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Pathologizing Sexual Deviance: A History

Andreas De Block [a] & Pieter R. Adriaens [a b]
[a] Institute of Philosophy, University of Leuven
[b] Centre for Research in the Arts, Social Sciences, and Humanities (CRASSH), University of Cambridge
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Pathologizing Sexual Deviance: A History

Andreas De Block
Institute of Philosophy, University of Leuven

Pieter R. Adriaens
Institute of Philosophy, University of Leuven; and Centre for Research in the Arts, Social Sciences, and Humanities (CRASSH), University of Cambridge

This article provides a historical perspective on how both American and European psychiatrists have conceptualized and categorized sexual deviance throughout the past 150 years. During this time, quite a number of sexual preferences, desires, and behaviors have been pathologized and depathologized at will, thus revealing psychiatry's constant struggle to distinguish mental disorder—in other words, the "perversions," "sexual deviations," or "paraphilias"—from immoral, unethical, or illegal behavior. This struggle is apparent in the works of 19th- and early-20th-century psychiatrists and sexologists, but it is also present in the more recent psychiatric textbooks and diagnostic manuals, such as the consecutive editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). *While much of the historical literature revolves around the controversy over homosexuality, this article also reviews the recent medicohistorical and sociohistorical work on other forms of sexual deviance, including the diagnostic categories listed in the latest edition, the* DSM-IV-TR*: exhibitionism, voyeurism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, and transvestic fetishism.*

Introduction

Before the dawn of modern psychiatry, many philosophers, physicians, and so-called naturalists had already attempted to construct theoretical accounts of the nature and incidence of what they considered unusual sexual behavior. The advent of psychiatry as a medical discipline both reflected and redefined this age-old interest in sexual deviance. Here we focus on psychiatry's historical struggle with the conceptualization and categorization of unusual sexual desires and practices, starting with the publication of Richard von Krafft-Ebing's *Psychopathia Sexualis* in 1886 and ending with the preparation of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*, to be published in 2013).

To this end, we review the recent historical literature on the topic, which we gathered by consulting the main databases that index and abstract articles and books in history (EBSCO's Historical Abstracts), psychology (PsycINFO), and the biomedical sciences (PubMed), and by systematically screening the major historical journals in the field (*Journal of the History of Sexuality, History of the Human Sciences, History of Psychiatry, Journal of the History of Medicine and Allied Sciences*, among others). This selection was further narrowed by focusing on a limited number of canonical or iconic authors, publications, and movements. They are called *canonical* and *iconic* because they figure prominently in all the existing historical overviews and introductions that deal with the topic at hand (e.g., Beccalossi, 2011; Cocks & Houlbrook, 2004). By focusing on these authors, publications, and movements, we do not claim that they have somehow single-handedly shaped and steered psychiatric history. Rather, they became "icons" because their ideas mirrored those of contemporary psychiatrists and society at large. Admittedly, however, writing the history of psychiatry is much more challenging than writing the history of any other scientific discipline (Porter & Micale, 1994). Reflecting the historian's intellectual, political, cultural, and ideological background, psychiatric history writing is a many-headed monster. Either implicitly or explicitly, the study of the (psychiatric) history of sexual deviance has often been a normative rather than a descriptive discipline. Reviewing the history of sexuality, Havelock Ellis and Magnus

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Correspondence should be addressed to Pieter R. Adriaens, Institute of Philosophy, University of Leuven, Kardinaal Mercierplein 2, 3000 Leuven, Belgium. E-mail: Pieter.Adriaens@hiw.kuleuven.be

Hirschfeld, for example, openly pursued an ethical and political course. In their view, the sexual instincts did not change much over time, but what did change were the social reactions to the expression of these instincts. The historical study, then, simply served to record the progress that was made in the attitudes toward unusual or bizarre forms of sexuality. This "repression versus expression framework," as Duggan (1990) dubbed it, was uncritically endorsed by most historians of sexuality (and psychiatry) until the 1970s. Often described as "Whiggish," their method of making history idealized the history of sexology and psychiatry as a triumph of scientific progress and ever increasing emancipation (Porter & Micale, 1994).

In the late 1960s, the French historian and philosopher Michel Foucault fundamentally altered psychiatric history writing (see, e.g., Duggan, 1990; Halperin, 2002; Peakman, 2009; Weeks, 2000). Although many contemporary historians of medicine and sexuality have distanced themselves from some of Foucault's all-too-sweeping claims and often uncritical allegiance with antipsychiatry, Foucault's lasting influence on these fields cannot be denied (Weeks, 1982). Foucault's legacy (Foucault, 1961,1976) reveals itself in the view, still widely adhered to in the contemporary historical literature, that what is accepted as normal and healthy sexuality is not determined by nature but changes with the values and norms of a particular society at a particular place and time (Crawford, 2006). Some historians and philosophers also follow Foucault in suggesting that some sexual conditions and behaviors have been created, at least partially, by a growing body of legal and medical thought (Hacking, 1999). Either way, psychiatrists' and sexologists' descriptions of new pathologies or types of persons should not be considered as discoveries but rather as inventions or constructions.

However, contemporary historians often fault Foucault for being obsessed with social control (e.g., Foucault, 1975), as if disorder categories were unilaterally imposed by psychiatrists or bourgeois society (Halperin, 2002; Sedgwick, 1990). "Patients . . . were not merely victims of the new psychiatric labeling," as Oosterhuis (2000, p. 212) observes; in his view, the construction of mental disorder categories, including the sexual deviations, should be seen as a joint venture between psychiatrists and their patients (see also Chauncey, 1995). Contemporary historians of psychiatry agree with Foucault, however, that the study of sexual deviation is always to some extent the production of deviance (Irvine, 1995).

Another element of Foucault's legacy is that many of the more recent articles about the history of sexuality explicitly discuss sophisticated methodological and philosophical issues, such as the relation between the study of history and critique, and the relative importance of discontinuities in what Foucault called "systems of knowledge." Although many of these reflections on "how to write the history of psychiatry" or on how historians are "making sexual history" (Weeks, 2000) are interesting and thought-provoking, we limit ourselves here to a more descriptive and less theoretically and politically engaged history of sexual deviance. More particularly, we sketch the main changes and continuities in psychiatry's conceptualization and classification of unusual sexual urges, fantasies, and behaviors. In the first section, we discuss how paraphilias were conceived and explained in the early decades of modern psychiatry up until the publication of the first edition of the *DSM* in 1952. The second section deals with the general changes in the nosology of sexual deviance in the second half of the twentieth century, from *DSM* to *DSM-5*. Both sections reveal that the history of psychiatry's dealings with sexual deviance is a constant wavering between two opposing viewpoints: the view that sexual abnormality constitutes a disease (the pathological approach; Gijs, 2008) and the view that the so-called perversions or paraphilias are biologically normal variants of sexual variation (the normality theory approach; Gijs, 2008).

Early Modern Psychiatry and the Perversions (1850–1950)

The Old Testament contains many prohibitions and warnings against a number of sexual practices, including same-sex sexuality, masturbation, anal sex, cross-dressing, and sex with animals (Gordon, 2008). Until 1850, the definition of sexual deviance was based primarily on moral, legal, and theological considerations. From then onward, the increasing popularity and authority of psychiatry resulted in a new conceptualization of certain forms of sexual deviance as medical or psychological problems. Given that the birth of modern psychiatry is usually dated around the beginning of the 19th century (Shorter, 1997), it took psychiatry only a couple of decades to throw its light on the study of deviant sexuality.

Yet why did aberrant sexual behavior become a medical and psychiatric issue? First of all, the pathologizing of sexual deviance was not radically new. Medical writings on sexual behavior and the dangers of masturbation, prostitution, and venereal diseases existed long before 1850 (Gagnon, 1975; Stolberg, 2000). In 1761, the Swiss physician Samuel August Tissot had published his *L'onanisme: Dissertation sur les maladies produites par la masturbation*, and many 18th-century Enlightenment thinkers, such as Thiry d'Holbach and Denis Diderot, agreed with him that masturbation and other kinds of nonreproductive sexual behavior could cause serious health hazards to both body and mind (Gilbert & Barkun, 1981; Hare, 1962). Even though it is true that these medical and philosophical writings did not

influence the public understanding of unusual sexual behavior the way late-19th-century psychiatry did, they nonetheless paved the way for the psychiatric approach to sexual deviance (Cryle & Downing, 2009). Furthermore, there was a growing political concern among both utilitarians and nationalists about the vitality and health of nations and peoples. To avert the danger of depopulation and degeneration, politicians enlisted the help of psychiatrists who, for various reasons, were held in high regard by both the public opinion and the authorities. Replacing the clergy as authorities in the sexual domain, 19th- and early-20th-century French psychiatrists were even paid by the government to take care of the supposedly declining mental hygiene of the French population (Oosterhuis, 2000). Such public esteem obviously granted psychiatrists the license to study and treat all sorts of problems, including sexual deviance. A final factor that contributed to the medicalizing of aberrant sexual behavior related to the internal development of psychiatry as a medical discipline. As long as insanity was seen as an illness of the human intellect, sexual deviance could less easily be conceptualized as a mental illness because sexual deviance did not affect intellectual judgment. From the 1860s on, psychiatrists broadened the traditional rationalistic conception of insanity (Berrios, 1996). They proposed and developed new definitions of insanity that included diseases of the will and the emotions, thus facilitating a psychiatric account of sexual deviance (Shorter, 2008).

However, the discontinuity between the legal, moral, and theological approaches, on one hand and the medical–psychological approach on the other hand is far from absolute. As a matter of fact, the continuities and synergies between both accounts of sexual deviance are sometimes very striking. For instance, the medicalization of aberrant sexual behavior was undoubtedly steered by the use of physicians and psychiatrists as forensic experts (Beccalossi, 2010; Oosterhuis, 2000). As Peakman (2009) noted: ''One example is Ambroise Tardieu's *Crimes Against Morals from the Viewpoint of Forensic Medicine* (1857) listing the inward and outward signs of pederasty in order to both help the law, and to ensure the state's better control over private morality—the 'feminized' appearance of these men was criticized'' (p. 42). Throughout the 19th century, physicians were often called upon by police forces for guidance on how to deal with sex offenders (Hill, 2005). While this way of working sometimes led to conflicts between law and medicine, it was equally common that lawyers actively sought to increase the influence of medical psychologists in court—with an eye to the promotion of the insanity defense (Eigen, 1995). With regard to the theological influence on psychiatry, it is noteworthy that many medical authorities in the field of sexual pathology continued to use the term and the notion of *perversion*. During the Middle Ages and the Renaissance, this term was used to denote an aberration or a deviation from a divine norm: any act that violated the laws of God was considered a perversion. Medieval theologians and Christian philosophers emphasized that the divine law was also a natural law. Even though there were sexual vices in line with nature, such as adultery, rape, and incest, the unnatural vices, such as masturbation, sodomy, and bestiality, were the worst sins because they could not result in conception (Oosterhuis, 2000). This distinction between natural and unnatural sexual vices dovetailed with the interests of 19th-century physicians in distinguishing healthy from pathological sexuality (Kamieniak, 2003).

