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Abstract

The diagnostic revolution that culminated in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (1980) began with the publication in 1972 of the Feighner criteria, a set of rules for the identification of 16 disorders. While Feighner et al. claim that their diagnostic categories rest on solid data, the fact is that one was soon to be removed by the APA from its classification of mental disorders: homosexuality. However, the anomaly of an extinct category in a list of supposedly validated diagnostic criteria never became a point of discussion, quite as if the topic were unmentionable. It was in fact even more of an embarrassment than either side in the homosexuality debate seems to have realized at the time. Upon examination, the evidence offered by Feighner et al. in support of the diagnosis of homosexuality proves to be nil. Had there not been an informal embargo on discussion of the status of homosexuality in the Feighner document, the makers of DSM-III might have recognized that the diagnosis fails all Feighner tests of validity. Had they attached greater importance to these tests, the concept of a disorder that was built into DSM-III might have taken a different shape.

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Buried in Silence: Homosexuality and the Feighner Criteria

Confusion and Order

The publication in January 1972 of what came to be known as the Feighner criteria (Feighner, Robins, Guze, Woodruff, Winokur & Munoz, 1972) marked an epoch in the history of American psychiatry. At a time when many psychiatrists were indifferent or even hostile to the niceties of diagnosis, and when conflicting interpretations of similar cases threatened the reputation of the profession itself, the Feighner criteria laid out specific rules for the diagnosis of 16 disorders, from depression to hysteria, from alcoholism to anorexia. Never before had the identifiers of such an array of conditions been codified so precisely. At once detailed and pragmatic, the Feighner specifications furnished a model and precedent for the Research Diagnostic Criteria (1978), which in turn served as the immediate precursor of the diagnostic criteria of the revolutionary third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual*, issued in 1980. The architect of DSM-III and first author of the RDC, Robert Spitzer, once claimed that before the new manual replaced impressionistic descriptions of mental disorders with specific criteria, the RDC tested and vindicated the possibility of doing

so (Spitzer, 1989). However, it was Feighner et al. who got the process started. If DSM-III put an end to “the disarray that has characterized psychiatric diagnosis” (Bayer & Spitzer, 1985), thus enabling the APA to emerge strong from a decade in which its unity and credibility were sorely tested, the Feighner criteria and their authors deserve a share of the credit.

Though readers in 1972 could not know that the Feighner document would contribute to the making of DSM-III (which was not yet under construction) and could not foresee the authority of a manual whose existence was not assured until the moment its text was ratified by the APA, the Feighner criteria’s imprint on the literature was immediate. When DSM-III finally appeared in 1980 they had already been cited hundreds of times; still more significantly, according to one present at their creation, within two years of their publication “the impact on the quality of research papers published in the U.S. was evident. We were now all speaking the same language!” (Kendler, Muñoz & Murphy, 2010). With investigators using the same diagnostic criteria, their findings could be expected to agree more often, thereby relieving psychiatry’s painful “reliability” problem. While reliability is a technical term referring in this context to concurrence of diagnostic judgments, the word also has lay connotations, and a profession whose research suffers from unreliability begins to seem to the public unreliable in its own right, that is, unworthy of trust. No wonder the Feighner criteria were greeted with enthusiasm. As of this moment, they have garnered some 6700 citations, a remarkable figure.

However, an asterisk should be attached to this tale of the Feighner criteria delivering psychiatry from its troubles and taming the chaos of conflicting diagnoses. If their wholesome influence took effect in less than two years, it was also less than two years after publication that one of the Feighner diagnoses—homosexuality—was removed from the list of mental

disorders by the Board of Trustees of the American Psychiatric Association, a decision affirmed by the APA membership. Historically speaking, then, no sooner was the ink dry on a document that appeared to set psychiatric diagnosis on a sound foundation than one of its categories officially ceased to exist. This is all the more ironic in that homosexuality clearly fails the tests used by the Feighner authors to certify disorders, most notably clinical profile (that is, presenting features), outcome studies and family studies, none of which apply to homosexuality at all. If the authors include homosexuality in the select cluster of disorders that have been duly validated, it is because, for some reason, they paid no attention to their own tests in this instance, not because the tests misled them.

Homosexuality

For a diagnosis of homosexuality, A through C are required.

A. This diagnosis is made when there are persistent homosexual experiences beyond age 18 (equivalent to Kinsey rating 3 through 6).

B. Patients who fulfill the criteria for transsexualism are excluded.

C. Patients who perform homosexual activity only when incarcerated for a period of at least one year without access to members of the opposite sex are excluded.

[The Homosexuality diagnosis in the Feighner criteria]

An Awkward Topic

The events leading to the excision of homosexuality from DSM-II in 1973 bear a brief review, in that they help explain how it is that the embarrassment of an extinct category in the Feighner criteria came to be buried in silence.

Beginning in 1970, gays enraged at the official classification of homosexuality as a mental disorder staged protests at the annual convention of the group responsible: the APA. After the disruption of a 1972 meeting attended by Robert Spitzer—who assumed, with most of his peers, that homosexuality was an illness, and had strong ties with the diagnostic reformers of the Feighner group—he arranged for one of the protesters and his allies to address the APA Task Force on Nomenclature and Statistics, on which he served. With the issue still alive, Spitzer then organized a symposium at the 1973 APA convention on the question of whether homosexuality was in fact a disorder. By that time, however, he had had a change of heart.

Having asked himself how we can recognize a mental disorder, Spitzer reasoned that it should cause either distress or impairment, and that because homosexuality does not necessarily do either, it is not a mental disorder at all. Political instinct told him, however, that the APA would not de-list homosexuality without putting something in its place. He therefore

proposed that the Task Force on Nomenclature and Statistics expunge homosexuality from DSM-II and add a new diagnosis of Sexual Orientation Disturbance for “those homosexuals who are troubled by or dissatisfied with their homosexual feelings or behavior” (Stoller, Marmor, Bieber, Gold, Socarides, Green & Spitzer, 1973). (More on this point later.) The Task Force and ultimately the APA Board of Trustees approved both the deletion of homosexuality and the installation of the new category, changes ratified in due course by the APA membership as a whole (Bayer, 1981; Mayes & Horwitz, 2005).

What this chronology leaves out is the bitter division of opinion within the APA, akin to a civil war, on the status of homosexuality. Indeed, it was the defenders of the original classification of homosexuality as a mental disorder who petitioned the Board of Trustees for the plebiscite that eventually went against them and removed the condition, from that day forward, from the APA index of disorders. The APA membership endorsed the action of the Board by a majority of 58%, a figure that may constitute a landslide in electoral terms but hardly bespeaks a united profession. If Spitzer parlayed his success in brokering a settlement of the crisis into a new (and as it turned out, historic) role as the engineer of an innovative taxonomy of mental disorders, this too implies that his service as a healer of divisions was greatly valued because the divisions themselves ran so deep.

