Chapter 1
Introduction to the Realm of Paraphilias

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Paraphilias and what we now call paraphilic disorders have been puzzling, curiosity-arousing, attention attracting, famous and infamous (take masochism and sadism), maligned, and misunderstood for centuries. Our full understanding of paraphilic behaviors is still lacking. The lack of understanding probably starts with the lack of consensus about the definition, its use, and, at times, its, unfortunately, pejorative use.

The term paraphilia is about 100 years old (the introduction of the term is credited to Friedrich Salomon Krauss in 1903, but it was more generally suggested/introduced by Wilhelm Stekel in German in 1908 and later in 1930). Its meaning and definition vary. The word paraphilia is a construction of two Greek words. The first is *para*, the meaning of which could vary from "beside, side by side" to "beyond,

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past, by" to "abnormal or defective" (e.g., in paranoia) to "irregular, altered." The other term -philia means love, friendship, brotherly love, affection. In "modern" language it could mean a whole spectrum from a friendly feeling toward something or someone, to an abnormal feeling, depending on the context. Thus, paraphilia in a general sense means love beyond the usual (less derogative term) to abnormal love or sexuality (whatever the term normal sexuality means). Some may also define paraphilia as "love for other/marginal object." The term paraphilia was, in a way, meant to replace terms such as sexual deviation, sodomy, or perversion. It seems that this well-meant semantic change has not been really successful. The definition of paraphilic or sexually "deviant" behavior is also problematic from a fuzzy border between the so-called "normal" or acceptable sexual behavior and abnormal sexual behavior. Take the example of occasional mild spanking of one's sexual partner during sexual activity enjoyed and asked for by the partner vs. binding, whipping, and even kicking the sexual partner during sexual activity. Where is the border between acceptable (or normal) behavior and abnormal behavior here?

Diagnosis of Paraphilia/Paraphilic Disorder

As we do not understand the etiology of paraphilias/paraphilic behaviors (like most mental disorders), our definition/diagnosis of paraphilias/paraphilic behaviors is purely descriptive. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) ([1], p 685) states that, "The term *paraphilia* denotes any intense and persistent sexual interest *other than* [Italics mine] sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physiologically mature, consenting human partners. In some instances, the criteria 'intense and persistent' may be difficult to apply, such as in the assessment of persons who are very old or medically ill and who may not have 'intense' sexual interests of any kind. In such circumstances, the term

paraphilia may be defined as any sexual interest greater than or equal to normophilic sexual interests. There are also specific paraphilias that are generally better described as preferential sexual interests rather than intense sexual interest. Some paraphilias primarily concern the individual's erotic activities, and others concern the individual's erotic target. Examples of the former include intense and persistent interest in spanking, whipping, cutting, binding, or strangulating another person, or an interest in these activities that equals or exceeds the individual's interest in copulation or equivalent interaction with another person. Examples of the latter would include intense or preferential interest in children, corpses, or amputees (as a class), as well as intense or preferential interest in nonhuman animals, such as horses or dogs, or in inanimate objects, such as shoes or articles made of rubber." The DSM-5 also points out a classification scheme for paraphilic disorders, dividing them into two groups: (a) those with anomalous activity preference (these are further divided into *courtship disorders*, which resemble distorted components of human courtship behavior—voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder) and algolagnic disorders, which involve pain and suffering—sexual masochism disorder, sexual sadism disorder); and (b) those with anomalous target preference—one directed at humans (pedophilic disorder) and two directed elsewhere (fetishistic disorder, transvestic disorder) ([1], p 685).

