

# Sexual dysfunction and paraphilias in the DSM-5: Pathology, heterogeneity, and gender

**Robbie Duschinsky**

Northumbria University, UK

**Netta Chachamu**

Cambridge University, UK

In the forthcoming 5<sup>th</sup> Edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5), as in previous editions, there are two overarching types of sexual problems. The first type is the 'sexual dysfunctions'. Animating this category, we would argue, is a concern to address sexual experiences and behaviours understood as insufficiently *intense* in duration, magnitude or frequency. The disorders included in the category are thus predominantly those associated with a lack of arousal or pleasure, or which are physically inimical to penetration. The second type of sexual problem is labelled 'the paraphilias'. DSM-5 distinguishes within the paraphilias as a diagnostic category between 'paraphilias' and 'paraphilic disorders': the former are understood as merely abnormal whereas the latter are pathological and require correction. Organising the category of the paraphilias, we would suggest, is a concern with forms of subjectivity with illegitimate *objects* of sexual attraction or pleasure. This 'point of view' article sets out to explore and explain, with swift brushstrokes, the gendered logic underlying the delineation of pathological desires, pleasures and acts in the proposed sexual dysfunctions and paraphilias. Our focus is on changes from previous editions of the DSM. We shall contend that the proposed sexual dysfunctions and paraphilias utilise, refract and ultimately naturalise troubling societal assumptions about gender.

Kristeva (1980 [1975]: 133) has argued that 'the notion of heterogeneity is indispensable' as a starting point for investigations of the logic of classificatory structures, and their role in organising and occluding relations of gender power. That is to say, confronted with a taxonomic system of forms of human life, Kristeva suggests that

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## Corresponding author:

Robbie Duschinsky, Coach Lane Campus East, Northumbria University, Newcastle upon Tyne, Tyne and Wear, NE7 7XX, UK.

Email: Robert.Duschinsky@Northumbria.ac.uk

we begin by examining the points at which diversity is either acknowledged or troubles the system in unacknowledged form. Since assumptions about human ontology and assumptions about gender are necessarily wrapped together, the difficulties faced by a taxonomic system of human beings will, she argues, lead us to the assumptions being made about gender. It is, then, of some note that the 'sexual dysfunctions' in females, such as Female Orgasmic Disorder and Female Sexual Interest/Arousal Disorder, have become much more internally heterogeneous categories in DSM-5 than in previous editions. In DSM-5 the diagnostic criteria for female sexual interest/arousal disorder, for instance, take the form of a list of six criteria (APA, 2012a). If a woman has three of these criteria and feels distressed or impaired by how they affect her life, then this merits diagnosis. These six are the reduced frequency or intensity of: interest in sexual activity; fantasy; initiation of sexual activity with partner; pleasure; arousal in response to cues; sensations during sexual activity.

In sharp contrast stands the lone criterion for the renamed Male Hypoactive Sexual Desire Disorder: the reduced frequency or intensity of 'fantasies and desire for sexual activity', such that it causes 'clinically significant distress or impairment' of 'sexual functioning' (APA, 2012b). This is a remarkable difference. 'Female sexual interest/arousal' is problematised as comprising different components, in an aggregate, such that any three measures of reduced frequency or intensity merit diagnosis. 'Male hypoactive sexual desire' places fantasies and interest as always already locked upon the sexual activity that pledges to temporarily fulfil them. This difference means that there are no diagnostic criteria that assess male sexual pleasure, sensations during sexual activity, or the initiation of sexual activity with a partner. If these are infrequent or lack intensity in a man, there is no pathology, so long as there is no 'clinically significant distress', and no 'impairment' of 'sexual functioning' (presumably the erection–penetration–ejaculation sequence). Moreover, in contrast to the strange construct of female 'sexual interest/arousal' which folds together behaviours and experiences, male arousal is taken to be cleanly physical, and is sequestered away from experience in delayed ejaculation, a separate diagnostic category (APA, 2012c).