Related but not identical or reducible to the conflict between those psychiatrists committed to diagnostic reform and those who played down diagnosis itself both in theory and practice, these sharp differences of opinion were on display in the 1973 symposium titled “Should Homosexuality Be in the APA Nomenclature?”—an event attended by almost a

thousand (Bayer, 1981). Two psychiatrists and one outspoken gay citizen argued for the frank deletion of the diagnosis, two psychiatrists for its retention, and one turned the tables, asking whether the APA lexicon should contain references to heterosexuality. Later the same year their presentations appeared in edited form in the *American Journal of Psychiatry*, supplemented by a paper by Spitzer—given in full—that lays out his compromise solution to the impasse (Stoller, Marmor, Bieber, Gold, Socarides, Green & Spitzer, 1973). Nowhere in this paper does Spitzer mention the Feighner criteria, even though the topic of debate was the validity of the homosexuality diagnosis, and the Feighner criteria, which strongly influenced him, list homosexuality as a validated diagnostic category. Indeed, as these events unfolded Spitzer worked closely with one of the authors of the Feighner criteria, Eli Robins (Kendler, Muñoz, & Murphy, 2010).

But why *would* Spitzer have brought up the Feighner paper? Not only does it offer no support for his compromise, it includes a diagnosis he had come to consider both unfounded and unjust. Presenting as they did a model for the reform of psychiatric diagnosis in its entirety, the Feighner criteria put Spitzer in an uneasy position. Though it was his work as the framer of the homosexuality compromise that advanced him to the forefront of the APA as it undertook the reconstruction of its diagnostic system, and though he would model this revision on the “operational criteria” introduced by the Feighner group, he could not mention the fourteenth of the Feighner criteria without seeming to suggest that there was a crack in their foundation. Once the compromise diagnosis of Sexual Orientation Disturbance was in place, therefore, Spitzer went about building on the Feighner criteria without bringing up the one diagnosis among them that divided the APA. He observes the same discretionary silence in his

1973 paper, written at a time when “Sexual Orientation Disturbance” was a proposal, not an official diagnosis, and when there was nothing to be gained by referring to the Feighner document in the first place.

After the APA Board of Trustees voted to de-list homosexuality but before the decision was ratified by the membership, Spitzer joined officers of the APA in defending the Board against the charge that it had attempted to legislate science. “Quite the contrary,” argued Spitzer and colleagues. “It has been the unscientific inclusion of homosexuality per se in a list of mental disorders which has become the main ideological justification for the denial of the civil rights of [homosexuals]” (Bayer, 1981). By “a list of mental disorders” Spitzer of course meant DSM-II, not the Feighner criteria, an itemized set of such disorders, every one of which purported to rest on good evidence. From Spitzer’s point of view, the less said about the weak point in the Feighner criteria the better. As we know, when he concluded that homosexuality is not a disorder, he did so not because it meets not a single one of the Feighner tests of validity but because it doesn’t necessarily cause distress or impairment.

It was the opponents of de-listing—men like Irving Bieber and Charles Socarides, both convinced that homosexuality represents a profound distortion of normal development, both speakers at the 1973 symposium—who had something to gain by invoking an influential document that judged homosexuality a disorder by nominally rigorous standards. Yet they too kept the Feighner criteria out of the discussion. Citing a set of diagnostic rules even for rhetorical purposes may have been distasteful to psychoanalysts like Bieber and Socarides. When DSM-III was under construction, one psychoanalyst derided its diagnostic system as displaying “a generous measure of linguistic and conceptual sterility. DSM-III gets rid of the

castles of neurosis and replaces it [sic] with a diagnostic Levittown” (Bayer & Spitzer, 1985). Unassuming little boxes that resemble one another and cannot serve as monuments to anything except anonymity, Levittown houses figure a checklist system also consisting of boxes, a system that succeeds only in imposing standardization on the rich clinical diversity of the world. (The metaphor also works the other way, however. Castles belong to the age of faith; and in the eyes of many the dogmatism of psychoanalytic doctrines—the demand that others take them on faith—made the diagnostic checklists of DSM-III look rational and attractively modern by comparison.) The Feighner criteria are a checklist in the making, and those who detested everything such an instrument stood for would probably have balked at the thought of citing it as an ally in the struggle to preserve the pathological status of homosexuality.

As in a genuine feud, the psychoanalysts’ disdain of their opponents was returned in kind. In his capacity as chair of the Psychiatry Department at Washington University, Eli Robins, one of the senior Feighner authors, is said to have installed a picture of Freud in a strategic position in the men’s room (Decker, 2013). After graduating from Harvard Medical School, Robins worked under the tutelage of the skeptical Mandel Cohen, co-author of an important paper cited by Feighner et al. that has this to say about a discourse by Freud on the topic of melancholy: “Actually statements such as the above quotation have no clear meaning to begin with, have no basis in fact, and are examples of a type of unscientific thinking from the last century that is still prevalent in some localities” (Cassidy, Flanagan, Spellman & Cohen, 1957). A similarly scathing aside appears in a 1951 paper on hysteria (conventionally psychoanalytical territory) co-authored by Cohen and Robins, and cited by the Feighner group as well (Purtell, Robins & Cohen, 1951). Running just below the surface of the Feighner criteria, this sort of

open derision suggests the intensity of the feuding between the empiricists who sought to reform psychiatric diagnosis on a medical model and the psychoanalysts who rejected empiricism root and branch. Why would the latter invoke a set of criteria that descend lineally from documents that jeer at their own school of thought, even if they could score a debating point by doing so?

Moreover, the most powerful argument the psychoanalysts could make during the homosexuality debate was too dangerous to use. With the help of the Feighner criteria, they could have argued that the empiricists who were on the rise in the APA, and who looked to the Feighner document as their model and standard, recognized full well that homosexuality was an illness but now took the opposite view in deference to the pressure tactics of gay activists; their new position reflected not science but expediency, in fact cowardice. What better proof that these men and women had betrayed their own convictions and principles than the status of homosexuality as a validated diagnosis in the Feighner criteria they so admired? As it happens, many members of the APA did regard the deletion of homosexuality from DSM-II as “a scientifically indefensible response to gay pressure” (Bayer & Spitzer, 1982). And regardless of the progressive position they were coming to espouse in public, much of the APA rank and file may well have leaned privately to the view that homosexuality is a pathology. As long as psychiatry itself leaned toward etiological explanations (that is, the practice of tracing disorders back to their presumed causes or origins), it was going to remain receptive to the notion that a condition persistently linked to a theorized wrong turn in early development represents a serious illness. In 1973, a diagnostic system explicitly “atheoretical with regard to etiology” (as the Introduction to DSM-III puts it) did not yet exist.

In any case, opponents of the removal of homosexuality from DSM-II who suddenly found themselves on the defensive could have gone on the attack, in terms like these:

The diagnosis of Homosexuality in the Feighner criteria, a document the reformers among us seem to think represents the way of the future, reveals what the members of this party really think and what they would say if they had the backbone to say it in the face of bullying and ridicule. Let the activists shout what they want, homosexuality is a mental disorder, just as the Feighner criteria state, and just as psychiatry recognized before the Feighner criteria were committed to paper. The reformers' interest in manufacturing a special diagnosis for the benefit of homosexuals who are unhappy over being homosexuals represents an attempt to soothe their conscience over the betrayal of their beliefs.

