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# The medicalisation of rape: A discursive analysis of 'Paraphilic Coercive Disorder' and the psychiatrisation of sexuality

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*In 2010 the American Psychiatric Association (APA) proposed revisions for the fifth edition of the Diagnostic and Statistical Manual (DSM-5). These revisions included criteria for 'Paraphilic Coercive Disorder' (PCD), which state that the individual '...has sought sexual stimulation from forcing sex on three or more non-consenting persons on separate occasions' (APA, 2010a). This proposed revision represents current attempts of psychiatry to medicalise 'sadistic' rape and normalise what the APA calls 'opportunistic' rape (APA, 2010b). Rape has always been a feature of the DSM nomenclature in various forms, however, this particular diagnosis has continually been proposed since the 1980s and the DSM-III. Despite vigorous protests from feminists, LGBTQ communities and forensic psychologists from the 1980s onwards, the DSM Work Group continues to push for its inclusion. This calls into question those positioned on the DSM Task Force, the lack of transparency in their selection (e.g. Zucker, 2009) and their own controversial work and 'treatments' (e.g. Zucker, 2006). This paper uses discourse analysis (Parker, 1992) to critically interrogate the construction of rape as a mental disorder using online texts. The APA encouraged comments on the proposed revisions on its website, but these were not accessible and the DSM Task Force criticised negative comments made outside of the APA (e.g. Zucker, 2010c; Aboraya, 2010). Therefore, data was collected from online blogs and the DSM-5 website regarding this proposed disorder and then analysed.*

**R**APE was considered a 'symptom' of mental illness long before the *Diagnostic and Statistical Manual (DSM)* was established (American Psychiatric Association (APA) [DSM-I], 1952; Moser, 2009). A century ago those diagnosed with 'Psychopathic Personality with Psychopathic Sexuality' (APA, 1918) or 'Sexual Psychopaths' were thought to experience 'uncontrollable sexual urges' that were considered a result of childhood trauma from within a psychoanalytic paradigm (Bourke, 2007). Today they are increasingly explained through evolutionary theory as a more extreme form of 'natural' male sexuality (e.g. Quinsey, 2010). Within the *DSM-I* (APA [DSM], 1952) rape fell under the vague diagnosis of 'sexual deviance,' which included sexual sadism. Sexual sadism was further described as 'including rape, sexual assault, [and] mutilation' (p.39). This persisted throughout the

*DSM-II* (APA, 1968) and *DSM-III* (APA, 1980), however, the latter explained that, 'Rape or other sexual assault may be committed by individuals with this disorder...*However, it should not be assumed that all or even many rapists are motivated by Sexual Sadism*' (p.275, italics added). This emphasis on the inadequacy of the psychiatric condition to explain rape more generally was removed from the *DSM-IV* (APA, 1994).

This medicalisation of rape has been, and continues to be, greatly influenced by the legal system's inability to contain those considered 'sexually dangerous'. In the US, the incorporation of sexual deviance into the *DSM* enabled the legal and psychiatric institutions to work together to incarcerate, indefinitely, those considered too dangerous to be a part of society (Bourke, 2007). Sexually Violent Predator Acts (SVPA) result in the involuntary civil commitment of 'sexual

deviants' after their criminal sentence has been completed (Douard, 2007). A psychiatric diagnosis is required for SVPAs to be enforced. Within the UK, sexual offenders are managed by community-based multi-agency monitoring and risk assessment, as current UK law does not allow for the indefinite incarceration of sex offenders (Ministry of Justice, 2010). However, it would be possible to enforce compulsory hospitalisation (or 'section' a 'sexually violent predator') if they had a diagnosis of a mental disorder and were considered at risk of harming themselves or others (Mental Health Act, 1983, 2007).

