Chapter 10
Are Paraphilias Mental Disorders? The Case of the DSM

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1 Introduction

Throughout history, many unusual[1] sexual behaviors and desires have been considered problematic. First of all, they have often been seen as criminal offenses. Numerous books of the Old Testament already stipulated that transvestism and bestiality, among many other things, should be punished harshly (Aggrawal 2009). Having sex with animals, for example, was described in *Leviticus* (20:16) as a capital offence for all parties involved: "And if a woman approach unto any beast, and lie down thereto, thou shalt kill the woman, and the beast: they shall surely be put to death; their blood shall be upon them." More recently, since 1871, the infamous "paragraph 175" of the German penal code made some homosexual acts punishable by imprisonment. The law remained on the books, at least in West Germany, until 1994 (Whisnant 2012). Secondly, unusual sexual behaviors and desires have also been condemned as vices. The moral condemnation of such behaviors and desires can be inferred from the wide range of depreciatory adjectives that have been used in the canon of Western literature to describe them: "inappropriate", "unfortunate", "depraved", "regrettable", "unnatural" and even "monstrous" (Bagemihl 1999). In this context, animals (again) often met with the same fate as humans. For example: when a nineteenth-century entomologist observed repeated copulations between male soldier beetles and male fireflies, he charged them with blatant immorality ("*une immoralité flagrante*") and guilty complicity ("*une complaisance coupable*") (Peragallo 1863, p. 663). Thirdly and finally, since

[1]The word "unusual" is used here to refer to both the (relative) statistical rarity of certain sexual behaviours and desires, *and* their salience, i.e. their being able to generate heated debates and extreme emotions.

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the mid-nineteenth century, unusual sexual behaviors and desires have also been conceptualized as disorders (or symptoms of disorders). Variously labeled as "sexual perversions", "sexual deviations" or, in recent years, "paraphilias" (Bullough 2003), they came to be seen as "aberrant", "abnormal", "defective" and "disordered".[2] Early psychiatrists and psychologists indeed interpreted these behaviors and desires as pathological modifications of the sexual instinct, rather than crimes or moral lapses (Oosterhuis 2000). They also devised new names for (some of) them, and constructed a list of "usual suspects"—a list of disease categories that included homosexuality, sadism, pedophilia, fetishism, exhibitionism, voyeurism, masochism, zoophilia, frotteurism, necrophilia and transvestism.

The above three attitudes towards unusual sexual behaviors and desires—criminalizing, moralizing, and pathologizing—peacefully coexisted throughout the past two centuries, and in fact they still do in many parts of the world. The main aim of this chapter is to contribute to a burgeoning literature that questions the legitimacy and usefulness of the third and most recent attitude towards sexual deviance, i.e. pathologizing (see, e.g. Davidson 2001; Roughgarden 2004; Moser and Kleinplatz 2005). Why are certain sexual behaviors and desires still conceptualized as (symptoms of) mental disorders? In other words: what reasons are there to believe that these conditions are *disorders* rather than, for example, instances of ordinary criminality, immorality, or eccentricity (social deviance)?

Here I will answer this question by focusing on the American Psychiatric Association's dealings with sexual deviance, as laid out in the consecutive editions of its famous manual, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). There are three reasons for choosing this particular focus. First, the DSM is the leading clinical manual of contemporary psychiatry. It is used worldwide for diagnostic and administrative purposes, and it provides the backbone of much of today's psychiatric research. Even though the manual has attracted vehement criticism in the past decades, and even though it certainly does not represent the opinions of all psychiatrists all over the world, it is unmistakably an authoritative document, compiled by the world's most powerful professional organization of psychiatrists. As such, it deserves our attention. Secondly, focusing on the DSM is timely. Its long-anticipated fifth edition (DSM-5) was published just recently, in May 2013, and the working group devoted to revising the subclass of the paraphilias in this edition announced some important changes vis-à-vis earlier editions. Ever since its first edition in 1952, the DSM has listed the sexual deviations as mental disorders. Will this tradition be continued, and perhaps legitimated, in DSM-5?

A third and final reason to focus on the DSM relates to the fact that it is based on an explicit definition of the concept of mental disorder. The question whether paraphilias are mental disorders inevitably leads us back to an underlying

[2]Note that, for reasons of readability, I will use such expressions and terms as "unusual sexual behaviours and desires," "sexual perversion," "sexual deviation," and "paraphilia" interchangeably. "Sexual deviance" refers to the set of unusual sexual behaviours and desires available to a particular society at a particular time.

conceptual question: what is mental disorder? What necessary and sufficient conditions, if any, does a set of behaviors and desires have to fulfill in order to be a mental disorder? Since 1980, the DSM provides, in its general introduction, an answer to this question. I will argue, however, that the manual fails to provide an exhaustive and coherent analysis of the concept of mental disorder. Moreover, it also fails to design a classification of mental disorders that is consistent with whatever analysis it does provide. In other words: given the manual's messy definition of mental disorder, advocates of the DSM cannot convincingly continue to claim that all paraphilias are mental disorders.

In the present chapter, I will start by explaining briefly how psychiatry got involved in studying sexual deviance in the first place. Then I will move on to a discussion of the DSM's conceptualization of sexual deviance, starting with the first two editions. These set the stage for one of the most intriguing chapters in the history of the American Psychiatric Association: the controversy over homosexuality. I will argue that this controversy has been vital in the introduction and formulation of a general definition of mental disorder in DSM-III, published in 1980. Further, in discussing the later editions of DSM, including the recent fifth edition, it will become clear that the paraphilias provide an excellent example of the manual's constant struggle to be consistent with its own definition of mental disorder. I conclude with a general critique of the DSM approach of sexual deviance.

