Why Are the Paraphilias Mental Disorders?

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Introduction

Sexual Medicine is concerned with the psychiatric as well as medical aspects of human sexuality and its nosology substantially influences both treatment and research. The proposed sex and gender diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), fifth edition (DSM-5), to be published by the American Psychiatric Association (APA) have a major impact on that nosology [1]. The DSM is considered by some to be the definitive reference for the diagnosis of mental and sexual disorders; its influence extends beyond clinical practice and research and has far reaching medico-legal ramifications [2]. DSM-based diagnoses have influenced employment decisions, child custody determinations, security clearances, inheritance, health insurance coverage, and societal attitudes [3–5]. These diagnoses can and often do have substantial interpersonal, psychosocial, and economic repercussions for the individual so diagnosed.

In recent years, the basis for diagnosing paraphilias (unusual sexual interests) as mental disorders with the DSM has been challenged [5–7]. The problems that individuals with a paraphilia are alleged to manifest are not delineated clearly, not supported by empirical data, and often are equally applicable to individuals without a diagnosed paraphilia [8]. The only clear indicator of these "diagnoses" is a tautology, i.e., taking part in or becoming aroused fantasizing about the behavior. In this commentary, we will discuss the evidence (or lack thereof) supporting inclusion of two of the more prominent paraphilias (sexual sadism and sexual masochism) in the DSM-5.

Bondage and Discipline, Dominance and Submission, Sadism and Masochism (BDSM)

BDSM is the term many practitioners use to describe one or several sexual behaviors or interests, wherein a power differential between sexual partners has been eroticized [4,9]. Although most practitioners have a preference for either the dominant or submissive role, there exist a substantial number of practitioners who assume both roles at different times or with different partners [10]. Most (if not all) of the activities and interests that are classified as BDSM can be diagnosed as sexual sadism and/or sexual masochism by DSM criteria. Technically, the individual must also be distressed or impaired by the BDSM interest to meet the diagnostic criteria for the diagnosis, but that distinction rarely is applied rigorously [5,7].

Evidence of BDSM interests in society abounds [4,9]. A Google search using the term "BDSM" reveals over 24 million "hits" with only 3.1 million hits using "BDSM porn" (search performed September 30, 2010). Also on September 30, 2010, Fetlife (www.fetlife.com), an internet social community (similar to Facebook) for individuals with BDSM interests, had 571,542 members. There are BDSM support groups, advocacy organizations, and social groups in most major cities and many countries. In the popular media, it is not uncommon to find characters involved in BDSM or references to BDSM activities.

BDSM fantasies are relatively common; Kinsey et al. found that 22% of men and 12% of women had an erotic response to stories with sadomasochistic themes [11]. In a sample of 94 healthy men, Crepault and Couture reported that fantasies of humiliation and being beaten occurred in 11.7 and 5.3%, respectively [12]. Reynaud and Byers found that approximately 60% of women have positive fantasies of being tied up or tying up a partner, and more than 30% of women report positive fantasies of whipping/spanking a partner, and/or being whipped/spanked by a partner [13].

BDSM behaviors are also common in the adult population. Kinsey reported that over 50% of subjects in his studies (both men and women) reported an erotic response to being bitten [11]. Janus and Janus reported that 11% of women and 14% of men had engaged in some form of sadomasochism, 11% of both genders had experience with dominance/bondage, and 5% of men and 7% of women used "verbal humiliation" as part of erotic play at some point in their lives [14]. Richters et al. reported that in a population of over 19,000 Australian men and women between the ages of 16 and 65, 1.8% of the sexually active population (2.3% of men and 1.3% of women) had engaged in some form of BDSM activity within the past year [15]. In a sample of 347 lesbian and bisexual women, approximately one-third had engaged in BDSM actvities [16].

Psychosocial Functioning of BDSM Practitioners

Moser and Levitt found that just 6% of their sample of 178 male BDSM practitioners reported "I wish I were not into S/M," although 16% had consulted a therapist regarding their BDSM desires [10], suggesting that most were able to resolve their concerns. Ahlers et al. reported that 62.4% of a sample of 342 German male volunteers reported arousal to some form of paraphilia, and only 1.7% reported feeling distressed by this [17]. A recent survey of sex therapists who see BDSM practitioners indicated that their BDSM interests are rarely the presenting problem [18].

In the Richters et al. study of adult Australians, BDSM practitioners and non-practitioners did not differ in their rates of subjective unhappiness and anxiety. There also was no significant difference in the rate of sexual coercion between practitioners and non-practitioners [15]. Cross and Matheson concluded that "measures of mental illness do not differentiate sadomasochists from non-sadomasochists" (p. 159) [9]. Connolly reported normative levels of psychopathology in 132 self-identified BDSM practitioners, although the BDSM population did tend to score higher on narcissism and dissociative measures. In an unpublished doctoral dissertation, Cannon confirmed Connolly's Minnesota Multiphasic Personality Inventory findings; he found no significant differences between BDSM practitioners and non-practitioners [19]. Finally, in a review of studies on sexual masochism, Krueger concluded that community BDSM practitioners by and large ". . . have shown evidence of good psychological and social function" [20].

After an extensive literature search, we were unable to find any empirical study to support the contention that an interest in Sexual Masochism or Sexual Sadism is correlated with a specific type of distress or impairment [5–7].