SVP laws have often been put in place in response to increased media attention regarding a particular 'sexual predator' that resulted in a media inspired moral panic. These moral panics also focused attention on the violent sexual predator outside of the home, and ignored the role of sexual coercion within heteronormative sex (Bourke, 2007). While the second wave of feminism drew attention to rape within domestic relationships (e.g. Brownmiller, 1971; Russell, 1982; Stanko, 1985), this progress has been undermined by the re-established interest in 'stranger danger' during the 1990s, which has resulted in a re-instigation of 'sexual predator laws' in the US (Bourke, 2007) and the persistent remedicalisation of rape as a symptom of mental illness (e.g. APA, 2010a).

### **The medicalisation of sex**

The 'psychiatrification' (Rose, 2006) of rape is part of a much larger '(re/over)medicalisation' (Kleinplatz, 2001; Nicolson & Burr, 2003; Tiefer, 1996) of sex where psychiatry and the pharmaceutical industry are continually defining and redefining the boundaries of 'normative' (hetero)sex. Historically, psychiatry has portrayed sex as a cause, symptom and form of madness, particularly when sexualities contested heteronormative and patriarchal discourses (Tiefer, 1996). Clitoridectomy, ovariectomy, (hetero)sexual intercourse and pregnancy have all been 'treatments' for female 'frigidity', 'nympho-

mania' and the 'dormant' 'wandering womb' (Bullough, 1994; Potts, 2002; Ussher, 1991, 1997). However, sexual behaviours that have been considered 'deviant' change over time to become normalised, such as oral sex, masturbation and the female orgasm (APA [DSM-III], 1968; Potts, 2002).

The application of biomedical understanding to sexuality brings with it 'binarised thinking' of healthy and unhealthy or normal and abnormal, '...that delimit the existence of alternative conceptualisations' (Potts, 2002, p.3). This categorisation of sex is framed as scientific, objective and based on physiology. However, as Ussher (1997) argues, '...clear ideological judgments about 'sex' and the status of 'woman' and 'man' underpin these supposedly objective systems of classification' (p.265). This identification and categorisation of 'abnormal' sexual behaviours legitimises sexologist's and psychiatrist's implementation of 'treatment' (Potts, 2002) and enables health insurance reimbursement as well as the introduction of 'sexuopharmacology' (Tiefer, 2001, p.39). Concerns over the increasing involvement of the pharmaceutical industry in funding and defining sexual 'dysfunctions' while providing a medical 'cure' (Tiefer, 2004) show that the 'postmedicalisation' era (Tiefer, 1996) is a distant aim and that feminist and LGBTQ activism are as important now as they were in the 1970s (APA, 1974). If this is the 'second sexual revolution' based on the medicalisation of sex '...from the Victorian era to the Viagra era' (Cacchioni, 2010, para. 2) then it is one that requires a vociferous feminist presence.

### **Paraphilic Coercive Disorder (PCD)**

During revisions of the third edition of the DSM, the paraphilias subcommittee proposed the inclusion of a disorder, separate from sexual sadism, called Paraphilic Coercive Disorder (PCD). PCD requires that the individual '...has sought sexual stimulation from forcing sex on three or more non-consenting persons on separate occasions' or has 'clinically significant distress or

impairment' (APA, 2010a, para. 1). The decision to keep this new diagnosis out of the *DSM* was influenced by protests and professional criticisms from feminist psychiatrists and psychologists that mobilised against the *DSM-III-R* (APA, 1987) revisions, which illustrates the importance of activism in the process of reconstruction/remedicalisation for the demedicalisation of contested diagnoses (Conrad & Angel, 2004). These protests targeted the inclusion of 'Self-Defeating Personality Disorder' (Caplan & Gans, 1991), 'Late Luteal Phase Dysmorphic Disorder' (Caplan, 1991; Caplan, McCurdy-Myers & Gans, 1992) and 'Paraphilic Coercive Disorder' (Tiefer, 2001). Regrettably, the controversial Sexual and Gender Identity Disorder Work Group is proposing PCD for the fifth time in the *DSM*'s history (APA, 2010a; Frances, 2011), although it has been relegated to the appendices (APA, 2011). However, the inclusion of 'Late Luteal Phase Dysphoric Disorder' to the *DSM-III-R* (APA, 1987) appendices illustrates that this can be a temporary measure to the long-term inclusion of controversial diagnoses. 'Premenstrual Dysphoric Disorder' which has a different name, but very similar criteria to LLPDD is currently being considered for the *DSM-5* (APA, 2011). PCD has received severe criticism and attracted media attention (Moser & Kleinplatz, 2005; Franklin, 2009; Clavant, 2010) and there are grave concerns over its potential misuse within the legal system (Moser, 2009; Miller, 2010; Frances, 2010). Some have argued that the entire paraphilias section is 'so severely flawed' that it should be removed (Moser & Kleinplatz, 2005, p.92).