In its attempt to address the wide criticism of labeling paraphilia as mental illness, the DSM-5 introduced the term paraphilic disorder: "*A paraphilic disorder* is paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention" ([1], pp 685–686) In spite of a wide criticism by many (see below), I view this as an important shift and step in the process of de-pathologizing paraphilias. The previous DSM definitions of paraphilia were basically

what the DSM-5 definition of paraphilic disorder is. Paraphilia was a disorder. The DSM-5 recognizes that paraphilia itself is an interest or even behavior which does not necessarily meet the criterion of mental disorder (in the sense of DSM definition of mental disorder). It is important to realize as Paul Fedoroff ([2], p 241) pointed out that paraphilias as a group of disorders are "remarkably consistent in their phenomenology, but highly variable in their expression."

Some have criticized classifying paraphilias/paraphilic disorders as mental illnesses in general terms, opposing what is called the pathologization of nonnormative sexual practices originally called "deviations" or "perversions" [3]. Downing [3] argues that the diagnosis of paraphilic disorder does nothing to overturn what she calls "the conservative and utilitarian view of sexuality as genitally oriented and for reproduction that has colored sexological and psychiatric history" ([3], p 1139). She also argues that using labels such as paraphilia and paraphilic disorder within the psychiatric diagnostic system is more ideological than properly scientific, and that the "normophilic" bias of the DSM is a bias in favor of heteronormativity and reproduction ([2], p 1139). Some (e.g., [4]) have argued that at least some, if not all, paraphilias/paraphilic disorders should not be included in the DSM classification. Shindel and Moser ([4], p 928) suggested that "Evidence-based medicine is now considered the basis of and guide for medical practice. Continuing to include the diagnoses of sexual sadism in the DSM in the absence of empirical evidence to support their inclusion violates a stated principle of the DSM revision process: 'all changes proposed for the text are to be supported by empirical data.' A basic tenet of medicine taught to all physicians is, 'First, do not harm.' These diagnoses have caused harm, been misused, and lack the scientific basis for designating these interests as pathological. The resistance to removing diagnoses which have significant negative effects, no clear positive effects, and no-established utility in patient management is bewildering. Therefore the APA (American Psychiatric Association—mine) should remove sexual masochism and consensual sexual sadism

from DSM-5. Based on the same logic, the other non-criminal paraphilias (transvestism, fetishism, partialism) should also be removed. Individuals who engage in non-consensual sexual behavior can (and should) be offered treatment to help them control their sexual urges. Existing psychiatric diagnoses that focus on inability to control behavior can be used. Impulse control maybe a more viable treatment goal than reparative therapies for unusual sexual interests." This is certainly an interesting argument and suggestion, but is it really providing a solution? Most diagnoses in our classification system are not perfect in terms of evidence-based medicine and lack of various empirical data. Should that be a basis for removal of many more diagnoses or should we rather study these behaviors more intensely and comprehensively? Lot has been written about the diagnoses of paraphilia and paraphilic disorder, but as noted by Blanchard [5], the field has not studied the diagnoses of paraphilias/paraphilic disorders properly. He writes that the field trials for DSM-III included three patients with paraphilias. Paraphilias were not included in the field trials for DSM-III-R or for DSM-IV field trials and to my knowledge neither in the DSM-5 field trials. Thus, as Blanchard states, "the sum total of patients who have been studied in conjunction with revising the DSM diagnostic criteria for the paraphilias is 3" ([5], p 861). Thus studying the diagnosis seems to be a better first step than abandoning it.

As pointed out by Moser [6] in his discussion of Ray Blanchard's work, the DSM definition of paraphilia is a definition by concatenation, i.e., by listing things that are paraphilias, yet preferable approach may be a definition by exclusion, i.e., to list everything what is not normophilic. Further issues which the diagnosis of paraphilia and paraphilic disorder faces include the importance of precision in the language defining these disorders and the outside societal and political pressures to define what is "normal," what is "acceptable" for the society and for the forensic arena. For instance, Wakefield [7] pointed out the tension between diagnostic validity and forensic utility of the diagnostic criteria of paraphilias. He noted that, "In order to prevent sexual crimes,

'sexual predator' laws now allow indefinite preventive commitment (at least in the U.S.—mine) of criminals who completed their prison sentences but are judged to have a paraphilic mental disorder that makes them likely to commit another crime. Such proceedings can bypass the usual protections of criminal laws as long as the basis for incarceration is the attribution of a mental disorder. Thus the difficult conceptual distinction between deviant sexual desires that are mental disorders vs. those that are normal variations of sexual preference (even if they are eccentric, repugnant, or illegal if acted upon) has attained important forensic significance. Yet the concept of paraphilic disorders—called 'perversions' in earlier times is inherently fuzzy and controversial and thus open to conceptual abuse for social control purposes" (7 - p 195).