Impugning the honor and honesty of those targeted, such a polemic could have made sworn enemies of "the reformers among us" from that day forward, could have blown up in the hands of those who fashioned it, or both. In brief, an ad hominem attack on the de-listers—with the Feighner criteria providing the gunpowder—could tear the institution of psychiatry apart, which is perhaps why the defenders of a diagnosis of long standing refrained from launching it. This restraint, combined with Spitzer and his party's avoidance of an awkward topic, seems to have put an effective ban on references to the Feighner criteria in the homosexuality debate shortly after their publication, even as they were beginning to make their mark on psychiatric research.

Once the divisive category was removed from the APA's diagnostic system it was never to be reinstated, and so the debate of 1973-74 receded into history, and the annulled Feighner

diagnosis into ancient history. The anomaly of a soon-to-be revoked diagnosis in a set of allegedly validated criteria never became a topic of public discussion or comment in the literature. Anyone who brought up the matter after the official rescission of the homosexuality diagnosis might well have been accused of reviving a dead issue, beating a dead horse, re-opening old wounds, etc. Even Spitzer, who was at the epicenter of the 1973-74 debate and probably knew the Feighner categories by heart, and Robins, who co-authored them, make no mention of deletion in describing how the Research Diagnostic Criteria built on Feighner. “In developing the RDC, many additional diagnoses were included, such as schizo-affective disorders, and a number of other diagnoses of importance in the differential diagnosis of affective disorders and schizophrenia. There are 25 major diagnostic categories” (Spitzer, Endicott & Robins, 1978). A decade later, long after the issue of homosexuality had cooled down, Spitzer still wrote around any deletions he and the co-authors of the RDC made to the Feighner criteria. “We changed the criteria for several of the disorders, added categories that were not included in the original criteria, and showed that the reliability of these new criteria . . . was considerably better than had been obtained for psychiatric diagnoses in previous studies” (Spitzer, 1989).

In time this version of events, along with a disregard of the status of homosexuality in the Feighner criteria, became something of a tradition. An important 2010 paper commemorating the composition of the Feighner criteria, two of whose authors were “directly involved with the events described” (Kendler, Muñoz & Murphy, 2010), contains no reference to homosexuality and no hint that any diagnosis in the forward-looking document was soon to be relegated to the status of an archaism. Similarly, Hannah Decker’s account of the

construction of DSM-III treats the crisis of confidence in psychiatry, Spitzer's rise to prominence as the framer of the homosexuality compromise, and the emergence of empirical diagnostic criteria without ever noting that the template for such criteria contains the very diagnosis that split the APA. The topic simply slips through the net, much as it did at the time. Years after the fact, David Healy asked Samuel Guze, one of the leaders of the Washington group and a co-author of the Feighner criteria, "When homosexuality got dropped [from DSM-II], did it give you the ground to say that if we've been so wrong on this, don't we need to go back and look at the rest?" Guze didn't answer, but did concede that "Until that time . . . I don't think we had even considered the issue of whether there is a medical model way [sic] of thinking about homosexuality" (Healy, 2000).

The denial of the trouble spot in the Feighner criteria is perhaps best illustrated by the claim by Robert Cloninger, a colleague of the authors, that each of the Feighner categories including homosexuality was "differentiated by explicit criteria that had been validated in controlled descriptive, follow-up, and family studies" (Cloninger, 1989). In reality, not even Feighner et al. claim that their diagnoses have been validated by "a complete series of steps" (Feighner, Robins, Guze, Woodruff, Winokur & Munoz, 1972). In the case of homosexuality, they achieved not even the first step, the description of characteristic features; and at that, none of the three small descriptive studies cited in support of the diagnosis assumes, concludes or suggests that homosexuality is a pathology.

Missing Evidence

The Feighner criteria are not exempted from scrutiny by their historical importance but, if anything, call for scrutiny because of their importance. Certainly the document's menus of diagnostic particulars (a format that carried through to DSM-III and beyond) invite inspection, rich as they are with details like numerical and temporal thresholds. For example, in the case of Antisocial Personality Disorder, the required showing of five symptoms out of a list of nine allows in principle for a diagnosis without either an arrest record, a poor work record, or a poor marital history, arguably the disorder's cardinal manifestations. Precisely because they reflect the subject's history, each of these "symptoms" helps establish the course of the disorder in conformity with the Feighner standards of validation. Poor marital history seems especially important, in that the antisocial father has much to do with the disorder's transmission, as documented by the first of the two sources cited by Feighner et al., Lee Robins' *Deviant Children Grown Up* (Robins, 1966).

Among the 19 diagnostic criteria for sociopathic (later antisocial) personality given by Lee Robins is homosexuality, classed as a perversion. The appearance of this judgment in a meticulous follow-up study of cases originating in the 1920's suggests that even a principled effort to clear one's work of loose terms and psychoanalytic influences may not be enough. And so it is with the Feighner criteria.

If the category of homosexuality in the Feighner criteria posed an embarrassment to those who wanted both to de-medicalize sexual preference and reform diagnostic criteria on the Feighner model, the issue should have been still more awkward than it was. The first sign

that something is amiss is that unlike every other Feighner diagnosis (one of which, hysteria, requires at least 20 symptoms), homosexuality has but a single inclusion requirement: “persistent homosexual experiences beyond age 18.” That someone who has “persistent homosexual experiences” exhibits homosexuality seems more like a tautology than a diagnosis. In the case of other disorders, the Feighner criteria offer sets of instructions for investigators interested in assembling a diagnostically uniform population; in the case of homosexuality, such investigators would have to rely on patients simply identifying themselves as homosexual, just as if the Feighner criteria didn’t exist.

Furthermore, and most importantly, homosexuality meets none of the Feighner standards of validation. It cannot be detected in the laboratory, does not have an outcome (and thus does not lend itself to outcome studies), does not run in families in the manner of a disorder with a strong genetic component, and cannot be linked with any particular family constellation, notwithstanding the ingenuity of psychoanalytic theorists. Indeed, it has no identifiers other than homosexuality itself, thereby ruling out clinical description, the first of the Feighner validators and preliminary to all the others. Perhaps because pointing to the literature seems the only remaining way to ground the diagnosis of homosexuality on something solid, Feighner et al. do just that. However, the studies they cite as validation of their diagnostic criteria offer no support for the classification of homosexuality as a mental disorder in the first place.

Sources Cited in Support of the Feighner Diagnosis of Homosexuality

1. Kinsey AC, Pomeroy WB, Martin CE: *Sexual Behavior in the Human Male*. Philadelphia, WB Saunders Co, 1948.
2. Hemphill RE, Leitch A, Stuart JR: A factual study of male homosexuality. *Brit Med J* 1:1317-1323, 1958.
3. Saghir MT, Robins E: Homosexuality: I. Sexual behavior of the female homosexual. *Arch Gen Psychiat* 20: 192-201, 1969.
4. Saghir MT, Robins E, Walbran B: Homosexuality: II. Sexual behavior of the male homosexual. *Arch Gen Psychiat* 21: 219-229, 1969.

With no specifics, and in one batch, Feighner et al. give four sources as authority for their homosexuality diagnosis, beginning with Kinsey's famous *Sexual Behavior in the Human Male*. No reason is given for omitting the companion volume on the human female, even though companion papers on male and female homosexuality are also among the four sources. And as we look into the four, our perplexity only deepens.