2 Revolutionizing Sexual Deviance

In retrospect, one may wonder why sexual deviance became a medical and psychiatric issue in the first place. Since time immemorial, sexual deviations had been repudiated by philosophers, physicians and naturalists, either as crimes or as vices. So how did they "suddenly"[3] come to be seen as disorders? Here I list two important reasons that help explain the nineteenth-century pathologising of sexual deviance.

First of all, the eighteenth and nineteenth century witnessed a growing political concern about the vitality and health of nations and peoples (Gerard and Hekma 1989); the birth of what French historian and philosopher Michel Foucault would later call "biopolitics". To address the spectre of depopulation and degeneration, politicians enlisted the help of physicians and psychiatrists, as they were held in high regard by both the public opinion and the authorities. Thus originated the eighteenth-century medical literature about the health hazards of masturbation and various other kinds of non-reproductive sexual behavior—a literature that continued to be popular

[3]Some historians of sexuality have argued that sexual deviance had in fact been pathologized before the nineteenth century. Commenting on Avicenna's work, for example, the fifteenth-century French physician Jacques Despars interpreted same-sex sexuality as a disorder that is not amenable to medical treatment (Neal 2008).

until well into the first half of the twentieth century. The nineteenth-century pathologizing of sexual deviance probably reflected (and certainly fed) a similar anxiety.[4] Much like the other two attitudes vis-à-vis unusual behaviors and desires, i.e. criminalizing and moralizing, pathologizing acted as a powerful deterrent to engage in such practices, and it provided the extra bonus of possible therapeutic interventions.

Secondly, nineteenth-century psychiatrists were able to set themselves up as experts in the domain of sexual deviance because they succeeded in *psychologizing* such deviance (Oosterhuis 2000). Unusual sexual behaviors and desires, they argued, should be understood at the level of an individual's psychology, rather than his or her behavior or anatomy. One of the landmarks in this process of psychologizing is the work of Richard von Krafft-Ebing—an Austrian forensic psychiatrist who authored the famous *Psychopathia Sexualis* in 1886. Krafft-Ebing drew an important distinction between sexual perversions and sexual perversities, equating the former with "diseases" and the latter with "vices" (Krafft-Ebing 1965 [1886], p. 54). In his view, *perversities* are occasional unusual sexual behaviors. It is only when the individual's personality as a whole becomes involved in producing such perversities that one is entitled to speak of a sexual *perversion*. The different perversions, then, are in fact different ways of being a person. As such, they cannot be diagnosed on the basis of behaviors alone; mental states, such as feelings and beliefs, need to be taken into account too. When discussing homosexuality, for example, Michel Foucault accurately captured Krafft-Ebing's "revolution" when he observed that "homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy into a kind of interior androgyny, a hermaphroditism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species" (Foucault 1978, p. 43). If psychiatrists are any good in dealing with the troubled mind, and if homosexuality is a "hermaphroditism of the soul" (43), then psychiatrists are indeed entitled to deal with homosexuality and, by extension, with all kinds of sexual deviations.

3 The Early DSM and the Paraphilias (1952–1980)

Many of Krafft-Ebing's ideas on sexual deviance have been immensely influential in twentieth-century psychiatry. His nomenclature and general biomedical perspective, for example, still pervade many contemporary psychiatric classifications of sexual deviations, including the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). In this section, I will briefly discuss the origins and early editions of this manual, while focusing on their dealings with sexual deviance.

[4]In fact both episodes in the history of sexuality are connected, to the extent that many nineteenth-century psychiatrists emphasised the role of masturbation in the aetiology of sexual deviations and various other kinds of insanity (Rimke and Hunt 2002).

The DSM originated from the need for a uniform reporting of statistics of the many mental hospitals in early twentieth-century America (Grob 1991). Its predecessor, the *Statistical Manual for the Use of Hospitals for Mental Diseases*, first published in 1918, reflected the then population of these hospitals, as it concentrated mostly on severe brain disorders, often with an organic etiology (National Committee for Mental Hygiene [NCMH] 1918). One of the manual's clinical groups was given the enigmatic name "Not Insane", and included a disease category called "constitutional psychopathic personality (without psychosis)," which in its turn referred to "criminal traits, moral deficiency, tramp life, sexual perversions and various temperamental peculiarities" (27). In a way, then, DSM's predecessor did not consider the sexual perversions as mental disorders. The message was more ambiguous, however, since "perverts" and tramps and criminals were also referred to as "pathological" and even "abnormal personalities" (27).

The origin of the *Statistical Manual* as an instrument to collect mental hospital data was predictive of the difficulties it was about to encounter. The strains and rigors at the fronts of World War II brought back shipments of American soldiers whose illnesses were nowhere to be found in the manual. Combat fatigue and shell shock produced relatively mild mental disorders, at least when compared to the grave afflictions found in mental hospitals. Faced with an enormous new patient population, the American Psychiatric Association quickly understood the need to expand its stock of disease categories. In 1952, it published the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM-I; APA 1952). Among its novelties was an extensive category of *Transient Situational Personality Disorders*.

