with words. They fostered an alcohol-fueled climate in which rapes were common, most sexual assaults went unreported, and women students felt so unsafe that they quit school, the story reports. Reporter Ruth Pollard documented a series of rapes and sexual assaults, including one incident in which about 30 drunk, naked men broke into a college and surrounded a young woman, touching and taunting her. The good news is that, if it's a contagious illness, there could be an immunization like the one for the H1N1 virus. So, while the DSM developers are frenetically[6] creating new diagnoses, let's not forget to work on finding some cures, too. (Franklin, 2009, para. 1–5)

While the tone is mocking, the frame is one of acceptance of psychiatry, which is mistaken rather than evil. Through the comic corrective Franklin gently reminds psychiatrists that diagnosis is not for its own sake, and that if they are going to concern themselves with rapists as a patient class then they should be thinking about how to 'cure' them.

Coercive paraphilia did not make it into DSM-5, though the definition of paraphilia (quoted above) explicitly includes a reference to non-consensual sexual acts, and a diagnosis that did make it, frotteuristic disorder, is characterized by "recurrent and intense sexual arousal from touching or rubbing against a nonconsenting person, as manifested by fantasies, urges, or behaviors," which seems to contain coercive paraphilia within an even larger discrete disease entity concept, since it is difficult to conceive of a scenario in which one could commit rape without touching or rubbing the victim (American Psychiatric Association, 2013, p. 691). As with coercive paraphilic disorder, which regarded three instances to be the threshold at which one could make a diagnosis, for a diagnosis of frotteuristic disorder, "'recurrent' touching or rubbing against a nonconsenting individual... may,

6 In these kinds of criticisms, it is almost a *pro forma* requirement to make a pun in which the production of the DSM is a display of madness.

as a general rule, be interpreted as three or more victims on separate occasions" (American Psychiatric Association, 2013, p. 692).

In case that were not enough, two catch-all categories were included: other specified paraphilic disorder and, if that were not sufficiently ambiguous, unspecified paraphilic disorder, for the weird that cannot be named, "situations in which the clinician chooses not to specify the reason" (American Psychiatric Association, 2013, p. 705). The chapter on paraphilic disorders explicitly cautions the reader that the "listed disorders to not exhaust the list of possible paraphilic disorders... The diagnoses of the other specified and unspecified paraphilic disorders are therefore indispensable and *will be required in many cases*" (American Psychiatric Association, 2013, p. 685, my emphasis). This is all despite the fact that Frances' criticism of coercive paraphilia appear in the context of criticizing the "inartful" wording of the DSM-IV diagnosis of paraphilia NOS, which was written at a time when "we were not aware of the consequential problems that would later arise from the fact that the section lacked the clarity and precision necessary for legal purposes," and yet was duplicated and then some in DSM-5 (Frances & First, 2011, p. 556). Presumably, it would be possible to diagnose both coercive paraphilia and hebephilia (provided one does not agree with Frances' contention that hebephilia is normophilic) indirectly with either of the catch-all paraphilic disorder categories.

What is one to conclude from this? It appears that DSM-5 was stripped of this diagnosis *by name*, while the chapter on paraphilic disorders was written in such a way that a trained (or just careful) reader would see that it was still there. Giving a disorder a distinct, unique, and officially named status certainly enhances its visibility—to critics, to attorneys, to pharmaceutical executives. Keeping the disorder but depriving it of its name is a way to manage and restrain the risks associated with the surplus of meaning that overflows from powerful words. This

aligns with Burke's account of the premodern concept of "word magic," which "has its origins, paradoxically, not in a naïve belief in the power of words, but in man's first systematic *distrust* of words" and which "began with the sense of the *ineffable*" (Burke, 1969a, p. 304).