Despite the historical continuities between the moral–theological, legal, and psychiatric accounts of sexual deviance, there is consensus among historians that the second half of the 19th century, and especially the publication of Richard von Krafft-Ebing's *Psychopathia Sexuali*s in 1886, marked a real turning point in the understanding and medicalization of sexual deviance. Before we discuss Krafft-Ebing's role and theories, we present a short sketch of how psychiatry dealt with unusual sexual behavior before 1886.

Before Krafft-Ebing: The Sexual Instinct and its Deviations

Pathological anatomists before the 19th century saw sexual perversions as diseases of the genitals, caused by an anatomical abnormality therein (Davidson, 1991). Throughout the 19th century, and particularly due to the influence of organological and phrenological theories such as Gall's (Gall, 1835; Shortland, 1987), the focus shifted to a link between sexual desire and sexual instinct, which was then thought of as a reproductive instinct, or an instinct for the propagation of the species. Perversions were more and more defined as functional diseases of this instinct. During the 1840s and 1850s, a number of thinkers entertained the idea that psychology and psychopathology should be founded on a theory of the instincts. Although there was a lively debate about the number and classification of the human instincts (Ellenberger, 1970; James, 1887), many psychologists and psychiatrists agreed that the sexual instinct played an important role in human life. In 1844, Russian physician Heinrich Kaan published his *Psychopathia Sexualis*, in which he distinguished between a number of pathological modifications of the sexual instinct (Oosterhuis, 2000; Van Ussel, 1968).

A very similar way of thinking found acceptance in France, partly under the influence of Esquirol. In 1847, a student of Esquirol, Louis Lunier, diagnosed a necrophilic soldier as suffering from a pathological failure of the sexual instinct (Kamieniak, 2003). Two years later, Claude-Francois Michéa proposed his own classification of the ''unhealthy deviations of the sexual instinct'' (Foucault, 2004; Hekma, 1991; Michéa, 1849). Another French physician, Paul Moreau de Tours (1880), argued

in *Des aberrations du sens génésique* that the sexual instinct was a sixth sense that could be disturbed like the other senses without affecting the functioning of other (mental) organs. According to Moreau de Tours, and many other 19th-century psychiatrists, the sexual instinct could be disturbed in different ways: it could be too strong (''augmentation''), too weak (''dimunition''), or even totally absent (''abolition''). The sexual perversions, however, formed a class of their own—a fourth class of pathologies of the sexual instinct, characterized by deviation of the instinct from its natural aim (Davidson, 2001).

This instinctual view of the perversions coincided with a change in the relations between the legal and the medical professions with regard to sexual deviancy. During the 17th and 18th centuries, acts against nature (e.g., bestiality, anal sex, homosexuality) were severely punished. If the evidence was considered to be strong enough, men and women who had sex with their dogs or other domestic animals were sentenced to death, as were those men who had anal sex with other men (Peakman, 2009). This happened all over Europe, from Spain to Denmark, and from England to France (for an overview, see the papers collected in Gerard & Hekma, 1989). In general, the acts were considered illegal, not the underlying desires, but sometimes both were condemned. In 1818, for example, Johann Heinroth's influential handbook on mental disorders treated the mental disorders as sins. According to Heinroth (1818), mental disorders were the result of a voluntary abandonment of freedom. Heinroth argued that this ''insight'' was particularly relevant for forensic psychiatry because it meant that mentally ill criminals, including sexual deviants, were criminals after all: they were culpable because their crimes were the consequence of a free decision (Gutmann, 2006). This view started to wane after 1860. More and more psychiatrists argued that perverse individuals should be cured rather than punished (see Ober's 1984 paper on Kotswara's death for one of the first uses of perversion as a defense to a charge of murder). Even psychiatrists such as Lombroso, who drew a parallel between sexual deviancy and criminality, did not necessarily advocate the punishment of sexual perversions but rather wanted to draw attention to the biological underpinnings of both (Beccalossi, 2011).

Eager to enhance their professional standing (Waters, 2006), 19th-century psychiatrists gladly assumed that, unlike the diseases of the genital organs, the perversions could and should be treated psychologically. Awaiting consensus on what such treatment should consist of, various (alternative) therapies were tried and tested (e.g., hydrotherapy, moral treatment, electrotherapy, hypnosis, and bloodletting by means of leeches on the penis or the uterus), yet without much agreement as to their effectiveness (Groneman, 2000; Oosterhuis, 2000). Still there was consensus about Wilhelm Griesinger's general claim that the appropriate therapy could be determined only after a sound diagnosis and a convincing etiological account. This was thought to hold for all pathologies, including the sexual perversions (Davidson, 2001). For example, French psychiatrists Charcot and Magnan believed that the psychogenesis of sexual perversions implied that they could be treated by means of psychotherapy (Ellenberger, 1970).

Given that prophylaxis and treatment of the perversions should be based on a proper understanding of their etiology, how did mid-19th-century psychiatrists conceive of the causes of sexual deviance? Different perspectives were developed to explain such causes (Fedoroff, 2009). Binet, for instance, argued that they were caused by learned associations. Most psychiatrists preferred a disease perspective, in which degeneration played a pivotal role (Beccalossi, 2010), even though there were almost as many degeneration theories as there were psychiatrists (Pick, 1989). One essential element in most such theories was the conviction that mental disturbances were hereditary diseases and that heredity, as Henry Maudsley once put it, was destiny. Most degeneration theories also held that aberrant sexual behavior, and particularly masturbation, could trigger or worsen the hereditary vulnerability, thus inducing or accelerating a downhill process in which all sorts of disturbances would progressively and inevitably grow worse throughout consecutive generations. So sexual deviance was not just considered to be the result of degeneration, it was also seen as the cause of many other ''degenerative'' or ''regressive'' illnesses, including alcoholism, pauperism, and moral insanity (Rimke & Hunt, 2002).

These degenerative diseases of the sexual instincts were often thought of as intimately intertwined with what we now call ''gender issues.'' Sexual deviance was usually seen as signs of feminization in men and masculinization in women (Cryle & Downing, 2009). Cesare Lombroso, for example, argued in *The Female Offender* that traces of masculinity (huge jaws and cheekbones, hard facial features, etc.) could be found in all degenerate women, including the sexually deviant ones (Lombroso & Ferrero, 1893/1999; Seitler, 2004). The connection between gender issues, degeneration, and sexual deviancy is nowhere more obvious than in the panoply of psychiatric theories about the nature and genesis of same-sex sexual behavior, which for a very long time was the most important category in many classifications of sexual deviance. In 1864, Karl Heinrich Ulrichs wrote that ''urnings'' (i.e., men who were sexually attracted to men) were actually born with a woman's spirit, whereas ''urnindes'' (i.e., women who were sexually attracted to women) had a male spirit trapped in a female body (Drescher, 2010; Ulrichs, 1864; see also Groneman, 1994). Very similar ideas circulated about the connection between masochism and femininity, and between sadism and masculinity

(McLaren, 1997; Siegel, 1995). Paradoxically, masochism in women was thought to be very rare, partly because most psychiatrists saw the desire to be submissive as a normal part of female sexuality—an idea that remained very popular among (male and female) psychoanalysts until the end of the 20th century (Crozier, 2004). Moore (2009) illustrated how different degeneration theories were used to explain the relation between gender and perversion:

> For most late-nineteenth-century writers, all gender variations of sadism and masochism inspired visions of degeneration. However, the kind of degenerative process imagined in relation to progress and European civilization differed in those cases where the sadist was a man or the masochist a woman. Since these were perversions of excess and not of deviation from gender norms, they tended to be imagined as a return of the barbaric evolutionary past rather than as a sickly decline to the decadent present. (p. 140)

Again, masturbation played a major role in the connection between effeminacy and degeneration, and between effeminacy and perversion, not in the least because the loss of seminal fluid was thought to have detrimental effects on masculinity (Stephens, 2008), an idea that Galen had already entertained in ancient times.

During the 1880s and 1890s, psychiatry's interest in the description, categorization, and etiology of sexual perversions grew rapidly, resulting in many articles and monographs on the topic. However, historians generally agree that Krafft-Ebing's taxonomy and discussion of the perversions was clearly the most influential of all 19th-century contributions to this nascent field (Oosterhuis, 2000).

Richard Von Krafft-Ebing's *Psychopathia Sexualis* (1886)

Richard von Krafft-Ebing (1840–1902) was an Austrian forensic psychiatrist and a university lecturer in Graz and Vienna. He wrote on a wide variety of psychiatric topics, but he made his name first and foremost with his work on sexual pathology (Hauser, 1994). His *Psychopathia Sexualis* is often thought to be the bible of 19th-century sexology (Downing, 2010). It is not the case, however, that Krafft-Ebing radically changed the existing conceptions of sexual deviance. Like many of his predecessors, Krafft-Ebing saw the perversions as functional deviations of the sexual instinct (''Geslechtstrieb''), which he presented as a force that emerges during puberty and slowly declines after age 40. Its seat is in the cerebral cortex, probably close to where the olfactory sense resides. He also believed that the diseases of the sexual instinct were caused by degeneration. Moreover, his account of sadism, lust murder, and masochism shows how he tied many of the sexual perversions to a gendered view of the sexual instinct: he considered the sexual instinct of sadists and lust murderers too manly (Cryle & Downing, 2009), whereas masochistic men were overly effeminate (Moore, 2009). Finally, Krafft-Ebing echoed other psychiatrists by emphasizing the role of masturbation in the etiologies of perversion and other forms of insanity (Krafft-Ebing, 1886/1965; Rimke & Hunt 2002).