DSM-I had very little to say about the sexual deviations. They were catalogued as one of the "sociopathic personality disturbances" that, in their turn, were part of the general category of "personality disorders." Interestingly, the description of "sociopathic personality disturbance" reads: "Individuals to be placed in this category are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals" (APA 1952, p. 38). It is one of the rare occasions where the editors of DSM-I hint at a definition of mental disorder. Unlike later editions of the manual, the first DSM did not provide an explicit definition of mental disorder (and neither did DSM-II), but its general outlook suggested that mental illness be understood either in terms of some organic defect, as in the case of the many brain disorders listed, and/or in terms of personal distress, as in the case of the neuroses. Somehow (some of) the perversions fell outside this implicit definition of mental illness, as they were seen primarily as instances of social deviance, rather than mental illness.

Like any psychiatric classification, DSM-I was a child of its time. Its descriptions of disease categories were riddled with psychoanalytic terms and concepts, such as "unconscious affects", "projection mechanisms" and "regressive reactions". Contrary to what some historians of psychiatry (e.g. Shorter 1997) and also some biological psychiatrists (e.g. Maxmen 1985) have claimed, the second edition of DSM, first published in 1968, did not really continue this tradition. Its descriptions

were shorter, and speculations as to the causes and mechanisms of disorders were kept to a minimum. The pursuit of a theory-neutral or "atheoretical" nomenclature would become ever more important in later editions of DSM.

As to the perversions, one of the minor novelties of DSM-II was the introduction of an extensive list of eight sexual deviations: homosexuality, fetishism, pedophilia, transvestism, exhibitionism, voyeurism, sadism and masochism. Also, while DSM-I and its precursor considered the perversions as a kind of personality disturbances, DSM-II listed them under the rather vague heading of "certain non-psychotic mental disorders." More importantly, however, all references to the pathogenic power of social norms in the general description of the sexual deviations were omitted. Whereas DSM-I had noted that "perverts" "are ill *primarily* in terms of society and of conformity with the prevailing cultural milieu, and *not only in terms of personal discomfort*" (APA 1952, p. 38; italics mine), DSM-II resolutely focused on the personal distress accompanying these deviations: "Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them" (APA 1968 p. 44). Much like the concern of theory-neutrality, the increasing emphasis on the criterion of personal distress was an early announcement of the looming landslide created by the appearance of DSM-III.

4 Homosexuality: A Crucial Controversy

The 1970s were turbulent times for the American Psychiatric Association. Since World War II, the majority of its members had been practicing psychoanalysts, but now the powers of psychoanalysis were waning (Decker 2007). This decline of psychoanalysis set the stage for a new wave of research psychiatrists, thus revealing a power struggle within the APA—a struggle that culminated in one of the most pressing, and perhaps even embarrassing problems in the build-up to the creation of DSM-III: the problem of homosexuality.

Perhaps more than DSM-I, DSM-II unambiguously qualified homosexuality as a mental disorder. Many commentators have coordinated this view with the predominance of psychoanalysis in the early post-war intellectual climate (e.g. Friedman and Downey 1998). Apparently many of the then psychoanalysts disagreed with Freud on the topic since Freud did *not* unambiguously consider all homosexuals to be mentally ill. In his famous letter to the mother of a homosexual man, he stated that "homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness" (Freud 1960 [1935], p. 423).[5] Another important difference between Freud and mid-twentieth-century psychoanalysts related to their views on the need for, and the prospects of, therapeutic interventions. Freud was remarkably clear on this topic:

[5]Elsewhere, however, he spoke of it as an "aberration" and an "abnormality" (Freud 1960 [1905]).

"In general to undertake to convert a fully developed homosexual into a heterosexual is not much more promising than to do the reverse, only that for good practical reasons the latter is never attempted" (Freud 1955 [1920], p. 32). For some reason, the therapeutic optimism of post-war psychoanalytic psychiatrists was markedly greater than Freud's, and many of them were actively engaged in so-called "conversion therapy" when the controversy over homosexuality erupted in the early 1970s (see, e.g. Bieber et al. 1962).

So why was it fashionable for psychoanalysts to consider homosexuality as a pathological condition? In fact many of them firmly believed that heterosexuality is a natural norm—again disagreeing with Freud. In the words of one of them, Irving Bieber: "humans are biologically programmed for heterosexuality" (Bieber 1987, p. 425). Traumatizing experiences and disturbed parent-child or peer relationships were thought to dislocate this "natural urge", thus resulting in abnormal sexual behavior. Psychoanalysts like Bieber indeed defined illness by its antecedents, and since their research supposedly showed these antecedents to be pathological, psychoanalysts could not but conclude that homosexuality was an illness. Coincidentally, the claim that heterosexuality is a natural norm was also defended by non-psychoanalysts in the 1970s. As Scholl and De Block relate, in this volume, the philosopher Christopher Boorse thought it reasonable to consider homosexuality as a disease, even though he was quick to add that such a claim would not have much practical significance (Boorse 1975, p. 63). In his view, homosexuality could be conceptualized as a disease because it conflicts with "one normal function of sexual desire," which is "to promote reproduction" (63). We will take a close look at this last claim in the final section of this chapter.