To anyone familiar with the Kinsey report, it can only be astonishing to see it cited as evidence of the pathological nature of homosexuality. Kinsey emphatically did not judge

homosexuality a psychiatric disorder; in defiance of one and all who traced it to a flaw or “arrest” of the normal process of development, he affirmed it as a natural variation of human sexual response. State he and his co-authors, “In view of the data we now have on the incidence and frequency of the homosexual, and in particular on its co-existence with the heterosexual in the lives of a considerable portion of the male population, it is difficult to maintain the view that psychosexual reactions between individuals of the same sex are rare and therefore abnormal or unnatural, or that they constitute within themselves evidence of neuroses or even psychoses” (Kinsey, Pomeroy & Martin, 1948). Of all the sexual practices Kinsey documented, and of all such practices widely deplored as deviant, the one the closest to his heart was undoubtedly homosexuality. Unbeknownst to the authors of the Feighner criteria and the world at large, Kinsey (who died in 1956) was himself a practicing homosexual, as well as a committed enemy of the moral code that branded homoeroticism as either a sin, a crime, or a sickness (Jones, 1997). His magnum opus—“the book he hoped would contribute to a public dialogue that would one day rid the United States of sexual repression, inhibitions, and prudery” (Jones, 1997)—was to have been a volume on homosexuality he did not live to write. It was in the spirit of Kinsey that in 1972 (the year of the Feighner criteria) one of his collaborators, Wardell Pomeroy, joined forces with the Gay Activist Alliance in its assault on psychiatric authority (Bayer, 1981). One can only imagine what Kinsey, an evangelist for sexual liberation, a controlling man who detested psychiatrists as officers of social control, would have thought of an influential psychiatric paper that cited his own work as somehow grounding the classification of homosexuality as a mental disorder.

While the Feighner group certainly could have invoked the psychoanalytic literature on homosexuality as an illness, they did no such thing, presumably because they gave no credence to psychodynamic theorizing. Their three additional sources, all descriptive, none theory-heavy, offer no more support than Kinsey for listing homosexuality as a mental disorder. Hemphill et al., the authors of a study of a population of homosexual men in two British prisons, conclude that their investigation “has demonstrated only minor differences between homosexuals and normals” (Hemphill, Leitch & Stuart, 1958). How minor differences might tend to validate the diagnostic category of homosexuality is not at all clear. Still more puzzling are the two remaining sources given by the Feighner authors: companion studies of female and male samples by teams headed by Marcel Saghir (Saghir & Robins, 1969; Saghir, Robins & Walbran, 1969). Both studies expressly disregard the question of whether homosexuality constitutes a pathology, though the first does suggest, on the basis of its sample, that “a homosexual woman is able to produce and achieve, despite any psychological and social handicaps that she might have to cope with,” while the second notes that 84% of the study population “had not had disability, psychiatric or social, of any significant degree.” The Feighner group’s citation of the paired studies as validation of the diagnosis at issue is bewildering not only in that both take an explicitly agnostic position on the pathology question, but in that both are co-authored by a senior member of the group itself, Eli Robins. Thus, Robins, wearing a Feighner hat, appeals to a conclusion that Robins in a Saghir hat never reached.

To compound the confusion, Robins co-authored both the Feighner criteria (which of course list homosexuality as a disorder), the Research Diagnostic Criteria (which do not), and

another paper published the same year as the RDC (which does). Though homosexuality does not support outcome studies because it does not have an outcome, Robins, a pioneer of such studies (Robins & Guze, 1970), groups homosexuality in the latter paper with a number of disorders whose chronicity has been established (Robins, 1978). It is as if he now interpreted homosexuality's lack of an outcome not as removing it from the category of disorders but as confirming its identity as an especially intractable one. The classification of homosexuality as a chronic disorder is hard to reconcile with Robins' general policy of diagnostic skepticism. "As Spitzer and [co-author] Endicott substantially expanded the number of disorders in the RDC [Research Diagnostic Criteria] beyond those considered in the Feighner criteria, Robins kept asking, in a persistent and skeptical manner, 'What is the evidence?' They came to appreciate, as a result of these interactions, the importance of basing diagnostic criteria, wherever possible, on data rather than solely on clinical wisdom" (Kendler, Muñoz & Murphy, 2010). The implication seems to be that the Feighner criteria rest on rock-solid data, and therefore any increase of diagnostic categories beyond the modest Feighner total had better do so as well. However, one of the Feighner categories rests on sand, as we discover as soon as we look into the sources alleged to validate it. The "data" underlying the Feighner diagnosis of homosexuality would have told a cautionary tale to anyone in the 1970's concerned with reforming the criteria of mental disorders, if only he or she were willing to investigate. However, an informal embargo on discussion of the status of homosexuality in Feighner et al. served to black out a living example of the potential weakness of even "validated" diagnostic criteria.

In the Feighner diagnosis in question, one such weakness is that the four cited sources differ so markedly that citing them as one lot is like asking parts designed for different engines to work together. The sample population in Kinsey's *Sexual Behavior of the Human Male* ran to some 5300 subjects, the corresponding populations in the three papers a few dozen each. Related is the vexed issue of representativeness. While Kinsey's critics argued that his highly selected sample did not represent the American population as a whole (and could not possibly represent anyone who declined to submit to his interview), Kinsey, calling on his experience as a taxonomist, believed sheer power of numbers could make up for the lack of random sampling. (Kinsey hoped eventually to collect 100,000 interviews, a figure suggestive of the extremity of the imperative that drove him.) Hemphill et al. seem to have chosen prisoners as their sample because "it is among habitual homosexual offenders that the most pronounced forms of homosexuality are often to be found" (Hemphill, Leitch, & Stuart, 1958); thus, the features of homosexuality will be exhibited with all possible salience and clarity. According to the authors, the very "intensity" of homosexuality in this sample lends "all the greater force" to their finding that the men do not differ significantly from the general population. Perhaps mindful of the Kinsey controversy, Saghir and Robins for their part candidly admit that they "do not know how representative this sample [of 57 women] is of the total female homosexual population" (Saghir & Robins, 1969), a disclaimer reiterated in the companion paper on males. Neither paper, therefore, can be taken as offering a description of the typical presenting features of homosexuality, assuming they exist. Similarly, while Kinsey's sample included prisoners, and while he seems to have sought out in particular those convicted of sex crimes (for whom he felt a strong sympathy), the Hemphill et al. study concerns *only* men imprisoned

for sex crimes, while the two remaining papers specifically exclude *any* subject who had been in state or federal prison. In short, the four sources agree only in not viewing homosexuality as a pathology. What were Feighner et al. thinking of when they cited this curious assortment as the evidentiary basis of the diagnosis of a mental disorder?

As if to compound the irony of grounding the classification of homosexuality as a mental disorder on four inapposite sources—with the most important being the work of a sexual libertarian—two of the Feighner authors (Woodruff and Guze) proceeded to co-author a textbook that includes homosexuality as a diagnostic category, while a third (Robins) co-authored a volume that recommends against treating it as a disease.