Yet Krafft-Ebing did more than simply repeat existing theories and classifications. For example, he disagreed with most of his predecessors about the kind of degenerative process that was responsible for the perversion of the sexual instinct. Krafft-Ebing favored the view that perversions were caused by ''hereditary taintedness'' in the family pedigree—a taintedness which leads to an imbalance between the sexual instinct and the inhibitory powers, and which can be aggravated by excessive masturbation (Money, 2003; Oosterhuis, 2000). In his view, even fetishism was mainly due to these hereditary defects, although Krafft-Ebing followed Binet and Lombroso in arguing that the particular sexual fetish was fixated as a result of associative psychological processes (Savoia, 2010).

That said, *Psychopathia Sexualis* did not become one of the most influential books on human sexuality because of some minor etiological points. If its publication is still seen as a pivotal point in the history of sexuality, it is because the book was the first comprehensive and thorough biomedical account of sexual deviance, illustrated and informed by a large number of autobiographical case studies (Oosterhuis, 2000). Because of the many case studies and Krafft-Ebing's habit to extensively quote different patients, *Psychopathia Sexualis* was a medical treatise that explored the boundaries between the medical, the psychological, and—at least in the eyes of many of his contemporaries—the pornographic. Theoretically speaking, the most important change—partly prepared by other psychiatrists like Jean-Etienne Esquirol, Carl von Westphal, and Heinrich Kaan—was the idea that perversions should be understood at a psychological level, since they are part of the individual's personality (Davidson, 1987). This psychiatric style of reasoning no longer considered aberrant sexual behavior to be a result of a weak will or a defective anatomy but rather as symptoms of a deep personality structure (Waters, 2006). Whereas ''perverts'' used to be seen as individuals who turned to evil, Krafft-Ebing spoke of the different perversions as different ways of being a person. Davidson (1991) astutely summarized Krafft-Ebing's basic assumption as follows: ''To know a person's sexuality, is to know that person'' (p. 314).

The emphasis on a functional and psychological understanding of the perversions led Krafft-Ebing to the view that *perversions* should be distinguished from perverse acts—acts he called *perversities*. Sadistic behavior is a perversity and differs, as such, from sadism,

which is a perversion. The same is true for all other sexual deviations. The difference between perversion and perversity has to do with where each is located. Since perversions are functional diseases, their causes should not be looked for in the brain or in the genitals, and they cannot be diagnosed on the basis of behaviors alone. Rather, they should be looked for in the person as a whole (Davidson, 1991; Savoia, 2010). It is only the involvement of the personality as a whole that turns a perversity into a proper perversion: ''In order to differentiate between disease (perversion) and vice (perversity) one must investigate the whole personality of the individual and the original motive leading to the perverse act. Therein will be found the key to the diagnosis'' (Krafft-Ebing, 1886/1965, p. 54). Perversions, Krafft-Ebing argued, are all about deriving sexual pleasure from imagination and fantasy. Diagnostically and clinically, inner feelings were much more important than sexual behaviors or cerebral lesions. The implication of this view is that masochists or fetishists can be masochists or fetishists even though they never realize their fantasies. Thus Krafft-Ebing thoroughly *psychologized* and *individualized* (deviant) sexuality, as Oosterhuis (2000, p. 279) has put it, taking great care to differentiate perversion from mere immorality and crime.

Echoing Moreau de Tours, Krafft-Ebing distinguished four classes of sexual disturbances, which he jointly called ''sexual neuroses'' and ''perversions of the sexual instinct'': the lessening of the sexual appetite (''anesthesia''); its abnormal increase (''hyperesthesia''); and its manifestation outside the biologically normal period (''paradoxia''); and the fourth and final class (''paraesthesia''), which psychiatry would increasingly focus on and which it would later describe as the ''proper perversions,'' ''sexual deviations,'' or ''paraphilias.'' Individuals in this class avoided the procreative act of genital copulation because they were aroused by inappropriate or unsuitable stimuli: ''With the opportunity for the natural satisfaction of the sexual instinct, every expression of it that does not correspond with the purpose of nature—i.e., propagation—must be regarded as perverse'' (Krafft-Ebing, 1886/1965, pp. 52–53). An important consequence of this view is that Krafft-Ebing considered sexual bondage to be a sexual abnormality but not a proper paraesthesia of the sexual instinct, simply because sexual bondage usually does not interfere with coitus (Oosterhuis, 2000).

Already in 1877, Krafft-Ebing had identified and categorized a number of proper perversions in a paper titled ''Certain Anomalies of the Sexual Instinct'' (see Waters, 2006). This classificatory work was further developed in *Psychopathia Sexualis*, in which he subdivided the class of (proper) perversions into three large groups: sadism, masochism, and antipathic sexuality or contrary sexual instinct (''die konträre Sexualempfindung''), a disorder that roughly encompassed homosexuality, transvestism, and transsexuality.[1] In his fourth edition of 1889, Krafft-Ebing added a fourth main perversion, fetishism, thus relabeling a whole set of data that he had already discussed in earlier editions of the book (Hauser, 1994). In later editions, new perversions were introduced, including pedophilia, urolagnia, coprophilia, necrophilia, and different types of bestiality, including ''zoophilia erotica'' and ''zooerasty.''

Freud, Psychoanalysis, and the Perversions

In *Psychopathia Sexualis*, Krafft-Ebing often discussed the boundaries between normal, criminal, and perverse sexual behavior, and in later editions he openly admitted that it was very difficult to demarcate these three domains. Thus he considered the perversions of masochism and sadism to be exaggerations of healthy male (sadism) or female (masochism) behavior (Hauser, 1994). Although Krafft-Ebing distinguished between pathological and physiological fetishism (the latter being the basis for all normal sexual attraction between two individuals), he also claimed that the differences between the two were, again, very vague (Savoia, 2010). A very similar claim about the relationship between normal and deviant sexuality was made by Sigmund Freud and many other Viennese sexual scientists (Oosterhuis, 2000). Krafft-Ebing undoubtedly influenced Freud on this and many other issues. Hauser (1994) correctly remarked that ''Freud scholars have seen him [Krafft-Ebing] as a representative of mainstream Viennese psychiatry and as one of the many who disagreed with Freud's ideas. More recently (and convincingly), however, they have begun to see him as a significant influence on Freud's own revolutionary work on sexuality'' (p. 210). Freud's views on sexual deviance, however, also initiated a shift in psychiatry's historical struggle with sexuality. This shift would prove important to the extent that psychoanalysis provided the general intellectual framework for much of psychiatry and its diagnostic manuals until the 1960s (Kandel, 1998; Shorter, 1997).

It is widely known that Freud took various elements from literature, mythology, and philosophy to construct psychoanalytic theory. This helped him get a grip on the meaning behind pathological behavior and thinking, including the meaning behind sexually motivated interests (Fedoroff, 2009). Equally important, however, is his indebtedness to the work of sexologists and biologists of his time (Sulloway, 1979). Freud's theorizing on human sexuality, both normal and pathological, made use of Meynert's libido concept, Havelock Ellis's notions of autoeroticism and narcissism, Fliess's theory of bisexuality, Moebius's critique on degeneration

[1]Magnus Hirschfeld and Havelock Ellis were the first to see homosexuality as different from transvestism and transsexuality (Blanchard, 2005; Hill, 2005; Meyerowitz, 2001).

theories, Moll's study of infantile sexuality, Chambard's and Bloch's notions on the erotogenic zones, and many elements of Marcuse's, Löwenfeld's, Eulenburg's, and Hirschfeld's works (Ellenberger, 1970). In the first essay of his *Three Essays on the Theory of Sexuality* (Freud, 1905/1960b), devoted to the "sexual aberrations," Freud seemed to do little more than reiterate and synthesize the different concepts and theories that circulated in early-20th-century Vienna and elsewhere. With regard to the classification of sexual aberrations, Freud largely followed one of Krafft-Ebing's last proposals and distinguished "aberrations according to the sexual aim" and "aberrations according to the sexual object" (Ellenberger, 1970). The latter included inversion (homosexuality), pedophilia, and bestiality. The aberrations according to the sexual goal were again divided in two categories: The first group consisted of what Freud called "anatomical transgressions." These included fetishism and anal and oral sexuality. The second group contained the "fixations of precursory sexual aims," and a subgroup that included frotteurism, sadism, masochism, exhibitionism, and voyeurism.

The very division into aberrations (or perversions)[2] "according to the sexual aim" and perversions "according to the sexual object" seems to suggest that Freud agreed with Krafft-Ebing and most other psychiatrists of his time in believing that biology determined the normal sexual object (a mature person of the other sex) and the normal sexual aim (coitus) and that all perversions are diseases because they result from an underlying psychopathological condition which makes it impossible to meet these natural norms. However, a deeper look into Freud's theories highlights how they differed from the erstwhile psychiatric consensus. Freud's theory as developed in the *Three Essays on the Theory of Sexuality* (1905/1960b) is not simply a psychopathological theory of sexual abnormality, even though it is often presented that way (see, e.g., Gijs, 2008). Freud believed that the statistical norm was a perverse norm, at least to the extent that "the disposition to perversions is itself of no great rarity but must form a part of what passes as the normal constitution" (Freud, 1905/1960b, p. 171). So there was indeed such a thing as a perverse disposition, but unlike his colleagues and predecessors Freud claimed such a disposition to be universal (De Block, 2005). Lacking an innate link between the sexual instinct and its objects and aims, all human beings are "polymorphously perverse" beings during a substantial part of their childhood (Davidson, 1987)—a point Freud elaborated on in the second part of the *Three Essays*. Basically, Freud characterized the child's sexuality as perverse because it consisted of a range of partial sexual instincts, each of which originated in one of the many erogenous zones of the child's body, and each of which pursued its own aims.

Even though it is difficult to deny that these views further blurred the line between normal and pathological sexual desire, Freud never completely abandoned such a distinction (Davidson, 1987). In fact he strongly believed that the child's polymorphously perverse sexuality could give rise to both healthy and pathological adult sexual fantasies and behaviors. Freud's early work focused on the exclusivity of particular fantasies and behaviors to demarcate the normal from the pathological (Savoia, 2010). In this view, being a pathological masochist implied not so much that one sexually enjoys humiliation or punishment but rather that one *only* enjoys humiliation and punishment, without any further interest in coitus or other sexual activities. In the *Three Essays*, the pathogenic mechanism that leads to such exclusivity was identified as a combination of a fixation on one of the partial sexual instincts during the first five or six years and a regression to this fixation at the beginning of puberty.