Throughout the 1960s, the illness view came under increasing attack from a variety of actors, including gay activists and public intellectuals. Judd Marmor, for example, an outspoken opponent of the psychoanalytic view, put it this way: "It is our task as psychiatrists to be healers of the *distressed*, not watchdogs of our social mores" (Marmor 1973, p. 1209). Critics of the illness theory of homosexuality put forward a number of arguments—some of which were reminiscent of the work of early European sexologists, including Magnus Hirschfeld and Havelock Ellis. First of all, they claimed that homosexuality was biologically natural. Marmor, for example, paraphrased "an eminent biologist" saying "human homosexuality reflects the essential bisexual character of our mammalian inheritance" (1209).[6] Secondly,

[6]Marmor obviously referred to the work of the American ethologist Frank A. Beach, who co-authored the classic *Patterns of Sexual Behavior* in 1951. Here the authors indeed made reference to "the bisexuality of the physiological mechanisms for mammalian mating behaviour" and a "fundamental mammalian heritage of general sexual responsiveness" (Ford and Beach 1951, pp. 258–9). By summarising evidence of same-sex sexual behaviour in humans and other animals, they also hoped to strengthen the view later defended by Marmor, i.e. that homosexuality should not be seen as some kind of physical abnormality, nor as a perversion of the sexual instinct. In the glossary of the book, the authors define "perversion" as "[a] term without scientific meaning. It refers to any form of sexual activity which a given social group regards as unnatural and abnormal. Activities that are classified as perversions by one society may be considered normal in another" (283).

they argued that even if heterosexuality would be a natural norm, then it would not follow that homosexuality is an illness. Celibacy and vegetarianism can also be considered as "violations" of a natural norm, Marmor argued, and yet we do not generally see them as illnesses. Thirdly, history and daily experience teach us that not all homosexuals are, or were, ill. Most of the evidence brought forward by psychoanalysts came from clinical practice, and to their critics it was obvious that such evidence could not be representative for the whole population of homosexuals (Torrey 1974). Fourthly and finally, even if the overwhelming majority of contemporary homosexuals would turn out to have psychological problems, then the question would be whether they do so because of some inherent pathology, as psychoanalysts maintained, or because of the oppressive power of a homophobic society (Gold 1973). The latter position was defended, at least implicitly, by the editors of DSM-I, and it matches the view that Scholl and De Block attribute, in this volume, to the French philosopher Georges Canguilhem. Basically, these authors take Canguilhem's analysis of the concept of normality to imply that some conditions, such as homosexuality, are diseases in some social environments, while they are normal in other environments. A homophobic society, then, is what transforms homosexuality into a disease.

By setting up arguments to show that homosexuality was neither abnormal nor an illness, Marmor provided fuel to the work of a variety of gay activist groups. From 1970 onward, some of these groups started protesting at the annual meetings of the American Psychiatric Association, where leading psychoanalysts presented their evidence to show that homosexuality was a truly pathological condition (Bayer 1981). In the midst of this dispute between activists and psychoanalysts, a young psychiatrist, Robert Spitzer, stepped up as a go-between. Spitzer was originally convinced that homosexuality did belong in DSM. Various events, however, including his attending an informal meeting of the "Gay-PA"—a secret group of homosexual APA members later known as the Association of Gay and Lesbian Psychiatrists—made him realize that many homosexuals were actually healthy and high-functioning individuals, who were often satisfied with their sexuality (Bayer 1987). Soon afterward he drafted a first compromise: homosexuality as such was to be removed from DSM, and to be replaced by "sexual orientation disturbance," which included those individuals troubled by their own sexual orientation (later rebranded as "ego-dystonic homosexuality," only to be removed altogether from DSM-III-R in 1987).

One of the important mainsprings behind this proposal was an attempt to define the concept of mental disorder. In Spitzer's view, such definition should entail two elements: "[I]t must either regularly cause subjective distress, or regularly be associated with some generalized impairment in social effectiveness or functioning" (Spitzer 1973, p. 1215). Many homosexuals did not fulfill either of these criteria, and therefore they should not be considered mentally ill. Importantly, Spitzer did not consider homosexuality as normal either: "No doubt, homosexual activist groups will claim that psychiatry has at last recognized that homosexuality is as

'normal' as heterosexuality. They will be wrong" (1216). To meet the expected objections of the psychoanalysts, he suggested to describe homosexuality as "an Irregular Form of Sexual Development" that is "suboptimal" when compared to heterosexuality. Yet suboptimal behavior, he argued, need not necessarily constitute disorder, as was shown in the examples of celibacy, racism, religious fanaticism, or vegetarianism, which he jokingly describes as "unnatural avoidance of carnivorous behavior" (1215; see also Spitzer 1981).

Despite its obvious diplomatic qualities, Spitzer's proposal met with fierce protest, and for different reasons. Activists expressed anger about the contention that homosexuality would not be as "valuable" as heterosexuality, while psychoanalysts, in their turn, repeatedly called on the APA officials not to capitulate to political pressure. Nevertheless, the proposal to eliminate homosexuality from DSM (and replace it with "sexual orientation disturbance") was unanimously accepted by the APA's board of trustees in December 1973. Following further protest from a number of leading psychoanalysts, the APA then organized a referendum: Should homosexuality be in the APA nomenclature or not? Spitzer's proposal was accepted by 58 % of the APA membership, and consequently homosexuality as such was deleted from the seventh printing of DSM-II in 1974. According to some commentators, the referendum was a public relations disaster for the APA. Devising a psychiatric nomenclature turned out to be a matter of politics rather than science (Shorter 1997; Kirk and Kutchins 1992).

Despite this sobering history, many of the then architects of DSM continued (and continue) to claim that the manual, and certainly its third edition, was the first real evidence-based and scientifically sound psychiatric classification. Until recently, Robert Spitzer stood by such views (see, e.g. Spitzer 2001). For some reason, however, he seems to have changed his mind. In an interview from early 2007, he conceded that the DSM-III task force did not always rely on research evidence. When asked about how new disease categories were included in the nomenclature, the following conversation ensued:

> Spitzer: You have to have a lobby, that's how. You have to have troops.
> Fink [one of the interviewers]: So it's not a matter of…
> Spitzer: Having the data? No.
> Fink: It's nothing to do with science then, and nothing to do with evidence?
> Spitzer nodded (Shorter 2008, p. 168).

