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Conceptualization, History, and Future of the Paraphilias

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Abstract

There is no accepted definition of the term paraphilia despite its being listed as an essential feature of a class of mental disorders known as the paraphilic disorders. The origin of the term, history of its inclusion as a diagnosis, and logical flaws inherent in the various definitions are discussed in this review. We examine the basis for pathologizing individuals with paraphilias, consider what paraphilias can tell us about how humans develop their sexual interests, and question the usefulness of dividing sexual interests into paraphilias and normophilias. The construct of the paraphilias appears to be poorly conceived and has outlived its usefulness.

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Sexual interest:

a stimulus that an individual finds sexually arousing, whether or not the individual actually acts upon it

Paraphilia: recurrent and intense sexual arousal to unconventional erotic stimuli as manifested by fantasies, urges, or behaviors

Normophilia:

recurrent and intense sexual arousal to conventional erotic stimuli as manifested by fantasies, urges, or behaviors

INTRODUCTION

It has been said that anything and everything can become a focus for sexual arousal, but how that process occurs is poorly understood. The strength and persistence of sexual arousal patterns vary, and we do not know which factors increase or decrease the likelihood of a sexual interest becoming recurrent and intense.

The term paraphilia has never been defined clearly, and the concept is controversial. As a working definition for the purpose of this review, paraphilias are defined here as recurrent and intense sexual arousal to unconventional erotic stimuli (sexual interests not seen as acceptable to the dominant culture) as manifested by fantasies, urges, or behaviors. Paraphilias are usually contrasted with normophilias—that is, recurrent and intense sexual arousal to conventional erotic stimuli (sexual interests seen as acceptable to the dominant culture) as manifested by fantasies, urges, or behaviors [see the 5th edition of the American Psychiatric Association’s (APA’s) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA 2013a)]. The distinction between conventional and unconventional erotic stimuli is discussed throughout this review. The line between these categories changes frequently.

How particular stimuli are linked to sexual response is not known, but the process may result in some individuals finding a particular stimulus erotic (e.g., fondling my partner’s feet is sexually arousing), curious (e.g., I always wanted to try fondling my partner’s feet), repugnant (e.g., even

the thought of fondling my partner's feet is repulsive), or neutral (e.g., the thought of fondling my partner's feet is neither sexually arousing nor repulsive). Over time, these responses can change and the blending of different responses can occur (so that one could be simultaneously aroused, repulsed, and repulsed at being aroused).

Clinically, we find that the nature and strength of sexual interests can evolve, develop, deepen, or wane with time. Some sexual interests become recurrent and intense, becoming an integral component of the individual's sexual pattern (i.e., a paraphilia or a normophilia). The intensity of different sexual interests may wane with time or may be rediscovered later.

In the DSM-5 (APA 2013a, p. 685), a paraphilia is defined as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human adult partners." "Normophilic sexual interests" (APA 2013a, p. 685) are those that are not paraphilic. Blanchard (2010a), editor of the DSM-5 paraphilia section, identifies individuals as having paraphilias when their paraphilic sexual interests are greater in intensity than their normophilic interests. However, there is no accepted measure distinguishing the intensity of either paraphilic or normophilic sexual interests. The endeavor to define the paraphilias is inherently fraught with complex problems. These problems become apparent when reviewing the DSM-5 paraphilia definition (Moser 2011, 2016, 2019). For over 50 years, the APA has been trying to define the term paraphilia, yet an acceptable or even logically consistent definition has not emerged.

The definition of the paraphilic disorders in the 11th edition of the World Health Organization's (WHO's) *International Classification of Diseases (ICD)* (WHO 2019, <https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2fcd%2fentify%2f2110604642>) is as follows:

Paraphilic disorders are characterized by persistent and intense patterns of atypical sexual arousal, manifested by sexual thoughts, fantasies, urges, or behaviours, the focus of which involves others whose age or status renders them unwilling or unable to consent and on which the person has acted or by which he or she is markedly distressed. Paraphilic disorders may include arousal patterns involving solitary behaviours or consenting individuals only when these are associated with marked distress that is not simply a result of rejection or feared rejection of the arousal pattern by others or with significant risk of injury or death.

Problems associated with both these definitions are discussed in detail throughout this review.

NORMOPHILIAS VERSUS PARAPHILIAS

What are or are not considered conventional stimuli vary by the culture and the era in which a given individual was raised or resides; hence, there can be many conceptions of normophilias rather than a singular conception. The DSM-5 (APA 2013a) editors allow for multiple paraphilias to exist concurrently and suggest that multiple normophilias (recurrent and intense responses to different conventional stimuli) can also coexist. In other words, multiple paraphilias and normophilias can exist simultaneously if they are all intense and recurrent.

Gregersen (1983, p. 120) relates the story of a Western, female researcher who went to a Pacific island where women customarily go topless but wear skirts that reach the ground. The native men ignored the bare breasts around them but were mesmerized (and scandalized) by the researcher's bare ankles. To be taken seriously, she adopted native dress and was then accepted by the locals.

Kafka (2010) suggests that the concept of hypersexuality is analogous to the concept of a paraphilia but that hypersexuality is focused on conventional sexual interests, whereas the construct of a paraphilia is focused upon unconventional sexual interests. Kafka implies that

DSM: the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association

ICD: *International Classification of Diseases*, published by the World Health Organization

a high total orgasmic rate would be a characteristic of either hypersexuality or the paraphilias but that orgasmic rate (or frequency of sexual activity) is not part of either definition. There are data indicating that the orgasmic rate among hypersexuals is indistinguishable from that of nonhypersexuals (Winters et al. 2010). Similarly, according to the DSM-5 (APA 2013a), when individuals seek psychiatric treatment because their conventional sexual interests interfere with their functioning, their sexual interests can be a focus of clinical attention, but the concern per se does not qualify as a mental disorder.

There are no data indicating that hypersexuality is commonly found among individuals with paraphilic disorders, but that did not stop the editors of DSM-5 (APA 2013a) from liberally sprinkling the term hypersexuality into much of the text on the paraphilic disorders (see Moser 2019). Hypersexuality had been rejected for inclusion as a new diagnosis or as a condition for further study in the DSM-5 (APA 2013a), so its presence here appears to be politically rather than scientifically motivated.

HOW COMMON ARE THE PARAPHILIAS?

It was believed for much of the twentieth century that the paraphilias were rare and that most individuals did not have any paraphilic tendencies. However, there is some indication that at least an interest in paraphilic stimuli is common (Castellini et al. 2018, Holvoet et al. 2017, Joyal & Carpentier 2017, Ogas & Gaddam 2011). As discussed in the section titled Paraphilias Throughout History, it is not clear whether the presence of these interests implies that the individual has a passing interest, a paraphilia, or a paraphilic disorder.