The rationale for the changes to female sexual interest/arousal disorder notes that 'the DSM-IV-TR uses a definition of desire (i.e. sexual fantasies and desire for sexual activity) that is highly problematic for some women, given that women report sexual experiences that are concordant with different models of sexual response (Sand and Fisher, 2007), and therefore loss of anticipatory desire for sex may be relevant only to some women' (APA, 2012a). Whereas even the very category of 'desire' is expunged by the rationale as too simplistic to describe female sexuality since 'desire connotes a deficiency and often implies a biological urge', 'sexual fantasies and desire for sexual activity' is accepted as a measure of male sexual desire. The rationale for female orgasmic disorder makes it very clear that the DSM-5's authors wish to 'avoid pathologising normal variations and short-term changes in orgasmic functioning women may experience', especially given that 'the prevalence of orgasmic problems varies across cultures' (APA, 2012d). This explicit concern with cultural and individual heterogeneity in female sexual 'interest/arousal' again stands in contrast to the biologicistic, unitary problematisation of

male sexuality. In fact, the achievement of a homogeneous construct of male arousal is stated as an explicit goal; the rationale for male delayed ejaculation explains that a particular goal in addressing male arousal is 'to define homogenous groups' (APA, 2012c). This is intended to insure that a real clinical entity is being diagnosed, with similar prognosis across patients. This desire for clinical specificity manifests in a simplified and unitary construct, despite the construction of other DSM-5 diagnoses (such as those for female sexual dysfunctions) as heterogeneous and complex.

Where, then, is the heterogeneity of male sexual experience and behaviour registered by DSM-5? Here we can turn to the paraphilias. These primarily male disorders problematise either the object of sexual attraction (e.g. fetishism, pedophilia) or the object of sexual pleasure (e.g. frotteurism, exhibitionism). Unlike the sexual dysfunctions, the paraphilias do not distinguish between male and female forms of the disorders they describe. Instead, most of the paraphilias are male by default. Although some community prevalence studies (e.g. Langstrom and Seto, 2006) find that women do have paraphilic sexual activities and interests (such as masochism, sadism, exhibitionism and voyeurism – though 2–4 times less common among women), detailed and large-scale studies of the paraphilias have used almost exclusively male, forensic participants. For instance, in a paper by Blanchard et al. (2008) on hebephilia, only 10% of his (all male) participants were not known to have committed a sexual offence. As such, the paraphilias can be considered to be predominantly male disorders in terms of the data used in creating the DSM-5 categories and in terms of their clinical usage (e.g. Kreuger, 2009a, 2009b).

As we have seen, in the sexual dysfunctions, the heterogeneity of female sexual experiences and behaviours is indexed by the diversity of measures of 'interest/arousal'; in the paraphilias, the heterogeneity of male sexual experiences and behaviours is registered in terms of the diversity of the objects of attraction or pleasure. However, the nature of this heterogeneity appears very different to that in the female case. Male sexual desire and expression are understood as able to be treated as a unitary physiological operation, primarily at risk of going awry in the erection–penetration–ejaculation sequence (male sexual dysfunction) or in becoming attached to an inappropriate object (paraphilia). By contrast, female sexual interest/arousal and expression are implied to be inherently amorphous and culturally organised.

We understand this different approach to reflect the different uses of the 'sexual dysfunctions' and the 'paraphilia' diagnostic categories in practice and in research, which has focused attention in particular – gendered – directions. Female sexual difference from a norm becomes pathology at the point at which an insufficiency in desire or behaviour inhibits sexual activity, or is inimical to vaginal penetration, and this is experienced as causing 'distress or impairment'. Despite ongoing attention to 'what women want', research has not succeeded in pinning down the nature of female desire, the problems with which were presumed to underlie these diagnostic categories. DSM-5's authors therefore cite some excellent research – which in turn cites feminist arguments – regarding the significance of culture in organizing such constructs as female 'pleasure' or 'interest/arousal' (Graham, 2009). To understand this cultural context, we turn to Gill's (2008) understanding of the cultural development she describes as 'compulsory sexual agency'.