Interestingly, we have been also unable to decide where in our diagnostic systems to classify paraphilias/paraphilic disorders. Previously, the DSM system placed paraphilias under "sexual and gender identity disorders." In the DSM-5, paraphilic disorders are separated from sexual dysfunctions and are placed, almost symbolically, at the very end of the DSM-5, just prior to "Other mental disorders." The International Classification of Diseases (ICD) (in its section on Mental and Behavioral Disorders) classifies paraphilias as "disorders of adult personality and behavior," and among these as "disorders of sexual preference." Sexual dysfunctions, on the other hand, are classified as "behavioral syndromes associated with physiological disturbances and physical factors." The paraphilias listed in ICD-10 include fetishism, fetishistic transvestism, exhibitionism, voyeurism, pedophilia, sadomasochism (sadism, masochism), other disorders of sexual preference (e.g., frotteurism, necrophilia), and disorder of sexual preference not otherwise specified. The DSM classification also lists eight paraphilic disorders (voyeuristic, exhibitionistic, frotteuristic, sexual masochism, sexual sadism, pedophilic, fetishistic, and transvestic—basic classification also used in this book) and all encompassing Other Specified Paraphilic Disorder with examples of what this entity encompasses being telephone scatophilia, necrophilia, zoophilia, coprophilia, klismaphilia,

and urophilia. Yet there are several hundreds of described paraphilias in the literature. For instance, Paul Fedoroff lists [8] 111 paraphilias plus paraphilia NOS and Other disorders of sexual preference, from abasiophilia (persistent sexual arousal toward disability) to zoosadism (persistent sexual arousal focused on harm to animals). Milner, Dopke, and Crouch [9] counted more than 150 named paraphilias in both the professional and general literature. However, as they [9] pointed out, many newly named paraphilias appeared to be subtypes of existing paraphilias and thus it is unclear how many newer paraphilias NOS (Not Otherwise Specified) categories or entities are needed ([9], p 390). In their very informative review and descriptions they divide paraphilias NOS to those focused on nonhuman objects (e.g., zoophilia, klismaphilia, mysophilia), suffering or humiliation of oneself or one's partner (e.g., telephone scatophilia, saliromania—soiling or damaging of a partner's clothing or body), children or other nonconsenting persons (e.g., somnophilia, necrophilia), and a large subcategory of those paraphilias having atypical focus involving human subjects (self and others) (e.g., hypoxyphilia, partialism, gerontophilia, or troilism).

There have been other possible paraphilias/paraphilic disorders, some of which were considered for inclusion in DSM-5 (e.g., hypersexual disorder, paraphilic coercive disorder, pedohebephilia, and compulsive online sexual behaviors), some of which are discussed in this book.

Treatment of Paraphilias

Treatment of paraphilias/paraphilic disorders has been a complicated task. General principles are outlined in Chap. 4 of this volume and specific in each chapter devoted to a particular paraphilic disorder. However, there are many unresolved and controversial issues in the management and treatment of paraphilias—now paraphilic disorders. I outlined some of them in the past [10]. These include the question of whether to treat or not to treat and what to treat; goals of treatment; how and with

what to treat; length of treatment; possible use of extreme treatments such as castration; and preventive treatment. Another issue is the lack of solid treatment studies.