ORIGIN OF THE TERM

The term paraphilia was introduced into English by Robertson but had been coined in 1903 by Friedrich Salomo Krauss (1859–1938) to describe an “inverted erotic instinct” (Robertson 1913). The German term *paraphile* was derived from the Greek *para* ‘beside, aside’ + *philos* ‘loving.’

Robertson (1913, p. 243) stated,

The neurotic whose accompanying fancies always lead into forbidden ground (and this is what constitutes the guilt feeling of pollutions) fights against masturbation [pollutions] because it is connected with incest fancies, criminal desires, perversions, or as F.S. Krauss calls them, paraphilias.

Contrary to the citation above, the *Oxford English Dictionary (OED)* suggests that the first English use of the term was in 1925 in J.S. Van Teslaar’s translation of Wilhelm Stekel’s *Peculiarities of Behavior II* (OED 2019). The *OED Online* parses the roots as *para* ‘analogous or parallel to, but separate from or going beyond, what is denoted by the root word’ and *philia* ‘love of or liking for’ (OED 2019). It should be noted that the root *philia* denotes a nonsexual love (e.g., Philadelphia, the city of brotherly love). A more appropriate root would have been *lagnia* (meaning lust, e.g., algolagnia). *Para* has also been interpreted as demented, as in paranoia.

However the term was derived, it was popularized by John Money, who argued for the change from the word perversions to paraphilias (Ehrhardt 2007). The term paraphilia was introduced in the DSM-III (APA 1980) because compared with previous terms, such as perversion, it “was less prejudicial and judgmental when describing people with unusual sexual behavior problems” (Ehrhardt 2007, p. 223). As the DSM-III stated, “The term Paraphilia is preferable because it correctly emphasizes that the deviation (*para*) is in that to which the individual is attracted (*philia*)” (APA 1980, pp. 266–77). Nevertheless, as a descriptor of a class of mental disorders, the term continues to imply that paraphilias are mental disorders, thereby promoting bias against individuals so diagnosed (Klein & Moser 2006, Kolmes et al. 2006, Waldura et al. 2016).

Before paraphilias were classified as mental disorders, they were viewed as sins or crimes (see Bullough & Bullough 1977). The medicalization of sin transformed the interest (or behavior) into a symptom that was pathognomonic for a mental illness.

Before the adoption of the term paraphilia by the APA, various other terms were used to describe the phenomena it encompassed (e.g., sexual deviation, sexual deviance, sexual perversion, sexual variance). As described in the section titled The DSM and ICD, the different editions of the DSM defined the term differently. The negative connotations of the term led to challenges to remove the diagnosis. Despite serious and obvious shortcomings, it remains firmly entrenched in the DSM (Moser 2019) as well as the ICD (Moser 2018).

BDSM: bondage and discipline, dominance and submission, sadism and masochism

PARAPHILIAS THROUGHOUT HISTORY

It is important to stress that even repeated participation in a specific sex act is not an indication of a paraphilia, nor does it imply the presence of either a paraphilia or a normophilia. Individuals engage in particular sex acts for a variety of reasons—for example, to please their partners, because it is expected by their cultures, out of curiosity, out of an interest in sexual exploration, or because they would face some penalty if they were to decline. To be deemed as having a paraphilia or a normophilia, the individual must be persistently and intensely aroused by the interest or activity.

Long before the concept was given a name, there were individuals who had recurrent and intense sexual arousal to unconventional stimuli. If discovered, individuals who had unconventional sexual fantasies, urges, or behaviors often risked loss of status, blackmail, imprisonment, and death. Sanctions against those who acted on recurrent and intense sexual arousal to conventional stimuli also existed (e.g., stigma and noxious treatments for nymphomania and masturbation). In fact, even recurrent and intense sexual fantasies, urges, and thoughts themselves were stigmatized.

It is difficult to ascertain whether the paraphilias existed prior to the Renaissance; however, it is clear that the behaviors existed. It is not clear that they were recurrent and intense or even primarily sexual. To use a modern-day example, hazing can be part of the initiation process to join college fraternities and sororities. The hazing can involve spanking, whipping, and other demonstrations of dominance and submission (see <https://www.phigam.org/document.doc?id=4217>). We do not know if the individuals (either initiates or the established members) are aroused by or fantasize about these activities. We do not know if they experience the activities as sexual; we do not know if the activities, fantasies, or urges become part of their sexual patterns once introduced; and we do not know if any individuals decide to join a fraternity or sorority because they find the idea of being hazed (or eventually hazing others) arousing. Anecdotally, some participants in the BDSM (bondage and discipline, dominance and submission, sadism and masochism) sexual subculture do date the dawning awareness of their interests in BDSM from hazing experiences.

Ancient sex manuals including the *Kama Sutra* (Vātsyāyana, ~450), the *Koka Shastra* (Kokkoka, ~1150), and the *Ananga Ranga* (~1500) discuss biting, marks left during sex, and love blows. While the presence of these activities in sex manuals implies that these techniques were arousing to some, it is unclear how common they were or if they were incorporated into individuals' enduring sexual patterns. It is also not clear how these authors formulated their suggestions or how popular their suggestions were. It does suggest that the authors recognized that educating their readers about the spectrum of sexual interests might be helpful in improving their sexual experiences.

With a few exceptions, there are no unambiguous erotic depictions of the paraphilias in Ancient Egyptian, Greek, or Roman erotic art. The exceptions appear to be some images of bestiality, pederasty (not involving prepubescent partners), and large phalluses. There are also depictions of oral sex, group sex, and same-sex contacts. From these depictions, we have no way of knowing how this artwork was understood in its time. The fact that these images continue to appear in the

historical record suggests that some people were aroused by the acts or imagery, but whether the arousal suggested by this art surpassed the arousal for normophilic interests of that time is not known.

Ford & Beach (1951) note several societies where painful stimulation techniques were common, though they point out that the dominant and submissive roles appeared to be lacking. Ellis [1936 (1903)] notes that some societies use coital aides (sex toys) that would be painful if used in the absence of sexual arousal. Nevertheless, the women in these societies would refrain from coitus if these devices were not used [Ellis 1936 (1903)]. The belief that Chinese culture eroticized bound feet has been discredited at least partially (see Foreman 2015).

