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SPECIAL SECTION: DSM-5: CLASSIFYING SEX

Heteronormativity and Repronormativity in Sexological "Perversion Theory" and the *DSM-5*'s "Paraphilic Disorder" Diagnoses

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Abstract The move from "paraphilias" to "paraphilic disorders," where only the latter constitute mental disorders, has been hailed as a major change to the conception of non-normative sexualities in *DSM-5*. However, this is a claim that has been criticized by numerous activists and doctors working for removal of *all* diagnoses of so-called sexual disorders from the APA's manual. This article, written from a critical humanities, queer theory-inflected perspective, examines the historical and ideological grounds underlying the inclusion of the newly branded "paraphilic disorders" in *DSM-5*. It argues that the diagnosis does nothing to overturn the conservative and utilitarian view of sexuality as genitally oriented and for reproduction that has colored sexological and psychiatric history. It suggests that despite homosexuality no longer being classed as a disorder, an implicit heteronormativity continues to define psychiatric perceptions of sexuality. In sum, this article proposes that (1) the production of the field of psychiatric knowledge concerning "perversion"/"sexual deviation"/"paraphilia"/"paraphilic disorder" is more ideological than properly scientific; (2) the "normophilic" bias of the *DSM* is a bias in favor of heteronormativity and reproduction; and (3) some sexual practices are valued above others, regardless of claims that the presence of a paraphilic practice itself is no longer a criterion for a diagnosis of mental disorder.

Keywords Paraphilias · Paraphilic disorders · Reproduction · Heteronormativity · Repronormativity · DSM-5

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Introduction

The pathologization of non-normative sexual practices, originally termed "deviations" or "perversions," has its foundations in the European alienism associated with names such as French doctors Claude François Michéa (1815–1882) and Paul Moreau de Tours (1844–1908). Toward the end of the nineteenth century, Austro-German physician Richard von Krafft-Ebing (1840–1902), the leading proponent of what would become "sexology" (*Sexualwissenschaft*), popularized the idea of sexual perversion as a mental and social disorder (Krafft-Ebing, 1886). He argued that perversion was one symptom among many "degenerate" traits indicative of a morally, mentally, and physiologically sick individual, and that the presence of such individuals in a population constituted a threat to the health of that society, via the mechanisms of both environmental corruption or contagion and the hereditary handing on of mental and moral flaws. Probably the earliest and most famous critic of this kind of sexological perversion theory was Sigmund Freud (1856–1939), who wrote in 1905 that, even in the case of those who practice the most "extreme perversions," "we should not be too ready to assume that people who act in this way will necessarily turn out to be insane or subject to grave abnormalities of other kinds" (Freud, 1953–1974, p. 161). In this way, Freud, according to Foucault (1990, p. 119), "rigorously opposed the political and institutional effects of the perversion-heredity-degeneration system."

Twentieth-century Anglo-American psychiatry changed the technical language in which "perversion" was discussed, eventually adopting "paraphilia" (which may be most accurately rendered as meaning "love for other/marginal objects"), after a suggestion by Wilhelm Stekel (1868–1940) made in German in 1908. "Paraphilia" is thought to have been used for the first time in the English language in 1934 by psychiatrist Benjamin Karpman, 1886–1962 (Nobus, 2006, p. 6), The intentions behind Stekel's recommendation to adopt the term

"paraphilia" were to free psychiatric terminology from its proximity to sexological degeneration theory, to distinguish it from the psychoanalytic lexicon which retained the concept of "perversion," and also to reject the originally religious implications of the term "perversion" as a moral "turning aside" from the path of righteousness. And yet, despite "paraphilia" being available since the early twentieth century, *DSM-I* (1952) and *DSM-II* (1968) chose the term "sexual deviation" (a direct inheritance from Michéa's tract, *Déviations de l'appetit vénérien*, 1849) for what would eventually become "paraphilia" in the 1980 *DSM-III*. In the words of one of the most important U.S. writers on paraphilia of the late twentieth century, John Money (1921–2006), "paraphilia" was intended to be "a biomedically impartial synonym for the morally judgmental term 'perversion'" (Money & Lamacz, 1989, p. 17).