The APA Work Group has also been the focus of intense criticism, which incites curiosity into how these individuals were selected in the first place as representatives of the psychiatric profession. The institutional selection of *DSM-5* Task Force members is very concerning particularly as the Sexual and Gender Identity Disorder Work Group members (such as Chair Ken Zucker) have accumulated much criticism of

their work and 'treatment' over several decades (e.g. Burke, 1996; Bryant, 2008; Hegarty, 2009; Hird, 2003; Langer & Martin, 2004; Lev, 2005; Tosh, 2011a; Wilson, 2000; Wren, 2002). Zucker (2006) maintains this influential position despite his rationales for 'treatment' for Childhood Gender Identity Disorder (GID) being the 'prevention' of homosexuality and transsexualism, which has resulted in online petitions (The Petition Site, 2008; iPetition, 2010) as well as several protests in the UK and Canada (Tosh, 2011b; in press; Wingerson, 2009). This 'treatment' approach is considered outdated by those outside of the profession (e.g. James, 2010), unrepresentative of support available for gender non-conforming youth (e.g. Menvielle & Tuerk, 2002) and against recommended guidelines (Meyer et al. 2001).

Zucker (2010a) overtly states that the *DSM-5* Work Group positions were not advertised and those considered did not undergo an interview for the position, however, he fails to outline the actual procedure taken to select members. Furthermore, during a conference presentation in Manchester (UK), Zucker (2010b) joked that he accepted the position because 'no-one else wanted it', but it would not be possible to determine this if the positions were not openly advertised. It would seem that the *DSM-5* will be another controversial and political document, debated for years to come and representative of the view of a powerful minority (Caplan, McCurdy-Myers & Gans, 1992).

In this paper I argue that the recent *DSM-5* proposal for the inclusion of 'Paraphilic Coercive Disorder' (PCD) illustrates the continuation of psychiatric attempts to medicalise and individualise rape. I will use several online texts produced by the psychiatry profession to interrogate the discourses used in these constructions of a particular form of sexual violence, which foreground bio-medical perspectives and disregard feminist research.

## **Method**

This analysis of online conversations of PCD includes the official *DSM-5* website (APA, 2010a and 2010b) and two critical blog posts. Forensic psychologist, Franklin (2009) produced a satirical piece describing PCD as a potentially contagious virus using a specific example from an Australian college campus. Frances (2010), a psychiatrist and previous Chair of the *DSM-IV* Task Force, criticises the *DSM-5* Work Group proposals on several new diagnoses, including PCD. Discourse analysis (Parker, 1992) was used to identify how rape and male sexuality were constructed. The aim of this paper was not to analyse the APA, Frances or Franklin's perspectives but to identify and critically interrogate discourses in use within professional discussions.

## **Analysis**

The analysis identified five discourses: Universal Rape; Toxic Rape; Pressure to Rape; Male Monopoly; and Pseudopsychiatric.

### ***Universal Rape Discourse***

This is an extract taken from the official *DSM-5* website, which is illustrative of their use of the term 'rape'.

'Among convicted rapists it is those who have more persistently engaged in rape and assault who are more likely to show preferential arousal to saliently-coercive rape in laboratory tests' (APA, 2010b, para. 8).