Ellis [1936 (1903)] notes that the first unambiguous example of sexual masochism appeared in the late fifteenth century. It was reported by Pico della Mirandola, who described a man who could only enjoy sex if he were beaten bloody with a whip dipped in vinegar. Other similar cases were noted by Coelius, Rhodiginus, Brundel, and Meibomius between 1516 and 1643. These descriptions suggest that the interests were intense and persistent. The male masochist role was unusual in societies that emphasized male dominance and female submission, so incidents of female submission probably were not documented.

The reader should be cautioned that the meaning of a given interest can be obscured. Possibly the best examples are rape fantasies and rape play. There are individuals who find fantasizing about rape or enacting a simulated rape scene to be erotic (see Bivona & Critelli 2009, Critelli & Bivona 2008). In the fantasy, the victim controls who, when, where, and what happens. It is rare for these individuals to desire an actual rape, which is primarily an act of violence rather than solely a sexual act. Similarly, within a BDSM scenario, individuals may be “forced” to engage in sex acts that do not arouse them. It is the force or surrendering of control that is the arousing aspect—not the particular act.

IS EVERYONE NORMOPHILIC OR PARAPHILIC?

It is not clear whether everyone is either normophilic or paraphilic. As discussed in the section titled Normophilias Versus Paraphilias, it is also possible that some individuals are both normophilic and paraphilic simultaneously. To suggest that someone with a paraphilia cannot develop a more intense normophilic interest is to imply that having a paraphilia somehow changes the person permanently. There are also individuals who may at one time have had a recurrent and intense sexual interest (normophilic or paraphilic) but then had that interest wane over time. The variety of possible reasons for the waning of desire (e.g., medical illnesses or treatment, trauma, stress, situational factors, aging, lack of partners, supplantation by another interest, or a mixture of these factors) leads to the question of whether such individuals still should be categorized as having a paraphilia or normophilia. Blanchard (2010b) argues that to qualify for diagnosis, individuals with paraphilic interests do not have to have them at the time of diagnosis. Blanchard (2010b) and the diagnostic criteria of the DSM-5 (APA 2013a) suggest that an individual diagnosed with a paraphilic disorder cannot resolve the diagnosis—at best, it is perpetually in remission (Moser 2019). The prevailing logic is that you can change a cucumber into a pickle, but you cannot change a pickle into a cucumber. It has not been established that applying this line of reasoning to individuals with a paraphilia is valid.

Some individuals (self-described as asexuals) report a lifelong lack of intense sexual arousal from any stimuli. They report that their sexual interests may be absent or not particularly intense. These individuals may engage in sexual activity, even regularly, but without experiencing the intense or recurrent sexual arousal to any (or all) specific erotic stimuli. They have other motivations, which include placating a partner, expression of romantic love, social acceptance, reproduction,

experimentation, and enjoyment of the sensations. These individuals may find their way to sex therapists and ask for help to develop more intense sexual interests, but they are difficult to treat effectively. They may never develop recurrent and intense sexual arousal to anything (see Moser 1992).

The concept of sexual fluidity suggests that the focus of arousal can change over time. Diamond (2009) originally introduced this concept as related to women who moved up and down the heterosexuality–homosexuality continuum. She later expanded this to men, showing similar movement (Diamond 2013). It is important to note that the direction of fluidity is not under the individual's control, so the individual cannot change sexual orientation at will. Similarly, individuals with a paraphilia may note their specific interest changing (e.g., BDSM dominants becoming submissive or vice versa) or developing (e.g., a sexual interest in feet now includes socks, which eventually may transform into an interest in dirty socks). Most of us recognize the fluidity of age attraction. We are typically attracted to similar-age peers. As we age, the age of prospective partners changes in tandem. For example, many 20-year-olds cannot imagine being attracted to a 60-year-old person, and 60-year-olds may have a hard time sustaining an attraction to a 20-year-old.

Whether the intensity of the sexual interest is current or not has implications for sex offender treatment programs, which primarily address individuals with paraphilic disorders. If the lack of intensity does not change the diagnosis, when would treatment be terminated?

Individuals without any intense sexual interests have been diagnosed with low libido, sexual interest/arousal disorder, and hypoactive sexual desire disorder. This is the so-called Goldilocks paradox: We treat individuals without intense sexual interests by trying to help them develop more intense sexual interests, fantasies, urges, and behaviors, but we also may treat individuals with intense sexual interests by trying to help them develop less intense sexual interests, fantasies, urges, and behaviors or to extinguish those unconventional interests. There is no consensus as to the optimal level of sexual interests.

THE DSM AND ICD

As mentioned in the Introduction, since the latter half of the twentieth century, there have been two major psychiatric diagnostic systems that list the paraphilias as mental disorders: the DSM and the ICD. They influence each other and are coordinated so as not to contradict each other overtly, though there are differences. In both the DSM and ICD, the paraphilias can be divided into two groups: the criminal, involving behavior with a nonconsenting person (or a person or animal unable to consent); and the noncriminal, involving behavior focused on a body part, an inanimate object, or a consenting person.

These definitions and the diagnostic nomenclature are reviewed below to demonstrate how the concept of paraphilias has evolved and how what it encompasses has changed.

DSM-I

What were to become the paraphilias were previously called sexual deviations in the DSM-I (APA 1952). In the DSM-I (APA 1952, pp. 38–39), the entire entry read as follows:

OOO-x63 Sexual deviation

This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenic and obsessional reactions. The term includes most of the cases formerly classed as “psychopathic personality with pathologic sexuality.” The diagnosis will specify the type of the pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation).

Sexual orientation: an intense sexual interest that is characterized by lust and relative immutability, that tends to be lifelong, that has an early onset, and for which there are consequences to the individual for either acting or not acting on the interest

Criminal paraphilia:

a paraphilia that constitutes a criminal offense should one act upon the paraphilic inclinations

There were five paraphilias named in the DSM-I (APA 1952): homosexuality, transvestism, pedophilia, fetishism, and sexual sadism (including rape, sexual assault, and mutilation). Note that sexual masochism was not listed, and rape was mentioned.

DSM-II

In the DSM-II (APA 1968, p. 44), sexual deviations were described as follows:

This category is for individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them.

This description implied that these sexual interests were “bizarre” (without definition) and abnormal and stated that individuals with paraphilias were unable to respond to nonbizarre stimuli.

In the DSM-II (APA 1968), eight different sexual deviations were listed: homosexuality, fetishism, pedophilia, transvestitism, exhibitionism, voyeurism, sadism, and masochism. The categories of other sexual deviation and unspecified sexual deviation were also included. Note that both exhibitionism and voyeurism were added, but rape was removed.