If the adoption of the term "paraphilia" by the APA in 1980 was indeed intended to destigmatize what had previously been called "deviation" or "perversion," it may appear that the change inaugurated in *DSM-5* of distinguishing "paraphilias" from "paraphilic disorders," where only the latter retains the status of mental disorder, marks a paradigm-shifting moment in this assumed narrative of progressiveness. A factsheet produced by the APA states that

> In the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), paraphilic disorders are often misunderstood as a catch-all definition for any unusual sexual behavior. In the upcoming fifth edition of the book, *DSM-5*, the Sexual and Gender Identity Disorders Work Group sought to draw a line between atypical human behavior and behavior that causes mental distress to a person or makes the person a serious threat to the psychological and physical well-being of other individuals. (APA, 2013a)

However, this is a claim that has been criticized by numerous activists and doctors, most prominent among them Charles Moser and Peggy Kleinplatz (Moser, 2009; Moser & Kleinplatz, 2002, 2006). A stated principle of the *DSM* revision process is that "all changes proposed for the text are to be supported by empirical data" (Shindel & Moser, 2011, p. 928). Moser's and Kleinplatz's calls to remove these diagnoses altogether, rather than to find new terminology in which to couch them, are made on the grounds that they are the products of normative value judgments, filtered through medical authority, rather than scientifically proven forms of mental disorder.

In this article, intended primarily as a polemical position paper and a document for discussion, I will argue that the change that has been wrought in *DSM-5* is, at base, primarily a change in name and that the logic subtending the pathologization of "paraphilic disorders" remains consistent with that underlying the "paraphilias" in earlier editions of the Manual. A further argument is that both "paraphilias" and "paraphilic disorders," as conceptualized by the APA, lie on a continuum with the "deviations" and "perversions" that were pathologized in nineteenth-century European sexology, especially in terms of the reasons underlying their relegation to mental illness. Namely, I argue that the view of "good" sexuality that subtends APA thinking falls into the realms of what queer feminist legal scholar Franke calls "repronormativity,"[1] and queer theorist Edelman calls "reproductive futurism."[2] These terms describe a direction taken by normalizing social power, whereby sexual acts that may lead to reproduction are privileged above those that may not, and where sexuality is imagined as a utilitarian force having as its proper purpose the propagation of the species. This biological logic informs psychiatric conceptions of sexuality (whereas disciplines such as psychoanalysis, while not necessarily less problematical from a feminist or queer theoretical point of view, have a model of sexuality that is based on *desire*—acknowledged as an errant, irrational, non-normative force that is squeezed into the shape of genitality and heterosexuality by means of torturous, unnatural, and often traumatic developmental processes).[3]

In his article in this special section, Giami has argued that a shift can be perceived in the *DSM* diagnoses of abnormal sexuality from a focus on pathologizing non-reproductive sex (pre-*DSM-5*) to the pathologization of primarily non-consensual sex (in *DSM-5*). Were this the case, it would appear to herald an ethically welcome change, one that both feminists and those activists who argue for the validity of non-normative sexualities could wholly endorse. However, it is equally possible to argue, as I shall demonstrate below, that, while the bias against non-reproductive sexuality may be *less explicitly signaled* in the current edition of the *DSM* than in earlier ones, and concerns to safeguard harm to others more explicitly articulated, the worldview that guides ideas of "sexual normality" in *DSM-5* remains constant with the repronormative history of sexology and psychiatry. Perhaps the best known work of queer theory that offers a model to thematize the problem I raise with regard to *DSM-5* and its predecessors is Rubin's (1984) essay "Thinking Sex," in which she describes a "sex hierarchy" which features the "charmed circle vs. the outer limits" of sexuality, showing that outlying acts, practices, relationship types, and sexual styles are precisely those that look least like the kinds of sex that embody the official narrative of what sex is supposed to

[1] Franke (2001) asks: "Why is it that we are willing to acknowledge that heteronormative cultural preferences play a significant role in sexual orientation and selection of sexual partners, while at the same time refusing to treat repronormative forces as warranting similar theoretical attention?" (p. 184).

[2] Edelman (2004) writes that "reproductive futurism" is a "compulsory narrative" (p. 21) in which "the biological fact of heterosexual procreation bestows the imprimatur of meaning-production on heterogenital relations" (p. 13).

[3] Lacan (1977) is perhaps best associated with this view of desire. Despite the conservatism of many of his adherents, the spirit of his discourse is a rejection of "the delusional 'normality' of the genital relation" (p. 245). (For a discussion of the inherent queerness of the Lacanian psychoanalytic model of desire, see Dean, 2000).

be and *be for*. (So, "casual," "non-procreative," "SM"[4] sex practices lie at the outer limits of the circle that has "procreative," "in a relationship," "vanilla" practices near its center.)