The term 'rape' is commonly used without further elucidation and represents a homogeneous, all encompassing and unified concept. The absence of a definition of the term 'rape' is consistent with several discussions related to PCD where the focus is directed on the category of rapists rather than rape. This universal (Wittig, 1983) discourse appears to be comprehensive and generic but actually masks a multifaceted, fractured and debated term. It assumes a shared meaning and shared understanding that is contrary to the diverse definitions of rape identified by qualitative methodologies (e.g. Hamby & Koss, 2003).

Universalising a category/object is reductionist and disregards 'contextual specificity' (Scott, 1986), which is counter to research highlighting the changes in the construction of rape over time (e.g. Brownmiller, 1971; Bourke, 2007) and across cultures (Sanday, 1981). This narrow conceptualisation also neglects many feminist attempts to broaden the definition of rape to incorporate a variety of forms of sexual violence (e.g. Russell, 1982; Kelly, 1987). This is consistent with the legal process requiring '...that a survivor present her experience as a simple, unambiguous event' to further justify/confirm its authority in defining the 'truth' (Hengehold, 2000, p.197). Using the term in this way could function to consolidate psychiatry's scientific claim to 'truth' (Foucault, 2005).

This uniform term '...sustain[s] discrete and binary categories' (Butler, 1988, p.523) and consolidates the false differentiation between consensual and non-consensual sex (Walker, 1997; Lea & Auburn, 2001), as well as overlooking the ambiguity and ambivalence that can occur in relation to sex and sexual coercion (Muehlenhard & Peterson, 2005). These realist assumptions that dichotomise rape and consensual sex are incompatible with the multiplicity of sexual experiences.

### ***Toxic Rape Discourse***

In Franklin's (2009) blog she states,

'A shocking news story out of Australia makes me think that if Paraphilic Coercive Disorder exists, it must be contagious' (para. 1)

Franklin positions rape as separate from 'normative' behaviour due to the blogs use of words such as 'shocking' that make occurrences of rape seem particularly unusual. However, the blog simultaneously constructs rape as widespread, due to later descriptions of PCD as an 'epidemic'. This contradiction is mirrored in Frances's (2010) blog where he differentiates between 'paraphilic rapists' and 'criminal rapists'; with 'paraphilic rapists' being viewed as less frequent/preva-

lent but more threatening. This separation of 'paraphilic rapists' from, what Frances terms 'simple criminals', reflects an intense fear of moral contamination posed by 'sexual deviance' (Douard, 2007). As Douard (2007) states, 'the fear of contamination triggers a need to establish boundaries between 'us' and 'them' (p.46). This mixture of medical and moral language, or a 'medicomoral' (Hunt, 1998) discourse, disguises underlying evaluations and judgments based on disgust and fear with psychiatric categories that enable the confinement of those deemed 'social problems' (Foucault, 2005; Douard, 2007). Douard (2007) argues that constructions of sex offenders as monstrous and dangerous is, '...designed not merely to frighten, but to reinforce sexual norms by setting apart deviant sexuality as especially horrifying' (p.40).

This toxic rape discourse, based on fears of moral contagion, functions to avert attention from the sexual coercion in hegemonic and normative discourses of heterosexual sex and assumes that there is a 'sexual purity' (Hunt, 1998) to aspire to. In the chosen name 'Paraphilic Coercive Disorder' 'Para' means 'other' or 'abnormal' and 'philic' means 'love' (Moser, 2001), therefore, PCD locates coercion as outside of normative heterosexual relations. However, sexual coercion is enmeshed in hegemonic heterosexual discourses (Hollway, 1995; Gavey, 2005; Anderson & Doherty, 2008) and, therefore, sexual coercion could alternatively be described as red blood cells (representing constructions of sexuality). Psychiatry could then be viewed as an antibody, protecting these gendered constructions and fending off 'infections' that challenge them, such as feminism. In this case, feminism is infectious.

### ***Pressure to Rape Discourse***

In Frances's (2010) blog he states that 'paraphilic rapists',

'...rape not opportunistically, or as an exercise in power, or under the influence

of substances or peer pressure – but specifically because it is their preferred form of sexual excitement' (para. 9).