DSM-III

The DSM-III (APA 1980) was the first edition of the DSM to include diagnostic criteria for the paraphilias. It also confirmed that “unusual or bizarre acts are necessary for sexual excitement. Such imagery and acts tend to be insistently and involuntarily repetitive” (APA 1980, p. 266). Paraphilias were further defined as focused upon “nonhuman objects. . .real or simulated acts of suffering or humiliation, or nonconsenting partners. In the absence of paraphilic imagery there is no relief from nonerotic tension, and sexual excitement or orgasm is not attained” (APA 1980, p. 267). The diagnostic criteria for each paraphilia varied as to whether the fantasy of the behavior was sufficient to diagnose the individual, whether acting on the behavior was necessary, or whether both had to be present to qualify for diagnosis. Whether the individual was distressed by the paraphilic interest was not included in the diagnostic criteria. The possibility that individuals without a paraphilia might respond sexually to paraphilic stimuli was noted.

In the DSM-III (APA 1980), zoophilia (another crime) was added, but homosexuality was removed from the list of paraphilias (for a discussion of the historical removal of homosexuality from the DSM, see Drescher 2015). Ego-dystonic homosexuality continued to be listed as a mental disorder but not as a paraphilia.

Zoophilia was included as a criminal paraphilia based on the inability of an animal to consent. It is not clear that animals consent to being killed for food or being caged for exhibition in a zoo or circus. There is no indication that animals necessarily experience pain or unpleasant feelings during sexual activity. We are not advocating for sexual contact with animals, but it is not clear that the preference is a mental disorder.

DSM-III-R (Revised)

In the DSM-III-R, the definition of the paraphilias was expanded to allow for the paraphilia to be expressed “episodically, for example during periods of stress” (APA 1987, p. 279). All the criteria for the individual paraphilia diagnoses now included the statement, “The person has acted on

these urges, or is markedly distressed by them.” Also, “Children” was specifically added to the list of nonconsenting persons. Again, the possibility that someone without a paraphilia might respond to the same erotic stimuli was noted.

In the DSM-III-R (APA 1987), frotteurism (another crime) was added to the list of paraphilias. Zoophilia and six other paraphilias were listed as examples of paraphilia not otherwise specified (NOS). Of these, telephone scatologia (i.e., obscene telephone calls) and necrophilia were also criminal acts. Partialism (i.e., the exclusive focus on a part of the body, such as feet), coprophilia (a focus on feces), klismaphilia (a focus on enemas), and urophilia (a focus on urine) were also added. Why these were named is not clear; coprophilia and urophilia would seem to fit the definition for fetishism or partialism. The rationale for these changes was not explained.

DSM-IV and DSM-IV-TR (Text Revision)

In the DSM-IV (APA 1994), the definition of the paraphilias continued to allow for paraphilias that were expressed “episodically, for example during periods of stress” (APA 1994, p. 523). This was an alternative to the requirement that the expression always be present. The phrase “(not merely simulated)” (APA 1987, p. 287) was replaced with “(real, not simulated)” (APA 1994, pp. 573–74). The examples listed in the paraphilia NOS section did not change. The paraphilic diagnostic criteria all included the following statement: “The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA 1994; see, e.g., p. 530).

In the DSM-IV-TR (APA 2000), the diagnostic criteria for the noncriminal paraphilias (i.e., fetishism, sexual sadism, sexual masochism, and transvestic fetishism) were identical to those in the DSM-IV (APA 1994). For the criminal paraphilias (i.e., exhibitionism, frotteurism, pedophilia, and voyeurism), the diagnostic criteria were changed to the following: “The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty” (APA 2000, pp. 569–75). The DSM-IV-TR editors did not indicate the reason for the change or what the difference was between “clinically significant distress or impairment in social, occupational, or other important areas of functioning” and “cause[s] marked distress or interpersonal difficulty” (APA 2000; see, e.g., p. 575). The criteria for sexual sadism were a mix of both—that is, either acting with a nonconsenting person or “caus[ing] marked distress or interpersonal difficulty.” One possible implication was that someone who met the diagnostic criteria for sexual sadism would have been unable to find a consenting partner, though the accompanying text did allow for consensual activity. This is an example of the bias of the editors, considering that BDSM social and support organizations were easily found across North America and on the Internet at that time.

In the DSM-IV (APA 1994) and DSM-IV-TR (APA 2000), the list of paraphilias in the text and in the paraphilia NOS section were unchanged. A caution was added to the text: “A Paraphilia must be distinguished from the **nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement** in individuals without a Paraphilia” (APA 1994, p. 525; APA 2000, p. 568; bolded in both editions). This appeared to establish the distinction between a paraphilia and a paraphilic disorder, which would be made more explicit in the DSM-5 (APA 2013a).

DSM-5

As mentioned above, the DSM-5 (APA 2013a) has enshrined a distinction between the paraphilias and paraphilic disorders, but the latter remain mental disorders. A paraphilia is framed as a necessary but not sufficient condition to diagnose a paraphilic disorder: The clinician is now to assess the existence of a paraphilia but to diagnose a paraphilic disorder only in the presence of a

Noncriminal paraphilia:
a paraphilia that does not necessarily constitute criminal acts

patient's accompanying distress and/or dysfunction. This change has been heralded in some quarters as a major step forward. However, it allows for even a few moments of distress (e.g., related to accepting that one has a paraphilia) to be sufficient to diagnose the patient with a paraphilic disorder. Furthermore, once the patient's initial distress is resolved, the individual never reverts to having just a paraphilia but, rather, is perpetually saddled with the diagnosis of a paraphilic disorder in remission. Despite the continued appearance of the paraphilias in the DSM, apparently the diagnosis has been applied only in forensic settings (see Krueger 2010).

The diagnostic criteria for the noncriminal paraphilias remain unchanged. The criteria for the criminal paraphilias (except pedophilic disorder) include a new phrase: "The individual has acted on these urges with a nonconsenting person" (APA 2013a, pp. 685–705). The current phrase for the diagnostic criterion for each of the noncriminal paraphilic disorders is "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA 2013a, pp. 685–705).

For pedophilic disorder, the phrasing of the criterion has been kept in the DSM-IV-TR (APA 2000, p. 572) style: "The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty." The rationale for this distinction has never been explained. The accompanying text also allows for any sexual interest in children (e.g., penile plethysmography findings, possession of child pornography, awareness of an interest) to be grounds for the diagnosis. Unlike the diagnostic criteria for the other paraphilias, the interest in children need not be greater than the individual's normophilic desires.

