Paraphilias and the construction of normative sexuality; a Foucauldian analysis of psychodiagnostic manuals.

Hanneke Elisabeth Brouwers

March 2011

Thesis in partial fulfilment of the requirements for the major in Genderstudies

as part of the Bachelor degree in Liberal Arts and Sciences

at Utrecht University.

Tutor: Dr. Kathrin Thiele

Studentnumber 3131041

Contents

Introduction

As a student of genderstudies, taking a psychology class on sexology showed me new ways to study and think about sexuality. Besides learning much about the individual and interpersonal aspects of sexuality, a lot of questions about the role of sexology in society came up in my mind. I wondered why sexual behaviours needed to be diagnosed as 'healthy' or 'unhealthy', who decides which is which, and what the consequences of these diagnoses are. It surprised me to see that my fellow students and my teachers were not concerned with these questions, while to me there seemed to be processes of power going on everywhere in the field of sexology.

The main topic in which I saw processes of power influencing sexuality, was the categorisation of paraphilias in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Paraphilias are non-normative sexual behaviours, and the DSM is the most influential handbook for the categorisation and diagnosis of mental disorders within psychology and psychiatry. When behaviours are listed in the DSM, this means mental health professionals consider them to be signs of mental disorder and will offer treatment for them. The fact that some sexual behaviours are listed 'disorders' while others are not, seemed to me likely to say more about the sexual norms of society than about the mental health of the people who engage in them. This view stems from social constructionism, which states that “all descriptions and understandings of human practices, no matter how strongly they claim to be empirically sound and value neutral, are socially structured. They thus inescapably embody the prejudices that guide our daily lives” (Greenberg, 1997, p 258). As a student of genderstudies, I believe that these prejudices should be studied to prevent sexology from unquestioningly reaffirming normativities.

The question I would like to answer in this thesis is: in what way are psychiatric diagnostic manuals and psychopathological diagnoses part of the construction of normative sexuality?

I will focus on the most influential diagnostic manual, the DSM, and on the group of diagnoses which most directly influences the construction of sexuality: the paraphilias. To answer this question I will do a Foucauldian discourse analysis of the DSM and the paraphilias, the responses to this discourse and the way in which these discourses construct normative sexuality. I have chosen a Foucauldian discourse analysis because Foucault himself has studied sexology extensively. Another reason to use Foucault to answer this question, is because he has a theory of power and discourses that allows for the complexities of the real world, in which power is more than simply repressive. In a Foucauldian sense, DSM definitions are a visible part of the power structures that help construct and maintain sexual normativity, but they are not the complete system itself.

A few terms need explaining before I can answer this research question. Sexology is the multidisciplinary study of human sexuality. In this research I will mostly focus on the disciplines of psychiatry and psychology within sexology. Nosology is the practice of classification of mental and physical diseases. Psychopathology is the study of mental illness, and psychopathologisation is the labelling of a behaviour as a mental illness. Normative sexuality is not interchangeable with heterosexuality. Some heterosexual acts are included in the DSM as paraphilias and are not part of normative sexuality, while homosexuality for many people is one of a diverse group of sexual behaviours and identities which are normative. Finally, I would like to point out that there are many opinions on what normative sexuality is, and that practices of psychiatry and sexology differ widely. This is why I will limit my analysis to current sexuality and nosology in 'Western'

society.

In order to answer the question in what way the classification of paraphilias in the DSM play a role in the construction of normative sexuality, I will first give a history of sexology based on the work of Foucault and on accounts from the field of sexology itself. Then I will give a methodological overview of Foucault's discourse analysis, focussing on his analysis of power and sexuality. Next I will explain the DSM classification of paraphilias further, and I will discuss the consequences, reasons and responses following from this classification. I will then combine the discourses surrounding the classification of paraphilias with a Foucauldian discourse analysis, analysing the powers, discourses and creation of knowledges involved in the construction of normative sexualities.

It is my hope that a discursive analysis from the perspective of the humanities can contribute to the knowledge of the social sciences, and to the way sexologists and those involved in nosology view the influence of their work.

1. A History of Sexology

In order to research the power structures that play a role in sexology and the nosology of sexuality, it is important to know how these fields have developed. I have chosen to focus this short[1] account of the history of sexology on changes in dominant paradigms on alternative sexual practices in the field of sexology, using both Foucault's own *History of Sexuality* and more recent information from the field of sexology itself.

Until the early twentieth century

Knowledge of sexuality has historically been used to proclaim which sexualities are allowed, and which are not. Foucault, in his *History of Sexuality; Volume One: The Will to Knowledge,* describes an important paradigm shift in sexology that happened in the nineteenth century. According to Foucault's research, civil and religious law were responsible for setting the norms of sexuality up to the late nineteenth century (Foucault, 1997, p 37). These laws tended to overlap, since they both focussed on heterosexual legal marriage, and denounced and punished most deviations from it. In other words, non-normative sexual practices were viewed as breaking the law, no matter what their nature was: "these different codes did not make a clear distinction between violations of the rules of marriage and deviations with respect to geniality. Breaking the rules of marriage or seeking strange pleasures brought an equal measure of condemnation" (Ibid., pp 37-38).

This changed during the late eighteenth century, when medical research into sexuality started to gain more influence. "[T]here appeared on the one hand infractions against the legislation (or morality) pertaining to marriage and the family, and on the other, offences against the regularity of a natural function" (Foucault, 1997, p 39). In other words: suddenly, being engaged in non-normative sexual practices could mean a person was breaking the law, or that a person was ill, and there was a fundamental difference between the two. During the nineteenth century, instead of being sent to prison, people who were engaged in non-normative sexual practices were studied and treated by medicine (Ibid., p 40), the underlying thought being that a sane, non-ill person could not be involved in these practices: "the sexual domain was no longer accounted for simply by the notions of error and sin, excess or transgression, but was placed under the rule of the normal and the pathological (which, for that matter, were the transposition of the former categories[2])" (Ibid., p 67).

Although this view (all deviation from the norm is pathological) might seem oppressive, this medical attention to non-normative sexual practices had two consequences that changed our knowledge of sexuality, rather than restricting it. The first is the fact that medical research into sexuality created discourse and knowledge. All this attention for non-normative sexual practices created attention for, knowledge of and differences between sexualities: "[t]he nineteenth century and our own have been rather the age of

[1] Since it is not possible to represent all the nuances and different opinions of the history of sexology, I will focus on the history of sexology's main paradigms in Europe starting from the seventeenth century, and the history of sexology in Europe and the United States from the 1940's.