This emphasis on external influences (of substances, peer pressure or because the opportunity presented itself) is constructed as making it difficult or impossible for a man to refuse sex. This colludes with the male sex drive discourse (Hollway, 1995) and portrays rape as a result of sexual urges that can usually be controlled except for certain situations. These 'opportunistic' rapes appear excusable, such as the APA's (2010a) PCD criteria, which states that the individual has raped 'three or more non-consenting persons' (para. 1). This selection of three or more rapes distinguishes between those 'opportunistic' rapes and those where rape is viewed, by the APA, as abnormal. This pressure to rape discourse functions to remove individual responsibility from rape and constructs 'untamed' male sexuality as universally aggressive and dangerous (Stein, 2005). However, as Lorde (1984) argues, '...rape is not aggressive sexuality, it is sexualised aggression' (para. 24).

This discourse also emphasises the role of groups of men. This fear of 'all male environments' as a catalyst of sexual pathology (Franklin, 2009; Frances, 2010; Hunt, 1998) links to the close tension between the desire for 'homosociality' (Sedgwick, 1985), a desire for male companionship and a fear of being viewed as homosexual by peers. Kimmel and Mahler (2003) state that homophobia is 'one of the key organising principles of heterosexual masculinity' (p.1446) and argue that peer humiliation can result in physical violence as well as sexual assault to reassert or reclaim masculinity due to the normalising of aggression within hegemonic masculinity discourses (Connell, 1987; 2005; Toriem & Durrheim, 2001; Wetherell & Edley, 1999).

### ***Male Monopoly Discourse***

Franklin (2009) goes on to describe,

'...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' (para. 4).

The blogs and the APA website commonly described rape by the observable actions of men and excluded woman's subjective experience (of fear, pain, humiliation, lack of pleasure, resistance, intoxication, etc). The APA (2010a) criteria for PCD briefly refer to the experience of the individual being victimised but this is reduced to a dichotomised category of 'non-consenting persons', which obscures the complexities of consent (Ehrlich, 1998; Beres, 2007) and the disregard of sexual refusals (Kitzinger & Frith, 1999).

This male monopoly discourse describes rape from the sole position of the man. Although this has advantages for reducing victim blaming, it simultaneously silences the woman's perspective. This exclusion of the victim's voice and of feminist conceptualisations of rape more generally could represent a manipulative silence. Huckin (2002) states that for a silence to be considered 'manipulative' there must be an omission of a perspective that is relevant to the context, deceives the audience and benefits the author. For example, the brief rationale outlined on the website draws on predominantly evolutionary and forensic research, many papers cited from individuals with direct contact with Work Group members (e.g. Quinsey, 2010; Thornton, 2010; Lalumière et al. 2003). It deceives its audience by claiming to be 'comprehensive' (APA, 2010c).

In the case of PCD, feminist research on rape could certainly claim to be relevant. However, the rationale for PCD is also deceptive in many of its claims. For example, the APA (2010b) rationale states that, 'Among convicted rapists it is those who have more persistently engaged in rape and assault who are more likely to show preferential arousal to saliently-coercive rape in laboratory tests' (para. 8). However, the research cited states, 'Rapists showed *little discrimination* between rape and consenting scenarios, and perhaps

a slight preference for rape' (Lalumière et al., 2003, italics added). This aim to differentiate 'rapists' from the 'normal' population or 'normal' rapists from 'pathological' rapists is very problematic, particularly as much feminist research has identified rapists as husbands, partners, relatives and acquaintances over the less frequent violent stranger rapes (e.g. Estrich, 1987; Russell, 1982; Stanko, 1985; Scully, 1994; Lea & Auburn, 2001).