In an attempt to clarify when atypical sexual interests become diagnosable mental disorders, the APA published a fact sheet that appeared online (APA 2013b). The fact sheet is not included in or even alluded to in the DSM-5 (APA 2013a), and it is not clear how many people even know the fact sheet exists. We discuss the implications of the fact sheet in the next section; here, we note that the fact sheet expands the basis for the diagnosis of a paraphilic disorder to individuals who "have a desire for sexual behaviors involving unwilling persons or persons unable to give legal consent" (APA 2013b, p. 1). The individual does not need to be distressed or to engage in criminal behavior to warrant the diagnosis. It appears that the APA has now pathologized thought crimes.

The DSM-5 (APA 2013a) also has not changed the list of paraphilic disorders or those included in the "other specified paraphilic disorder" section. As one exception, partialism is now subsumed under fetishism, so that an individual with a shoe fetish and a foot partialism is now an individual with both foot and shoe fetishes.

ICD

The WHO first listed mental disorders in the sixth edition of the ICD (WHO 1948). "Sexual Deviation" (320.6) was listed with "other Pathological personality disorders" in both the ICD-6 (WHO 1948) and the ICD-7 (WHO 1955). In the ICD-8 (WHO 1965), sexual deviation (302; note change in code number) was subdivided into eight categories (homosexuality, fetishism, pedophilia, transvestism, exhibitionism, voyeurism, sadism, and masochism) as well as "other and unspecified categories." Frotteurism was not included, but homosexuality was still listed as a mental disorder.

In the ICD-9 (WHO 1975), the diagnostic category of sexual deviations and disorders was expanded to include transsexualism, sexual dysfunctions, disorders of psychosexual identity (e.g., gender-role disorder), and ego-dystonic homosexuality. The sexual deviations included zoophilia, pedophilia, transvestism, exhibitionism, fetishism, voyeurism, sexual masochism, and sexual sadism. The ICD-9 (WHO 1975) also included "other" and "unspecified psychosexual disorder" categories. Homosexuality was removed from the list of sexual deviations.

The ICD-10 (WHO 1990) renamed the psychosexual disorder category as disorders of sexual preference. This category included dual-role transvestism (i.e., cross-dressing without sexual arousal or desire to transition) in addition to fetishistic transvestism. This edition combined sexual sadism and sexual masochism into a single new category named sadomasochism. The list included the same paraphilias as before. In contrast to the DSM edition that was current at the time (APA 1987), frotteurism was not listed in the ICD-10. The category of other and unspecified sexual preference remained, but a new diagnostic code for multiple disorders of sexual preference was added.

Political activism led to the removal of the noncriminal paraphilias from the ICD, first in the Nordic countries and then by the WHO internationally (see <https://revisef65.net/about/>) (Krueger et al. 2017). Of interest, whereas the ICD-11 definition of paraphilic disorders (see the Introduction section of this review) includes sexual activities that are associated with a significant risk of injury or death, nonsexual activities that carry such risk are not listed in an equivalent diagnostic category. Marked distress about nonsexual activities is also not listed. It is unclear why ICD singles out sexuality for special diagnostic consideration.

The ICD-11 (WHO 2019) has added coercive sexual sadism disorder and other paraphilic disorder involving nonconsenting individuals as criminal paraphilias. The APA considered and rejected (both as a diagnosis and as a condition for further study) a similar diagnosis, coercive paraphilic disorder, for inclusion in the DSM-5 (APA 2013a). In the ICD-11 (WHO 2019), non-criminal paraphilias have been eliminated and replaced by paraphilic disorder involving solitary behavior or consenting individuals [see Moser's (2018) critique of the problems with this new category]. Of interest, the criterion of recurrent and intense sexual arousal is replaced with "sustained, focused and intense pattern of sexual arousal—as manifested by persistent sexual thoughts, fantasies, urges, or behaviors" (see, e.g., WHO 2019, section 6D30). It is noteworthy that this latter phrase newly pathologizes thoughts, similar to the APA fact sheet (2013b) discussed in the previous section. This new phrase is included for exhibitionistic, voyeuristic, pedophilic, coercive sexual sadism, and frotteuristic disorders.

Without explanation, the wording of the descriptions was changed for "other paraphilic disorder involving nonconsenting individuals" and "paraphilic disorder involving solitary behavior or consenting individuals." The diagnostic criteria for these disorders include the phrase "persistent and intense pattern of atypical sexual arousal—manifested by sexual thoughts, fantasies, urges, or behaviours" (see, e.g., WHO 2019, section 6D36). One may wonder why the WHO added a new category for individuals acting alone or with mutual consent. The answer lies in the criterion for this diagnosis that "involves significant risk of injury or death either to the individual or to the partner (e.g., asphyxophilia)" (WHO 2019, section 6D36). There are no clear statistics as to the prevalence of individuals who engage in asphyxophilia. Preventable deaths are never acceptable, yet the number of participants and the incidence of injuries or accidental deaths from drowning, motor vehicle accidents, skiing, and gun discharge may well be much higher, and there are no mental disorder diagnoses listed in the ICD for those activities. Thus, in the aftermath of the fight to remove the noncriminal paraphilia diagnoses from the ICD, which was apparently won (see <https://revisef65.net/about/>), the pathologizing of atypical sexual interests seems to be creeping back into the text (Moser 2018).

The WHO has introduced a new diagnostic category in the ICD-11, conditions related to sexual health, which covers conditions that are not mental disorders. Although the editors considered including paraphilic disorders in this category, paraphilic disorders continue to be listed under mental, behavioral or neurodevelopmental disorders. Thus, the paraphilic disorders are still designated as mental disorders. The category of conditions related to sexual health includes sexual dysfunctions, sexual pain disorders, etiological considerations in sexual dysfunctions and

sexual pain disorders, gender incongruence, other specified conditions related to sexual health, and conditions related to sexual health, unspecified.

DIAGNOSTIC CONFUSION IN THE DSM AND ICD

The types of sexual interests included in the paraphilia classification have changed from edition to edition of the DSM and ICD. The definitions of the paraphilias (and related constructs) have changed without explanation. A strict reading of the definitions leads to the conclusion that many sexual interests previously considered healthy are now considered pathological and that previously pathological sexual interests are now deemed healthy.

The ICD-11 (WHO 2019) paraphilia designation depends on what is defined as atypical or what is defined as a significant risk of injury or death. These characteristics are not clear, and few physicians or therapists have training in making these determinations. Also, conceptions as to what is sexually typical change with location and history. Unprotected anal sex constituted a significant risk of injury or death, especially among gay men, in the 1980s and 1990s. However, the whole notion of adding homosexuality back into the diagnostic nomenclatures as a paraphilia was not contemplated seriously.