[2] It is clear that Foucault supports a social-constructionist view of both illness and morality: he states that sin, breaking the law and being ill are in effect the same thing. I will briefly expand on this view later in this chapter, while discussing the dominant paradigm of sexology in the 1970's and 1980's.

multiplication: a dispersion of sexualities, a strengthening of their disparate forms, a multiple implantation of "perversions". Or epoch has initiated sexual heterogeneities" (Foucault, 1997, p 37). So, rather than silencing and diminishing non-normative sexual practices, medical attention multiplied the "production of sexuality" (Ibid., p 105).

A second consequence has to do with nosology: classification is central to western medicine, and has created an identity with every non-normative sexuality. Where under civil law a man having sex with a man was simply breaking the law, medicine made sexual acts part of the person themselves. "The sodomite had been a temporary aberration; the homosexual was now a species" (Foucault, 1997, p 43), in fact, the term 'homosexual' was invented and taken into use before the term 'heterosexual' was coined to describe the norm. This labelling of people according to their sexual activities had consequences for everything from their personalities to their style of dress: "every given person, just as he or she was necessarily assignable to a male or female gender, was now considered necessarily assignable as well to a homo- or a hetero-sexuality, a binarised identity that was full of implications, however confusing, for even the ostensibly least sexual experiences of personal existence" (Sedgewick, 1990, p 2). Sexuality started to be seen as the one thing that defines everything about a person and their identity, rather than simply a description of an activity.

From the 1940's

In the late 1940's, the emphasis of some sexology research shifted from categorising 'groups' of 'unhealthy' people, to the sexuality of the normative (heterosexual, adult and preferably married) couple. A major shift was the sudden attention for the study of non-pathological sexuality, as in the famous Kinsey-studies. Alfred Kinsey's group of researchers was the first to study sexual behaviours of large groups of adults who were considered healthy, and found that these people engaged in many sexual behaviours that were considered 'abnormal' (Gijs et al., 2009, P26). Kinsey himself responded to this finding: "In the light of these accumulated data, we must conclude that current concepts of normality and abnormality in human sexual behaviour represent what are primarily moral justifications" (Kinsey in: Gijs et al., 2009, p 26).

There have been two main perspectives that sexologists have had on this focus on 'healthy/normal' and 'unhealthy/abnormal'. In the 1970's and 1980's, the social constructionist perspective was most influential. Social constructionism states that "sexual behaviour is not an expression of a fixed sexual instinct, but is a socially constructed meaning given to biological possibilities" (Gijs et al., 2009, p 30)[3]. In other words: what is considered sexual is constructed rather than a biological or moral fact. Another consequence of the social constructionist view of sexuality is that 'normal/healthy' is dictated by society. Kinsey responded to his findings that many 'healthy' people have 'abnormal' sex, stating that "[t]he problem of the so-called sexual perversions is not so much one of psychopathology as it is a matter of adjustment between an individual and the society in which he lives" (Kinsey in: Gijs et al., 2009, p 27).

The second influential perspective within sexology is the biological/biomedical perspective, which came up in the 1980's and, since the commercial and clinical availability of Viagra, gained influence in the 1990's. Within sexual psychology and psychiatry in Europe and North America, the current most influential theories are sociobiology and evolutionary psychology (Gijs et al., 2009, pp 30-31). These theories view the social behaviour of people as influenced or even predestined by biology. All social behaviour, including sexuality, originates in evolutionary functionality according to this perspective. Currently, biomedical research

[3] All translations from Dutch are my own.

based on evolutionary psychology is the most influential and funded research within sexology (Ibid., p 31).

Different paradigms within sexology can have a large influence both on sexology and on society at large. One of the most influential changes within sexology was strongly linked to the social constructionist view of sexuality, which was dominant at the time this change was made: the removal of homosexuality from the DSM. In 1973, the American Psychiatric Association decided to no longer list homosexuality as a mental illness, 'curing' millions of people simply by saying that their 'illness' was no longer an illness. Central to the argument to remove homosexuality from the DSM was a social constructionist paradigm:

> [w]hile critics were concerned with showing that homosexuals were not diseased, they also had to account for the strong evidence that many homosexuals indeed suffered psychological distress related to their sexual orientation. (…) this pathology was viewed not as inherent to homosexuality, but to the society in which the homosexual functioned. (Greenberg, 1997, p 260)[4]

To summarise, the study of non-normative sexual behaviours has gone through several paradigm shifts. To engage in these acts used to be viewed as breaking a judicial or religious law. At the end of the eighteenth century, non-normative sexual behaviour was viewed from a medical perspective, creating new knowledge about sexualities and emphasising sexual identity over sexuality as behaviour. Within this medical paradigm, the emphasis has shifted from a social constructionist view of sexuality to a biological view of sexuality. The way sexuality is viewed in society is strongly influenced by the dominant paradigm. When Michel Foucault wrote his *History of Sexuality*, social constructionism was very influential in sexology. This helps explain the importance Foucault puts on power relations in society when discussing the construction of sexuality.

In the next chapter I will discuss the methods of discourse analysis and the theories of power Foucault uses in his study of sexuality. Discourse analysis and an analysis of processes of power in a Foucauldian sense will be central to finding out what part sexology's nosology plays in the construction of normative sexuality.

[4] For a more in-depth critical discussion on the role of social constructionism in the nosology of sexuality, the removal of homosexuality from the DSM, and "the inescapable political nature of psychotherapy" (p 256) at large: see Greenberg, 1997.

2. Methodology: Foucault

Unlike any historian or philosopher before him, Michel Foucault's studies of sexuality had a focus on discourse. Central to Foucault's study of the history of sexuality are the construction of sexuality and the role that the psychopathologisation of non-normative sexualities plays in this construction. Foucault analyses discourses on sexuality, the way these discourses construct sexuality and the different powers that are involved in construction. In this chapter I will give a methodological overview of two relevant parts of Foucault's work: his views on power and on sexuality. I will later use these methodologies to explore the ways contemporary diagnostic manuals construct normative sexuality.

Foucault on power

In the last chapter I have shown that the nineteenth century, instead of simply being a prude time in which sexuality was repressed, saw an expansion of sexualities and studies about them. This view of the nineteenth century as having a “discursive explosion” (Foucault, 1997, p 17) about sexuality, is central to Foucault's *History of Sexuality*. In order to explain how the involvement of medical power in sexualities has created new sexualities and knowledge about them, Foucault needed to investigate and redefine 'power':

> [T]he aim (…) is to move less towards “a theory” of power than toward an “analytics” of power: that is, toward a definition of the specific domain formed by relations of power, and toward a determination of the instruments that will make possible its analysis (Foucault, 1997, p 82).