From 1915 onward, Freud started to modify his conception of the sexual perversions—a shift that had become necessary because of the numerous concepts (such as narcissism, the id, penis envy, and so on) he added to his theoretical framework after the first edition of the *Three Essays on the Theory of Sexuality* in 1905. The first modifications were relatively minor, but in 1927 Freud initiated quite a dramatic revision. In a short paper on fetishism and a subsequent paper on the splitting of the ego, Freud suggested that the etiology of most sexual perversions was much more complex than he had previously thought. While still reserving an important role for the fixation of sexual instincts, his conception of the fixation's genesis had completely altered. In his earlier work, Freud related the fixation to physiological causes, in other words, the relative strength of particular partial instincts. Now he considered it to be the result of the denial of a traumatizing sexual experience—particularly the castration anxiety that accompanied the child's inevitable Oedipal wishes (Freud, 1927/1964b). In attempting to retain sexual pleasure, masochists sexualize castration, Freud claimed, while fetishists sexualize specific objects to avert such castration. Freud believed that every perversion could be interpreted as an attempt at reassurance and defense against castration anxiety—an idea that hugely influenced later psychoanalytic theories of sexual deviance (Metzl, 2004).

This theoretical shift in Freud's work did not imply that he now considered all sexual deviance as pathological. Homosexuality, for instance, was not considered to be a psychiatric illness. In a now-famous letter to the mother of a homosexual man, Freud wrote in 1935:

[2]Freud vacillated between *aberration* and *anomaly* but chose in the end to use the term *perversion* to denote pathological sexual behavior (Roudinesco & Plon, 1997). However, he deplored the word *perversion* because it had moralistic connotations (Kamieniak, 2003). The term *paraphilia* was first used to signify homosexuality by Freud's friend and colleague Sandor Ferenczi (Socarides, 1978).

"Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development" (Freud, 1935/1960a, p. 423). In his case study of a lesbian girl, published in 1920, Freud gave a very similar account of female homosexuality. Here Freud explicitly claimed that most cases of homosexuality were not the outcome of an Oedipal conflict (Freud, 1920/1955). Basically, homosexuality differed from the pathological perversions in that it did not result from pathogenic defenses against the sexual instincts or drives. Moreover, Freud also rejected the link between gender identity and object choice: homosexual men/women were not necessarily more feminine/masculine than heterosexual men/women.

The birth of psychoanalysis more or less coincided with the birth of sexology, or sex psychology. Moll's *Libido Sexualis* was published in 1897, as was Havelock Ellis's first volume of the *Studies in the Psychology of Sex*. Two years later, Magnus Hirschfeld founded the very first specialized yearbook, *Jahrbuch für Sexuelle Zwischenstufen*, in which he tried to cover the steady growth of the scientific literature on sexuality. It should not surprise us, then, that Freud's work grew to a large extent part out of sex psychology (Ellenberger, 1970; Roudinesco & Plon, 1997). Conversely, psychoanalysis and its concepts were often used in sexological literature. Many of the early sex researchers, including Hirschfeld and Bloch, soon accepted or adopted psychoanalytic views. For a brief period (1908 to 1911), Hirschfeld even became a member of the Berlin Psychoanalytic Association (Roudinesco & Plon, 1997).

Of course, there were also many points of disagreement between Freud and his followers on the one hand, and the founding fathers of sex psychology, on the other. Apart from disputes about the importance of heredity, the groups clearly had different objectives. Even though Freud himself remained skeptical regarding the possibility of curing the sexually perverted (Freud, 1937/1964a), psychoanalysis presented itself mainly as a method of medical treatment. The early sexologists, by contrast, were not interested in treating sexual deviance. Their main objective was to describe and classify the many variants of human sexuality by means of methods borrowed from criminology, history, and ethnography (Cocks & Houlbrook, 2004). If anything, many of these sexologists wanted to cure society, rather than the individual, so their objective was more emancipatory than therapeutic—although some sexologists, such as Albert Moll, believed in the need for a sexual science above the political fray (Waters, 2006). Sexology's disinterest in treating sexual deviance partly explains why psychoanalysis had such an impact on psychiatry's later conceptualizations of the perversions (Shorter, 1997). Yet sex psychologists did influence psychiatry's dealing with sexual deviance, just like Freud's views were not simply echoed by analysts of later generations, including those responsible for the construction of the first *Diagnostic and Statistical Manual of Mental Disorders*, as discussed in the next section.

Early European and American Sexology and its Relation to Psychiatry

Around the beginning of the 20th century, more and more anthropologists, biologists, historians, and physicians started to think about sexuality (Waters, 2006), and very soon sexology became a reasonably well-defined intellectual discipline. Especially in Germany and the German-speaking world, sexology had explicitly political objectives. Magnus Hirschfeld, the founder of the first journal of sexology and of the Institute for Sexual Science in Berlin, even defined sexology as a "progressive science" (Meyenburg & Sigusch, 1977). In his view, this was perfectly in line with his scientific findings, which he believed to demonstrate that deviations from the sexual norm were neither pathological nor dangerous to society (Steakley, 1997). Another founding father of sexology, Henry Havelock Ellis largely shared Hirschfeld's aims by claiming that sexology should play a central role in the politics of sex reform (Weeks, 2000), for instance, by trying to obtain sympathy and support for sexual inversion (Ellis, 1936). This explains why some of these early sexologists are sometimes seen as scientific revolutionaries that paved the way for the permissive society of the 1960s (Van Ussel, 1968).

Quite central to the sexological project was the view that the perversions were not as problematic as many psychiatrists and educators had claimed. Iwan Bloch, for instance, argued that theorizing about sexuality should not be limited to the medical sciences. As Matte (2005) put it: "Bloch proposed the new study of *Sexualwissenschaft* (Sexual Science, or 'Sexology'), which would incorporate anthropological and historical data into understanding the variety of sexualities. He argued that since sexual 'perversions' existed in all cultures and times, what really needed explaining was that they continued to be so repressed" (p. 257; for a diverging view on Bloch, see Crouthamel, 2008).

Although Bloch, Hirschfeld, Ellis, and many of the other early sexologists held on to the view that the sexual instinct was a procreative instinct, they emphasized at the same time that nonprocreative sex was enjoyed by many and—more importantly—that it was relatively harmless. Ellis and Hirschfeld spent most of their intellectual efforts on the study of the causes and the natural history of homosexuality (Ellis, 1936; Hirschfeld, 1952), and their activism mainly centered on the reform of the laws concerning homosexuality. In fact, they shared this objective with many psychiatrists of their time. Even Emil Kraepelin and Ernst Rüdin, German psychiatrists who did consider homosexuality to be a mental disorder,

demanded the abolition of §175, a provision of the German criminal code that made homosexual acts between men a crime (Mildenberger, 2007).

Still, the interest of sexologists was not limited to homosexuality. For one thing, they fiercely opposed the idea that masturbation led to all sorts of diseases (Steakley, 1997; Weeks, 2000). For another, Ellis devoted a supplementary volume of his *Studies in the Psychology of Sex* to a discussion of other sexual pathologies, including fellatio, cunnilingus, coprophilia, undinism, sadism, masochism, frotteurism, necrophilia, and transvestism (Ellis, 1936). The central message of this volume was twofold. First, he argued the phenomena that were central to the pervert's desire (e.g., pain) were closely related to normal sexual desires, thereby implying that so-called perverse individuals were much more normal than commonly thought (Crozier, 2004). Ellis's work is in fact one of the best examples of what has been called "the dimensional perspective" (Fedoroff, 2009). In Ellis's view, sexual interests, like many other biological properties, are distributed across a normal distribution, with most of the population located near the mean (the sexually "normal" people) and only a handful of individuals located at either extreme (the sexually "abnormal" people). Second, he urged society to accept that "these things existed, and that they were only harmful when another individual was hurt" (Weeks, 2000, p. 37).

Nonetheless, Ellis and Hirschfeld did not completely reject Krafft-Ebing's disease perspective. They accepted the idea that there were a few genuine disturbances of the sexual instinct. Ellis, for example, defined exhibitionism as a perversion of the courtship instinct (Freund & Watson, 1990), and he felt that excessive masturbation had harmful side effects (Weeks, 2000). Sometimes these disturbances needed treatment, as in the cases of hypersexuality that Hirschfeld described in *Geschlechtskunde*, because if they were left untreated they could lead to self-destruction (Steakley, 1992). However, they did not expect too much of such treatment. After all, Ellis and Hirschfeld believed that the individual life history only marginally influenced sexual desire, and that homosexuality and the (other) perversions arose mainly because of hereditary factors (Crozier, 2008). Their emphasis on hereditary factors as the causes of sexual perversions did not, however, entail a degenerationist view. Ellis edited Eugene Talbot's book *Degeneracy: Its Causes, Signs, and Results* in 1898 (Seitler, 2004), but he shared Moebius's and Freud's skepticism regarding the explanatory power and scientific viability of the degeneracy concept.

Ellis's books and ideas found a generally receptive audience in the United States, perhaps because Ellis's work was less overtly theoretical than the German and French approaches to sexuality and sexual deviance (Gagnon, 1975). Even before World War I, American sexology was mainly about empirical and statistical studies, often based on extensive questionnaires. These studies of the sex lives of ordinary people were primarily intended as support for what was seen as social amelioration (Waters, 2006). Some of them became best-selling popular science books in the Interbellum, for example, Katherine Davis's study titled *Factors in the Sex Life of 2200 Women* and Dickinson and Beam's *One Thousand Marriages*, for which Havelock Ellis wrote an introduction (Gagnon, 1975).

To some extent, Kinsey's work is also part of the American tradition of statistical research on sexual behavior. But Kinsey combined a statistical approach of case histories with a biological/taxonomic view of human sexual practices, and used this biostatistical framework to argue that most (if not all) so-called perversions were not in fact pathological (Meyerowitz, 2001). First, he believed his reports indicated that many supposedly deviant sexual practices were actually quite common in the American population. This statistical argument was complemented by a biological argument: Because most of the perversions can also be found in nonhuman animals, it makes no sense to assume that the perversions violate some natural norm. *Sexual Behavior in the Human Male* (Kinsey, Pomeroy, & Martin, 1948) and *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, Martin, & Gebhard, 1953) were partly intended to show that human sexuality is as varied as animal mating practices. Even though Kinsey's influence among psychiatrists remained quite limited (Bullough, 1998), generally, his evidence and arguments did play a role in the discussion about how to distinguish between normal and abnormal sexuality—an issue that has haunted psychiatry throughout the 20th century, reaching a climax in the 1970s. In the next section, we discuss psychiatry's dealings with sexual deviance in the second half of the twentieth century by focusing on the place and role of the sexual deviations in the consecutive editions of the American *Diagnostic and Statistical Manual of Mental Disorders*.