As will be clear, my analysis in this article is a broadly Foucauldian one, insofar as I understand the character of the power of sexual science—the power to name, classify, and control—as a *normalizing* form of discursive power. That is, rather than arguing that psychiatry oppresses or censors sexual subjects in a straightforward way, I argue that psychiatry sorts them (us) into categories of "normal" and "abnormal," according to where we fit on a (sliding) scale of deviation. The two terms are not merely descriptive; rather, the weight of health is ascribed to the former while the weight of sickness accrues to the latter.

From "Diagnosing" to "Ascertaining"

The *DSM-5* sees a number of changes to the ways in which paraphilia may be considered as a mental disorder compared to earlier editions. Paraphilia has moved from the section on "Sexual and Gender Identity Disorders," where it was located in *DSM-IV-TR,* to its own separate section in *DSM-5.* Most significantly of course, the new edition makes the move of separating "paraphilia" off from the new diagnosis of "paraphilic disorder." A paraphilia is to be *ascertained* in clinical practice whereas a paraphilic disorder is *diagnosed*. This decision may, at first glance, appear as a triumph for the longstanding attempts on the part of fetish and BSDM activist groups, as well as certain medical doctors, to encourage the acceptance of "benign sexual variation," as Rubin (1984) terms it. Yet, many commentators have raised questions as to whether the distinction between "paraphilia" and "paraphilic disorder" is an improvement, or even represents a meaningful change to the *DSM-IV-TR*'s understanding. Fedoroff (2011), for example, points out problems with the notion of "ascertaining" something that is allegedly not, in and of itself, suggestive of a mental disorder and that therefore, arguably, should not appear in the *DSM* at all:

> The invention of ascertainment may be an attempt by the *DSM-5* work group to acknowledge that it is possible to have unconventional sexual interests that do not cause problems. If so, why list them in *DSM-5*? The problem is that the coined term ascertainment opens the door to permit the labeling of anyone with a sexual interest different from the examiner. (p. 239)

Fedoroff rightly raises the specter of (possibly unconscious) clinician bias in dealing with sexual tastes that are not close to the psychiatrist's own—or that do not fall in the center of the charmed circle.

Wakefield (2011) has described the paraphilia/paraphilic disorder distinction as "a terminological revision rather than an actual change in the criteria" (p. 203). Indeed, a comparison of the new diagnostic definition with the previous version is enlightening. A paraphilic disorder in *DSM-5* is defined as "a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed harm, or risk of harm, to others" (APA, 2013b, p. 685). In *DSM-IV-TR*, a paraphilia was diagnosed where the sexual behavior was shown to "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, 2000, p. 526). As has been suggested, there is not much difference between the two formulations, and the terms "distress" and "impairment" that are retained are highly imprecise, subjective, and cannot easily be scientifically measured. Moreover—and significantly—the degree to which such distress may be dependent upon an individual's internalization of the ideological value judgments of the society in which they live, rather than directly resulting from their sexual inclination, is crucial but impossible to determine. The APA's paraphilic disorder factsheet states that the person diagnosed in this way must "feel personal distress about their interest, not merely distress resulting from society's disapproval" (APA, 2013a). Yet, since people are often unclear about the sources of their own feelings of distress or anxiety, the distinction is largely meaningless.

Moser (2010) summarized this problem thus

> Most people seek mental health treatment because they are experiencing distress or impairment in some form. It is difficult to imagine that unusual sexual interests, denigrated by society, would not add to the distress or impairment resulting from an unrelated problem. Thus, the distinction between ascertaining a paraphilic interest and diagnosing a disorder could be meaningless in practice. (p. 1226)

It is telling that "ego-dystonic homosexuality" (homosexuality that is in conflict with the individual's sense of self) was eventually removed from the *DSM* once it had been decided that homosexuality was not, itself, a disorder, following the findings of Evelyn Hooker and others regarding the comparable "well-adjustedness" of heterosexual and homosexual populations (Bayer, 1987; Minton, 2002). Equally significantly, the fact that there has never been "ego-dystonic heterosexuality" or "ego-dystonic normophilia" underlines neatly the fact that the problem in the psychiatric worldview, despite claims to the contrary, is the non-normative *content* of the paraphilia, rather than the presence of distress.