Gill (2008: 54–55) has traced ‘the construction of a new figure’, a ‘woman who knowingly and deliberately plays with her sexual power and is always ‘up for it’ (that is, sex)’. In contemporary society, ‘a new version of female sexual agency is on offer that breaks in important ways with the sexual objectification and silencing of female desire’. She suggests that ‘in some respects, this shift is a positive one, offering modernised representations of femininity that allow women power and agency, and do not define women exclusively as heterosexual. In particular, it is striking that... women’s sexual agency is flaunted and celebrated, rather than condemned or punished’ (Gill, 2008: 52). Yet in other respects, this development is problematic, and retains a misogynistic thread. ‘Possession of a ‘sexy body’... is presented as women’s key (if not sole) source of identity’, and women continue to be held responsible for the ‘monitoring, surveillance, discipline and remodeling’ of this body, and for gatekeeping reproductive sexuality’ (Gill, 2006: 244). Against this backdrop, the DSM-5 description of aberrant female sexuality can be theorised as an attempt to help women manage the demands of compulsory female sexual agency. Simultaneously, in making diagnosis dependent on individual women’s self-described distress and impairment, DSM-5 individualises the problem and in doing so brackets these normative demands on female sexuality.

Within the frame of the DSM-5 sexual dysfunctions, female but not male pleasure, sensation and initiation of sexual activity with a partner are problematised. This is, we would suggest, quite logical given the underlying goal of this diagnostic category in DSM-5. Proximally, this goal is to offer medical support and intervention to those who experience their sexual experiences or behaviours as so lacking in duration, magnitude or frequency that this is, for them, a source of distress or impairment. Ultimately, this goal is to offer medical solutions for the suffering or disability that is caused by the distance between individuals and the normative female subject, always ‘up for it’ whilst simultaneously maintaining the age-old role as sexual gatekeeper. Male sexual desire is, in the process, presumed to be a relatively homogenous and natural matter, a drive towards the sexual act.

We can observe the tensions associated with such essentialising moves. They can be seen, for instance, in the influential paper by Blanchard et al. (2008) in which hebephilia was proposed as a new DSM-5 diagnostic category for people who are preferentially attracted to young adolescents (aged 11–13). Blanchard et al. are forced to work hard in order to maintain a model of male sexual desire as relatively unitary and natural, but attached in the paraphilias to the wrong kind of object. Blanchard et al. operationalise male sexual desire in terms of both the sex and the age of the desired object. They begin with the assumption that, since age is a continuum, men will experience a maximal attraction to a particular age range and this will then be diminished with distance from that age. This theoretical idea is borne out by their phallometric data (measurement of bloodflow to the penis of the subject under different conditions), intended as a measure of desire.

In contrast to this ‘continuum’ view of sexual attraction along the axis of age, the men in Blanchard’s study are classified as ‘homosexual’ and ‘heterosexual’ based on the mean of their self-reported attraction to male or females of any age. The 34 men with precisely equal mean attraction to males and females

were excluded from further analysis. This points to a dichotomised view of sexual orientation, in which 'bisexuality' is operationalised as *precisely equal* attraction to both sexes (and then dismissed). We are left to assume that many of the 'homosexual' men self-rated as having some desire for women, and conversely for 'heterosexuals', but no data on this is presented. Furthermore, the participants' phallometric response to stimuli depicting their 'less preferred' sex is collected but not presented or analysed in the paper. This paper, which forms the basis of the new inclusion of 'hebephilic' and 'pedohebephilic' as discrete 'types' under the diagnosis of pedophilic disorder (APA, 2012f), thus initially sets out that neither age nor sex of the object of the attraction are exclusive; nonetheless, both to some degree end up treated as though they are discrete taxa in the specification of subtypes in the diagnostic criteria.