In order to do this, Foucault chose to analyse power by studying different kinds of power interactions and their results.

In the first place, he reviewed the idea that power is only capable of repressing, of prohibiting and of censoring (Foucault, 1997, p 10). In the most common view of power, “[i]t is defined in a strangely restrictive way, in that, to begin with, this power is poor in resources, sparing in it's methods, monotonous in the tactics it utilizes, incapable of invention, and seemingly doomed always to repeat itself. Further, it is a power that only has the force of the negative on its side, a power to say no; in no condition to produce, capable only of posting limits, it is basically anti-energy. (…) And finally, it is a power whose model is essentially juridical, centered on nothing more than the statement of the law and the operation of taboos” (Ibid., p 85). In other words, power is seen as something that can only respond negatively to things, works the same in every situation and works top-down. Yet when we look at the nineteenth century, we see that educators, doctors, legislators, parents and patients have all been involved in much more that simply repressing sexuality. They have all had different goals, reached (or not) these goals in different ways and have created much attention for and knowledge about sexuality.

In order to explain how power can create and be so diverse, Foucault redefined what power is. It is not simply the law of a society, or the institutions that enforce this law (Foucault, 1997, p 92). Instead, Foucault states that:

> power must be understood in the first instance as the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own

> organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them; as the support which these force relations find in one another, thus forming a chain or a system, or on the contrary, the disjunction and contradictions which isolate them form one another; and lastly, as the strategies in which they take effect, whose general design or institutional crystallization is embodied in the state apparatus, in the formulation of the law, in the various social hegemonies. (Ibid, pp 91-92)

When defined like this, power is much more flexible and interactive, rather than simply repressive. There is not simply one person who has invented power, the way it is exercised and its results, but instead power is part of the relationships between people. Power is not simply top-down: it is an intrinsic part of interactions, instead of being external to them, and so is resistance to power (Ibid., pp 94-95). For instance, in the relation of the therapist and the patient, there is not simply 'a power' that the therapist has over the patient. There are power interactions between the patient and the therapist (who pays for the treatment, what is expected of both of them, their willingness to cooperate), between them and different parts of society (medical consensus, society's concepts of health and illness, taboos or expectations, laws), and these power relations are intrinsic to the relationships between patient, therapist and society. There is no person 'with' power and a person 'without' power in a relationship, it is rather a matrix of interactions and shifts (Ibid., p 99). This means that “[p]ower is everywhere; not because it embraces everything, but because it comes from everywhere” (Ibid., p 94).

This does not mean that power works randomly. Power is embedded in a system of knowledge, structures and interactions in society. Patterns of power could not work if they did not “enter into an over-all strategy. And inversely, no strategy could achieve comprehensive effects if it did not gain support from precise and tenuous relations (…) There is no discontinuity between them” (Foucault, 1997, p 99). Going back to the example of the patient and therapist, the power relationship between them would not be the same in a society without a system of knowledge in which mental healthcare by professionals has a place. And the concept of mental healthcare deciding what is healthy and unhealthy behaviour, can not exercise power in a society without people accepting this or taking on the roles of patient and therapist. Systems of knowledge are not just supportive of power relationships; they are entwined and depend on each other for their validity and creation: “[b]etween techniques of knowledge and strategies of power, there is no exteriority” (Ibid., p 98).

Like power, knowledge is not uniform and repressive. It is created through interactions between discourses: “it is in discourse that power and knowledge are joined together (..) we must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as multiplicity of discursive elements that can come into play in various strategies” (Foucault, 1997, p 100). A person might lose power and even rights when they are labelled a 'patient' in our society, but at the same time this healthcare-discourse might be the starting point for a discourse in which patients resist the medical establishment, or work together with it to improve care.

Foucault's analysis of power reveals a power that is not simply top-down, uniform and repressive. Power can produce knowledge, is an intrinsic part of the interactions between people and differs depending on situation, resistance and interactions with other constructs in society. Power works in interaction with systems of knowledge, and these systems of knowledge are just as interactive and changing as power itself, creating discourses where power and knowledge come together.

The discursive nature of sexuality

In the work of Foucault, sexuality is viewed as a social construct: “Sexuality must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries gradually to uncover. It is the name that can be given to a historical construct” (Foucault, 1997, p 105). This construct is created through discourse, in which both knowledge and power play a role. In order to learn more about the powers that have a role in creating sexuality, Foucault analyses the discourse of sexuality. He asks why sexuality has been discussed so much, what has been said about is, what the power effects are of what has been said, who has done the speaking, and what the viewpoints and institutions involved are (Ibid., p 11). “What is at issue, briefly, is the over-all “discursive fact”, the way in which sex is “put into discourse” (…) Hence, too, my main concern will be to locate the forms of power , the channels it takes, and the discussions it permeates” (Ibid., p 11).

In the same way that power is interactive and non-hierarchical, so are discourses on sexuality more complex than simply repressive or prescribing what to think. First, discourses on sexuality can be created in different ways and have different effects. A discourse can create incite people to speak or to censor, can create knowledges and misinformation, and can support incentive or repressive powers (Ibid., p 12).

Secondly, there is not simply one discourse that constructs sexuality. Back again to the example of a patient and a therapist: when the patient is being treated for their engagement in non-normative sexualities, it is not just the medical-diagnostic discourse which states this person is involved in something 'unhealthy'. There is also an evolutionary-psychological discourse which states this is an 'illness' for evolutionary reasons, an opposing social constructionist discourse which has an alternative view on normality, a patient-activist discourse that might be opposed to nosology in general, the discourses of insurance companies, religion and many more. All these discourses interact with and influence each other, adjusting and changing with different powers and in time: “we are dealing less with *a* discourse on sex than with a multiplicity of discourses produced by a whole series of mechanisms operating in different institutions” (Ibid., p 33).

A third aspect of discourses is that they produce truths. This means that Foucault views sexology, the study of sexuality, as a method of producing the truth about sex (Foucault, 1997, p 68). As the history of sexology has shown, sexuality is supposed to say very much about a person, making 'the homosexual' a fundamentally different person from 'the heterosexual'. Sexuality is viewed as central to a person's identity, which makes knowledge about sexuality into a very important truth:

> The essential point is that sex was not only a matter of sensation and pleasure, of law and taboo, but also of truth and falsehood, that the truth of sex became something fundamental, useful, or dangerous, precious or formidable; in short, that sex was constituted as a problem of truth. (Foucault, 1997, p 56)

The importance of the 'truth' about sexuality in our societies can be seen in the emphasis put on 'coming out'. Having a sexual identity instead of engaging in certain activities is viewed as such a fundamental part of a person, that speaking the truth about it is essential to 'being oneself'. This is another reason to analyse the discourses on sexuality: to analyse the constructions of these truths.