To take this further, one can argue that, by rendering sexual variation a potential matter of mental disorder at all, one may elicit in the person experiencing desires that do not fit the norm a sense of understandable anxiety. The likelihood of a person with a paraphilia experiencing distress is thus quite high. Hence, the

[4] "SM" and "BDSM" are used interchangeably in this article. The former refers to "sadomasochism," while the longer compound acronym denotes the activities and identities involved in the following: Bondage and Discipline; Dominance and Submission; Sadism and Masochism.

paraphilic disorder may be the logical outcome of paraphilia ever having been a matter of psychiatry in the first place. The paraphilic-disordered person is a casualty of history. S/he is precisely the *product* of the diagnosis in a Foucauldian logic that understands institutional diagnostic discourse as *constitutive* rather than *descriptive* of abnormal subjects.

On Repronormativity

For both the father of modern sexology, Richard von Krafft-Ebing, and for psychoanalyst Sigmund Freud, who disagreed with many of his tenets, what defined unusual sexual practices as problematic and pathological were their qualities of *fixation* and *rigidity*. A perversion was pathological when it *replaced* rather than *accompanied* the possibility of sexual intercourse leading to reproduction. Davidson (2001) has demonstrated that the concept of "perversion" in nineteenth-century medical circles makes sense only if the human sexual instinct is understood as identical with the drive for reproduction, ensuring the preservation of the species. According to Moreau de Tours's understanding of the functioning of sexual instinct as *instinct génésique* (always pulling towards the opposite sex, because always seeking propagation of the species), everything except penetrative heterosexual intercourse would logically come under suspicion as abnormal or *contra naturam*. And, following a similar logic, in the 1980s, Money (1988) would define paraphilia as

> A condition occurring in men and women of being compulsively responsive to and obligatively dependent upon an unusual or personally or socially unacceptable stimulus, perceived or in the imagery of fantasy, for optimal initiation and maintenance of erotosexual arousal and the facilitation or attainment of orgasm. (p. 267)

Just as fixation on a perversion *to the exclusion of coitus* defined sexual sickness for the nineteenth-century sexologist, so for Money, a paraphilia was only pathological if a person was "compulsively responsive to and obligatively dependent upon" it. That same act, then, may be considered not unhealthy *if* it is one practice among many and—crucially—if it accompanies coitus. While replacing the nineteenth-century "*instinct génésique*" with the social environmental concept of the "lovemap" (a template in the mind/brain which can be "vandalized"), Money nevertheless retained intact the central importance of coitus as a signifier of mental health.

And, in line with this broad genealogical sweep, in 2010, Blanchard, head of the Paraphilia Subgroup for *DSM-5*, offered the following working paper definition of paraphilia: "A paraphilia is any powerful and persistent sexual interest other than sexual interest in copulatory or pre-copulatory behavior with phenotypically normal, consenting adult human partners" (quoted in Moser, 2011, p. 483). This is not the final wording that made it into *DSM-5*. Instead, the published phrasing is as follows: "the term *paraphilia* denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, consenting adult human partners" (APA, 2013b, p. 685). Writing, as I am, in the shadow of deconstruction, the rejected definition—the definition under erasure, which persists, trace like, in the history of the formulation of a text—tells us as much, or even more, about what is at stake than the final edited version. Blanchard clearly maintains the ideological privileging of genital and reproductive behavior as the guarantor of normality that has been seen throughout modern sexological history. The bias of this logic—which assumes that penetration is the cornerstone of sexuality (retained in the term "preparatory," even when the more explicit term "pre-copulatory" has been removed)—is heteromasculine, as well as implicitly repronormative.[5]

To illustrate that non-normative bodily practices (what the *DSM-5* terms "*anomalous activity preferences*," p. 685) are under scrutiny for the degree to which they differ from the aim of copulation (with its implied if not articulated link to reproduction), we can turn to the case study of "sexual masochism disorder." While some argue that sexual sadism and sexual masochism, practiced consensually, should have no place at all in the *DSM*, the Subgroup for *DSM*-5 used their separation of "paraphilia" from "paraphilic disorder" as a subtle tool to create the new psychiatric subject of the "sexual masochism-disordered" person, who is supposedly a distinct clinical entity from the non-pathological masochist. Within the category of masochism, a new qualification or diagnostic