The Paraphilias and Psychiatric Diagnoses

The current conceptualization of sexual sadism and sexual masochism as mental disorders violates the principles of psychiatric diagnosis, which require that a mental disorder be associated with present distress, disability, or substantially increased risk of harm [1]. The specific type of distress or impairment that BDSM individuals supposedly experience has never been specified [7], and there are no data which associate interest or participation in BDSM with present distress, disability, or an increased risk of harm. A review of the medical literature did not report BDSM participants coming to the attention of emergency departments or

primary care physicians for any harm associated with their BDSM practices. There is a contention that there are one to two deaths per million population that are related to hypoxyphilia practices (mostly autoerotic) [1], but the association with BDSM in these cases is not always clear, the risk appears small, and hypoxyphilia appears to be a rare BDSM interest; as of September 30, 2010, there were 5,000 individual Fetlife.com members interested in asphyxiphilia out a total membership of 571,542 (0.9%). [Correction added after online publication 2-Nov-2010: "Fetlife.com" has been added to the preceding sentence for clarification.]

Even if data existed to support an association between BDSM interests and a specific type of psychopathology, correlation does not imply causation. The lifetime risk of major depressive disorder in women is twice the rate for men (10–25% vs. 5–12%), but women are not pathologized on the basis of this finding (p. 372) [1]. Similarly, a correlation between BDSM interests and another mental disorder does not imply that BDSM interests are intrinsically pathological.

Even in cases where individuals identify their sadomasochistic interests as the cause of psychopathology, the individual may be echoing unsubstantiated statements from the media or other professionals. Mental distress or dysfunction among BDSM practitioners may be the result of societal discrimination or recrimination [4]. In those cases, the cause of the distress is external to the individual; the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition text revision text specifically excludes deviant sexual behavior or "conflicts that are primarily between the individual and society (p. xxxi)" as examples of mental disorders [1].

Sexual Sadism, Sexual Masochism, and the DSM

Sexual sadism and sexual masochism have been included as paraphilias in all recent editions of the DSM; Krueger's review articles suggest that these diagnoses will be included in DSM-5 [20,21]. Krueger and Hucker have argued that the diagnoses should be maintained for the following reasons: [20–22].

Because of a Small Number of Serious Injuries/ Deaths Associated with the Activity

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. Other sexual activities, including heterosexual and homosexual coitus, can result in serious health consequences as well (sexually transmitted infections, fractured penis, myocardial infarction). Education, not pathologization, is used to decrease the morbidity and mortality associated with all these activities, and a similar approach can be used to reduce any injuries or death associated with sadomasochistic activities.

To Facilitate Further Research

This assertion is made in spite of the dearth of research using the DSM Sexual Masochism and Sexual Sadism criteria over the past several decades. It also assumes that these diagnoses are accurate representations of the disorder to be researched, which is questionable.

For Individuals Who Are Distressed by Their Interest in or Practice of the Activity

Although this argument may have some merit, there are other DSM diagnoses that may be used in these situations (e.g., sexual disorder, not otherwise specified; identity problem; adjustment disorder). These diagnoses have the advantage of not identifying the sexual interest as the problem per se, but rather focusing on the problems associated with accepting ones interests or integrating these interests with other life goals.

For Use in Forensic Cases

Krueger's own assessment concludes that the published articles are flawed methodologically and that the results are inconsistent [20,21]. Considering the consequences of employing these diagnoses in forensic situations (incarceration and/or court-mandated treatment for purported psychiatric illness) their validity as diagnoses should require an even higher level of scientific certainty than other disorders.

To Be Applied to the "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"

This is reminiscent of previous psychiatric misadventures. At different points in history, the psychiatric/medical establishment has assigned pathological status to excessive masturbation, promiscuity, nymphomania, and homosexuality; it is implied that in such cases, the amount or focus of sexual behavior differed from the arbitrary "norms" of the individual(s) making the diagnosis and was therefore *de facto* evidence of psychopathology. All of these diagnoses led to serious repercussions for those individuals unfortunate enough to be so labeled. Despite these concepts being rejected, proposals to reinstate them into the DSM are made continuously [22].

To Provide a Diagnostic Label for Individuals Who Engage in Such Activities with Non-Consenting Partners

Any sexual act, including BDSM, can involve non-consenting participants; the perpetrators of these acts are criminals and not necessarily mentally disordered. The difference between consensual coitus and rape is consent; similarly the difference between consensual BDSM and sexual violence is consent.

Recommendations for DSM-5

Evidence-based medicine is now considered the basis of and guide for medical practice. Continuing to include the diagnoses of sexual sadism and sexual masochism in the DSM in the absence of empirical evidence to support their inclusion violates a stated principle of the DSM revision process: "all changes proposed for the text are to be supported by empirical data." A basic tenet of medicine taught to all physicians is, "First, do no harm." These diagnoses have caused harm, been misused, and lack the scientific basis for designating these interests as pathological. The resistance to removing diagnoses which have significant negative effects, no clear positive effects, and no established utility in patient management is bewildering. Therefore, the APA should remove sexual masochism and consensual sexual sadism from DSM-5. Based on the same logic, the other non-criminal paraphilias (transvestism, fetishism, partialism) should also be removed.

Individuals who engage in non-consensual sexual behavior can (and should) be offered treatment to help them control their sexual urges. Existing psychiatric diagnoses that focus on inability to control behavior can be used. Impulse control may be a more viable treatment goal than reparative therapies for unusual sexual interests.

BDSM practitioners with another psychiatric disorder (e.g., mood disorder) should be diagnosed with the other psychiatric disorder, not sexual masochism or sexual sadism *plus* the other psychiatric disorder. Treatment should be directed toward the established psychiatric disorder, not the BDSM interests.

Conclusions

It is in the best interest of Sexual Medicine and Psychiatry that DSM-5 be an evidence-based document. Ergo, the highest stan-

dards of scientific objectivity, not political or moral considerations, are critical in the construction of psychiatric diagnoses. If the decision is made to retain sexual sadism and sexual masochism as mental disorders in the DSM-5, empirical data should be produced to support the diagnosis OR it should be explicitly and clearly stated that these diagnoses are not supported by requisite empirical data.

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