In the DSM-5 (APA 2013a), with the exception of pedophilia, the paraphilias named in the text do not necessarily meet the manual's definition of paraphilias. Specifically, most individuals diagnosed with a paraphilia also manifest normophilic interests (Chivers et al. 2014, Langevin et al. 1998). It seems that an individual with a sexual interest in feet, who fondles a partner's feet before moving to coitus, does not meet the criteria for a paraphilia. If the individual obtains an erection from fondling a partner's feet and then ejaculates prior to coitus, is that a foot fetish or premature ejaculation or both? If the definition is intended to be applied only to the individual who wants to fondle a partner's feet but has little or no interest in pursuing coitus, that would encompass only a very tiny percentage of those who eroticize feet. Is someone who wants to fondle a partner's breasts but has no interest in pursuing coitus similarly at risk of being diagnosed? There are people with no interest in pursuing coitus for religious, social, or physical reasons who can now and possibly will be pathologized. It is not clear if individuals with normophilic interests (e.g., fellatio, cunnilingus) but no desire for coitus would also be designated as having a paraphilia. This line of reasoning reveals more about the sex-negative bias of psychiatry than it does about the nature of sexuality (whether paraphilic or normophilic).

None of the noncriminal paraphilic disorders (i.e., fetishistic, sexual masochism, sexual sadism, and transvestic disorders) fit the new DSM-5 (APA 2013a) paraphilia definition (Fedoroff et al. 2013, Moser 2011). The vast majority of individuals who have these interests also have an intense interest in genital stimulation with "phenotypically normal, physically mature, consenting human partners" (APA 2013a, p. 685). For that matter, the concept of "phenotypically normal, physically mature partners" leaves much to be desired. Both men and women spend considerable amounts of time and money to alter their appearance so as to conform to sociocultural ideals—rather than phenotypic norms—to attract partners. These alterations, including hair removal, dying hair to colors not seen in nature, tattooing, piercing, and augmenting breasts with silicone, are not phenotypically normal. We doubt the APA meant to categorize individuals who eroticize these characteristics as having paraphilias. Blanchard (2009) notes that being aroused by a partner who happens to be an amputee does not indicate a paraphilia, but sexual attraction to someone because he or she is an amputee does qualify. Can one choose prospective partners because they have desirable characteristics (blond hair, large breasts, muscular physique, intelligence) without having a paraphilia? What, if any, characteristics can serve as the basis for ongoing sexual attraction without qualifying individuals with such attractions as paraphilic?

The APA also has introduced a new definition of mental disorders in the DSM-5 (APA 2013a). A mental disorder is “characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior” (APA 2013a, p. 20). The mental disorder definition specifically excludes socially deviant sexual, political, and criminal behavior. (This exclusion was added in the 1980s during the Cold War as a way of protesting the threat to silence Soviet dissidents by declaring them mentally ill.) The definition of a mental disorder includes an exception to the exclusion of socially deviant sexual, political, and criminal behavior, which is when the deviance “results from a dysfunction in the individual” (APA 2013a, p. 20). The APA specifies that this dysfunction stems from “personal distress about their interest, not merely distress resulting from society’s disapproval” (APA 2013b, p. 1).

The new definition of a paraphilic disorder does not fulfill the criteria for the new definition of a mental disorder. Paraphilias are not mental disorders and do not result from a dysfunction in the individual. They should not be used as the basis for the diagnosis. The disturbance in cognition, emotional regulation, or behavior must result from the distress and impairment associated with the paraphilic disorder. The text of the DSM-5 (APA 2013a) does not indicate, and the scientific research does not identify, any characteristic disturbances in cognition, emotion regulation, or behavior in individuals with paraphilic disorders aside from the behavioral expression of their paraphilias.

The paraphilic disorder classification also allows for the diagnosis to be made if the sexual desire or behavior “involves another person’s psychological distress, injury, or death, or a desire for sexual behaviors involving unwilling persons or persons unable to give legal consent” (APA 2013b, p. 1). If this were the case, it would constitute the only entry in the DSM-5 in which the diagnosis is contingent on the effect of one person’s desire or behavior on another person. It pathologizes rape fantasies and turns the act of fantasizing into a thought crime.

As mentioned above, distress and impairment are common among those without paraphilias (or paraphilic disorders). What is different about the distress and impairment associated with paraphilic disorders compared with other distress and impairment often encountered in the general population? It is logically inconsistent to diagnose an individual with a mental disorder on the basis of otherwise nonpathological distress or impairment or a nonpathological interest (i.e., the paraphilia).

The final point of confusion relates to the target of treatment. If all blonds were diagnosed with dysthymic disorder, then the appropriate focus of treatment would be on the dysthymic disorder rather than on changing patients’ hair color. If patients were distressed about their normophilic sexual interests, most psychotherapists would try to alleviate the distress, not change the patients’ sexual interests. Given that the paraphilia is not a mental disorder, why would treatment be aimed toward changing or eradicating the paraphilia?

There are people who fervently desire to be rich. These individuals may think about, fantasize about, and have urges to rob banks. They do not receive a diagnosis if, in fact, they rob banks. By contrast, for people with criminal paraphilias who think about, fantasize about, and have urges related to their sexual interests, committing the sexual act inexorably leads to a paraphilic disorder diagnosis. If the problem is the criminal behavior, why do we not treat all criminals?

ARE PARAPHILIC DISORDERS MENTAL DISORDERS?

The disorders listed in the disruptive, impulse-control, and conduct disorders section of the DSM-5 “are manifested in behaviors that violate rights of others. . .and/or that bring the individual into significant conflicts with societal norms” (APA 2013a, p. 461). The editors of the DSM-5 (APA 2013a) have not provided a rationale as to why sex offenses are not included in this section. There

is no discussion of how paraphilic disorders are similar to or different from disruptive, impulse-control, and conduct disorders. The differential diagnoses sections of these disorders do not even include a discussion of how to distinguish them from paraphilic disorders.

There is no indication that most individuals with a paraphilia or a paraphilic disorder cannot control their behavior. Individuals with a variety of mental disorders can and do commit crimes, but with the exception of the paraphilic disorders, no mental disorders are defined specifically on the basis of committing a crime. Crimes (even repetitive acts) are not mental disorders—that is, there is no “embezzlement disorder.” Even when a mental disorder leads to repeated criminal acts (e.g., an individual with opioid use disorder who frequently steals money to obtain drugs), the diagnostic criteria do not mention the crime. Antisocial personality disorder mentions “repeatedly performing acts that are grounds for arrest” (APA 2013a, p. 659), but the specific crimes are not mentioned. The presence of impulse-control disorders might suggest the commission of a crime (e.g., arson or theft), but most people who set fires or steal do not have the disorders of pyromania or kleptomania.