The interviewers seem to have been shocked at this "confession," but in a sense Spitzer's honesty should not really surprise us. Immediately after the APA board's decision to delete homosexuality from their manual, the psychoanalyst Irving Bieber publicly asked Spitzer whether he would consider deleting other sexual deviations from DSM, too. Spitzer answered: "I haven't given much thought to [these problems] and perhaps that is because the voyeurs and the fetishists [unlike the homosexuals] have not yet organized themselves and forced us to do that" (quoted in Bayer 1987, p. 397; see also Bieber 1987, p. 433).

5 On Being Consistent: Defining the Paraphilias in DSM-III and DSM-IV (1980–2012)

In May 1974, immediately after the controversy over homosexuality, the American Psychiatric Association appointed Spitzer chair of the new Task Force on Nomenclature and Statistics, and his first decision was to assemble a completely new core committee. Unlike the task force of DSM-II, all members of Spitzer's group were in favor of biological psychiatry, rather than psychoanalysis, and a symptom-based rather than etiologic approach to diagnosis (Shorter 1997).

As a consequence, DSM-III, first published in 1980, differed in many ways from its predecessor (Mayes and Horwitz 2005). One novelty was the introduction of diagnostic criteria—in order to be eligible for a particular diagnosis, the patient had to fulfill a specific number of such criteria. Together with a significant increase in the number of disease categories,[7] the inclusion of these criteria more than doubled the size of the manual's previous edition. Another interesting novelty was an attempt, on the very first pages of the manual, to define the concept of mental disorder:

> In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (APA 1980, p. 6)

As I explained earlier, homosexuality was deleted from DSM-II mainly because it did not fit in with this definition of mental disorder that, according to Spitzer (1981), was also employed, though implicitly, when constructing the first two editions of the manual. This implicit definition was based on two criteria: distress and disability (or functional impairment). Because many homosexuals were not in any way distressed by their sexual orientation, and since most of them appeared to function very well, both socially and professionally, it was clear that homosexuality per se should be excluded from the manual.

But what about the other sexual deviations, such as voyeurism or sexual sadism? What evidence was there to believe that these conditions, unlike homosexuality, did cause significant distress or disability? Spitzer himself believed that the status of some of the perversions, particularly voyeurism and fetishism, as mental disorders was "questionable," and he was aware that many expected him, following the APA decision about homosexuality, to delete these conditions from the manual (Spitzer 1981, p. 406). It is possible that these reservations led him to conclude the manual's definition of mental disorder with the following caveat: "When the disturbance is limited to a conflict between an individual and society [which, according to DSM-I,

[7]The total number of diagnostic categories increased from 106 in DSM-I to 182 in DSM-II, and again to 265 in DSM-III. The penultimate edition, DSM-IV (APA 1994), contained no less than 297 different categories (Mayes and Horwitz 2005, p. 251).

was certainly the case for many sexual deviations], this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder" (APA 1980, p. 6); the very same statement was repeated more or less verbatim in all subsequent editions of DSM.

Still, all of DSM-II's sexual deviations simply reappeared in DSM-III, if only under a different name ("paraphilias"), and in a different diagnostic class ("psychosexual disorders"). The term "paraphilias" was preferred to the old "sexual deviations" "in that it correctly emphasizes that the deviation (para) is in that to which the individual is attracted (philia)" (APA 1980, p. 267). The new name was not just more accurate, however; it also sounded more scientific and less moralistic or judgmental (Bullough 2003). The manual went on with a list of the usual suspects: fetishism, transvestism, zoophilia, pedophilia, exhibitionism, voyeurism, sexual masochism, sexual sadism, and some "atypical" paraphilias (e.g. frotteurism and necrophilia). According to DSM-III, the common denominator of all paraphilias is "that unusual or bizarre imagery or acts are necessary for sexual excitement," involving "sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity" (261).

It is noteworthy that the general description accompanying this class of disorders again reflected Spitzer's reservations to include them in the manual. First of all, and contrary to his aversion to all things related to theory and tradition, he noted that "the Paraphilias included here are, by and large, conditions that *traditionally* have been specifically identified by previous classifications" (APA 1980, p. 267; italics mine). Secondly, Spitzer seemed to be doubtful about how to fit in the paraphilias with DSM-III's general definition of mental disorder. He himself noted that "these individuals [with a paraphilia] assert that the[ir] behavior causes them no distress" (267) (the first criterion in the definition). Moreover, he could not but concede that at least some of them appeared to function well, both socially and professionally (the second criterion in the definition). So why did DSM-III continue to present sexual deviations as mental disorders?

DSM-III explicitly acknowledged that there may well be a continuum between sexual health and sexual deviance (APA 1980, p. 6), and that paraphilic fantasies or acts could be part of a normal sexual repertoire and a healthy sexual relationship. It recognized, for example, that "women's undergarments and imagery of sexual coercion are sexually exciting for many men" and that "masochistic fantasies of being bound, beaten, raped or otherwise humiliated may facilitate sexual excitement in some [normal] individuals" (267 and 273–274). Diagnostic criterion A stipulated, for all paraphilias, that it was only when such imagery or fantasies became "insistently and involuntarily repetitive," "repeatedly preferred or exclusive," or even "necessary" in order to achieve sexual gratification, that it was to be considered part of a proper paraphilia. In sum, what made an unusual sexual behavior or desire (or fantasy) a mental disorder, according to DSM-III, was its exclusivity and its repetitivity in arousing sexual excitement. Curiously, DSM-III seemed to

follow a Freudian characterization of the paraphilias here,[8] thereby *ignoring* its very own definition of mental disorder, which it did use to legitimate the removal of homosexuality[9] (Primoratz 1997; Silverstein 1984). The general definition of mental disorder in DSM-III did not mention a word about repetitivity.