There is no clear and widely recognized guidance as to whether and when to treat and which paraphilic disorders to treat [10]. Treatment of paraphilic disorders is a minefield of ethical issues, especially when pharmacotherapy is used [11] (some of them are addressed in Chap. 16). The goals of treatment are also not very clear. Should we treat patients to "extinguish" fantasies, or urges, or behaviors? Another ethical question is whose wish and beneficence should we respect, the patient's or society's? The beneficence of society clearly prevails in some paraphilic disorders, such as pedophilic or sadistic ones. But does it prevail in all paraphilic disorders?

We lack data on how long to treat patients with paraphilic disorders. Garcia and Thibault [11] recommend treating severe paraphilias with a high risk of sexual violence for a minimal duration of 3–5 years. They also recommend that mild paraphilias (a bit unclear term) be treated for at least 2 years, then treatment should be discontinued, the patient monitored, and treatment restarted in case of reoccurrence sexual fantasies. However, these recommendations leave many unanswered questions, some of them especially important in the case of paraphilic disorders. As Balon [10] asked: How long should the patient be treated after becoming symptom-free? Should the number of relapses be another guiding principle, similar to the guidance for treatment of depression (three relapses would mean lifelong treatment)—but would society require fewer relapses for starting lifelong treatment of paraphilic disorders?)? Should natural decline of testosterone levels be considered in the hormone treatment of paraphilic disorders?

A preventive approach to paraphilic disorders would probably be quite desirable from the societal point of view and interest. Primary prevention of paraphilic disorders is not possible, as we do not know the etiology of these disorders. Secondary prevention—diagnosing and treating the disorder in its early stages before it causes significant morbidity and harm to others—means quick intervention when the urges,

fantasies, and behaviors first occur [10]. That may be problematic as some (probably most) individuals would not seek treatment. It seems impossible to evaluate effectiveness of secondary prevention. Laws [12] proposed that secondary prevention should include targeting children, adolescents, and adults, e.g., make adults aware of unusual sexual activity or interest in children who were abused. Tertiary prevention—reducing the negative effect of the disorder, reducing disorder-related complications, and preventing recurrence is done only in cases of pedophilic disorder, sadism/rape, and exhibitionistic disorder [10]. Again the ethical questions are multiple and guidance regarding treatment length is nonexistent. A solid approach to prevention of paraphilic disorder would probably require creating more programs such as The National Sex Offender Treatment Programme in Canada.

Treatment of paraphilic disorder is also an area of a possible clash between medicine and the legal system. The demands and requirements of the legal system may, and usually are, different. As Borneman [13] pointed out in his book on possible rehabilitation of child molesters, "…if an object of medical treatment, child sex abuse is an illness, and hence requires healing; if an object of law, child sex abuse is an intended crime, and hence deserves punishment. Medicine is about health and illness, law about innocence and guilt. Child sex offenders have become, then, simultaneous or alternating objects of medicine—afflicted by a 'paraphilic disorder'—and of law—individuals who intend to commit or have committed a crime, subjects to the claims of expertise in both fields."

Stigma of Paraphilias/Paraphilic Disorders

As pointed out by Cantor [14], atypical sexual interests remain highly stigmatized in the Western society, especially in the United States. Paraphilic disorders are definitely highly stigmatizing and probably one of the most despised groups of mental disorders (e.g., paraphilic disorder with a sexual interest in prepubescent children—[15]). This stigma limits the