The diagnosis of pyromania or kleptomania is not based on the crime itself but, rather, “pleasure, gratification, or relief” (APA 2013a, pp. 476, 478) associated with the act. Although sex can lead to pleasure, gratification, or relief, none of those elements are essential for diagnosis of a paraphilic disorder. The APA implies that individuals who commit sex crimes, whether distressed or impaired (or motivated by pleasure, gratification, or relief), are mentally disordered; the crime is the disorder.

As indicated in the DSM-5, “The diagnosis of a mental disorder should have clinical utility” for the patient (APA 2013a, p. 20). A diagnosis of a paraphilic disorder is usually made as part of a court-ordered evaluation after an arrest or prior to the individual’s release from prison after serving a sentence for a sex crime. If a paraphilic disorder diagnosis is made in the United States, the finding may be used to incarcerate the individual involuntarily (usually for life) as a sexually violent predator (SVP). Rather than having any clinical utility for the patient/inmate, the purpose appears to be preemptive incarceration under the guise of treatment. If society wishes to extend the sentences of sex offenders, it should act explicitly to do so through the legislative process. The APA should act proactively to prevent the misuse of its diagnoses for social or legal control. At least at one time, the APA agreed that it had “a strong interest in ensuring that medical diagnoses not be improperly invoked to support involuntary confinement. . . [and SVPs] are not mentally ill under normal standards justifying civil commitment” (APA 1996, p. 1).

The exclusion of rape as a paraphilia is curious. There are individuals who have recurrent and intense sexual arousal to rape fantasies (whether in the role of the perpetrator or victim). Nevertheless, numerous versions of diagnostic criteria for rape (or equivalent) as a paraphilia have been rejected for inclusion in different editions of the DSM. Despite this, some courts have held that rape is a type of paraphilic disorder not otherwise specified (nonconsent). By this logic, individuals can be involuntarily remanded to a forensic psychiatric program for treatment of a mental disorder that has been rejected by the APA, and their release can be determined by “treatment” staff judging that the patients have been treated successfully.

Sexual sadism disorder and similar diagnoses in earlier versions of the DSM included both consensual and nonconsensual interests. The WHO attempted to remove consensual sexual sadism from the ICD. This led to the creation of a new diagnosis, coercive sexual sadism disorder, that would encompass the nonconsensual aspects of the sexual interest. The difference between coitus and rape is consent; the difference between nonconsensual sexual sadism and consensual sexual sadism is consent. It is possible, maybe even probable, that coercive sexual sadism disorder will be used as an umbrella diagnosis for rape and eventually to introduce rape as another paraphilic disorder.

DO INDIVIDUALS WITH PARAPHILIAS HAVE DEFICITS IN PSYCHOLOGICAL FUNCTIONING?

It is reasonable to ask how many individuals with paraphilias present for psychotherapy, either to treat their paraphilic attractions or for other mental disorders; unfortunately, that information is not known. The data concerning the noncriminal paraphilias suggest that individuals rarely present for treatment. Krueger (2010) reports that there were no diagnoses of sexual sadism or sexual masochism in almost half a billion visits to psychiatrists, urologists, obstetricians/gynecologists, and general/family/internal medicine physicians. BDSM participants report encountering significant discrimination when seeking medical care for any purpose (Kolmes et al. 2006, Waldura et al. 2016, Wright 2006). The data concerning the criminal paraphilias are difficult to evaluate because criminal history clearly influences how presenting problems are perceived. Mandated reporting laws in US jurisdictions may have the effect of preventing individuals who are aroused by nonconsensual sexual acts from seeking help out of fear that they will be reported and possibly arrested.

Studies evaluating the psychological health of BDSM participants suggest that they are indistinguishable from other community samples (Cross & Matheson 2006, Richters et al. 2008, Wismeijer & van Assen 2013). Studies on other noncriminal paraphilias are not available.

WHY DO WE CLASSIFY SEXUAL INTERESTS?

Every society tries to influence the sexual behavior of its members. There is often a belief that if other sexual interests were legalized or accepted by a society, it would lead to the collapse of the society or threaten the moral order. The data to support this belief do not exist; we have not been able to find any societies that have collapsed because of changing sexual behavior or mores (see Diamond 2011).

Most people can control their sexual behavior and may decide to refrain from specific sexual activities. Some people choose celibacy. It is unlikely that those choices change the specifics of their normophilic or paraphilic interests. It appears that many such people are successful at abstinence, but we do not know how these choices affect their relationships or personal satisfaction. There are also individuals who have found abstaining from their interests untenable and subsequently resume their preferred activities.

DO THE PARAPHILIAS CONSTITUTE SEXUAL ORIENTATIONS?

Just as the concepts of paraphilia and normophilia are poorly defined, the same may be said of the concept of sexual orientation. Most everyone agrees on the existence of two sexual orientations—that is, homosexuality and heterosexuality. Beyond these, there is a lack of consensus. There is debate about whether bisexuality constitutes its own, unique sexual orientation, though the latest data suggest that it does (Rosenthal et al. 2012; Safron et al. 2017, 2018). It is possible that for some individuals, bisexuality constitutes the coexistence of sexual/gender orientations to both men and women (van Anders 2015) or that bisexuality comprises a sexual orientation with sexual behavior that is inconsistent with that orientation. It is possible that each of these possibilities can pertain to a subset of “bisexual” individuals.

It also has been suggested that homosexual–heterosexual classifications are not binary classifications but, rather, a continuum that can be further subdivided into other discrete orientations (Vrangalova & Savin-Williams 2012). Other sorts of sexual orientations have been proposed including asexuality (Bogaert 2015), pedophilia (Seto 2012), and polyamory (Tweedy 2011). Bailey

(2009) has suggested that women (or at least some women) may not have an orientation. For some individuals, the paraphilias could also be characterized as sexual orientations.

The concept of sexual interests describes what individuals want to do, whether or not they act upon these desires. By definition, a sexual interest is sexually arousing to the individual. Sexual interests may be construed as less intense forms of sexual orientations, where it may be possible to change interests easily, the consequences of stopping the associated behaviors are minimal, and the interests may not be lifelong and may not have had an early onset (Moser 2016).