In the case of both age and sex of the object of attraction, we see an initial acknowledgement that male sexual desire can be complex and contextual; however, these complexities are folded out of sight. The complications produced by heterogeneity are largely ignored, treated as invalid data. For instance, some men claim not to experience sexual attraction in response to particular groups, despite the fact that they are known to have committed sexual offences against a person in that group in the past. This is assumed to stem from a 'non-cooperative' attitude on the part of these men, who are then excluded from analysis. Thus, the complexity of male sexuality is blurred and simplified in both the research paper and the diagnostic category. We theorise that this is due to the intertwining of forensics and psychiatry, and that the overriding aim is to legitimise control of a patient understood as potentially dangerous. For this aim, a nuanced and internally heterogeneous set of diagnostic criteria such as those proposed for the female sexual dysfunctions would be a hindrance.

There is a circularity here: the diagnostic criteria state that there must be a 'recurrent and intense sexual arousal from [the paraphilia], as manifested by fantasies, urges, or behaviors' (added emphasis) (APA, 2012f). In this way, the behaviours themselves become an index of paraphilic disorder. The disorder, in turn, explains the presence of the paraphilic behaviours. Identifying this problem and arguing against 'hebephilia' as a psychiatric diagnosis, Franklin (2010) claims that attraction to adolescents is in fact common, 'evolutionarily adaptive', and that 'across time and culture' men have 'tended to prefer younger partners who are at the peak of both beauty and fertility'. In making these claims, she does not acknowledge that the beauty norms which mean that very young women are 'at the peak of... beauty' are culturally variable. Moreover, she forecloses analysis of the interplay of forms of gender power organising the ubiquitous sexual assessment and self-assessment of female adolescents (Renold and Ringrose, 2011). Franklin does not depart from what we have suggested is a core assumption in organising the difference between and the internal operation of the DSM-5 sexual dysfunctions and paraphilias: male sexual desire, extracted from its social context, can be viewed as a straightforward outcome of biological forces, which sometimes go awry in their object choice. She differs, then, only in where she draws the line between the normal and the abnormal object choice, justifying her choice on the grounds of

prevalence and evolution, thereby perpetuating the silence of DSM-5 on the role of social and relational forces in the assemblage of male sexuality.

In conclusion, we would like to suggest that our argument regarding the gendered assumptions that organise the proposed sexual dysfunctions and paraphilias in DSM-5 can be framed in terms of Foucault's (1997 [1984]: 269) distinction between sexual desires, pleasures and acts. Foucault proposes that in modern Western societies, we have become focused on the nature of our desires, with acts placed as 'not very important' and pleasure given a subsidiary role. Yet the DSM-5 throws up its hands in defeat in attempting to distinguish between mere abnormality and medical pathology in female desire; in doing so it re-centers attention upon pleasure and distress as the site and measure of pathology. In distinction, male sexual heterogeneity is not primarily problematised at the level of the pleasure. Instead, male sexual heterogeneity is problematised in the DSM-5 primarily at the level of the desire and the act, which is pathological by virtue of its illegitimate sexual object or source of pleasure. The reason for this is that the paraphilic disorders come to clinical attention primarily in forensic contexts. In fact, desire and act are not only problematised together in the paraphilic disorders but the possibility of separating them is practically excluded, as male sexual desire is framed as ever at risk of becoming a sexual act. Perhaps most immediately because forensic institutional forces shape the discourse of the DSM-5 on the paraphilias (and much of the research it builds upon), male sexual desire is depicted as a torrent that moves without mediation, buffer or qualification from desire to act. Yet this is also in line with wider discourses on normative masculinity (Kehily, 2001), and affirms them – given that paraphilic desires are presumed to share their form, though not their object, with the desires of normative males. Culture and contingency are thereby evacuated at a crucially significant political site: the organisation of male agency.