The Woodruff and Guze textbook of diagnosis defends listing homosexuality on the grounds that it “leads to psychiatric consultations, meets the criteria for a useful category, and—as long as this persists—is a subject physicians should know something about” (Woodruff, Goodwin & Guze, 1974). While a merely useful diagnosis falls short of validity as the authors well knew, the category remains, hanging in mid-air. The only evidence given that homosexuality constitutes an illness is that “both homosexual men and women are at relatively higher [sic] risk for depression, suicide attempts, and alcohol or drug abuse,” all of which might be explained just as readily by the abhorrence of their condition by the world around them as by the condition per se. While a Preface states that the authors abstain from speculative theories of causation (as DSM-III would state as well), they continue to presume that homosexuality in and of itself causes the distress associated with it. The Preface was written in

December 1973, the month in which the trustees of the APA erased the homosexuality diagnosis from DSM-II.

Also in 1973, Saghir and Robins published *Male and Female Homosexuality: A Comprehensive Investigation*, which resembles conceptually the 1957 study of manic-depressive disease led by Robins' mentor Mandel Cohen, except that while the Cohen population was severely ill, the homosexual sample was not ill at all. Though the introductory material employs terms like "syndrome," "etiology," "treatment," "natural history," and "outcome," all of which pertain to disorders, the authors explicitly assume that homosexuality is not a disorder and conclude that "treating homosexuality as a disease and homosexuals as patients is neither scientifically tenable nor actually feasible and practical."

What If?

Allowing themselves a bit of counterfactual speculation, the authors of a history of the Feighner criteria ask, "What would have happened to the course of American psychiatry if they had never emerged?" When they put this question to Spitzer, he suggested that the campaign to reform diagnosis would have been less successful and its upshot, DSM-III, quite unlike the manual we know. "The effect would have been big. Operationalized criteria would probably have emerged, but it would have been years later and probably in a less systematic form. DSM-

III would have been delayed and would likely have looked quite different” (Kendler, Muñoz & Murphy, 2010).

In a similar spirit of the counterfactual we can ask, “After the APA de-listed homosexuality, what if reformers acknowledged that one of the Feighner categories had been nullified, and what if inspection of the evidence supporting it revealed that it had really been invalid all along?” The second of these questions hinges on the distinction between the reliability and validity of diagnostic criteria, the former referring to their capacity to generate identical findings, the latter referring to their accuracy or objective warrant. To the practitioners of psychoanalysis, “reliability” and “validity” were foreign terms; indeed, both belonged to the effort to introduce the diagnostic practices of a medical discipline into a field under heavy psychoanalytic influence. However, while the Feighner team may have sought to dismantle the castles of neurosis, they continued to use the psychoanalytic catch-all in the name of three disorders: Anxiety Neurosis, Obsessive Compulsive Neurosis, and Phobic Neurosis, all imported from DSM-II. The persistence in the Feighner paper of the heavy-laden term “neurosis” (eventually excluded from DSM-III after yet another furor) suggests that the document is not a clean break with past practice and may not be entirely committed to its own more rhetorical claims—above all, that its criteria owe nothing to tradition and are wholly evidence-based, that is, valid.

At the time of the Feighner criteria, the diagnostic term “validity” was in its infancy. Born of enthusiasm over the possibilities of biological psychiatry, it had been introduced in 1969 by two researchers, Donald Klein (later a member of the DSM-III Task Force) and John

Davis, who proposed that certain mental maladies have specific causes, knowledge of which allows for accurate prognosis and appropriate treatment, as with somatic diseases; diagnosis in such cases has “explicit validity” (Shorter, 2005). Clearly, the diagnosis of homosexuality does not meet this ambitious standard, if only because the alleged disorder has no cause (beginning), course (middle) or proven treatment (end). In the Feighner paper, with its admission that none of the listed disorders has yet been “fully validated,” the term “validity” has already lost some of its ebullience. In an interesting comment, the authors note that they have excluded diagnoses for which “sufficient data for even limited diagnostic validation are not available,” for example, the still-unestablished diagnosis of Passive-Aggressive Personality Disorder. The paper they cite in this connection uses Washingtonian tests, including clinical profile, course and outcome, but does not offer its findings as confirming, as yet, the existence of a disease entity (Small, Small, Alig & Moore, 1970). How the Feighner group came to believe that the diagnosis of homosexuality survives the same tests is hard to fathom. To be sure, this is not to suggest that the tests are misconceived; on the contrary, the *diagnosis* is misconceived, as the tests themselves show.

In the construction of DSM-III, for its part, it appears that emphasis fell on the reliability of diagnostic criteria, and with it their potential to put an end to the scandal of inconsistent diagnoses that threatened the credibility of American psychiatry as a whole. The Feighner diagnosis of homosexuality brings the distinction between reliability and validity into sharp relief, in that a patient with “persistent homosexual experiences beyond age 18” obviously exhibits homosexuality, yet it is not obvious that homosexuality itself qualifies as a mental disorder. Hence the conflicting positions taken by Feighner authors on the latter issue in books

published shortly after the Feighner criteria themselves. By claiming that homosexuality serves as a useful diagnostic category for psychiatry, but not going so far as to claim that the category is valid, two of these authors appear to acknowledge that a diagnosis can give psychiatry something to work with despite lacking an evidentiary foundation. It happens that another of the Feighner authors, Robins, is on record as assessing the accuracy (that is, validity) of the DSM itself at close to zero (Healy, 2002).

According to Nancy Andreasen, a member of the DSM-III Task Force who had been a resident under George Winokur, one of the authors of the Feighner criteria (Decker, 2013), “principles of validity” were “much less emphasized” than reliability while DSM-III was under construction; that is, the designers were preoccupied with drafting diagnostic criteria clear and specific enough to bring different observers to the same conclusion (thereby putting an end to the public spectacle of psychiatrists wrangling over their own ABC’s) (Andreasen, 2007). The hope was that validating evidence for the various “reliable” diagnostic categories would accumulate over time. However, as some, including Andreasen, have observed, over the years the DSM categories tended to harden, as if they had been underwritten by solid evidence all along. According to Andreasen, the unfortunate and unintended result of the framers’ focus on reliability, and of the canonization of DSM categories over time, is that the DSM system came to suffer from a critical lack of validity. “Validity has been sacrificed to achieve reliability. DSM has given researchers a common nomenclature—but probably the wrong one.” Loss of validity follows inevitably from the decision by the framers of DSM-III to add no fewer than 241 diagnoses to the 24 of the Research Diagnostic Criteria, which themselves expand on the Feighner 16. What could have discouraged such taxonomic exuberance more effectively than

the warning example of a paper that set diagnostic standards but includes an annulled diagnosis—one whose complete lack of supporting evidence somehow escaped notice in real time?

Almost simultaneously with Andreasen's comment on the framers' over-emphasis on reliability came Horwitz and Wakefield's well-founded critique of the DSM diagnosis of depression. Contending that sadness in response to the adversities of life itself should not be judged a mental disorder, they too underscore the cost of allowing reliability to overshadow validity of diagnosis.

As many concerned critics pointed out, just creating a reliable system that has clear rules that everybody can follow does not ensure even an approximation of validity: unless the rules are accurate, the reliability might just represent everybody together getting the same wrong answer! For example, if symptoms of intense sadness are used to indicate depressive disorder, such symptoms might be identified reliably, but the vast majority of conditions so recognized might not, in fact, be disorders. (Horwitz & Wakefield, 2007)

Analogously, if a rule dictates that any adult who has persistent homosexual experiences suffers from the mental disorder of homosexuality, then a dozen psychiatrists will have no difficulty arriving at the identical finding that James, a practicing gay male, has this disorder even if it is not in fact a disorder—as the APA ruled in 1973. If the members of the APA had used the decision to remove homosexuality from DSM-II as an occasion to reflect on the recent and

already influential attempt by Feighner et al. to set diagnosis on a secure foundation, they might have realized then and there how readily validity can be “sacrificed to achieve reliability.”