Foucault's analysis of sexuality as a construct shows that sexuality is discursive and that these discourses and the power involved should be analysed. Discourses on sexuality are multiple and have different effects and powers. Since sexuality is viewed as central to a person's identity, discourses on sexuality construct truths.

In summary, discourses on sexuality are influenced by knowledge and power, and these discourses construct sexuality itself. Powers, knowledges and discourses are heterogeneous, interactive and can have different sources and effects. They are not simply top-down or repressive. Asking questions about the powers involved in the discourses on sexuality can help us analyse the construction of sexuality in a Foucauldian sense. Methods for this analysis would be to analyse the different powers and power relations in place, the interactions and consequences of these powers, the creation of knowledge and discourse, the different discourses and their effects, and the way in which these discourses produce truths.

In the next chapter I will describe sexology's main discourses on non-normative sexualities, the effects of these discourses and the discourses that have developed in response to sexology's main discourses.

3. On paraphilias in diagnostic manuals

Foucault's methodologies have made clear that in order to analyse the power structures at play in sexology, it is important to study the discourses involved. Since discourses on sexuality are heterogeneous and multiple, it will be impossible to discuss all of the discourses involved in the construction of normative sexuality. I will limit my analysis of the role of psychiatric diagnostic manuals and psychopathological diagnoses in the construction of normative sexuality somewhat: I will only discuss the current version of the most influential diagnostic manual in Western psychiatry, the *Diagnostic and Statistical Manual of Mental Disorders*, and the psychopathological diagnoses I will discuss are the paraphilias.

First I will give a short explanation of the DSM, of psychiatric nosology in general and of the diagnoses of paraphilias specifically. Secondly I will discuss the consequences this classification has had. Then, I will show the reasons given for the classification of paraphilias and the reasons given against it, and finally I will discuss the responses to this classification.

DSM classification

The DSM is used in the fields of psychiatry and psychology to help diagnose mental illness and as a classification tool in the research of mental disorders. It is also used in education and law with respect to people who deviate from the norm. The DSM is written by the American Psychiatric Association, and revised on a regular basis, with definitions changed and diagnoses added or removed. Currently, a complete revision for a fifth edition is on its way. The idea of psychiatric nosology is that explicit definitions of mental disorders are essential for clinical diagnoses, which in turn can help with research and treatment.

The definition of mental disorder as used in the DSM is:

> a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (e.g., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain disability, or an important loss of freedom[5]. (…) 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, as described above. (APA, 2000, p xxxi)

This means that mental disorders have to cause distress, disability or risk to the individual suffering from them, in order to be defined as a mental disorder[6]. The introduction to the DSM adds that these definitions are based on professional consensus, that diagnoses can only be made by a trained and experienced professional, and that it only classifies mental disorders that people have, rather than individuals themselves

[5] I cannot help but note that the loss of freedom as a diagnostic criteria seems to be a self-fulfilling prophecy in a society where the metal health profession has the possibility to incarcerate the people it diagnoses, either directly or via its legal influence.

[6] There are many arguments that can and have been made against this definition of mental disorder. Most point out that distress, disability and risk are strongly dependent on the context of society, and that mental disorders are therefore social constructs. I will shortly touch on these arguments later in this chapter, but it is beyond the scope of this thesis to do so extensively. For a more in-depth discussion of the problematic nature of the definition of mental disorder: see Gert and Culver, 2009; Greenberg, 1997 and Drescher, 2010.

(APA, 2000, pp xxx-xxxi). This means that the DSM does not speak of 'a transvestite', but of 'a person with Transvestic Fetishism'.

Paraphilias are a sub-category of the Sexual and Gender Identity Disorders within the DSM. A definition of all paraphilias in the DSM can be found in the Appendix. Paraphilias in general are defined:

> The Paraphilias are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (e.g. , are obligatory, result in sexual dysfunction, require participation of nonconsenting individuals, lead to legal complications, interfere with social relationships). (APA, 2000, p 566)

The definition specifically states that what makes a paraphilia a paraphilia, is the fact that it is both 'unusual' and causes distress. 'Normal' sexual behaviour that causes distress is not considered paraphilic. The paraphilias included in the DSM are: “Exhibitionism (exposure of genitals), Fethishism (use of nonliving objects), Frotteurism (touching and rubbing against a nonconsenting person), Pedophilia (focus on prepubescent children), Sexual Masochism (receiving humiliation or suffering), Sexual Sadism (inflicting humiliation or suffering), Transvestic Fetishism (cross-dressing), and Voyeurism (observing sexual activity)” (Ibid., pp 566-567). The DSM also has a category for paraphilias that are less common and are not included in this list: Paraphilia Not Otherwise Specified.

To give an example of diagnostic criteria for paraphilias in the DMS, and because I will discuss its diagnostic criteria further on, I will give the diagnosis of Transvestic Fetishism here. Transvestic Fetishism is diagnosed when a heterosexual man[7] has “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing” (Ibid., p 575) and these cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (Ibid., p 575). In earlier versions of the DSM, Homosexuality was also included as a paraphilia. I will occasionally use this fact as an example of the results of and responses to classification.

Effects of classification

The classification of non-normative sexual behaviours as mental disorders in the DSM, means that they are considered by many people in our societies to be illnesses. DSM classification is often used to decide which people are allowed to receive medical or psychological treatment. Many medical insurance companies and laws state that only a person with a DSM diagnosis can have free or subsidised health care for a mental problem, so a DSM classification can be very useful for a person suffering from their non-normative sexual urges (Drescher, 2010, p 450) and can provide them with psychotherapy, medication, and often also the view that they are not responsible for these urges or fantasies.

DSM classification is also used in criminal law: serious offenders, when diagnosed and found guilty, can be forced to receive psychiatric treatment in many countries. The fact that a person is diagnosed with a mental disorder can both increase and decrease the sentence, depending on the legal system and the crime and disorder involved. Other legislation can also exclude people with a mental disorder: the diagnostic category of Homosexuality has been used in the United States in the past to deny people rights to military

[7] The fact that Transvestic Fetishism can only be diagnosed in heterosexual men is obviously problematic from the perspective of Gender Theory. I will shortly address this in the next chapter.

service, immigration, insurance and marriage (Drescher, 2010, p 447).