In a paper published shortly after DSM-III, Spitzer (1981) provided an alternative account of the decision to keep the paraphilias listed as mental disorders. His account focused on the importance of impairment, rather than distress or repetitivity. As Spitzer said: "we decided that even in those cases where there was no distress, the behavior represented impairment […] in the important area of *sexual* functioning" (Spitzer 1981, p. 406, italics in original). Fetishists, zoophiliacs, and voyeurs were considered mentally ill because their behaviors and desires impaired them to engage in affectionate and reciprocal relationships; and somehow such relationships were valued more highly than a relationship between a human being and an animal, or between a human being and an inanimate object. As Spitzer concluded his paper: "I guess that deep in our bones we [psychiatrists] must believe that sex is more fulfilling when it is between human beings" (414). This argument was then and remains debatable, as I will argue later on, but it was at least compatible with the DSM's own definition of mental disorder. For some reason, however, later editions of the manual tended to ignore this specific argument, as they focused more or less exclusively on the role of distress, and introduced new disorder conditions that were not part of the general definition.

Spitzer and his colleagues were quick to spot some of the inconsistencies of DSM-III in dealing with the sexual deviations, and partly corrected them in a major revision, which was published in 1987 as DSM-III-R. One of the important novelties in DSM-III-R was that considerations of exclusivity and repetitivity were no longer deemed essential in diagnosing the paraphilias. Such considerations were replaced by two basic diagnostic criteria that applied to all paraphilias listed.

[8]In his early work, Freud indeed focused on the exclusivity of particular sexual behaviors and desires to distinguish between normal sexuality and pathological sexuality. Thus he claimed, in his *Three Essays on the Theory of Sexuality*: "In the majority of cases we are able to find the morbid character of the perversion not in the content of the new sexual aim but in its relation to the normal. It is morbid if the perversion does not appear beside the normal (sexual aim and sexual object), where favourable circumstances promote it and unfavourable impede the normal, or if it has under all circumstances repressed and supplanted the normal; the *exclusiveness* and *fixation* of the perversion justifies us in considering it a morbid symptom" (Freud 1960 [1905], p. 22; italics in original). .

[9]In the annotated listing of the differences between DSM-II and DSM-III (Appendix C; APA 1980, p. 380), Spitzer cited some evidence to warrant the exclusion of homosexuality: "The crucial issue in determining whether or not homosexuality per se should be regarded as a mental disorder is not the etiology of the condition, but its consequences and the definition of mental disorder. A significant proportion of homosexuals are apparently satisfied with their sexual orientation, show no significant signs of manifest psychopathology […], and are able to function socially and occupationally with no impairment. If one uses the criteria of distress or disability, homosexuality per se is not a mental disorder."

Criterion A required the presence of "recurrent intense sexual urges and sexually arousing fantasies, over a period of at least six months," while Criterion B stipulated that "the person has acted on these urges, *or* is markedly distressed by them" (APA 1987, pp. 282–90; italics mine). There was no mention of impairment or disability in the criteria. The latter part of Criterion B, about distress, could be seen as an attempt to fit the paraphilias into the manual's general definition of mental disorder. Surprisingly, however, and contrary to this definition, distress was considered as sufficient but not necessary for a condition to qualify as a paraphilia. According to DSM-III-R, some urges and fantasies needed only be acted on to indicate disorder, even if they did not cause any distress to the individual. Repeated sexual behaviors, then, or even a single sexual behavior, could constitute a mental disorder. This conclusion was rather counter-intuitive, and it was certainly at odds with an intellectual heritage that dates back to the work of Krafft-Ebing, and his distinction between sexual perversities and sexual perversions. Krafft-Ebing once noted that "[t]he nature of the act can never, in itself, determine a decision as to whether it lies within the limits of mental pathology […]. The perverse act does not per se indicate perversion of instinct" (Krafft-Ebing 1965 [1886], p. 501).

In DSM-IV, published in 1994, the above inconsistency was resolved by omitting the first part of criterion B. This criterion now required, for all paraphilias, only that "the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA 1994, p. 523). Failing distress or impairment, unusual sexual fantasies, urges or behaviors were considered non-pathological. They may well be seen as instances of criminality or eccentricity, but not as disorders.

Even though the DSM-IV's wording of the diagnostic criteria of paraphilia was by far the most consistent with the DSM's own definition of mental disorder, its amendment was short-lived. In a later editorial, the editors of DSM-IV-TR (APA 2000), Michael First and Allen Frances, related how they were attacked by "conservative religious groups" who "*mistakenly* worried that the change meant DSM-IV did not recognize pedophilia as a mental disorder unless it caused distress" (First and Frances 2008, p. 1240; italics mine). In the view of First and Frances, the editors of DSM-IV *did* think pedophilia was a mental disorder even if it caused no distress—a statement that is obviously incorrect. As I just explained, DSM-IV stipulated that child offenders should not be considered mentally ill unless their offenses caused them distress or impairment in functioning. Yet the editors of DSM-IV-TR explicitly speak of a "misinterpretation" of DSM-IV (1240). In the end, DSM-IV-TR simply reverted to the (inconsistent) diagnostic criteria for paraphilia in DSM-III-R. For those paraphilias that may involve non-consenting victims (e.g. pedophilia) the authors simply reintroduced the old Criterion B, which required either acting on unusual urges or fantasies, *or* experiencing distress about these urges or fantasies (APA 2000, p. 566). For the remaining paraphilias (e.g. fetishism) the diagnosis is made if the urges, fantasies, or behaviors cause distress or impairment in functioning.