Sexual Deviance and the *DSM* (1952–2000)

The post–World War II history of psychiatry is characterized by the growing power of professional organizations. The American Psychiatric Association (APA) is perhaps the world's most powerful professional organization of psychiatrists. It is involved in health campaigns, the publication of psychiatric books and journals, and the organization of conferences. Its most visible work, however, is the preparation and publication of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), a standardized psychiatric classification system. Today, it is the leading clinical diagnostic manual worldwide, and it is also used for

research and administrative purposes all over the world. In this section, we focus on how the *DSM* has dealt with sexual deviance from its first edition in 1952 to publication of the current *DSM-IV-TR* in 2000, ending with a note on the proposed revisions for *DSM-5*. We focus on the *DSM* because, first of all, the debates surrounding the construction of this manual reveal a wealth of ideas concerning psychiatry's reasons to pathologize unusual sexual fantasies and behaviors. Second, these debates often revive positions and arguments presented in the work of early psychiatrists—the iconic authors discussed in the first half of this article.

Reflecting the general popularity of psychoanalysis in mid-20th-century U.S. psychiatry, the first two editions of the *DSM* (APA, 1952, 1968) were inspired mostly by psychodynamic concepts and etiological theories. The original *DSM*, for example, contended that sexual deviations are often symptomatic of an underlying neurotic or psychotic disorder (APA, 1952, p. 38). Similarly, other psychiatric textbooks taught that sexual perverts pursued infantile sexual aims and that all sexual perversions should be understood as defenses against castration anxiety (Metzl, 2004). However, shortly after the publication of *DSM-II* in 1968, the popularity of psychoanalysis started to wane among APA psychiatrists. The astonishing success of the first tranquilizers, such as meprobamate (Miltown) and diazepam (Valium), at least suggested that there might be more to mental disorders than psychological conflicts. Biochemistry became the new buzzword. Furthermore, health services and insurance companies reprehended the proliferation of psychotherapeutic treatments and the lack of quality criteria. Finally, a growing group of "young Turks," with a firm background in science and statistics, were annoyed about the poor systematics of psychoanalytic psychiatry, as well as about its want of univocal diagnostic rules and criteria (Decker, 2007; Shorter, 1997).

One of these psychiatrists, Melvin Sabshin, became the medical director of the APA in 1974. Sabshin almost immediately decided that a new and evidence-based edition of the *DSM* was badly needed. His decision would prove prophetic, because ever since the publication of *DSM-III* (APA, 1980), the APA's diagnostic manual has been immensely influential in psychiatry worldwide. *DSM-III*'s reliance on empirical evidence was just one reason it was a turning point in the history of the *DSM*. Another was the APA's decision to include a general definition of mental disorder. In what follows, we show that the sexual perversions, and specifically homosexuality, have been vital in the formulation of this definition and, by extension, in the construction of new editions of the *DSM*. Ever since the deletion of homosexuality from the *DSM* in 1974, various proposals to include or exclude disease categories have been discussed by referring to that very definition.

The Early *DSM* and the Sexual Deviations

The early-20th-century United States generally witnessed a strong statistical interest in psychiatric research. Thus the now-ubiquitous *DSM* originated from the need for a uniform reporting of statistics of the many mental hospitals on U.S. soil (Grob, 1991). Reflecting the then population of these hospitals, the *Statistical Manual for the Use of Hospitals for Mental Diseases* (National Committee for Mental Hygiene [NCMH], 1918) concentrated mostly on severe organic mental illnesses, such as psychoses associated with cerebral syphilis and alcoholism. In addition, the *Statistical Manual* was a crash course in hospital bookkeeping, advising the administration to use white cards for first admissions, red ink for female patients, and so on. The manual went through eight consecutive editions before being revised and incorporated in the New York Academy of Medicine's *Standard Classified Nomenclature of Disease* (National Conference on Nomenclature of Disease, 1933), a consensus-based nomenclature of all sorts of disease.

The origin of the *Statistical Manual* as an instrument to collect mental hospital data was predictive of the difficulties it was about to encounter. The strains and rigors at the fronts of World War II brought back shipments of American soldiers whose illnesses were nowhere to be found in the manual. Combat fatigue and shell shock produced relatively mild mental disorders, at least when compared to the grave afflictions found in mental hospitals. Faced with an enormous new patient population, the APA quickly understood the need to expand its stock of disease categories (Grob, 1991). In 1952, it published the first edition of the *Diagnostic and Statistical Manual: Mental Disorders*. Among its novelties was an extensive category called "transient situational personality disorders," a diagnosis "justified only in situations in which the individual has been exposed to severe physical demands or extreme emotional stress, such as in combat" (APA, 1952, p. 40). Another major change was the introduction of the "psychophysiologic autonomic and visceral disorders," which brought together a whole panoply of previous neurotic afflictions, such as "nervous vomiting," as well as a number of sexual dysfunctions, including "sex impotence," "leukorrhea," and "dyspareunia," all of allegedly psychogenic origin.

The 1952 *DSM* had very little to say about the sexual deviations. They were catalogued as one of the "sociopathic personality disturbances" that, in their turn, were part of the general category of personality disorders. Interestingly, the description of "sociopathic personality disturbance" read: "Individuals to be placed in this category are ill primarily in terms of society and of conformity with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals" (APA, 1952, p. 38). The statement reminds

us of Kinsey's claim that "the problem of the so-called sexual perversions is not so much one of psychopathology as it is a matter of adjustment between an individual and the society in which he lives" (Kinsey et al., 1948, p. 32). The *DSM*'s description of the sexual deviations was in fact one of the rare occasions where the editors hinted at a definition of mental disorder. Contrary to later editions of the manual, no explicit definition of mental disorder was given in the first *DSM* (Cooper, 2005), but its general outlook suggested that mental illness was understood either in terms of some organic defect, as in the case of the many brain disorders listed, and/or in terms of personal distress, as in the case of the neuroses. Some of the perversions fell outside this implicit definition of mental illness, because they were seen primarily as instances of sexual deviance, rather than mental illness.

The *DSM*'s predecessor, the *Statistical Manual*, was equally ambiguous on the topic. The manual discussed 21 clinical groups of predominantly organic psychoses and added a final group ("Not Insane") for the unlikely "occasional case which after investigation and observation gives no evidence of having had a psychosis" (NCMH, 1918, p. 29). One of the conditions that often led to such mistaken admissions, the manual continued, was "constitutional psychopathic inferiority (without psychosis)." This condition was defined rather vaguely as "a large group of pathological personalities whose abnormality of make-up is expressed mainly in the character and intensity of their emotional and volitional reactions" (NCMH, 1918, p. 27), with such examples as "criminal traits, moral deficiency, tramp life, sexual perversions and various temperamental peculiarities."[3] The manual's conclusion was somewhat surprising: "Psychopathic inferiors without an episodic mental attack or any psychotic symptoms should be placed in the not insane group" (NCMH, 1918, p. 28). It seems, then, that the *Statistical Manual* did not consider sexual perversions to be mental illnesses. The message was more ambiguous, however, since perverts (and tramps and criminals) were also called "pathological" and even "abnormal" personalities. It could be that the manual used "psychotic" and "insane" synonymously, leaving open the possibility that sexual deviations were mental illnesses after all. But then again there was a fairly elaborate clinical group called "psychoneuroses and neuroses," including hysteria and neurasthenia, which at least suggests that the manual considered minor afflictions to be diseases too. In short: Both the *Statistical Manual* and the 1952 *DSM* were somewhat undecided about classifying the sexual deviations as mental disorders.

The *DSM-II* was a locally adapted version of the mental disorder section of the World Health Organization's (WHO) eighth *International Classification of Diseases* (*ICD-8*). This section was in itself the product of a gargantuan attempt to provide a middle ground between psychiatrists of different nationality, institutional background, and theoretical orientation (First, Frances, & Pincus, 2004). In his introduction to *DSM-II*, Morton Kramer admitted that the end result was, inevitably, "a compromise which will fully satisfy psychiatrists neither in the U.S. nor in any other country" (APA, 1968, p. xv). Generally, DSM-II was much more neutral in tone than the first *DSM*. Like any classification of mental disorders, the 1952 *DSM* had been a child of its time (Grob, 1991). Even though its architects had explicitly set out "to give complete coverage to all areas of psychiatry" (APA, 1952, p. viii), the descriptions of disease categories were riddled with psychoanalytic terms and concepts: "unconscious affects" in the psychophysiologic disorders, "projection mechanisms" and "regressive reactions" in the personality disorders, and so on. Contrary to what some historians of psychiatry (e.g., Shorter, 1997) and also some biological psychiatrists (see, e.g., Maxmen, 1985) have claimed, *DSM-II* did not really continue this tradition. Its descriptions were shorter, and speculations as to the causes and mechanisms of disorders were kept to a minimum. Thus the functional psychoses, the psychophysiologic disorders, the neuroses, and most of the personality disorders were no longer seen as "reactions": "manic depressive reaction" became "manic-depressive illness," for example, while "depressive reaction" became "depressive neurosis." The pursuit of a theory-neutral or atheoretical nomenclature would become ever more important in later editions of the *DSM*.