Providing the disorder with its name, a mantra to be recited by nefarious individuals eager to harness its power, was judged to be too dangerous; the elimination of coercive paraphilia from the official list should be thought of as desanctification. Burke notes that "the need to 'desanctify' the world is essentially but an appreciation of the fact that all things possess power... [and] the rights of desanctification are designed to mitigate the intensity of these powers" (p. 304). Yet the disorder was not removed, but only hidden to those on the outside in the parables of the other specified paraphilic disorder and the unspecific disorder, seemingly "so that they may be ever seeing but never perceiving, and ever hearing but never understanding" (Mark 4:12, New International Version). When the text says, as quoted above, that these two diagnoses "are therefore indispensable and will be required in many cases," one could imagine as the next line, "Whoever has ears to hear, let them hear" (American Psychiatric Association, 2013, p. 685; Mark 4:9, New International Version).

The explicit rationale for listing the eight named paraphilic disorders is that they are "relatively common" as far as paraphilia is concerned, and that "some of them entail actions for their satisfaction that, because of their noxiousness or potential harm to others, are classed as criminal offenses" (p. 685). The subtext seems to be that the lawyers of the world can have at these eight, but the others are for the true believers endowed with the (dia-)*gnosis* of 'clinical judgment,' and proper faith in the institution of psychiatry, just as Clement of Alexandria, writing at the beginning of the third century of the common era, argues in Book I of the *Stromateis*:

> Nor is the word, given for investigation, to be committed to those who have been reared in the arts of all kinds of words, and in the power of inflated attempts at proof; whose minds are already preoccupied, and have not been previously emptied. But whoever chooses to banquet on faith, is steadfast for the reception of the divine words, having acquired already faith as a power of judging, according to reason. Hence ensues to him persuasion in abundance... But secret things are entrusted to speech, not to writing, as is the case with God... And we profess not to explain secret things sufficiently – far from it... Some things I purposely omit, in the exercise of a wise selection, afraid to write what I guarded against speaking: not grudging – for that were wrong – but fearing for my readers, lest they should stumble by taking them in a wrong sense; and, as the proverb says, we should be found "reaching a sword to a child." (Clement of Alexandria, 2012, pp. 12–14, Bk. I, ch. 1)

Esoteric knowledge should be trusted least of all with those who are trained advocates but who have no genuine understanding and no orienting faith. Clement is concerned about the risks associated with the written disclosure of secret knowledge. The Platonic distinction between speech and writing appearing here is important – in a written text, which is forced to speak for itself as it were, the writer of esoteric truths must anticipate how the uninitiated might interpret the text in a *dangerous* way.

This accords with the argument made by Frances and First against even including the disorder in an appendix (or what became section III of DSM-5). They suggested that with DSM-IV, they felt that including rejected diagnoses in the appendix

> seemed like a *benignly obscure* way to encourage future research. If paraphilic coercive disorder were like the average rejected DSM suggestion, it would similarly make sense to park it in the appendix... This might facilitate the work of researchers and also provide some guidance to clinicians in assessing the rare rapist who does have a paraphilic pattern of sexual arousal... Including paraphilic coercive disorder in the DSM-5 appendix and suggesting it as a possible example of the proposed other specified paraphilic disorder category would confer an undeserved backdoor legal legitimacy on a disavowed psychiatric construct... We did not include any reference to

> paraphilic coercive disorder in DSM-IV, and it should not find its way in any form, however humble and unofficial, into DSM-5. (Frances & First, 2011, pp. 559–560, my emphasis)

Even including the disorder in an appendix would be akin to 'reaching a sword to a child,' by this reasoning.

Perhaps due to the alleged misuse of paraphilia NOS, the first section of DSM-5 ends with a 'Cautionary Statement for Forensic Use of DSM-5,' which argues that in "most situations, the clinical diagnosis of a DSM-5 mental disorder... does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability)," and accordingly the use "of DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised" (American Psychiatric Association, 2013, p. 25). This draws a very careful line, as it does not say that DSM-5 cannot be used for forensic purposes, but rather that the text can only be interpreted by the authorized priestly caste of experts. If a mental health professional wishes to act as an expert witness and offer testimony in support of the judicial relevance of a DSM-5 diagnosis, they certainly may, but their argument should not get any unfair boost from the authority of the DSM itself.