[5] As a backdrop to this framing of *DSM-5*'s understanding of paraphilia/paraphilic disorder, one cannot ignore the fact that Blanchard was a controversial choice to head the work group, both for some clinicians and for some trans activists. Blanchard's theory that MtF "transsexualism" is a form either of heterosexuality, which he named "autogynephilia" (sexual arousal at the thought of oneself as a woman), or of displaced homosexuality, rather than an issue of gender identity, has a number of opponents from various fields and political standpoints (e.g., Moser, 2008; Serano, 2010), as well as a mixed demographic of staunch defenders, including both self-defined "autogynephilic transsexuals" (e.g., Lawrence, 2013) and clinicians (e.g., Bailey, 2003). The publication of Bailey's book *The Man Who Would be Queen* brought considerable public attention to the diagnosis but also drew criticism from trans activists and from some psychiatrists (e.g., Bancroft) (cited in Dreger, 2008, p. 391). Dreger (2008) wrote a long account in *Archives of Sexual Behavior* of the complex reaction to Bailey's book, which, in turn, has faced criticism from a number of clinicians (e.g., Nichols, 2008). A key objection to autogynephilia is that, while some individuals doubtless experience and report the phenomenology associated with it, it is a very bold logical—and ideological—leap to conflate *all* MtF trans identity with a paraphilia (autogynephilia) or a sexual orientation (homosexuality), and to assume that trans women are (deluded) men. It fails to respect many trans women's descriptions of their own experiences and identities. My own view is that the heteronormativity and repronormativity which I identify in *DSM-5*'s "paraphilic disorder" diagnosis are wholly in keeping with an institutional worldview in which trans men and women are not seen as "real" men and women, the latter still being defined primarily, if implicitly, by reproductive capacity.

tool is also added, namely the clinician is advised to indicate whether the patient's masochism is "with asphyxiophilia: if the individual engages in the practice of achieving sexual arousal related to restriction of breathing."[6] The technique of specifying one practice that needs special note is worthy of analysis.

My research on Money's writing on paraphilia (Downing, Morland, & Sullivan, 2015) revealed a rhetorical device he frequently deployed that presents a useful parallel with this clinical guideline. The device involves the singling out of specific—what would be thought of as extreme or unusual—practices, especially those with the potential for bodily harm or a death-linked content, and making them, by repetition and implication, stand metonymically for the threat of paraphilia *in general*. Indeed, it is not coincidental that it was Money who gave the technical name to "asphyxiophilia," as this is one of the practices he deploys in this particular way. One can see the *DSM*'s "asphyxia tick box" technique as a reminder of the extremes of paraphilia, a way of calling to mind the danger that non-normative sexual practices signify. And the threat of death, in the *DSM* as in Money's texts, signifies not just as the opposite of "health," but also the absence of "life-giving" or reproductive sex. Discussions of the appropriateness of taking sadism and masochism out of the *DSM* have included the objection, made by Krueger (quoted in Shindel & Moser, 2011, p. 928), a psychiatrist specializing in paraphilia, that "serious injuries and deaths have been associated with some BDSM practices," practices of asphyxia being obviously prominent among them. Relatedly, Krueger writes of the importance of retaining pathologization of "extreme forms of sadism and masochism…thereby distinguishing them from the more benign manifestations of what may well be a continuum of behaviors that merges with 'normal' sexual expression" (quoted in Shindel & Moser, 2011, p. 928).

Yet, as I have argued elsewhere with regard to recreational asphyxia (Downing, 2007), and as Shindel and Moser (2011) point out with regard to "bodily harm" more generally, physical risk is not policed to this degree in any sphere other than the sexual. I have shown how BDSM teacher and medical doctor Wiseman cautions against the practice of "breath play" since the risk of fatality can never be removed, while admitting that he is an active and enthusiastic judo practitioner—a martial art that, as Wiseman concedes, involves chokeholds carrying the same medical risks as asphyxiophilic practices. Similarly, Shindel and Moser (2011) write "By this criterion, one could argue that participation in other risky activities (e.g., skiing, bicycling, SCUBA diving, etc.) is a sign of a mental disorder" (p. 928). Clearly, taking the risk of death in the service of (non-normative) sex is to be understood differently than taking that risk in other contexts. Shindel and Moser also reveal the degree to which normative ideology is at play in *DSM-5* sexuality diagnoses, when considering the potential risk underlying normophilic practices. They point out that "Other sexual activities, including heterosexual and homosexual coitus, can result in serious health consequences as well (sexually transmitted infections, fractured penis, myocardial infarction)" (Shindel & Moser, 2011, p. 928); yet, such practices are not problematized in the *DSM*. A psychiatrist might object that a sexual paraphilia is a syndrome (pattern of coexistent symptoms) whereas fracturing one's penis during coitus is not; however, to accept this counterargument is to accept the psychiatric understanding of non-normative sexual acts (and the person who practices them) as qualitatively different from normative ones.