As to the perversions, one of the minor novelties of *DSM-II* was the introduction of an explicit list of eight sexual deviations: homosexuality, fetishism, pedophilia, transvestism, exhibitionism, voyeurism, sadism, and masochism. The last three categories did not appear in *ICD-8*; they had been added specifically to *DSM-II* ("for use in the United States only"; APA, 1968, p. 1). The reason for this is unclear, but it probably relates to the fact that there had been some discussion regarding the personality disorders (including sexual deviations) in the groundwork leading to the publication of *ICD-8*. In his historical introduction to *DSM-II*, Kramer touched on this issue when discussing the results of an international WHO meeting in 1963: "The areas that still remained in disagreement were the affective disorders, neurotic depressive reaction, [and] several of the personality disorders (paranoid, antisocial reaction, and sexual deviation)" (APA, 1968, p. xiii). Also, while the *DSM* and its precursors had considered the perversions

[3]The *Statistical Manual* probably owed this term to Kraepelin's classification of "constitutional psychopathic states," which included "contrary sexual instincts." Kraepelin's work became popular in the early-20th-century United States due to an early English translation and adaptation of his famous *Lehrbuch der Psychiatrie* (published as *Clinical Psychiatry: A Text-Book for Students and Physicians*, Kraepelin & Diefendorf, 1902).

as a kind of personality disturbance, *DSM-II* listed them under the rather vague heading of "certain non-psychotic mental disorders," together with alcoholism and drug dependence. Furthermore, *DSM-II* divided the sexual deviations into three groups, depending on whether the sexual interests were directed (a) toward objects other than people of the opposite sex, (b) toward sexual acts not usually associated with coitus, or (c) toward coitus performed in bizarre circumstances (APA, 1968, p. 44). More importantly, however, all references to the pathogenic power of social values and norms in the general description of the sexual deviations were omitted. Whereas *DSM* had noted that "perverts" "are ill *primarily* in terms of society and of conformity with the prevailing cultural milieu, and *not only in terms of personal discomfort*" (APA, 1952, p. 38; emphasis added), *DSM-II* resolutely focused on the personal distress accompanying these deviations: "Even though many find their practices distasteful, they remain unable to substitute normal sexual behaviour for them" (APA, 1968, p. 44). Much like the concern of theory neutrality, the increasing emphasis on the criterion of personal distress was an early announcement of the looming landslide created by the appearance of *DSM-III*.

Homosexuality: A Crucial Controversy

The 1970s were turbulent times for the American Psychiatric Association. Since World War II, the majority of its members had been practicing psychoanalysts, but now the powers of psychoanalysis were waning (Decker, 2007; Shorter, 1997). This decline of psychoanalysis set the stage for a new wave of research psychiatrists, thus revealing a power struggle within the APA—a struggle that culminated in one of the most pressing and perhaps even most "embarrassing" (Kirk & Kutchins, 1992, p. 77) problems in the buildup to the creation of the *DSM-III*: the problem of homosexuality.

Perhaps more so than the 1952 *DSM*, the *DSM-II* unambiguously qualified homosexuality as a mental disorder. Many commentators have coordinated this view with the predominance of psychoanalysis in the early postwar intellectual climate (Friedman & Downey, 1998). Apparently many of the psychoanalysts of the time disagreed with Freud on the topic since, as described, Freud did *not* unambiguously consider all homosexuals to be mentally ill. Another important difference between Freud and mid-20th-century psychoanalysts related to their views on the need for, and the prospects of, therapeutic interventions. Freud was remarkably clear on this topic: "In general to undertake to convert a fully developed homosexual into a heterosexual is not much more promising than to do the reverse, only that for good practical reasons the latter is never attempted" (1920/1955, p. 32). The therapeutic optimism of postwar psychoanalytic psychiatrists was markedly greater than Freud's, and many of them were actively engaged in so-called "conversion therapy" when the controversy over homosexuality erupted in the early 1970s (see, e.g., Bieber et al., 1962). So why was it bon ton for psychoanalysts to consider homosexuality a pathological condition? In fact, many of them firmly believed that "humans are biologically programmed for heterosexuality" (Bieber, 1987, p. 425)—again disagreeing with Freud. Traumatizing experiences and disturbed parent–child (or peer) relationships were thought to dislocate this supposedly natural urge, thus resulting in abnormal sexual behaviour. Defining illness by its antecedents, which their research supposedly showed to be pathological, psychoanalysts could not but conclude that "homosexuality is other than a normal sexual adaptation" (Bieber, 1987, p. 417).

Throughout the 1960s, however, this view came under increasing attack from a variety of actors, including gay activists and public intellectuals (Cooper, 2005). In *The Manufacture of Madness*, antipsychiatrist Thomas Szasz, for example, pulled to pieces the 1967 decision of the U.S. Supreme Court to deport a Canadian inhabitant, Clive Boutilier, on the grounds of his being homosexual. The decision was based on the Immigration and Nationality Act of 1952, stating that "aliens afflicted with psychopathic personality . . . shall be excludable from admission into the United States"; and "the legislative history of the Act indicates beyond a shadow of a doubt that the Congress intended the phrase 'psychopathic personality' to include homosexuals such as petitioner" (qtd. in Szasz, 1970, p. 246). The medicalization of homosexuality, Szasz argued, legitimated a new kind of witch-hunting, where "the physician has replaced the priest, and the patient the witch" (Szasz, 1970, p. 259). By labeling homosexuals as mentally ill, psychiatry had paid lip service to a repressive society keen on imposing conformity on its members.

Other public intellectuals supported Szasz on this point. Judd Marmor (1973), for example, an outspoken opponent of the psychoanalytic view, put it this way: "It is our task as psychiatrists to be healers of the distressed, not watchdogs of our social mores" (p. 1209). Critics of the illness theory of homosexuality advanced a number of arguments—some of which were reminiscent of the work of early sexologists, including Hirschfeld and Ellis. First, they claimed homosexuality was biologically natural, thus reviving the "bisexuality hypothesis" from the mid-1800s, as found in the work of James Kiernan and Frank Lydston (Sulloway, 1979). Marmor (1973), for example, quoted an "eminent biologist" saying "human homosexuality reflects the essential bisexual character of our mammalian inheritance" (p. 1209). Furthermore, they argued that even if heterosexuality would be a natural norm, then it would not follow that homosexuality is an illness. Celibacy and vegetarianism can also be considered as violations of a natural norm,

Marmor argued, and yet we do not generally see them as illnesses. Third, history and daily experience teach us that not all homosexuals are, or were, ill. Most of the evidence brought forward by psychoanalysts came from clinical practice, and to their critics it was obvious that such evidence could not be representative for the whole population of homosexuals (Torrey, 1974). Finally, even if the overwhelming majority of contemporary homosexuals would turn out to be mentally ill, then the question would be whether they are so because of some intrinsic or inherent pathology, as psychoanalysts maintained, or because of the oppressive power of a homophobic society (Gold, 1973).

By setting up arguments to show that homosexuality was neither abnormal nor an illness, Szasz and many other members of the intelligentsia provided fuel to the work of a variety of gay activist groups. From 1970 onward, some of these groups started protesting at the annual meetings of the American Psychiatric Association, where leading psychoanalysts, such as Bieber and Charles Socarides, presented their evidence to show that homosexuality was a truly pathological condition (Bayer, 1981; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997). In the midst of this dispute between activists and psychoanalysts, psychiatrist Robert Spitzer stepped up as a go-between. As a technical consultant to the DSM-II Committee on Nomenclature and Statistics, he had already been praised for his contribution to ''the articulation of Committee consensus as it proceeded from one draft formulation to the next'' (APA, 1968, p. x). Spitzer was originally convinced that homosexuality did belong in the *DSM*. Various events, however, including his attending an informal meeting of the ''Gay-PA''—a secret group of homosexual APA members later known as the Association of Gay and Lesbian Psychiatrists—made him realize that many homosexuals were actually healthy and high-functioning individuals who were often satisfied with their sexuality (Bayer, 1987; see also Bayer, 1981, p. 126). Soon afterward Spitzer drafted a first compromise: Homosexuality as such was to be removed from the *DSM* and to be replaced by sexual orientation disturbance, which included those individuals troubled by their own sexual orientation.[4]

One of the important hubs behind this part of the proposal was an articulation of the definition of mental disorder, which, in Spitzer's view, should entail two elements: ''[I]t must either regularly cause subjective distress, or regularly be associated with some generalized impairment in social effectiveness or functioning'' (Spitzer, 1973, p. 1215). Because many homosexuals did not fulfill either of these criteria, they should not be considered mentally ill. Importantly, Spitzer did not consider homosexuality as normal either: ''No doubt, homosexual activist groups will claim that psychiatry has at last recognized that homosexuality is as 'normal' as heterosexuality. They will be wrong'' (Spitzer, 1973, p. 1216). To meet the objections of the psychoanalysts, he proposed to describe it as ''an irregular form of sexual development'' that is ''suboptimal'' when compared to heterosexuality. Yet suboptimal behavior, he argued, need not necessarily constitute disorder, as was shown in the examples of celibacy, racism, religious fanaticism, or vegetarianism, which he jokingly described as ''unnatural avoidance of carnivorous behaviour'' (Spitzer, 1973, p. 1215; Spitzer recounts his own doubtfulness about the diagnostic status of homosexuality in Spitzer, 1981).

Despite its diplomatic qualities, Spitzer's work met with fierce protest, and for different reasons. Activists expressed anger about the contention that homosexuality would not be as ''valuable'' as heterosexuality, while psychoanalysts, in their turn, repeatedly called on APA officials not to capitulate to political pressure. Nevertheless, the proposal to eliminate homosexuality from the *DSM* (and replace it with sexual orientation disturbance) was unanimously accepted by the APA's board of trustees in December 1973. Following further protest from a number of leading psychoanalysts, the APA then organized a referendum: Should homosexuality be in the APA nomenclature or not? Spitzer's proposal was accepted by 58% of the APA membership, and consequently homosexuality as such was deleted from the seventh printing of *DSM-II*.

According to some commentators, the referendum was a public relations disaster for the APA. Devising a psychiatric nomenclature turned out to be a matter of politics rather than science. As Shorter (1997) put it:

> Once it became known how easily the APA's Nomenclature Committee had given way on homosexuality, it was clear that the psychiatrists could be rolled…. [Sexual orientation, stress, or women's menses] could all apparently be pathologized and depathologized at the will of the majority, or following campaigns of insistent pressure groups. The underlying failure to let science point the way emphasized the extent to which DSM-III and its successors, designed to lead psychiatry from the swamp of psychoanalysis, was in fact guiding it into the wilderness. (pp. 304–305)

All parties involved in the controversy over homosexuality did, however, claim to have science on their side (Kirk & Kutchins, 1992, p. 88; see also Stoller et al., 1973, for a good overview of the arguments). Spitzer himself was one of the few to realize that science could not have the last word in deciding whether homosexuality was a disorder simply because ''the concept of 'disorder' always involves a value judgment'' (Spitzer, 1981, p. 415). One could argue, he said, that homosexuality is a mental disorder after all, because it implies an inability

[4]Sexual orientation disturbance appeared in *DSM-III* as ego-dystonic homosexuality, only to be removed altogether from *DSM-III-R* in 1987.

to function heterosexually. This argument assumes, however, that heterosexual functioning should be used as a sexual norm, and that is "a value judgment, not a factual matter" (Spitzer, 1981, p. 407).