Sexual orientations are characterized as lifelong—that is, not subject to change. Some proclivities that are currently designated as paraphilias (e.g., BDSM) may meet the definition of sexual orientation (Moser 2016). Some people would suggest that BDSM is just an unusual sexual interest, while others would suggest that it is serious leisure (Williams et al. 2016). In some cases, paraphilias may be permanent and not subject to change. In other cases, treatment may result in change (or just better control of their expression). In yet other instances, paraphilic arousal may be fluid [e.g., it may wane or intensify, but the direction of change cannot be predicted or controlled (Moser 2016)]. As cited above, the label is applied when the paraphilic sexual interest is greater than the normophilic interest, but once applied it cannot revert to normophilia even if the intensity of the normophilic interest comes to surpass the paraphilic interest (Blanchard 2010a,b). The current diagnostic criteria mandate that engaging in a criminal paraphilic behavior is pathognomonic for a mental illness. Blanchard (2010a, p. 308) suggests “that child pornography use may actually be a stronger indicator of pedophilia than is sexual offending against children (see also Seto, Cantor & Blanchard 2006; Blanchard et al. 2009).” Blanchard (2010a, p. 310) also doubts that “ego-syntonic, euthymic, chaste pedophiles. . .are common, compared with the numbers who are distressed by their pedophilia.” There are now studies reporting the existence of “gold-star pedophiles” (Cantor 2014).

THE SPECIAL CASE OF PEDOPHILIA

Any suggestion that pedophilia is not a psychiatric disorder evokes strong feelings of moral outrage and leads to accusations that the authors believe that sex acts with children should be legalized. Nothing is further from the truth. We fervently believe that sex acts with children are odious crimes, and we do not support decriminalization in any way. Individuals convicted of sex crimes should be punished as provided by the laws in the jurisdiction in which these crimes occurred. The courts should impose penalties as prescribed by law and sentencing guidelines. Rape, another odious crime, is not classified as a mental disorder. However, that has not prevented the courts from meting out severe penalties.

Our criticism of the diagnostic systems that classify pedophilia as a mental disorder is focused on the lack of scientific evidence to support that determination. Historically, similar beliefs were used to pathologize homosexuality, oral sex, nymphomania, and masturbation. One would have hoped psychiatry would have learned from those misadventures.

WHY THE CONSTRUCT OF THE PARAPHILIAS IS IMPORTANT

Why does it matter if some people become sexually aroused by, for example, caressing their partners' feet versus caressing their partners' genitals? Why do governments, health care professionals, the clergy, and the public care what individuals do sexually? If there were research demonstrating that paraphilias (or even a particular paraphilia) led to distress or dysfunction, there might be some reason to pathologize the phenomenon and intercede, but those data do not exist. There are no

data to suggest that individuals with paraphilias are flooding into hospital emergency departments or psychotherapy offices because of the distress, dysfunction, or injuries related to their sexual interests. Heterosexuality and homosexuality are also recurrent and persistent sexual interests that may result in distress, dysfunction, or even criminal activity (see Kleinplatz & Moser 2005, Moser & Kleinplatz 2005a).

Being seen as having a paraphilia invokes more stigma than merely noting different sexual interests. Individuals with paraphilias experience bias in health care, psychotherapy, employment, and political and social spheres (Waldura et al. 2016; see also Moser & Kleinplatz 2002). The recent acknowledgment by the APA that not all individuals with paraphilias have mental disorders and the removal of several paraphilia diagnoses from the ICD are steps in the right direction, but these measures fall short of destigmatizing the label.

There is little doubt that paraphilias existed before there was a name for these interests. What constitutes an unconventional sexual interest changes from society to society and over time. Currently, same-sex sexual behavior is relatively accepted in the United States, as is evident in gay marriage laws. In several Muslim countries, same-sex sexual behavior can carry a death sentence, though it is not clear how many people have been executed for homosexual acts in recent years (Ali 2016).

Alcohol use disorder is a psychiatric disorder diagnosis, and drunk driving kills thousands of people (see CDC 2019). Alcohol use disorder tends to be characterized by relapses. Nevertheless, individuals with alcohol use disorder are not incarcerated for years after serving their sentences, even though they might relapse again. Again, we question why individuals with paraphilias are singled out to be treated differently in our legal system and society.

THE FUTURE OF THE PARAPHILIAS

By definition, in any given society there will be people who conform and others who flout that society's norms, sexual and otherwise (Moser 2001, Moser & Kleinplatz 2005b). The paraphilias, however, are a psychiatric construct with serious social and legal implications. The history of the nosology of the various versions of the DSM and ICD, with their interesting vicissitudes of additions and removals of sexual diagnoses, illuminates the flimsiness of these diagnoses. The existence of individuals with statistically atypical sexual interests is indisputable. However, the belief that the paraphilias represent a scientifically valid phenomenon is a conceit. The APA asserted in 1980 that going forward, the DSM was going to be an empirically based nosology (APA 1980, pp. 3, 6–8). A careful examination of the history of the paraphilias as exemplified within the pages of the DSM and ICD assists us in foretelling the future of the paraphilias. There is no future for the construct of the paraphilias (Moser & Kleinplatz 2005b). It is a faulty concept used to distinguish between us and them. It creates a class ripe for discrimination. This is beyond a scientific issue—it is a human rights issue.

CONCLUSION

Psychiatry and sexology have failed to demonstrate the benefit of dividing sexual interests into those that are socially approved or disapproved, have failed to define the paraphilias unambiguously, and have failed to justify pathologizing the paraphilias as mental disorders despite over 150 years' worth of efforts.

Psychiatry should reconsider its role in the involuntary incarceration of another oppressed minority. Individuals who commit crimes should be charged as criminals; psychiatry should not

be complicit in the involuntary incarceration of these individuals. The field also needs to consider how the continued listing of the paraphilias disadvantages individuals so diagnosed in employment, child custody cases, and access to health care.

Psychiatry will need to make a case for the continued presence of paraphilic disorders as diagnoses or remove them from both the DSM and ICD. Individuals who engage in risky activities in pursuit of sexual excitement should be judged by the same standards as individuals who engage in risky activities in pursuit of nonsexual excitement (e.g., mountain climbing, scuba diving, race car driving).

There is essentially no research that demonstrates any difference in psychological functioning between individuals with paraphilias and those with normophilias (Pascoal et al. 2015, Richters et al. 2008, Wismeijer & van Assen 2013). Some have suggested that it is important to maintain the paraphilias in the DSM and ICD to spur further research. Unfortunately, psychiatry has ignored the existing research.

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Demonstrates the equivalence of paraphilias and normophilias.

Demonstrates the prevalence of these interests.

Demonstrates how widespread these interests are in the general population.

An attempt to begin to define our terms.

Analysis of the latest edition of the ICD.

Analysis of the latest edition of the DSM.

Shows no difference in functioning between BDSM and non-BDSM contexts.

Demonstrates the effects of stigma among individuals with a paraphilia.

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