Since one criterion for a paraphilic disorder is that it involves "a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others," there is presumably no possibility of an "out" "asphyxiophiliac" escaping the label of mentally disordered, since risk of "personal harm" is an intrinsic feature of the preferred practice. Risk to self or other is also an intrinsic feature of heterosexual coitus itself. However, "normophilic" behavior does not need to be ascertained, much less diagnosed, in the clinical setting. The question of the exercise of normative power is, therefore, at stake once again. Only in the service of certain aims can bodily risk be undertaken that could prove harmful or damaging without the suspicion of mental disorder falling upon a person. Thus, the man who practices judo is not seen to be suffering from a mental disorder. The woman who risks the traumatic, potentially harmful, or even fatal, activity of giving birth is *definitely* not seen as mentally disordered (rather, she is the ideal normative female subject of the psychiatric universe). But the person for whom the risk of bodily harm in the service of a non-approved sexual pleasure is a risk worth taking is immediately labeled as mentally disordered.

It is important to add here that, of course, the same person may practice all three of the activities described above. Yet, the subjects who are most likely to come to the attention of psychiatrists are those whose practices take place at the outer margins of the "charmed circle." The person who practices his or her paraphilia in the marital bed, on a "part-time" basis, may well be able to stay within the bounds of the acceptably kinky, recalling Krueger's mention of "a continuum of behaviors that merges with 'normal' sexual expression." By contrast, the unmarried, promiscuous, or non-heterosexual paraphiliac, and the person who pursues their paraphilia *to the exclusion of other*, more acceptable, acts (fixation having been one key, technical criterion of perversion/paraphilia throughout its history as a clinical entity), is much more likely to be subject to a diagnosis of "paraphiliac disorder." That is, just as in Freud's day, the occurrence of intercourse may clinically *mitigate* the presence of a paraphilia.

[6] Fedoroff (2011) rightly points out that this does not clearly distinguish between those who are aroused by being asphyxiated and those who are aroused by asphyxiating others: "The proposed specifier 'asphyxiophilia' is inadequate, because it fails to distinguish between people who are aroused by being asphyxiated, those who are aroused by asphyxiating others, or those who are aroused by both."

Conclusion

According to Blanchard, *DSM-IV*'s definition of paraphilias was "a definition by concatenation" (quoted in Moser, 2011, p. 483). That is, it focused on listing types of sexual practice rather than on discursive description and definition. This is the model for which we can thank Money, among others. Money's response when approached by Spitzer for his suggestions for additions to *DSM-III-R* was to send in a list of the many paraphilias he had named. This model of "definition by concatenation" draws on and continues the nineteenth-century taxonomical trend of Krafft-Ebing and his fellow sexologists. But, crucially, it is in some ways a less freighted way of thinking about sexuality than both the working definition of paraphilic disorder that Blanchard would initially propose, and the definition that made it into *DSM-5*. Where the model of taxonomy at least stresses variation, Blanchard's definition overlays the field of sexuality with a heterosexist bias in defining "normal" sexuality as "behavior" that is "preparatory" to intercourse (suggesting that not only "paraphilic practices," but also, for example, erotic practices between lesbians that do not involve penetration of at least one partner's body, are not *real sex*.) Moreover, the mention of choosing "phenotypically normal" sexual partners risks being interpreted as a piece of transphobic logic, suggesting, as it does, that only cis-,[7] binary-gender-identified, or non-intersexed, persons are fit objects of erotic interest for the sexual subject, who is assumed to be "phenotypically normal" himself or herself, in a model in which bodily normativity, gender normativity, and normophilic sexual practices fit together like Russian dolls. Moreover, were it not still assumed that the purpose of sexuality is reproduction, the question of one's partner's "phenotypical normality" would be, practically speaking, irrelevant.

Thus, both the APA's understanding of paraphilia in general, and its specific pathologization of some practices of sexuality as "paraphilic disorders" in particular, rest on the same logic that has underpinned theorizations of "perversion" and "deviation" since the inception of modern sexual medicine: the belief that to be normal, sexuality should be genitally organized. Despite the many disclaimers that homosexuality is not (or, more correctly, is no longer) a disorder, sexuality in the DSM universe is always, implicitly at least, heterosexually organized. Heterosexuality and reproduction are thus the stubborn ghosts that haunt the *DSM*'s sexual imagination.

[7] "Cisgender" or "cissexual" are terms taken from trans* activism and Trans* Studies. They describe states of non-transness, i.e., people whose identities are congruent with the sex/gender to which they were assigned at birth. The language of "cis" is a way of destigmatizing transness as the marked other or abnormal way of being.

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