Since the concepts of mental health and mental disorder are given meaning within a social context, it is nearly impossible to "know whether the term is used in an empirical or in a normative way" (Schutte, 1997, p 46). While personal preferences, moral or religious rules and even the law are often topics of discussion, the fact that mental health is preferable over mental illness seems beyond doubt in our society. This means that the effect of a sexual DSM category can be very pervasive: the fact that a non-normative sexual behaviour is labelled unhealthy makes it automatically undesirable and wrong.

Reasons for and against classification

The main reason why paraphilias are included in the DSM is because they are observed by psychiatrists to fall under the definition of mental disorders. In the words of Robert Spitzer, a psychiatrist in charge of rewriting the definition of mental disorder for the DSM-IV:

> When the reasons for identifying certain conditions as mental or physical disorders are understood, it will be apparent that the question, "Is condition A (whether it be homosexuality, schizophrenia, left-handedness, or illiteracy) a disorder?" is more precisely stated as, "Is it useful to conceptualize condition A as a disorder?" or, "What are the consequences (to society, the individual with the condition, and the health profession) of conceptualizing condition A as a disorder? (Spitzer in: Drescher, 2010, p 452)

It is clear from Spitzer's explanation that he himself views mental illness as a social construct, useful for the patient, for society and/or for the health profession. Many psychiatrists and psychologists view the DSM category of paraphilias as a useful one, either because it can be the basis of treatment (for instance for a person troubled by their Transvestic Fetishism), or because it can be used in criminal law (for instance to help convict a person who has acted on their Sexual Sadism with a nonconsenting partner). They claim it is a legitimate category, based on psychiatric fact.

At the same time, there are many people within and outside of the psychiatric profession who argue against the inclusion of some or all of the paraphilias in the DSM. Some people argue for the removal of paraphilias from the DSM on the same basis that homosexuality was removed from the DSM: they claim distress in people with paraphilias stems from a conflict between an individual and society, not from the paraphilias themselves (Drescher, 2010, p 443). They also argue that a DSM diagnosis adds to this social stigmatisation.

Psychologist Odd Reiersol and activist Svein Skeid state that "[t]here is no reason to make a diagnosis based on the person's sexual preference or practice" (Reiersol and Skeid, 2006, p 248). They argue that there are no good reasons to separately diagnose paraphilias, and believe sexual behaviour should not be separated from other behaviour. When a person is doing anything, sexual or otherwise, with a nonconsenting person, they have a personality disorder (Ibid., p 248), and distress about non-normative sexual desires could also be otherwise diagnosed:

> If someone is compulsive about acting out his or her sexuality, no matter what kind of sexuality, he/she could be diagnosed with Obsessive Compulsive Disorder (OCD). Hence, there is no more reason to single out "paraphilic OCD's" than to single out "philateletic OCD's" into specific diagnostic categories. In other words, there is no reason to make a diagnosis based on the person's sexual preference and practice, per se. (Ibid., p 252)

The core of their argument is that when sexual acts are diagnosed on the basis that they are unusual, like homosexuality, oral and anal sex used to be, but are no longer, this is completely unrelated to scientific fact, and the "diagnostic criteria merely mask moral indignation" (Ibid., p 247).

This view that DSM classifications are used to guard morality and keep the status quo[8], rather than to help people who suffer from an illness, is supported by Bernhard Gert and Charles Culver's study of the criteria of different paraphilias. They have compared the DSM's definition of mental disorder and the criteria of paraphilias and have found that they do not always correspond. The definition of mental disorder in the DSM, as I have shown earlier in this chapter, states that deviance alone is not enough to be diagnosed with a mental disorder. A person should themselves suffer distress, disability or risk to be diagnosed. This means that a person with Transvestic Fetishism or a person with Sexual Sadism, when they act on their non-normative sexual desires but have no problem with it, should not be diagnosed with a mental disorder. But the DSM classifies a person with Exhibitionism, Frotteurism, Pedophilia, Sexual Sadism and Voyerism, the paraphilias which can harm others, as having a mental disorder as soon as they act on it, whether they have a problem with their disorder or not: a clear moral judgement in these diagnoses[9] (Gert and Culver, 2009, p 487).

> This makes it clear that, with regard to the paraphilias, DSM-IV-TR does not distinguish between behavior that causes, or increases the probability of an unconsenting person suffering some harm, that is, immoral behavior, and a condition that causes, or increases the probability of, the agent suffering some harm, that is, a mental disorder. (Ibid., p 493)

Yet at the same time, some non-normative and immoral sexual behaviours, like rape and knowingly putting another person at risk for Sexually Transmitted Infections, are not considered sexual disorders. It seems that in the DSM, the definition of mental disorder is not used consistently when it comes to sexual behaviour.

Responses to classification

Different groups and people involved with and influenced by the DSM classification of paraphilias, have responded to this classification in different ways. The fact that the DSM considers paraphilias to be a mental disorder means that psychologists, psychiatrists and sexologists offer treatment for them. These treatments range from psychotherapy to promote the patient's and their partner's acceptance of their non-normative sexual behaviour to androgen-suppressant hormonal therapy to minimise sexual desire (Gijs et al, 2009, p 479). A DSM diagnosis also means that in most countries, health insurance companies will pay for the treatments of these paraphilias.

The fact that paraphilias are classified in the DSM has also paved the way for research into these non-normative sexual behaviours. This can be research aimed to normalise the behaviour, statistical research to find out how many and which kinds of people are engaging in them, research into treatment

[8] One example of how nosology has been involved in maintaining the status quo of society has been the diagnosis of Drapetomania: a disorder that was said to cause slaves to run away from their masters (Drescher, 2010, p 441).

[9] It is not possible for me to go deeper into the discussion of whether or not psychiatric nosology should have a moral function here. For a further discussion of this topic and the arguments for removal of the paraphilias from the DSM, read: Drescher (2010), Gert and Culver (2009), Greenberg (1997), Reiersol and Skeid (2006) or the work of Robert Spitzer on disfunction.

methods, or research which studies the legitimacy of paraphilias' status as mental disorders. The aims researchers have can be very different: they might want to promote a certain kind of therapy, they might want to simply learn more about people with non-normative sexual behaviours, they might work for the pharmaceutics industry and want to promote psychopharmaceutical medication, be activists who want to remove (certain) paraphilias from the DSM, or be activists who want to retain (certain) paraphilias in the DSM.