## References

- American Psychiatric Association (2012a) DSM-5 development: Female sexual interest/arousal disorder. Available at: <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=432> (accessed 30 April 2012).
- American Psychiatric Association (2012b) DSM-5 development: Male hypoactive sexual desire disorder. Available at: <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=60> (accessed 30 April 2012).
- American Psychiatric Association (2012c) DSM-5 development: Delayed ejaculation. Available at: <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=173> (accessed 30 April 2012).
- American Psychiatric Association (2012d) DSM-5 development: Female orgasmic disorder. Available at: <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=172> (accessed 30 April 2012).
- American Psychiatric Association (2012e) DSM-5 development: Transvestic disorder. Available at: <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=189> (accessed 30 April 2012).
- American Psychiatric Association (2012f) DSM-5 development: Pedophilic disorder. Available at: <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=186> (accessed 30 April 2012).

- Blanchard R, Lykins AD, Wherrett D, et al. (2008) Pedophilia, hebephilia, and the DSM-V. *Archives of Sexual Behavior* 38(3): 335–350.
- Duschinsky R (2011) Ideal and unsullied: Purity, subjectivity and social power. *Subjectivity* 4: 147–167.
- Foucault M (1997 [1984]) On the genealogy of ethics. In: Rabinow P (ed.) *Ethics: Essential Works*. London, UK: Penguin, pp. 253–280.
- Franklin K (2010) 'Hebephilia: Quintessence of diagnostic pretextuality. *Behavioural Sciences and the Law* 28: 751–768.
- Gill R (2006) *Gender and the Media*. Cambridge, UK: Polity.
- Gill R (2008) Empowerment/Sexism: Figuring female sexual agency in contemporary advertising. *Feminism & Psychology* 18(1): 35–60.
- Graham C (2009) The DSM diagnostic criteria for female orgasmic disorder. *Archives of Sexual Behaviour* 39(2): 256–270.
- Kehily MJ (2001) Understanding heterosexualities: masculinities, embodiment and schooling. *Men and Masculinities* 4(2): 173–185.
- Krueger RB (2010) The DSM diagnostic criteria for sexual sadism. *Archives of Sexual Behaviour* 39(2): 325–345.
- Krueger RB (2010) The DSM diagnostic criteria for sexual masochism. *Archives of Sexual Behaviour* 39(2): 346–356.
- Kristeva J (1980 [1975]) From one identity to another. In: Roudiez LS (ed.) *Desire in Language: A Semiotic Approach to Literature and Art*. New York, NY: Columbia University Press.
- Långström N and Seto M (2006) Exhibitionistic and voyeuristic behavior in a Swedish National Population Survey. *Archives of Sexual Behaviour* 35(4): 427–435.
- Renold E and Ringrose J (2011) Schizoid subjectivities? Re-theorising teen girls' sexual cultures in an era of 'sexualisation'. *Journal of Sociology* 47(4): 389–409.

**Robbie Duschinsky** is a Senior Lecturer in Social Science for Social Work at Northumbria University. His research has focused on children and families, the use of psychology in social policy and professional practice, and social and political theory. His articles have appeared in a variety of journals including: *The Journal of Social Policy*; *Sociology*; *Philosophy*; *Social Politics*; *Subjectivity*; and *Social Compass*. Together with Leon S. Rocha, he has published an edited book with Palgrave Macmillan on 'Foucault, the Family and Politics'. He is presently co-organising a conference on changing discourses on gender and sexuality in DSM-5 entitled 'Classifying Sex', to be held in Cambridge in July 2013.

**Netta Chachamu** is a postgraduate researcher in Sociology at Cardiff University, having previously studied Experimental Psychology and the History and Philosophy of Science at Cambridge University. Her main research interest is Sociology of Psychiatry, using a psychosocial approach, a topic she has most recently addressed in an article on 'Abnormality' for the *International Encyclopaedia of Critical Psychology*. She is presently engaged in a study of gendered discourses and psychiatric classification, and is also involved in co-organising the 'Classifying Sex' conference for July 2013.