Parental Alienation Syndrome

One other extremely controversial proposed disorder that ultimately failed to be included in DSM-5 that raises similar concerns is Parental Alienation Syndrome [PAS], a diagnosis that would have applied to a child who engages in a "campaign of denigration" against one of his or her parents with "no justification," and is at best able to offer only "weak, frivolous, or absurd rationalizations" for the vilification, which occurs in the complete "absence of guilty [regarding his or her] cruelty to and/or exploitation of the alienated parent" (Gardner, 2001, p. 10). Formulated in this way, PAS is conceived of as a kind of psychosis. Like with coercive paraphilia,

this is a diagnosis that has much more relevance in the courtroom than in the clinic. Accordingly, rhetorical concerns are even more relevant than scientific concerns, although in general it seems that diagnoses that appear to serve only a forensic purpose tend to have scanty scientific backing (after all, justice and the good tend to resist hypothesis testing). In the case of PAS, supposing the described phenomena actually occur, a diagnosis of delusional disorder is available—so the inclusion of PAS would primarily work to legitimize the idea that such kinds of delusions are so common that they deserve special recognition.

One psychiatrist who opposed inclusion of PAS in DSM-5 is Paul Fink, a past president of the APA. His criticism of the *scientific* basis of PAS was explicitly framed as a *rhetorical* matter:

> [Many] of the controversies [about what to include in DSM-5] are and will be political with proponents on each side of the issue. *All of us love rhetoric that seems reasonable* to the reader. One such area is parental alienation syndrome (PAS). I am *personally involved* in opposing the inclusion of this bit of *junk science invented* by a psychiatrist in the 1980s, the late Dr. Richard A. Gardner. All of his books and most of his papers were published by his own publishing company. *He protected child sexual abusers* in court and was very abusive to the mothers of the children caught up in custody hearings. Many children and mothers have been hurt by this man's beliefs, but over 15 years, he developed many converts to his beliefs, including judges, lawyers, guardians [*ad*] *litem*, and psychologists who liked *the neat packaging of his ideas*. In recent years, the ball has been picked up by "father's rights" groups who don't like to be interfered with when they are sexually abusing their children. This group has petitioned the DSM task force to include PAS in the publication. This is a good example of the political activity into which DSM is drawn. *The task force members want to be fair to all parties, so we are now involved in putting together data around this issue to disprove it to the DSM task force*. (Fink, 2010, para. 29–34, my emphasis)

By combining science and rhetoric, emotion and reason, morality and medicine, personal character and public credibility, this criticism is representative of many DSM-5 related arguments. The legitimacy of a particular forensic tactic (i.e., expert witness impeachment) is now a medical question. Dr. Gardner is described as an

effective rhetor who has managed to persuade legal authorities to accept his “junk science” by means of the “neat packaging of his ideas.” According to this depiction, Gardner has engaged in a form of sophistry that Plato compared to pastry baking, which he defined as

> the flattery that wears the mask of medicine... [It is] a mischievous, deceptive, disgraceful... thing... that perpetrates deception by means of shaping and coloring, smoothing out and dressing up... [What] pastry making is to medicine, oratory is to justice. (Plato, 1997b, sec. 469b–469c)

The diagnosis is not problematic merely because it is 'incorrect' or 'invalid,' but because it is risky. The risks created by this diagnosis derive from its rhetoricity. Fink viewed the DSM-5 debate as an opportunity to challenge the validity claims implied in Gardner's discourse (with data) before those claims could become unquestionable.

Conclusion

The three controversies analyzed in this essay demonstrate some of the pitfalls of crafting medical diagnoses for the courtroom rather than the clinic. The residual clinical need for some of these diagnoses (hebephilia and coercive paraphilia) lead to their inclusion in DSM-5 in an esoteric fashion, written in such a manner that doctors but not lawyers could make use of them in their institutional practices. The arguments that were generated that lead to this conclusion reveal the delicate line that needs to be walked when institutions of expertise overlap their knowledge bases while maintaining conflicting institutional logics.

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