While the Feighner authors appear to view their criteria as preliminary constructs that may one day lead to actually valid specifics, they also claim to have tested their validity with impressive results. The fact is that “most of the key features of the Feighner criteria were not directly based on systematic empirical study” (Kendler, Muñoz & Murphy, 2010), as two who witnessed their construction report. To evaluate their validity, therefore, one is obliged to investigate the literature underlying them, which I have tried to do in the case of the one unmentionable Feighner category. Notwithstanding the group’s claim that their criteria are “based on data rather than opinion or tradition” (Feighner, Robins, Guze, Woodruff, Winokur & Munoz, 1972), it turns out that the Feighner criteria for a diagnosis of homosexuality are based on nothing at all. Nor is this the only Feighner diagnosis whose textual sources repay examination.

Anyone who looked into the primary source for the first set of diagnostic criteria drafted by the Feighner group—those of depression, soon to become the feature diagnosis of the Research Diagnostic Criteria and later the most common diagnosis by far under the post-1980 DSM system (Horwitz, 2011)—would discover that it does not intend its checklist of symptoms for diagnostic use. The report of the 1957 study led by the Freud-skeptic mentioned earlier, Mandel Cohen, concludes, “Manic-depressive disease can be diagnosed by the usual medical procedure of using history, examination, and laboratory data” (Cassidy, Flanagan, Spellman & Cohen, 1957)—not by means of a checklist. The checklist in this study was not used

diagnostically but administered to a group of in-patients who had already been diagnosed—with no shortcuts or ticked boxes—as suffering from manic depression (Justman, 2018). Much as gays in the early 1970s made the telling argument that psychiatry could not generalize with any validity from the small sample of gay patients seen by psychiatrists, the eventual use of criteria closely modeled on the Feighner list (which was itself closely modeled on the 1957 list) to screen for depression was open to the objection that the criteria evolved from an instrument designed for use on profoundly ill patients and are therefore inapplicable to the general population without loss of validity.

Similarly, whereas homosexuality does not have an outcome or (without doing violence to language) a clinical course, the symptom-period for depression set by DSM-III at two weeks is so brief that it can easily catch transient episodes and does not in any case allow clinical course to manifest itself. In the 1957 study by the Cohen group half the patients had been ill for more than six months, and a third for more than a year. With no reason given, the Feighner criteria for depression set the symptom-period at one month. The Research Diagnostic Criteria, with no reason given, lower the threshold to as little as one week for “probable” and two weeks for “definite” depression. Placing symptoms in a social vacuum (like one who evaluates a gay person’s self-conflict in disregard of the loathing of homosexuality in the world at large), the DSM-III checklist modeled on the RDC is easy to apply and therefore lends itself to reliable or reproducible diagnosis, even though its two-week threshold, a product of authorial fiat, lacks validity.

If, as some believe, the same sort of debate that led to the removal of homosexuality from DSM-II could have broken out about many DSM-III diagnoses if the stakes were high

enough (Kirk and Kutchins, 1992), then the homosexuality issue potentially resonates throughout the DSM system. Before or after the de-listing controversy in 1973, anyone who checked the sources underwriting the diagnosis of homosexuality in the Feighner criteria, instead of veiling the entire issue in silence, might indeed have been led to rethink the matter of reliability and validity from the ground up. More generally, discussion of the absence of evidentiary support for the Feighner diagnosis might well have inspired diagnostic modesty, a virtue in anyone who sets out to design a taxonomy of the mind's ills, like DSM-III. What the three medical studies cited by Feighner et al. as validation of the homosexuality diagnosis actually suggest is that when psychoanalytic doctrine is set aside, evidence of the pathological nature of homosexuality seems to go with it. The Robins and Saghir studies in particular, with their methodological resemblance to work by the anti-Freudian Mandel Cohen, are strikingly free of both analytic terminology and the preconceived conclusions about homosexuality packed into it. Unburdened by presumptions of pathology, these studies too serve as encouragement to humility.

While we can't be sure that the effect of spotlighting the homosexuality problem in the Feighner criteria would have been big, it's just possible that if leaders of the APA like Spitzer had unearthed and examined the sources offered in support of the Feighner criteria, reliability and validity would have found a better balance in the diagnostic system they created. If they had realized that the absence of clinical profile, course and outcome accounts for the absence of evidence offered by Feighner et al. for the pathological nature of homosexuality, they might have attached due importance to such validators as they went about constructing a new classification of mental disorders. For at least one member of the DSM-III Task Force, public

exposure of the baselessness of one of Feighner diagnoses would have touched a nerve. As a co-author of the Feighner criteria, Robert Woodruff had a personal stake in their reputation. Perhaps he would have reacted defensively to free and open discussion of the hollowness of one of them; perhaps not. In either case, he might well have been led to reconsider his standards of validity and if so, he was well positioned, as a member of the Task Force's inner circle (Decker 109), to shape the evolving text of DSM-III accordingly. In the event, Woodruff committed suicide while DSM-III was in the draft stage.

The Making of a Disorder

Wrote Christopher Boorse a few years ago, "If, as many people believe, the American Psychiatric Association normalized homosexuality in 1973 because of a fear of further public protests, it was the end of psychiatry's claims to be a science" (Boorse, 2014). Patently inapplicable to homosexuality, Washingtonian validators like clinical profile, course and outcome offered the APA an opportunity to normalize homosexuality not only without violating the canons of science but as part of the effort to make diagnosis more scientific, as Feighner et al. aspired to do. This opportunity was sadly missed. During and after the declassification affair, combatants on both sides leveled the accusation that science was being sacrificed to expediency, and Spitzer later concluded that the controversy came down to a question of values (Spitzer, 1981). If he himself hadn't chosen to ignore homosexuality's zero score on the

Feighner tests, the APA might have had something other than passion and preference to guide its action.

Some would argue that all the Feighner criteria can do is delineate one mental disorder from another—they can't establish whether a condition amounts to a disorder in the first place. It was the firm belief of the Feighner group, however, that in the current state of knowledge investigations like family- and follow-up studies, which underlie their diagnostic criteria (in part), represent the best way to establish disorder. They envisioned themselves as working to set psychiatry on an appropriate medical foundation and, more particularly, to codify the identifiers of specific disorders at a time when diagnostic standards were weak and the existence of any and all mental disorders was hotly disputed. As shown by their recommendation of no diagnosis for cases where symptoms are "minimal," they certainly gave thought to the line between disorder and non-disorder. If (as they note) diagnosis guides treatment, it would be a travesty to treat a disorder that is really a non-disorder. Yet the inclusion of homosexuality in a list of validated disorders is itself a travesty. If the anomaly of homosexuality in the Feighner document had been discussed at the time, all would have recognized what was at stake—its very standing as a disorder—and anyone who wanted to make the case that it *is* a disorder despite not behaving like one would have borne a heavy burden of argument.