Despite this sobering history, many of the architects of *DSM-III* continued (and continue) to claim that this edition was the first real evidence-based, scientifically sound and clinically useful psychiatric classification. As Maxmen (1985, p. 31) once quipped: "The old psychiatry derives from theory, the new psychiatry from fact." Until recently, Spitzer stood by such views: "The DSM-III committee shared the view that progress in psychiatric nosology will come primarily from data collected in empirical research studies" (Spitzer, 2001, p. 354; see also APA, 1980). For some reason, however, he seems to have changed his mind. In an interview from early 2007, he conceded that the *DSM-III* task force did not always rely on research evidence. When asked about how new disease categories were included in the nomenclature, the following conversation ensued:

> *Spitzer:* You have to have a lobby, that's how. You have to have troops.
> *Fink* [one of the interviewers]: So it's not a matter of...
> *Spitzer:* Having the data? No.
> *Fink:* It's nothing to do with science then, and nothing to do with evidence?
> Spitzer nodded. (Shorter, 2008, p. 168)

The interviewer seems to have been shocked at this "confession," but in a sense, Spitzer's honesty should not really surprise us. Directly or indirectly, lobby groups often aim to transform societal norms and values, and if such norms and values play any role in defining mental illness, as Spitzer believes, then lobbying inevitably affects psychiatry's diagnostic process. Immediately after the APA board's decision to delete homosexuality from their manual, Irving Bieber publicly asked Spitzer whether he would consider deleting other sexual deviations from *DSM*, too. Spitzer answered: "I haven't given much thought to [these problems] and perhaps that is because the voyeurs and the fetishists have not yet organized themselves and forced us to do that" (qtd. in Bayer, 1987, p. 397; see also Bieber, 1987, p. 433).

On Being Consistent

Defining the paraphilias in the DSM-III. In May 1974, immediately after the controversy over homosexuality, the APA appointed Spitzer chair of the new Task Force on Nomenclature and Statistics, and his first decision was to assemble a completely new core committee. Unlike the *DSM-II*'s task force, all members of Spitzer's group were in favor of biological psychiatry, rather than psychoanalysis, and a symptom-based rather than etiologic approach to diagnosis. Gerald Klerman (1978), one of *DSM-III*'s consultants, refers to the task force members as "neo-Kraepelinians"—an epithet Spitzer always resisted even though it is clear, both from his correspondence within the APA and from his published papers, that he preferred Kraepelin over Freud (see, e.g., Decker, 2007; Kirk & Kutchins, 1992; Shorter, 1997). As a consequence, *DSM-III* differed in many ways from its predecessor. More than thrice the size of *DSM-II*, it contained many novelties, including an enormous list of advisory committees and experts, a complex multiaxial evaluation system, and a greatly expanded list of disease categories, all of which were, for the first time, provided with a set of diagnostic criteria. The patient had to fulfill a specific number of such criteria to be eligible for a particular diagnosis.

Another interesting novelty was an attempt, on the very first pages of the manual, to define the concept of mental disorder. As explained earlier, homosexuality was deleted from *DSM-II* mainly because it did not fit in with the definition of mental disorder that, according to Spitzer (1981), was employed implicitly when constructing the first two editions of the manual. This definition was based on two criteria: distress and disability (or functional impairment). Because many homosexuals were not in any way distressed by their orientation, and since most of them appeared to function very well, both socially and professionally, it was clear that homosexuality per se should be excluded from the *DSM*. What about the other sexual deviations, however, such as voyeurism or sexual sadism? What evidence was there to believe that these conditions, unlike homosexuality, did cause significant distress or disability? Some members of the gay activist committee involved in the debate about homosexuality were in favor of removing all sexual deviations from the *DSM*. Charles Silverstein (2009), for example, asked: "If there was no objective, independent evidence that a homosexual orientation is in itself abnormal, then what justification was there for including any of the other sexual behaviors in DSM?" (p. 162). The decision not to put this broader issue on the agenda was rather selfish: "We were fighting for our rights as gay people and had no intention to argue for the broadening of the boundaries of acceptable sexual behavior that would have invariably led to increased opposition by conservative professionals, as well as frightening away those who sided with us" (Silverstein, 2009, p. 162). Spitzer himself believed that the status of the perversions, particularly voyeurism and fetishism, as disorders was "questionable," and he was aware that many expected him, following the APA decision about homosexuality, to delete these conditions from the manual too (Spitzer, 1981, p. 406; see also Spitzer, 1973). It is possible that these reservations led him to conclude the *DSM-III*'s definition of mental disorder with the following caveat: "When the disturbance is limited to a conflict between an individual and society, this may represent

social deviance, which may or may not be commendable, but is not by itself a mental disorder'' (APA, 1980, p. 6; the same statement was repeated nearly verbatim in all subsequent editions of the *DSM*). In short, deviant sexual behavior is not always a (symptom of a) mental disorder.

Still, most of *DSM-II*'s sexual deviations reappeared in *DSM-III*, if only under a different name (''paraphilias'') and in a different diagnostic class (''psychosexual disorders''), which also included the gender identity disorders (e.g., transsexualism) and psychosexual dysfunctions (e.g., premature ejaculation). The term *paraphilias* was preferred to the old *sexual deviations* ''in that it correctly emphasizes that the deviation (para) is in that to which the individual is attracted (philia)'' (APA, 1980, p. 267). The new name was not just more accurate, however; it also sounded more scientific and less moralistic or judgmental (Bullough, 2003). The manual went on with a list of the usual suspects: fetishism, transvestism, zoophilia, pedophilia, exhibitionism, voyeurism, sexual masochism, sexual sadism, and some ''atypical'' paraphilias (e.g., frotteurism and necrophilia). According to *DSM-III*, the common denominator in all these conditions was ''that unusual or bizarre imagery or acts are necessary for sexual excitement,'' involving ''sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity'' (APA, 1980, p. 261).

It is noteworthy that the general description accompanying this class of disorders again reflected Spitzer's reservations to include them in the manual. First, and contrary to his aversion to all things related to theory and tradition, he noted that ''the Paraphilias included here are, by and large, conditions that *traditionally* have been specifically identified by previous classifications'' (APA, 1980, p. 267; emphasis added). Second, in the annotated listing of the differences between *DSM-II* and *DSM-III* (Appendix C), Spitzer did not cite any evidence to warrant the inclusion of the paraphilias in general (except for the new category of zoophilia), while he did so to warrant the exclusion of homosexuality. Third, he seemed to be doubtful about how to fit in the paraphilias with the *DSM*'s definition of mental disorder. Given that ''individuals with these disorders tend not to regard themselves as ill''; that ''frequently, these individuals assert that the behaviour causes them no distress'' (APA, 1980, p. 267), and that at least some of them appeared to function well, both socially and professionally, it seemed that some paraphilias did not fulfill the criteria set out in the introduction to the manual. Perhaps they could be considered as instances of social deviance, but deviance, as Spitzer stressed, ''is not by itself a mental disorder'' (APA, 1980, p. 6). So why did *DSM-III* continue to present sexual deviations as mental disorders?

First, *DSM-III* explicitly acknowledged that there may well be a continuum between sexual health and sexual deviance: ''[I]n DSM-III there is no assumption that each mental disorder is a discrete entity with sharp boundaries between it . . . and No Mental Disorder'' (APA, 1980, p. 6). The editors recognized that paraphilic fantasies or acts could be part of a normal sexual repertoire and a healthy sexual relationship. They recognized, for example, that ''women's undergarments and imagery of sexual coercion are sexually exciting for many men,'' and that ''masochistic fantasies of being bound, beaten, raped or otherwise humiliated may facilitate sexual excitement in some [normal] individuals'' (APA 1980, pp. 267, 273–274). Diagnostic criterion A stipulated that it is only when such imagery becomes ''insistently and involuntarily repetitive,'' ''repeatedly preferred or exclusive,'' and even ''necessary'' to achieve sexual gratification, or when such imagery is effectively acted upon (as in the case of masochism or sadism), that it is to be considered part of a proper paraphilia. In sum, what made an unusual sexual fantasy or urge a mental disorder, according to *DSM-III*, was its exclusivity and/or its repetitivity in arousing sexual excitement. Curiously, *DSM-III* seemed to follow Freud's characterization of the paraphilias here, thereby ignoring its very own definition of mental disorder, which it *did* use to legitimize the removal of homosexuality (Primoratz, 1997; Silverstein, 1984). As noted previously, homosexuality was not deleted from *DSM-II* because it was somehow shown to involve occasional, as opposed to exclusive and/or repetitive, sexual acts or fantasies. Rather, it was deleted because many homosexuals were not in any way distressed or impaired by their sexual orientation.

In a paper published shortly after the publication of *DSM-III*, Spitzer (1981) provided an alternative account of the decision to keep the paraphilias listed as mental illnesses. His account focused on the importance of disability or impairment, rather than distress. ''After agonizing over whether or not these conditions should be considered disorders only if the person was distressed by the symptom (as many expected, given the 1973 decision), we decided that even in those cases where there was no distress, the behavior represented *impairment in an important area of functioning*. That is, the necessity for sexual arousal of the unusual or bizarre imagery or acts was regarded as impairment in the important area of *sexual* functioning'' (Spitzer, 1981, p. 406; italics in original). Even if people with a paraphilia were living rewarding lives, and even if their behavior caused them no distress, the *DSM-III* would still consider them mentally ill. The reason was that their sexual behavior impaired them to engage in an affectionate and reciprocal relationship. Pedophiles, sadists, and voyeurs were considered mentally ill because they were unable to form a mutual, loving relationship with another human being. Spitzer concluded his paper with a whimsical

fictional account of a dialogue between a ''nosologically sophisticated'' fetishist (F) and his psychiatrist (P), which again reveals his conviction of the importance of values in labeling conditions as mental disorders:

> *F:* I am beginning to think that there is something about my preference itself that your profession doesn't care for.
> *P:* Well, I think you may have hit on something there. We do believe that optimal sexual functioning involves two human beings (at least), and not exclusively or preferentially inanimate objects.
> *F:* Why do you believe that?
> *P:* I guess we believe that if you are unable to be sexually aroused by another human being, then you are at a disadvantage.
> *F:* Why is it a disadvantage? Shoes are easy to get.
> *P:* I guess that deep in our bones we must believe that sex is more fulfilling when it is between human beings. (Spitzer, 1981, p. 414)

The argument that paraphilias are mental disorders because they impair normal sexual functioning is perhaps debatable, but it was at least compatible with the *DSM*'s general definition of mental disorder. For some reason, however, later editions of the *DSM* tended to ignore this argument, as they focused more or less exclusively on the role of distress.