Elsewhere, and adding to the confusion, the editors of DSM-IV-TR also emphasized that sexual offenders should not be considered mentally ill simply because they have committed sexual offenses. They concluded: "Defining paraphilia based on acts alone blurs the distinction between mental disorder and ordinary criminality" (First and Frances, 2008, p. 1240). More recently, First has argued that, in order to avoid such confusion, it is absolutely essential to take into account the nature of the fantasies and urges preceding or accompanying the acts. Thus he remarked: "A paraphilia is […] fundamentally a disturbed internal mental process (i.e., a deviant focus of sexual arousal) which is conceptually distinguishable from its various clinical manifestations" (First 2010, p. 1240). First's recommendation to DSM-5 is to revive a forgotten aspect of the DSM's general definition of mental disorder. Ever since DSM-III, this definition indeed specifies that a condition can only qualify as a disorder if it causes distress or impairment *and* if it is considered "a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (APA 2000, p. xxiv). Unfortunately neither First nor any of the editions of DSM tell us how to define such underlying dysfunction, or how it is to be ascertained. What part of the mind would be dysfunctioning in the case of the paraphilias, for example? The answer to that question depends on how one defines the concept of function, and how one understands the function of sexuality. I will return to this issue in the final section of this chapter.

6 DSM-5, Paraphilias, and Paraphilic Disorders

Looking back, the first four editions of the *Diagnostic and Statistical Manual of Mental Disorders*, perhaps excluding DSM-II, at least allowed for the possibility that some paraphilias were not mental disorders. Both in the manual and elsewhere, editors reminded us that not all unusual sexual behaviors and desires should be considered as pathological. This view is in line with a growing literature suggesting that many paraphilias are actually harmless and hence do not necessitate any kind of intervention, whether legal or psychiatric. Studies have shown that people with paraphilias are often of above-average intelligence and social status (McConaghy 1997); that they enjoy their sexual behaviors and desires; and that actually such fantasies etc. are reported by a significant number of healthy subjects (Hinderliter 2010). On the other hand, there is also a sizable literature about putative genetic or hormonal defects and anomalous brain development in people with paraphilia (Blanchard et al. 2006); and about comorbidity with other mental disorders and various medical conditions (Kafka and Hennen 2002; Gijs 2008).

The fifth edition of DSM seems keen on making this distinction between "harmless" and "harmful" paraphilias more explicit. Early on in the revision process, the work group devoted to revising the subclass of the paraphilias in DSM-5

announced a consensus that paraphilias are not "*ipso facto* mental disorders" and that by themselves they would "not automatically justify or require clinical intervention" (APA 2012; italics in original). Therefore, the work group proposed to differentiate between paraphilias and paraphilic disorders: "A Paraphilic Disorder is a paraphilia that is currently causing distress and impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others in the past. A paraphilia is a necessary but not a sufficient condition for having a Paraphilic Disorder" (APA 2012).

Even though DSM-5 explicitly distinguishes between deviance and disorder, it makes the very same mistake it has often made in the past. Like all past editions of the manual, excluding DSM-IV, the proposal of the work group suggests indeed that acting on unusual sexual urges is relevant for psychiatric diagnosis: "[A] paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others in the past" is considered as a paraphilic disorder (APA 2012). In this view, acting on unusual sexual urges determines the difference between a (harmless) paraphilia and a (harmful) paraphilic disorder. Hence, in some cases of pedophilia, sadism, voyeurism, exhibitionism, and frotteurism, the only difference between a non-disordered individual with a paraphilia and an individual with a paraphilic disorder is that the latter has had victims. The work group fails to explain, however, why and how harming others would amount to more than merely immoral or criminal behavior. Why would sexual offenses be mental disorders?

7 Arguing Against the DSM

Are paraphilias mental disorders, or are they not? To answer this question, I have scrutinized the presentation and discussion of unusual sexual behaviors and desires in the consecutive editions of the *Diagnostic and Statistical Manual of Mental Disorders*, from its very first edition in 1952 up until the freshly printed DSM-5. Since 1980, the manual boasts an elaborate definition of the concept of mental disorder—a definition it can fall back on to decide whether specific (sets of) mental or behavioral states are to be considered as mental disorders. At first glance, the DSM definition of mental disorder includes three basic conditions: distress, impairment (or disability), and dysfunction. It would seem relatively easy, then, to answer the question whether paraphilias are mental disorders or not. We just need to check whether they fulfill the relevant conditions.

Unfortunately there are a number of difficulties in following this strategy. First of all, many editions of the manual have smuggled in new disorder conditions while discussing the paraphilias—conditions that are nowhere to be found in the definition of mental disorder in the manual's general introduction. In this chapter I provided two examples of such ad hoc conditions: the condition of repetitivity in DSM-III, and the condition of acting in DSM-III-R, DSM-IV-TR, and DSM-5. The presence of these conditions conveys the impression that some juggling was needed to keep

the paraphilias listed as mental disorders.[10] Secondly, some of the conditions in question are rather vague. I explained earlier, for example, that it is unclear what it means for a mental or behavioral state to be a manifestation of an underlying dysfunction. What is a dysfunction anyway? And how does it differ from impairment ? The manual itself remains utterly silent on this issue. In the remainder of this section, I will focus on this condition of dysfunction, which has been taken up by some of the past editors of DSM (Spitzer 2005; First 2010), and I will argue that in at least some of the interpretations of this condition, paraphilias need not be dysfunctions.