acceptance of the individual by the society, the availability of places to live, and, in a way, access to treatment, as individuals suffering from paraphilic disorder usually do not seek treatment on their own and specialized treatments are frequently not available. In some places in the Unites States, being a severe sexual offender (e.g., cases of pedophilic disorder) means basically indefinite if not lifelong sentence. These offenders are, after serving a prison sentence, being held indefinitely in special facilities under a policy of civil commitment, having being deemed "sexually dangerous" or "sexual psychopathic personalities" by courts. The intent is to provide treatment to the most dangerous sex offenders until it is safe for the public for them to go home [16]. Some of them have been held for decades. (In all fairness, these policies are being reevaluated—[16]). As Wakefield ([7], p 196) pointed out, "the Supreme Court (of the United States) has ruled that preventive institutionalization of potential sexual criminals is constitutionally acceptable and does not imply constitutionally barred 'double jeopardy' even after such individuals have served full prison terms for their crimes, but only if it could be demonstrated that the threat of renewed harm upon their release is due to a mental disorder that renders the individual unable to exercise normal-range volitional control over sexual behavior." As discussed before, we do not have the ability to really predict future dangerousness well. As the Court emphasized that dangerousness in the form of inability to control one's impulses must be due to a mental disorder to warrant preventive civil commitment [7], some argued against categorizing paraphilias/paraphilic disorders as mental disorder. Wakefield [7] suggested that diagnostic criteria of paraphilic disorders may be open to forensic abuse. The issue of continuous institutionalization and preventive commitment certainly applies to the individuals who committed severe crimes with harm to others. However, in the public's mind this extends to all paraphilic, or what many call perverse behavior, and thus the stigma expands. The legal definition of what is deviant or paraphilic behavior at times differs from medicine's view of what paraphilic or deviant is. The DSM-5

([1], p 697) criteria of pedophilic disorder note that the person suffering from a pedophilic disorder should be at least age 16 years and at least 5 years older than the child or children with whom he/she is sexually involved. The DSM-5 text also notes that individuals in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old should not be included in this diagnostic category. However, there have been many cases of 15–16-year-old boys who after it was revealed that they had sex with girls of the same age or just a bit younger were labeled as sexual offenders and ended-up listed in the Sex Offender Registry.

The stigmatization also impacts other areas of functioning and a person's health. Cruwys and Gunaseelan [17] in a recent survey of depressed patients found that experiencing mental illness (in this case depression) was associated with poorer well-being. However, they also found that social identification magnified, rather than buffered, the relationship between stigma and well-being. Thus, they felt that the stigma of mental illness is a double-edge sword—in addition to the direct harm for well-being, by direct identification with other people suffering from mental illness, stigma might expose sufferers to harmful social influence processes. There is no study like this one in the area of paraphilic disorders, but it could be assumed that the impact of stigma on well-being in patients suffering from paraphilic disorders could be at least the same if not greater. The role of stigma and its impact in paraphilias/paraphilic disorders is underappreciated and needs to be addressed. As Cantor [14] wrote, "anyone with an atypical sexual interest should benefit from greater tolerance." The decrease of stigma or destigmatization of atypical sexual interests or paraphilias/paraphilic disorders is also connected to the issue of civil rights. Here Cantor [14] wrote, "…everyone with atypical sexual interests deserves respect and full recognition of all their civil rights…more importantly, questions of rights fall outside the purview of science. People deserve respect and civil rights *regardless* of the scientific classification of their sexual interest."

Conclusion

The realm of paraphilias/paraphilic disorders is a complicated, poorly understood, stigmatized, and insufficiently studied area. Many conclusions and recommendations about paraphilias/paraphilic disorders have been made based on ideological, philosophical, and political reasoning rather than based on science or clinical observation. Some argue that paraphilias/paraphilic disorders should not be considered disorders and as such should not be classified within our diagnostic system. The arguments came from different points of view, ideological, civil liberties, moral, religious, societal, forensic, or within the profession of psychiatry itself (interestingly, many psychiatrists do not like to take care of difficult or complex patients…and patients with paraphilias/paraphilic disorders are at times difficult, at times complex, and at times both difficult and complex). However, this complexity and involvement of various points of view makes the field of paraphilias more fascinating, intellectually stimulating, and at times therapeutically satisfying.

And, as one of my colleagues once said about another group of not-so-well-liked patients, "at the end, they are still our *patients*." This book is intended to help improve the clinical care of these patients, of course those who feel they need help and seek it.

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Recommended Reading

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