The APA (2010b) goes on to claim that 'Coercive sexual fantasy is commonly reported by rapists while participating in treatment' (para. 8) but refers to a paper that does not mention 'coercive sexual fantasies' and was based on 13 convicted rapists. Therefore, the use of the word 'commonly' is very misleading. Furthermore, research that the APA (2010b) draws on to demonstrate a difference between paraphilic rapists and criminal rapists or the 'normal' population includes results that actually show the similarity of arousal (recorded by phallometric measurements) between those defined as 'coercive' and those defined as 'non-coercive' (Lalumière & Quinsey, 1996). Therefore, the APA (2010b) has very selectively constructed an argument for the inclusion of PCD at the omission of contrary research. This silencing of other perspectives marginalises the position of the victim and feminist discourses around rape.

Furthermore, this emphasis on penal measurements of arousal assumes that sexuality is a fundamentally biological and internal phenomenon, where social and cultural context is irrelevant. It also focuses on the internal desires of the individual rather than the observable acts to differentiate from 'pathological' and 'non-pathological' rapists (i.e. a rapist without coercive fantasies or desires is defined as a 'criminal' rather than 'mentally ill'), which is problematic due to the complexity and intrinsic subjectivity of sexual desire (Jordan-Young, 2011).

### ***Pseudopsychiatric Discourse***

Franklin (2009) states,

'I posted last week about a proposal to create a new mental disorder in the *DSM-5* for preferential rapists' (para. 1).

Franklin's emphasis on the recentness of this proposal by use of the word 'new' is misleading as it masks the long history of psychiatric constructions of rape as 'symptomatic' of mental illness. It also moves focus away from the already problematic 'Sexual Sadism' and 'Paraphilia Not Otherwise Specified' categories. However, her use of the word 'creation' functions to undermine psychiatry's position as 'science' and apolitical by constructing the *DSM* as a product of psychiatry rather than a description of reified mental illnesses. 'Creation' could also act to incite connotations with 'creative' and 'creativity' which again could challenge these 'disorders' as a product of the imagination of psychiatrists rather than psychiatry's assertion that mental disorders are a result of 'objective scientific enquiry'.

However, Franklin (2009) also portrays psychiatry as anxiously trying to justify its current position, perhaps replicating its previous crisis of legitimacy (Mayes & Horowitz, 2005), when she later states that, '...the *DSM* developers are frenetically creating new diagnoses.' Frances (2010) also utilises this pseudopsychiatric discourse when he states, that PCD '...is based on the idea that some... rapists qualify for a diagnosis of mental disorder' (para. 9). This again emphasises PCD as a theory and not based on empirical evidence. Also, Frances (2010) goes on to state that PCD was 'explicitly rejected' and 'given no serious consideration' which undermines the authority or

validity of this 'idea'. This in conjunction with Franklin's (2009) satirical metaphor of PCD as an infectious illness mocks the medical construction and in so demonstrates the absurdity of conflating rape with biological or medical illness.

However, these constructions place PCD in a state of 'pre-existence' and once the diagnosis is entered into the *DSM* it would be regarded as 'existing'. Psychiatry then becomes definer and constructor of 'abnormality' and like legal discourse, becomes definer of 'truth' (Smart, 2002). It simultaneously undermines the profession, and places it in a position of authority. This illustrates the dual purpose of the *DSM* as defining abnormality while simultaneously convincing those outside the profession of its authority over the treatment of mental illness (Pilgrim, 2007).

### **Conclusions**

The impending release of the *DSM-5* offers an opportunity to reflect, analyse and intervene in the reconstruction of normality. The proposal to include PCD represents a persistent attempt to individualise and medicalise rape and, therefore, it is vital for the *DSM-5* Work Group, and the wider psychiatric community to be aware of the feminist concerns regarding this diagnosis that have been voiced from the 1980s onwards. As Szasz (1991) states, "Therapists treating rapists"? This is bad enough as a pun. It is intolerable as a social reality.' (p.36)

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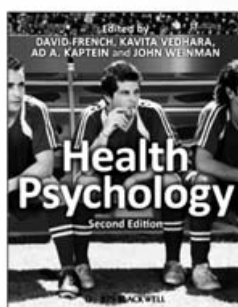
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