Disordering the Other

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Abstract

This paper will examine the history of homosexuality and paraphilias, compare the categories against the criteria for a mental disorder, and highlight controversies in disordering alternate sexualities. The author will argue that there is no way to justify the inclusion of lawful paraphilic disorders as a category in the DSM-5, or future DSMs. The inclusion of non-lawful paraphilic disorders can also be contested, but under slightly different considerations.

Keywords: Paraphilias, paraphilic disorders

Disordering the Other: Alternate Sexualities and the DSM

Currently, in the DSM-5 homosexuality is no longer considered a disorder or a necessary part of any disorder, but it was included in most previous versions, under changing names and criteria, reflecting societal protests against stigmatizing same-sex behavior (Gordon, 2008).

In the first DSM homosexuality was considered a sociopathic personality disorder. In the first six printings of the DSM-II it was simply called 'homosexuality (302.0) and included in a category of 'sexual deviation'; the interest in the same-sex itself being grounds for a disorder.

A large change occurred in in the later printings of the DSM-II, starting in Dec 1973. In these homosexuality was listed under 'Sexual orientation disturbance [homosexuality]' and required that the person are "disturbed by, in conflict with or wish to change their sexual orientation" (Gordon, 2008).The grounds for this change, given by the APA were that all disorders must cause subjective distress or be associated with impairment, both of which did not inherently apply to homosexuality. Those who fought against homosexuality being labeled a disorder stated it was scientifically incorrect, caused an adversary relationship between psychiatry and the community and was misused by those who wanted to deny rights to homosexuals. These reasons were accepted as valid by many in the APA (American Psychiatric Association, 1973).

In the DSM- III the name of the disorder was changed to ego-dystonic homosexuality (302.00), and the essential feature was that the desire is unwanted and is a source of distress. (Caplan, 2011)). The revised DSM-III, published in 1986, still allowed for distress from homosexuality to be classified as a disorder under 'Sexual Disorder not Otherwise Specified'

(with a sub-point including sexual orientation disturbance as a possibility). This category continued into the DSM-IV (Herek). Only in the DSM-IV-TR, published in 2000, was distress due to homosexual urges no longer a possible disorder, and homosexuality was removed entirely.

The category of non-normative sexual practices, which formerly included homosexuality, was renamed 'Paraphilias' and the three criteria were that the fantasies, urges or behaviors involved non-human objects, the suffering or humiliation of one's self or ones partner, or children or other non-consenting persons (American Psychiatric Association: *Diagnostic and Standard Manual of Mental Disorders*, Fourth Edition). Most of the same paraphilias listed in the DSM-IV-TR had been listed since the DSM-II.

In the DSM-5 a paraphilia is defined by exclusion and is an 'intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physiologically mature, consenting human partners". To highlight the diversity of the term, some paraphilias include pedophilia, frotterism, voyeurism, exhibitionism, sexual sadism, sexual masochism, fetishism, and cross-dressing for sexual arousal. The first two are often non-consensual, the next two can be consensual, sexual sadism and masochism are often consensual in pairs of one person with each fetish, and the latter two paraphilias may only involve the one person with the paraphilia (American Psychiatric Association: *Diagnostic and Standard Manual of Mental Disorders*, Fifth Edition).

In the DSM-IV simply having a paraphilia was considered a disorder but in the DSM-5, the paraphilia had to be causing distress or impairment to be a Paraphilic disorder. This allows for the ability to have these urges without having a disorder, as has been the case with homosexuality since 1973.The distress has to be a direct result of the paraphilia not the result of

another factor, such as guilt, anxiety, impaired social relations, or reactive depression. (APA, *DSM* Fifth Edition). Examples of direct distress are not given, and there is controversy over the fact that reasons other than those excluded are unlikely in individuals coming in for clinical consultation. (Fedoroff, Di Gioacchino, & Murphy, 2013). Separating paraphilic disorders from paraphilias is seen as a step forward, but communities of those with these urges object to having a disorder if they feel distressed about their desires when the same cannot be said for those experiencing non-paraphilic sexual interests. Therefore, what makes consensual paraphilic disorders worthy of inclusion into the DSM?

The Diagnostic and Standard Manual of Mental Disorders, Fifth Edition defines a mental disorder as a "clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.", with the caveat that socially deviant behaviors are not considered mental disorders unless they stem from the type of disturbance listed (Maisel, 2013). The author believes that paraphilias and paraphilic disorders do not meet this definition, and there is precedent for change in the DSM.