Even as the influence of the Feighner criteria began to make itself felt, the APA worked on a definition of mental disorder in an effort to parry the claim that psychiatry was not a medical discipline at all, merely an institution of social control (Cooper, 2005). Feighner et al. affirm psychiatry's medical identity by predicating the classification of a condition as a mental

disorder on its natural history. In effect, they assume that if a condition behaves like a disorder—has characteristic presenting features, runs in families, follows a typical course and lends itself to follow-up studies, like schizophrenia, for example—then in all likelihood it *is* a disorder, even in the absence of a known cause. (Conversely, however, if a condition in no way behaves like a disorder, then in all likelihood it isn't.) While Spitzer sought out and worked with the Washington school, the DSM concept of disorder he did much to frame—that of a syndrome associated with distress or impairment—does not have a Washingtonian cast. How then did DSM-III defend itself against the charge that psychiatry is simply an enforcer of social norms? By specifying that a disorder does not simply reflect “a conflict between an individual and society.” As noted by Wakefield in a thoughtful commentary, the DSM concept of disorder factors in to this extent the circumstances in which a patient is immersed. It follows that “labeling people as disordered when their distress is due to an oppressive environment is not only incorrect but potentially harmful because it suggests that something is wrong with the person and it directs interventive attention toward the person's internal functioning and away from the person-environment interaction. For example, a child in an abusive environment, a homosexual person in a homophobic environment, and a dissident in a politically repressive environment might experience distress, but it is incorrect and potentially harmful to label such people as disordered on that basis alone” (Wakefield, 1992). Sometimes, it seems, distress is too well-founded, too appropriate, to be deemed disordered.

According to Wakefield, while the DSM definition of disorder has its merits, in all it represents a failed attempt to operationalize the concept of harmful dysfunction—that is, a damaging malfunction of an internal mechanism. A malfunction implies, in turn, a failure to

work as nature intends; and it seems to me that we get nowhere by circling back to the old question of whether or not nature intends human beings to be homosexual. However, the status of homosexuality isn't at issue in Wakefield's paper, in that the DSM-III-R definition under discussion specifically excludes "deviant behavior, e.g., political, religious, or sexual." Still, in another sense homosexuality lies at the heart of the paper, because it was in the context of the homosexuality controversy that Spitzer first framed the distress and disability criteria that govern the concept of disorder that *is* at issue. Recall that Spitzer reasoned that a disorder must cause distress or disability, and that because homosexuality doesn't necessarily do either, it doesn't constitute a disorder. For one whose orientation does cause distress he proposed the diagnosis of Sexual Orientation Disturbance, even if the patient happens to be "a homosexual person in a homophobic environment." Thus, because many homosexuals are not distressed, homosexuality is not a disorder, but because many are, they qualify for disorder anyway. This deft application of the notion of distress solved an acute political crisis, at once legitimizing the de-listing of homosexuality and keeping it on the books in deference to those unprepared to say that it wasn't psychiatry's concern.

If Spitzer had related the distress of Sexual Orientation Disturbance to the possibly distressing circumstances in which the subject lives, instead of defining distress per se as a cardinal symptom of a brand-new disorder, the concept of a disorder that was built into DSM-III might have taken a different shape, because (as noted) it was in response to the homosexuality crisis that Spitzer first advanced the notion of a mental disorder as turning upon distress or impairment. Had the crisis itself evolved differently, perhaps the DSM concept of disorder—liberal enough to allow for the diagnosis of homosexuality after it had been rescinded, provided

only that patients were in conflict with themselves—would have been anchored to some form of Washingtonian validation. (Spitzer himself once observed that the diagnosis of PTSD may well reduce to depression plus phobia [Rosen, Spitzer & McHugh, 2008]—Feighner categories, as it happens.) After all, to substantiate his claim that the DSM-II diagnosis of homosexuality lacked a scientific foundation, Spitzer need only have pointed out that it fails every Feighner test, beginning with the basic requirement of distinctive clinical features. However, at a historical juncture when DSM-II was crumbling and new diagnostic standards—in the first instance, the Feighner criteria—were coming into play, the improvised notion of Sexual Orientation Disturbance did its job of patching up a conflict in the APA well enough that its weakness as a diagnosis attracted little attention.

The Feighner authors were not indifferent to considerations of distress and impairment, both of which figure in their paper as measures of symptom severity, not determinants of disorder. In the DSM system introduced in 1980, distress and impairment serve as the latter, occupying something like the governing position held by tests of validation in the Feighner document. It is these gatekeepers—distress and impairment—that have presided over an immense expansion of the index of mental disorders beyond the handful codified by the Feighner group in 1972. While DSM-III was being drafted, letters flowed in to the Task Force arguing that a given condition should be included in the new manual because psychiatrists see patients with it—not necessarily because it satisfies the abstract definition of a disorder (Cooper, 2005). Effectively granting these entreaties, the distress and impairment criteria serve to credential the sort of conditions seen by psychiatrists (or enough psychiatrists), in that patients visit psychiatrists because they feel distressed or impaired in the first place. So it is

that the number of DSM diagnoses has swelled as if it were scarcely subject to constraint in theory or practice. In the end, it seems, the legacy of the Feighner criteria is not diagnostic skepticism and correspondingly rigorous standards of validation but a checklist format that gives an impressive appearance of rigor and precision. Recall that in Spitzer's estimation, if the Feighner criteria hadn't emerged the most consequential difference is that "operationalized criteria"—in plain words, checklists—would have been delayed for years.

Perhaps we can consider the diagnostic device of Sexual Orientation Disturbance, for those distressed by their own sexuality, as the starting point of the proliferation that ultimately made the very table of contents of DSM-5 some 27 pages long. After the deletion of homosexuality from DSM-II, psychiatrists could conceivably have continued to treat gay patients for depression, a well-established condition for which they were at elevated risk, according to the textbook co-authored by two of the Feighner group. How much difference is there, really, between being *distressed* by one's sexuality and being *depressed* by it, that is, overcome with discouragement (even despondency) and guilt (even self-loathing)? Feighner et al. recognize a possible overlap between homosexuality and depression, specifying as they do that in order to qualify for the latter one cannot be suffering from any of a number of "preexisting psychiatric conditions," including homosexuality. Even so, under the Feighner categories there is the diagnosis of "secondary depression" for one whose distress comes from homosexuality—say, a gay male who deeply regrets being unable to have children (Ruse, 1981). That anyone really stood to be psychiatrically orphaned by the APA's declassification of homosexuality seems unlikely. And yet the APA trustees opted for a new, not to say newfangled, diagnosis, as if the removal of one disorder demanded the creation of another.

Did they consider that they might be setting a precedent for the creation of makeshift diagnoses?

Crafted by Spitzer specifically to give the warring factions of the APA something to agree on, the diagnosis of Sexual Orientation Disturbance may have been reliable but could hardly be deemed valid. Certainly neither Spitzer nor anyone else could pretend that it was validated by the likes of follow-up investigations, if only because such things take time, and the disorder in question was no sooner coined than codified. A diagnosis in search of patients, Sexual Orientation Disturbance, under the new name of Ego-dystonic Homosexuality, was little used in clinical practice (Conrad, 2007) and was deleted from DSM-III-R and largely forgotten, having served its purpose as an interim category for those APA members who weren't ready to let go of homosexuality and needed to taper off. It too was a useful category. With its brief moment of existence, SOD is only a little less tenuous than disorders that never quite achieved existence, such as "Self-Defeating Personality Disorder," a construct that was floated in an appendix to DSM-III-R but didn't win enough support to enter the DSM canon of entities.