A reason why some people with non-normative sexual behaviours might want to retain the DSM diagnoses of paraphilias is that medicalisation can play a role in the decriminalisation of certain behaviours. In some cases, having a mental illness can release a person from some of the responsibility for their actions, which can be an advantage for people involved in non-normative sexual behaviours that are illegal. At the same time the legal system is strongly influenced by psychiatry. When a certain behaviour is classified as a mental disorder, the stigma put on the behaviour might make it more likely for the behaviour to become or stay illegal.

Psychiatrist Jack Drescher states that:

> [p]sychiatric classification can initially increase public empathy for people who are seen as suffering from a “disease” and can even enable oppressed groups to be treated more humanely, but classification comes at the cost of reinforcing the belief that certain behaviors are deviant, subnormal, or pathological, and therefore less deserving of genuinely equal rights. (Drescher, 2010, p 444).

These equal rights can involve custody rights over children, equal division of money in a divorce or the right to sexual non-discrimination in the workplace. Drescher has observed several strategies people with non-normative sexual behaviours have developed to strive for equal rights: adopting and developing theories of sexuality that claim non-normative sexual behaviours are normal variations instead of dysfunctions, doing cross-cultural studies to show how normative sexuality is socially constructed and using statistics to prove that the behaviour is not rare or unusual (Ibid., p 444).

A last response to the DSM classification of paraphilias is the appropriation of an identity. This happened with the diagnosis of homosexuality, which was adopted by people engaged in same-sex sexual behaviours to describe themselves. From there, they strove to get homosexuality accepted as simply a natural variation of sexuality, a sexual orientation, rather than a mental disorder. This method of appropriating the identity prescribed by classification and then naturalising it as a sexual orientation has been adopted by people involved in fetishism, sexual sadism and masochism and transvestic fetishists.

In summary, the DSM is a classification and diagnostisation tool for mental disorders. A mental disorder is defined as a condition that causes distress or suffering for the person with the disorder, and several paraphilias, non-normative sexual behaviours or desires which cause distress, are included in the DSM. As a result, people suffering from paraphilias can receive treatment, but might also face negative labelling as a result of the inclusion of their non-normative sexual behaviour in the DSM. Arguments used against classification of paraphilias are, among others, that distress from paraphilias is a result from a conflict between the individual and society instead of a disorder; that other diagnoses are better suited for these problems and finally that diagnoses of paraphilias are used to generate moral judgements and protect the status quo. DSM classification has given way to different responses: increased research, increased public

empathy and leniency, increased social stigma and removal of rights, the creation of counter-theories and the appropriation of identity.

In the next chapter I will analyse the different discourses created by and through the DSM classification of paraphilias, the power interactions at play, and the way these discourses and powers are involved in the construction of normative sexuality.

4. Applying Foucault to nosology

The DSM classification of paraphilias is involved in many discourses, power interactions and in the creation of knowledges. As I have discussed earlier, a discourse analysis in the Foucauldian sense focuses on the different discourses and power relations involved, on the production of knowledges and on the construction of truths. In this chapter I will use a Foucauldian discourse analysis to find out which powers and discourses surround the DSM classification of paraphilias. I will also discuss which knowledges are created as a result of this classification. Finally, I will analyse how these discourses, powers and knowledges are involved in the construction of truths about sexuality, and as such are involved in the construction of sexuality itself.

Power and discourse

The nosology of non-normative sexual behaviours started when medicine began to categorise previously criminal behaviours, connecting these behaviours to certain groups of people. Within the medical discourse, the social constructionist view of sexuality and the biological view of sexuality are most influential. According to Foucault's theories of power, as discussed earlier, both discourses and power are created in interactions, are heterogeneous and are not simply repressive. In fact, power is capable of creating new discourses and knowledges. I will discuss the discourses in which the DSM classification of paraphilias is involved, and the effects of these discourses on sexuality.

The power that the DSM has to classify certain sexual behaviours as 'unhealthy', is not a repressive power-over. Rather, the power of diagnostic manuals is created within society, for society and the institutions in it, and by an interaction of different groups within society. Some of those involved in the nosology of paraphilias have mostly scientific motives and want to come to the most scientifically correct diagnoses. Others want to use nosology to protect society from non-normative sexual behaviours. Others again want to use nosology to help people:

> While physicians and psychiatrists are often accused of seeking power and control, there are also altruistic reasons for turning “sinners” into “”patients”: the medical model's promise of hope for treatment and cure. An ill person was not necessarily responsible for his or her “symptoms” and, in the best of circumstances, would benefit from therapeutic compassion rather than religious judgement or condemnation. (Drescher, 2010, p 441)

Increased public empathy and leniency can be a goal of medical discourses. At the same time, being labelled a 'patient' can have strong negative consequences for a person. The power of the medical discourse in our society means that, besides offering treatment, it also prescribes what is 'healthy' and 'unhealthy', which are terms with strong connotations. In addition, there is a lot of interaction between the medical and the legal discourses, which might cause people who are diagnosed with a paraphilia to be more likely to be deemed criminal. This makes medical discourses very useful for promoting the status quo and for negatively labelling non-normative sexualities.

The medical discourses do offer starting points for discourses on paraphilias with alternative goals. Academics and activists have used the medical discourses to argue faults in nosology and scientific

consistency, comparing definitions of mental disorder with the definitions of paraphilias. Another discourse which responds to the inclusion of paraphilias in the DSM, focuses on sexual identities rather than behaviours. It takes the categorisations from the DSM as starting point, and bases identities on them. I will discuss this discourse further when I discuss the construction of sexualities.

A reason why the medical discourse creates so many powers, is because it is embedded in a system of discourses and institutions which support each other:

> Therapists, more than most other professional groups, help to guide the consensus by pronouncing what is good and bad, by providing the distinctions by which consensus is achieved. That they do so under cover of *health* and *illness* does not change the fundamentally political nature of this influence. (Greenberg, 1997, p 265)

The fact that medicine is considered a science, that most people consider science to be more capable of deciding what is 'right' and 'wrong' than morality or religion, the fact that the legal system adopts this faith in the medical discourses, all these are part of the system that make the medical discourses so powerful and their consequences so plentiful.

Creation of knowledges

Knowledge plays an important role in the creation of discourses and in the creation of power. At the same time, the power of discourses has an important role in deciding which knowledge is being created. This is why a study of the knowledges created is a central part to the discourse and power analysis of the nosology of paraphilias. According to Foucault, knowledges come from different sources, are not created in a top-down way and are used to reach different goals, just like power and discourses.

As we have seen before, the medical discourses can be used as a starting point for opposing discourses which use nosological criteria and definitions themselves. This creates a whole new body of knowledge, stating that other diagnoses are better suited for problems that are now diagnosed as paraphilias; that distress from paraphilias is a result from a conflict between individual and society instead of a disorder; and that the diagnostic criteria of paraphilias include moral, non-scientific, criteria.