Ever since its third edition, the DSM has stipulated that in order for a "behavioral or psychological syndrome or pattern" to be a mental disorder, it must not only be associated with distress or impairment, but also with "a behavioral, psychological, or biological dysfunction" (APA 1980, p. 6). The latter condition is extremely important, as it allows us, still according to DSM-III, to differentiate deviance from disorder: "Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual" (APA 1994, p. xxxi). As explained earlier, none of the editions of DSM provides any definition of the concept of dysfunction. Spitzer (1999) acknowledged this lacuna and suggested adoption of Jerome Wakefield's evolutionary interpretation of the concept of dysfunction in the construction of DSM-5. In Wakefield's view, the concept of mental disorder is intrinsically hybrid, in that a disorder judgment requires both a value judgment that there is harm (more or less equivalent to the notion of distress in DSM) and a scientific judgment that there is a dysfunction. Wakefield (1992, p. 384) then defined dysfunction as "the inability of some internal mechanism to perform its naturally selected function." Depression, for example, can be seen as a mental disorder because it is a harmful dysfunction of our capacity to experience low mood—a mental mechanism that evolved to allow us to deal with various adverse life events (see, e.g. Price et al. 2007).

Spitzer attempted to apply this concept of dysfunction to the paraphilias in a book devoted to a critique of the sexual and gender diagnoses of DSM-IV-TR (Karasic and Drescher 2005). There he argued that sexual arousal has a specific evolutionary function, which consisted of "facilitating pair bonding which is facilitated by reciprocal affectionate relationships" (Spitzer 2005, p. 114). In Wakefield's terminology, the paraphilias represent a failure of sexual arousal to perform its naturally selected function, because people with a paraphilia are unable to be sexually aroused by

[10]Moreover, I have already explained that the ad hoc condition of acting cannot, in itself, be considered a sufficient condition for an unusual sexual desire or urge to be a disorder. The editors of DSM-IV-TR indeed admitted as much themselves, when they claimed that "[d]efining paraphilia based on acts alone blurs the distinction between mental disorder and ordinary criminality" (First and Frances 2008, p. 1240). Some would probably go one step further to argue that, for most paraphilias, the condition of acting cannot even qualify as a *necessary* condition. In Krafft-Ebing's view, for example, one can be a paraphiliac without ever realizing any of one's unusual sexual desires or fantasies (Oosterhuis 2000).

another human being or are unable to engage in a mutual loving relationship. Curiously, Spitzer's wording reminds us of an argument that he already put forward in 1981, when defending the decision of the DSM-III core committee to keep the paraphilias in the manual. At that time, he said: "we decided that even in those cases [of paraphilias] where there was no distress, the behavior represented impairment […] in the important area of *sexual* functioning" (Spitzer 1981, p. 406, italics in original). If impairment and dysfunction are indeed identical disorder conditions, why are they systematically and explicitly distinguished in all editions of DSM since 1980?

More importantly, however, one wonders what to think of Spitzer's evolutionary argument that the sole function of sexual arousal is to facilitate pair bonding. In my view, his argument is questionable, and for two reasons. First, pair bonding can be facilitated in many ways, including, but most certainly not limited to "reciprocal affectionate relationships" (Spitzer 2005, p. 114). Sexual arousal can indeed serve to form and maintain pair bonds, but human history and the animal sciences teach us that this connection can be established via many intermediaries, including various paraphilias such as pedophilia, sadism, masochism, and transvestism. Secondly, Spitzer's argument ignores the extensive literature on the many different functions of sexuality and sexual arousal (see, e.g. Symons 1981; Roughgarden 2004). According to evolutionary biologists, any one organismal trait can have several evolutionary functions, and it is very likely that the same is true for sexual arousal. Recent work in behavioral ecology, for example, distinguishes at least half a dozen potential evolutionary functions of animal homosexuality, some of which are not directly related to pair bonding. Thus it would serve to communicate one's rank within a so-called dominance hierarchy, i.e. a ranking system which determines access to resources and mates (Vasey 1995); or it would help to reduce tension and facilitate reconciliation among group members (Bailey and Zuk 2009), and even to control population size (discussed in Vasey and Sommer 2006). Unfortunately, there is very little research on the potential function(s) of unusual sexual behaviors and desires other than homosexuality,[11] but it is possible that at least some of them may turn out to be functional, rather than dysfunctional. If so, then they cannot be considered as disorders, at least when "disorder" is defined as dysfunction, and "dysfunction" in its turn is defined as the failure of an evolved mental mechanism.

8 Conclusion

Are paraphilias mental disorders, then, or are they not? The cautious answer to this question is that it depends on what conditions we associate with the concept of mental disorder. In the end, the DSM definition of mental disorder stands on two relevant conditions: distress and dysfunction. I have argued that it is at least unclear

[11] Aronsson (2011) is an intriguing exception, but it is based on the assumption that paraphilias are biologically dysfunctional sexual preferences.

whether all unusual sexual behaviors and desires fulfill both of these conditions. By distinguishing between (non-disordered) paraphilias and paraphilic disorders, DSM-5 acknowledges this argument. Like most previous editions of the manual, however, it fails to explain where and how we should draw the line between both. Why are we to regard some unusual sexual behaviors and desires as disorders, and others as normal variations of human sexuality?

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