In that those afflicted with it bring suffering on themselves and spoil their chances of success, "Self-Defeating Personality Disorder" appealed implicitly to the distress and impairment criteria that entered the DSM cultural system through Spitzer's efforts. With his argument that a single set of criteria, three words long, disqualified the diagnosis of homosexuality and underwrote the replacement diagnosis of Sexual Orientation Disturbance, Spitzer wielded a sort of Occam's razor that cut neatly through the argumentative noise of the homosexuality debates. Quite unlike other Occam's razors, though, the distress and impairment criteria allowed for the multiplication of entities, and that in the not very long run.

Under the welcoming aegis of distress and impairment, innumerable disorders have sought and very many have found DSM status since 1980. Though homosexuality has long since disappeared from the DSM system, then, it did not disappear without a trace. As a result we are compelled to this day to think carefully about the foundation of proposed and even existing diagnostic categories, as in the de-classification drama of the 1970s.

References

Andreasen, N. (2007). DSM and the death of phenomenology in America: an example of unintended consequences. *Schizophrenia Bulletin*, 33, 1, 108-12.

Bayes, R. (1981). *Homosexuality and American psychiatry: the politics of diagnosis*. Princeton: Princeton University Press.

Bayer, R. & Spitzer, R. (1982). Edited correspondence on the status of homosexuality in DSM-III. *Journal of the History of the Behavioral Sciences*, 18, 1, 2-52.

Bayer, R. & Spitzer, R. (1985). Neurosis, psychodynamics, and DSM-III: a history of the controversy. *Archives of General Psychiatry*, 42, 87-96.

Boorse, C. (2014). A second rebuttal on health. *Journal of Medicine and Philosophy*, 39, 683-724.

Cassidy, W., Flanagan, N., Spellman, M. & Cohen, M. (1957). Clinical observations in manic-depressive disease. *JAMA*, 164, 14, 1535-46.

Cloninger, C. R. (1989). Establishment of diagnostic validity in psychiatric illness: Robins and Guze's method revisited. In L. Robins & J. Barrett (Eds.) *The validity of psychiatric diagnosis*. New York: Raven Press.

Conrad, P. (2007). *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press.

Cooper, R. (2005). *Classifying Madness: A Philosophical Examination of the Diagnostic and Statistical Manual of Mental Disorders*. Dordrecht, Netherlands: Springer.

Decker, H. (2013). *The making of DSM-III: a diagnostic manual's conquest of American psychiatry*. Oxford: Oxford University Press.

Feighner, J., Robins, E., Guze, S., Woodruff, R., Winokur, G. & Munoz, R. (1972). Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry*, 26, 1, 57-63.

Jones, J. (1997). *Alfred C. Kinsey: A Public/Private*. New York: Norton.

Healy, D. (2000). *The Psychopharmacologists*. Vol. III. Oxford: Oxford University Press.

Healy, D. (2002). Mandel Cohen and the origins of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition: DSM-III*. *History of Psychiatry*, 13, 209-30.

Hemphill, R., Leitch, A. & Stuart, J. (1958). A factual study of male homosexuality. *British Medical Journal*, June 7, 1317-23.

Horwitz, A. (2011). Creating an age of depression: the social construction and consequences of the Major Depression diagnosis. *Society and Mental Health*, 1, 1, 41-54.

Horwitz, A. & Wakefield, J. (2007). *The loss of sadness: how psychiatry transformed normal sorrow into depressive disorder*. New York: Oxford University Press.

Justman, Stewart. (2018). When checklists were new: the prototype of DSM's operational Criteria. *Ethical Human Psychology and Psychiatry*, 20, 1, 17-26

Kendler, K., Muñoz, R. & Murphy, G. (2010). The development of the Feighner criteria: a historical perspective. *American Journal of Psychiatry*, 167, 2, 134-42.

Kinsey, A., Pomeroy, W. & Martin, C. (1948). *Sexual behavior in the human male*. Philadelphia: W. B. Saunders.

Kirk, S. & Kutchins, H. (1992). *The selling of DSM: the rhetoric of science in psychiatry*. New York: Aldine de Gruyter.

Mayes, R. & Horwitz, A. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences*, 41, 3, 249-67.

Purtell, P., Robins, E. & Cohen, M. (1951). Observations on clinical aspects of hysteria: a quantitative study of 50 hysteria patients and 156 control subjects. *JAMA*, 146, 10, 902-09.

Robins, E. (1978). Diagnosis and chronic mental illness. *Psychiatric Quarterly*, 50, 3, 166-77.

Robins, E. & Guze, S. (1970). Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. *American Journal of Psychiatry*, 126, 7, 107-11.

Robins, L. (1966). *Deviant children grown up: a sociological and psychiatric study of sociopathic personality*. Baltimore: Williams and Wilkins.

Rosen, G., Spitzer, R. & McHugh, P. (2008). Problems with the post-traumatic stress disorder diagnosis and its future in DSM-V. *British Journal of Psychiatry* 192: 3-4.

Ruse, M. (1981). *Is Science Sexist?* Dordrecht, Holland: D. Reidel.

Saghir, M. & Robins, E. (1969). Homosexuality: sexual behavior of the female homosexual. *Archives of General Psychiatry*, 20, 2, 192-201.

Saghir, M. & Robins, E. (1973). *Male and female homosexuality: a comprehensive investigation*. Baltimore: Williams and Wilkins.

Saghir, M., Robins, E. & Walbran, B. (1969). Homosexuality: sexual behavior of the male homosexual. *Archives of General Psychiatry* 21, 2, 219-29.

Shorter, E. (2005). The history of nosology and the rise of the *Diagnostic and Statistical Manual of Mental Disorders*. *Dialogues in Clinical Neuroscience*, 17, 1, 59-67.

Small, I., Small, J., Alig, V. & Moore, D. (1970). Passive-aggressive personality disorder: a search for a syndrome. *American Journal of Psychiatry*, 126, 7, 973-81.

Spitzer, R. (1981). The diagnostic status of homosexuality in DSM-III: a reformulation of the issues. *American Journal of Psychiatry*, 138, 210-15.

Spitzer, R. (1989). The development of diagnostic criteria in psychiatry. *Current Contents. Social and Behavioral Sciences*, 19, 20.

Spitzer, R., Endicott, J. & Robins, E. (1978). Research diagnostic criteria: rationale and reliability. *Archives of General Psychiatry* 35, 6, 773-82.

Stoller, R., Marmor, J., Bieber, I., Gold, R., Socarides, C., Green, R. & Spitzer, R. (1973). A symposium: should homosexuality be in the APA nomenclature? *American Journal of Psychiatry*, 130, 11, 1207-16.

Wakefield, J. (1992). Disorder as harmful dysfunction: a conceptual critique of DSM-III-R's definition of mental disorder. *Psychological Review*, 99, 2, 232-47.

Woodruff, R., Goodwin, D. & Guze, S. (1974). *Psychiatric diagnosis*. New York: Oxford University Press.