As an example of the DSM being affect by social movements, although not identifying with the gender assigned by society can cause inherent distress and impairment, this condition is not a disorder in the DSM-5. The current diagnosis of 'gender dysphoria' is the result of protests, led by the World Professional Association for Transgender Health (WPATH) against the psychopathologisation of individuals uncomfortable with the gender society sees them as (Winters, 2010). Previously the condition was called 'Gender Identity Disorder' but the APA now makes it clear that gender dysphoria is not a disorder, but a 'condition'. The reason for a diagnosis would be to help individuals receive appropriate care and have insurance pay for their

gender transition to the gender they wish to be seen as. The APA does not take the position that the person should change their gender identification because they feel distress, but they should be allowed to change their outward sex markers in order to match the gender they identify with. ("Gender Dysphoria.")

Do paraphilias inherently cause impairment or distress? In a study by Ahlers et al., 62.4% of a sample of 342 German male volunteers reported arousal a paraphilia but only 1.7% reported associated distress. To take an example of two commonly linked paraphilias that have appeared in the DSM since the second edition, according to a study done by Moser and Levitt only 6% of their sample of 178 men practicing sexual sadism or machoism (BDSM) reported wishing to not have that paraphilia, although 16% had visited a therapist regarding those desires. Other studies showed that BDSM practitioners did not vary from non-practitioners in sexual coercion, rates of mental illness or MMPI scores. Researchers were unable to find these paraphilias correlating to any specific impairment. (Shindel & Moser, 2011) In a recent position statement by the APA they state that same-sex attraction does not inherently imply impairment in any category, implicitly as a reason it is not included a disorder. (APA, 2013)

Although sexual sadism and machoism may inherently not cause distress, societal reactions can lead to negative consequences. In 1998 a survey by the National Coalition for Sexual Freedom found that 30 percent of those who practice these paraphilias report they have faced discrimination, 24 percent losing and 3 percent a child, due to stigma against them (Jason, 2007). These are likely causes for coming in to therapy which do not have to do with the practice itself.

A reason given by the APA for the inclusion of paraphilic disorders is that it helps individuals distressed about their sexual inclinations receive treatment. Keenan argues against this defense stating that one can feel distress over a myriad of issues, and linking those issues to the distress is counter-productive. One can seek treatment for the distress without having a set category that correlates that distress with such a specific cause. For example distress over writing a novel that you are choosing to write can be caused by anxiety, depression, low self-esteem or societal expectations around the result, among other factors, but 'novel-writing disorder' does not exist. Almost any activity can cause distress depending on the person and their cognition. This idea is even more relevant for an activity that goes against societal norms, such as a paraphilia. Listing paraphilic disorders suggests that there is something unique to them which inherently causes problems, but this has not been proven (Keenan, 2013).

Some of the treatments for paraphilic disorders and the former treatments for homosexuality, attempt, or attempted, to adjust the sexual desire to 'normal'. Currently, libido reducing medicines such as SSRIs and certain anti-psychotics are used to treat paraphilic disorders, reducing overall desire. (Gordon, 2008)) Cognitive-behavior therapy is a reconditioning method, which was once used for homosexuality, and is now used for paraphilic disorders. One of the techniques of CBT is 'orgasmic reconditioning', in which the client has an orgasm "while fantasizing about or watching normative sexual behavior with adults." Many of these treatments were designed out of a need to recondition sexual offenders, such as convicted pedophiles, but are also used, less commonly, for those with non-criminal paraphilic urges, such as transvestic fetishism (Kaplan & Krueger 2012) . In 1998 the APA released a statement opposing reconditioning for homosexuality stating the risks to self-esteem were great and that the APA no longer sees the need for homosexuality to be changed (APA, 2000). This concept did

not officially carry over to paraphilias, but it is left to the discretion of the therapist whether they lean towards treating the distress or the paraphilia. Relating the distress and impairment to the paraphilias, as the DSM-5 does, leads to the logical conclusion of seeing the paraphilia as the cause of the distress and therefore what must be removed (Shindel & Moser, 2011).

Conclusions

The DSM has a deep impact on society and continuing to pathologize non-criminal paraphilias does not positively impact treatment of those with distress, understanding of mental illness, or acceptance of sexual variations. Although they are socially deviant that is no grounds for inclusion, according to the DSM itself. What is normal varies throughout time periods and societies, as long as alternate sexualities continue to be thought of as disordered the battle that was waged which led to the removal of homosexuality and GID from the DSM is not over. The author of this paper calls for a revision of the reasons why lawful paraphilias and paraphilic disorders continue to be included in the DSM and a critical consideration of the benefits and harms of doing so.

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