The fact that paraphilias are included in the DSM has also paved the way for more research into these non-normative sexual behaviours. This research can be implicitly supportive of the medical discourses, for instance statistical research of the prevalence of paraphilias, but it can also be critical of the medical discourses, for instance research into normalising theories of paraphilias which claim that they are non-pathological variations in sexual orientation.

Finally, inconsistencies and bias in the DSM give space for critique on the entire process of nosology, on psychopathological discourses and on the construction of sexuality in general. For example: the fact that Transvestic Fetishism can only be diagnosed in heterosexual men expresses a gendered bias towards masculinity, femininity and sexual identity. This creates space for a discourse in which there is a gendered critique of the entire nosological process.

Construction of sexuality

The discourses that construct sexuality are influenced by interactions of knowledges and powers. According to Foucault's *History of Sexuality*, these processes are interactive, heterogeneous and have

different sources and effects, just like powers, knowledges and discourses. Together, these interactions, powers, knowledges and discourses construct sexuality in a dynamic, not in a top-down, way.

The main method by which the DSM in involved in the construction of sexuality is Othering. The term Othering comes from the social sciences and describes a process in which defining the 'Other', implicitly defines and reinstates the norm as well (Nagel, 2003, p 13). In the case of the DSM the message given by Othering is: sexual behaviours that are in the DSM are 'unhealthy' and sexual behaviours that are not in the DSM are therefore 'healthy'. A second Othering message is that all the sexual behaviours that are included in the DSM (fetishism, transvestic behaviour for heterosexual men, sadism, voyeurism) are not and should not be part of normative and 'healthy' sexual behaviours.

A consequence of these processes of Othering is that behaviours that are not in the DSM are considered 'healthy', or at least not a sign of a mental illness, because of that fact. Women dressing as men or gay men dressing as women, homosexuality, oral and anal sex, all these behaviours were once considered signs of mental illnesses. Now, people can use the DSM to claim this is not 'unhealthy' behaviour, which gives space for the expansion of what is considered normative sexuality. Of course the construction of normative sexuality is not only influenced by medical discourses. Judicial, moral, religious and other discourses might still claim that prostitution, homosexuality, or knowingly putting oneself or others at risk for Sexually Transmitted Infections are not part of normative sexuality, but they can not use the DSM to claim these behaviours to be 'unhealthy'.

When the DSM declares a behaviour to be 'unhealthy', this does not only mean it is considered clinically unhealthy for the individual, but also that it is considered 'abnormal'. When homosexuality was removed from the diagnoses of paraphilias this did not only express that homosexuality was seen as 'healthy' behaviour for an individual, but it also normalised homosexuality as a variety of human sexual behaviour. In this way, the removal of homosexuality expanded what was considered to be normative sexuality. In fact, this was a signal that non-reproductive sexual behaviours in general, like anal and oral sex, could be considered 'healthy' and 'normal' behaviour in the medical discourses. This normalisation of sexual behaviours that are not in the DSM, is of course only one of the discourses which construct sexuality, and there are many discourses disagreeing with it.

DSM diagnoses can also construct a 'healthy' or 'normal' sexuality where there might not actually be one. This can have a negative effect on people suffering from distress from their sexual desires or behaviours, for example when they are denied treatment. Think for instance about the diagnosis of Transvestic Fetishism, which can only be applied to heterosexual men who experience sexual arousal from wearing women's clothing and who suffer distress or problems from it. This diagnosis means that a homosexual man who suffers distress from his desire to wear women's clothing, or a women who suffers distress from her desire to wear men's clothing, are simply being told their behaviour is 'healthy' and there is no reason for them to receive treatment, whether they feel in need of it or not. In this way the categorisation of paraphilias in the DSM can construct sexuality in a way that negatively affects people who do not fall into these categories.

Finally, DSM nosology of paraphilias is involved in the construction of sexual identities. Foucault describes this process of a sexual identity being constructed in response to the medical categorisation of homosexuality: the medical discourses

> made possible the formation of a “reverse” discourse: homosexuality began to speak on its own behalf, to demand that its legitimacy or “naturality” be acknowledged, often

> in the same vocabulary, using the same categories by which it was medically disqualified. (Foucault, 1997, p 101)

People who had sexual and romantic relations with people of the same sex, started to use the nosological category 'Homosexuality' to describe themselves. They used the medical discourses and knowledges to normalise their sexual behaviours, representing them as natural variations of sexual behaviour. This method is currently also used by people who fall into the category of Transvestic Fetishism (using the term transvestites for their appropriated group and sexual identity), and by people who fall into the categories of Sexual Sadism and Sexual Masochism (using the terms sadomasochists for their appropriated group and sexual identity). The use of homosexuality's 'reverse discourse' has in many ways met its goals: a lot of people now accept homosexuality as a sexual identity, this has caused it to be removed from the DSM and to be, by many people, considered 'healthy' and 'normal' sexual behaviour. DSM categorisation of paraphilias has in this way generated the construction of a new sexual identity and new views on what constitutes 'normal' sexuality.

Conclusion

In order to answer the question in what way the classification of paraphilias in the DSM plays a role in the construction of normative sexuality, I have discussed the history of the study and classification of sexuality; discussed Foucault's theories of power and discourse; explained the DSM classification of paraphilias and its effects; and have combined this in a Foucauldian analysis of the discourses surrounding the powers, knowledges and constructions of sexualities influenced by the DSM classification of paraphilias.

It is safe to conclude that normative sexuality is constructed dynamically and differs for different people. The discourse that is represented in the DSM, a medical view which focuses on 'healthy' and 'unhealthy' sexuality, is a very dominant and influential one, but is certainly not the only discourse involved in constructing normative sexuality. The fact that the classification of paraphilias discusses the topic of sexuality, and non-normative sexual behaviour at that, means that many fields and discourses are also involved, such as discourses on law and gender. This causes an explosion of different discourses, which interact and are together involved in the construction of normative sexuality. Because normative sexuality is created in interactions, the effect of powers and discourses is not always as intended.

So, in what way is the DSM classification of paraphilias involved in the construction of normative sexuality? First of all, the classification of paraphilias labels these non-normative behaviours as 'unhealthy'. The fact that they warrant treatment implies that these behaviours are considered unwanted and abnormal, instead of a non-pathological instance of sexual diversity. The fact that this negative labelling is so powerful, is because it works in a system of discourses and institutions that confirm its power: the health systems and discourses, judicial systems and systems of knowledge about sexuality. Negative labelling of paraphilias constructs normative sexuality through the process of Othering. When non-normative sexualities are clearly defined and viewed as 'unhealthy', this implies that the behaviour that is normative and 'healthy' can not include these sexual behaviours. In other words: by clearly defining and labelling non-normative sexual behaviours, the DSM categorisation of paraphilias implicitly constructs what constitutes normative sexuality.

This process of Othering seems to imply that sexual behaviours that are not categorised in the DSM can therefore be considered normative, but this is too simplistic a view of the construction of sexuality. Although the removal of homosexuality from the paraphilias has meant for many people that homosexuality should not only be considered 'healthy' but also 'normal', this is certainly not true for everybody. Since there are many discourses involved in the construction of normative sexuality, and many of those discourses view homosexuality as non-normative, it is not possible to say it became normative the moment it was removed from the DSM. In the same way, sexual behaviours like prostitution, anal and oral sex, rape, and consciously taking STI-risks cannot all be said to be part of normative sexuality simply because they are not classified in the DSM.

A second way in which the classification of paraphilias in the DSM is involved in the construction of normative sexuality, is that it creates new knowledges. The nosology of non-normative sexual behaviours is a starting point for research into these behaviours. This research and the knowledges produced can have distinctly different effects on the construction of normative sexuality. On the one hand, the creation of more knowledge of the exact nature of paraphilias helps confirm and secure the 'nature' of normative sexuality and the status quo. These knowledges specify which exact behaviours are considered normative. On the other hand, the creation of knowledges of normalising theories and of arguments against classification aims to

redefine normative sexuality to include certain paraphilias and behaviours that are currently considered non-normative. Knowledges created by the classification of paraphilias in the DSM can therefore both narrow or expand our view of normative sexual behaviours.

And finally, the nosology of paraphilias constructs normative sexuality by being a discursive starting point for the creation and appropriation of sexual identities. These sexual identities can be used to further exclude people involved in non-normative sexual behaviour based on their sexual identity. In this way, non-normative sexual identities can create a more narrowly defined normative sexual identity. But the appropriation of a sexual identity based on the DSM classification of paraphilias can also be used to build new normative sexualities.

A Foucauldian discourse analysis has made it clear that there are many ways in which the classification of paraphilias in the DSM are involved in the construction of normative sexuality. The process of Othering, the creation of knowledges and the appropriation of sexual identities can all influence the construction of normative sexuality by specifying and limiting what is included in it, or by expanding which sexual behaviours can be viewed as normative. I hope to have shown that the construction of normative sexuality is strongly influenced by the diagnostic manuals and their diagnoses, and hope that those involved in the classification of paraphilias will not lose sight of the many heterogeneous powers, knowledges, discourses and consequences that result from their work.

References

American Psychiatric Association, (2000), *Diagnostic and Statistical Manual of Mental Disorders (4th edition, revised)*, Washington.

Drescher, Jack, (2010), 'Queer Diagnosis: Parallels and Contrasts in the History of Homosexuality, Gender Variance, and the Diagnostic and Statistical Manual', in: *Archives of Sexual Behaviour*, Vol. 39, No. 2.

Foucault, Michel, (1997), *The Will to Knowledge; History of Sexuality: Volume One*, Penguin Books, London. First published in French in 1976.

Gert, Bernhard, and Culver, Charles, (2009), 'Sex, Immorality and Mental Disorders', in: *Journal of Medicine and Philosophy*, Vol. 34, No. 5.

Gijs, Luk, Gianotten, Woet, Vanwesenbeeck, Ine, and Weijenborg, Philomeen, eds., (2009), *Seksuologie*, Bohn Stafleu van Loghum, Houten.

Greenberg, Gary, (1997), 'Right Answers, Wrong Reasons: Revisiting the Deletion of Homosexuality From the DSM', in: *Review of General Psychology*, Vol. 1, No. 3.

Nagel, Joane, (2003), *Race, Ethnicity and Sexuality; Intimate Intersections, Forbidden Frontiers*, Oxford University Press, Oxford.

Reiersol, Odd, and Skeid, Svein, (2006), 'The ICD Diagnoses of Fetishism and Sadomasochism', in: *Journal of Homosexuality*, Vol. 50, No. 2.

Schutte, Ofelia, (1997), 'A Critique of Normative Heterosexuality; Identity, Embodiment, and Sexual Difference in Beauvoir and Irigaray', in: *Hypatia*, Vol. 12, No. 1.

Sedgewick, Eve, (1990), *Epistemology of the Closet*, University of California Press, Berkely.

Appendix
Diagnostic criteria for paraphilias, according to the DSM-IV-TR.

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, American Psychiatric Association, 2000.

Cautionary Statement (xxxvii)

The specified diagnostic criteria for each mental disorder are offered as guidelines for making diagnoses, because it has been demonstrated that the use of such criteria enhances agreement among clinicians and investigators. The proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills.
These diagnostic criteria and the DSM-IV Classification of mental disorders reflect a consensus of current formulations of evolving knowledge in our field. They do not encompass, however, all the conditions for which people may be treated or that may be appropriate topics for research efforts.
The purpose of DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgements, for example, that take into account such issues as individual responsibility, disability determination, and competency.

Sexual and Gender Identity Disorders:
Paraphilias

The Paraphilias are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (e.g. , are obligatory, result in sexual dysfunction, require participation of nonconsenting individuals, lead to legal complications, interfere with social relationships). The Paraphilias include Exhibitionism, Fetishism, Frotteurism, Paedophilia, Sexual Masochism, Sexual Sadism, Transvestic Fetishism, Voyeurism, and Paraphilia Not Otherwise Specified.

302.4 Exhibitionism
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger.

B. The person has acted on these urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.81 Fetishism
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments).

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator).

302.89 Frotteurism
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or

behaviors involving touching and rubbing against a non-consenting person.

B. The person has acted on these urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.2 Pedophilia
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The person has acted on these urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Specify if:
Sexually Attracted to Males
Sexually Attracted to Females
Sexually Attracted to Both
Specify if:
Limited to Incest
Specify type:
Exclusive Type (attracted only to children)
Nonexclusive Type

302.83 Sexual Masochism
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

302.84 Sexual Sadism
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The person has acted on these urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.3 Transvestic Fetishism
A. Over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
With Gender Dysphoria: if the person has persistent discomfort with gender role or identity

302.82 Voyeurism
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

B. The person has acted on these urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

Paraphilia Not Otherwise Specified

(Accessed at: http://www.behavenet.com/capsules/index.htm, on 04-03-2011)