Defining the paraphilias in the DSM-III-R, DSM-IV, and DSM-IV-TR. Spitzer and his colleagues were quick to spot *DSM-III*'s inconsistencies in diagnosing the paraphilias and partly corrected them in a major revision of the manual, which was published in 1987 as *DSM-III-R* (see also Krueger, 2009). The main reason to revise *DSM-III*, Spitzer related, was that ''despite extensive field testing of the DSM-III diagnostic criteria before their official adoption, experience with them since their publication has revealed, as expected, many instances in which the criteria were not entirely clear, were inconsistent across categories, or were even contradictory'' (APA, 1987, p. xvii). The criteria used in diagnosing the paraphilias seemed to be a good case in point. On first inspection, nothing much had changed for this diagnostic category. Together with the subclass of sexual dysfunctions, the paraphilias were now part of the class of sexual disorders, rather than psychosexual disorders, as they were called in *DSM-III*. The gender identity disorders had been moved to the class of ''disorders usually first evident in infancy, childhood, or adolescence,'' ''since these [gender identity] disorders invariably begin in childhood'' (APA, 1987, p. 425). (In *DSM-IV* and *DSM-IV-TR*, they reappeared in the class of sexual and gender identity disorders.) There were still eight paraphilias listed, and zoophilia had changed places with frotteurism—one of the ''atypical paraphilias'' in *DSM-III*.

A closer look, however, revealed some important novelties. For one thing, considerations of exclusivity or repetitivity were no longer deemed essential in diagnosing the paraphilias. Such considerations were reconceptualized as ''criteria for severity of manifestations of a specific Paraphilia,'' ranging from mild to moderate and severe, and were replaced by two basic diagnostic criteria that applied to all paraphilias listed. Criterion A required the presence of ''recurrent intense sexual urges and sexually arousing fantasies, over a period of at least six months,'' while Criterion B stipulated that ''the person has acted on these urges, *or* is markedly distressed by them'' (APA, 1987, pp. 282–290; emphasis added). There was no mention of disability or impairment in the diagnostic criteria, even though the general description of the paraphilias repeated *DSM-III*'s claim that there is ''impairment in the capacity for reciprocal, affectionate sexual activity'' (APA, 1987, p. 281). The latter part of Criterion B could be seen as an attempt to fit the paraphilias into the *DSM-III*'s general definition of mental disorder.[5] Surprisingly, however, and contrary to this definition, distress was considered as sufficient but not necessary for a condition to qualify as a paraphilia. According to *DSM-III-R*, some urges and fantasies needed only to be acted on to indicate disorder, even if they did not cause any distress to the individual.

In the *DSM-IV*, published in 1994, this final inconsistency was resolved by omitting the first part of Criterion B. This criterion now required, for all paraphilias, only that ''the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning'' (APA, 1994, p. 523). Failing distress or impairment, unusual sexual fantasies, urges, or behaviors were considered nonpathological. Either they were normal—''a stimulus for sexual excitement in individuals without a paraphilia'' (APA, 1994, p. 525)—or they should be understood as ordinary criminality.

Even though the *DSM-IV*'s wording of the diagnostic criteria of paraphilia was by far the most consistent vis-à-vis the *DSM*'s own definition of mental disorder, its amendment was short-lived (Moser & Kleinplatz, 2005). In an editorial, the editors of the *DSM-IV-TR* (APA, 2000), Michael First and Allen Frances, related how they were attacked by ''conservative religious groups'' who ''mistakenly worried that the change meant DSM-IV did not recognize pedophilia as a mental disorder unless it caused distress'' (First & Frances, 2008, p. 1240). *DSM-IV* indeed stipulated that child offenders should not be considered mentally ill unless

[5]It is interesting to note that in *DSM-III-R* (APA, 1987, p. 281) the word *traditionally* was omitted from the general description of the paraphilias, probably because the architects felt they had ''saved'' these conditions as mental disorders by adding ''distress'' to their diagnostic criteria.

their offenses caused them distress or impairment in functioning. Yet First and Frances explicitly spoke of a "misinterpretation" of *DSM-IV* (Spitzer, 2005, p. 115, even called it a "public relations disaster"), which led them to revert, in *DSM-IV-TR*, to the *DSM-III-R*'s diagnostic criteria for paraphilia.[6] For those paraphilias that may involve nonconsenting victims—pedophilia, voyeurism, exhibitionism, frotteurism, and sexual sadism—the authors simply reintroduced *DSM-III-R*'s Criterion B, which required either acting on unusual sexual urges or fantasies, *or* experiencing distress about these urges or fantasies (APA, 2000, p. 566). For the remaining paraphilias—fetishism, sexual masochism, and transvestism—the diagnosis is made if the urges, fantasies, or behaviors cause distress or impairment in functioning (see also First & Pincus, 2002; Hilliard & Spitzer, 2002).

In their editorial, First and Frances also emphasized, however, that sexual offenders should not be considered mentally ill simply because they have committed sexual offenses (see also Moser & Kleinplatz, 2005; Moser, 2009). In this context, they contradicted their own wording of *DSM-IV-TR*'s diagnostic Criterion A. This criterion stipulated, for all paraphilias, that "over a period of at least 6 months," the individual should display "recurrent, intense sexually arousing fantasies, sexual urges, *or* behaviors" (APA, 2000, p. 566; emphasis added). Still, according to First and Frances, some forensic psychiatrists deliberately misinterpreted this criterion "to justify making a paraphilia diagnosis based solely on a history of repeated acts of sexual violence" (First & Frances, 2008, p. 1240). The problem with this interpretation, they concluded, is that "defining paraphilia based on acts alone blurs the distinction between mental disorder and ordinary criminality" (see also Gert & Culver, 2009).

More recently, First has argued that, to avoid confusion between illness and criminality, it is absolutely essential to take into account the nature of the fantasies and urges preceding or accompanying the offenses. Thus, he remarked: "A paraphilia is . . . fundamentally a disturbed internal mental process (i.e., a deviant focus of sexual arousal) which is conceptually distinguishable from its various clinical manifestations" (First, 2010, p. 1240; see also First, 2008).[7] First's recommendation to *DSM-5* is to revive the importance of a forgotten aspect of the *DSM*'s general definition of mental disorder. This definition specifies that a condition can only qualify as a disorder if it causes distress or impairment *and* if it is considered "a manifestation of a behavioral, psychological, or biological dysfunction in the individual" (APA, 2000, p. xxiv). Much like Krafft-Ebing's (1886/1965) speculations about an underlying "general neuropathic or psychopathic condition" (p. 501), the *DSM* unfortunately does not tell us how to define such underlying dysfunction or how it is to be ascertained.

Spitzer (1999) acknowledged this lacuna and suggested adoption of Wakefield's evolutionary interpretation of the concept of dysfunction in the construction of *DSM-5*. In Wakefield's view, the concept of mental disorder is intrinsically hybrid, in that a disorder judgment requires both a value judgment that there is harm and a scientific judgment that there is a dysfunction. Wakefield (1992, p. 384) then defined *dysfunction* as "the inability of some internal mechanism to perform its naturally selected function." Spitzer attempted to apply this concept of dysfunction to the paraphilias in a book devoted to a critique of the sexual and gender diagnoses of the *DSM* (Karasic & Drescher, 2005). There he argued that sexual arousal has a specific evolutionary function, which consisted of "facilitating pair bonding which is facilitated by reciprocal affectionate relationships" (Spitzer, 2005, p. 114). In Wakefield's (1992) terminology, the paraphilias represent a failure of sexual arousal to perform its naturally selected function, because people with a paraphilia are unable to be sexually aroused by another human being or are unable to engage in a mutual loving relationship. Spitzer's argument is questionable, however, because it ignores the extensive literature on the many different nonprocreative functions of sexuality and sexual arousal (see, e.g., Roughgarden, 2004, and Symons, 1981). Moreover, preliminary reports on proposed revisions to the *DSM-5*'s general definition of mental disorders do not give the impression that Wakefield's definition of dysfunction will be adopted (Stein et al., 2010). In fact, there seems to be no intention to define or even clarify the concept of dysfunction in the upcoming edition of the manual (APA, 2012b).

DSM-5, Paraphilias, and Paraphilic Disorders

Spitzer once argued that, among other reasons, the paraphilias cannot be removed from the *DSM* "because it would be a public relations disaster for psychiatry" (Spitzer, 2005, p. 115). Still, he was one of the first to contend that "perhaps some of the . . . sexual deviations, when in mild form, such as voyeurism" did not belong in the *DSM* (Spitzer, 1973, p. 1215). In fact, most of the editions of the *DSM*, perhaps excluding *DSM-II*, allowed for the possibility that some paraphilias were not mental disorders. *DSM-III-R*, for example, explicitly states that sexually deviant behavior is not to

[6]This change contradicted the *DSM-IV-TR*'s own statement that "all proposed changes were limited to the text sections. . .. No substantive changes in the criteria sets were considered" (APA, 2000, p. xxix; see also Hilliard & Spitzer, 2002, p. 1249; Moser & Kleinplatz, 2005, p. 98).

[7]The parallel with Krafft-Ebing's work is striking, as the latter once noted: "The nature of the act can never, in itself, determine a decision as to whether it lies within the limits of mental pathology, or within the bounds of mental physiology. The perverse act does not per se indicate perversion of instinct" (Krafft-Ebing, 1886/1965, p. 501).

be considered a mental disorder ''unless the deviance . . . is a symptom of a dysfunction in the person'' (APA, 2000, p. xxii). This statement is in line with a growing literature suggesting that many ''paraphilias'' are actually ''non-pathological'' and hence ''do not necessitate intervention, either disciplinary or ostensibly curative'' (Money, 2002, pp. 90–91). Studies have shown that people with paraphilias are often of above-average intelligence and social status (McConaghy, 1997; but see also Fedoroff, 2009); that they enjoy their sexual fantasies, urges, and behaviors; and that actually such fantasies, urges, and behaviors are reported by a significant number of healthy subjects (McConaghy, 1993; Renaud & Byers, 1999; see also Hinderliter, 2010; Frances, 2010; McConaghy, 1999; Moser & Kleinplatz, 2005; Silverstein, 1984). On the other hand, there is also a sizable literature about putative genetic or hormonal defects and anomalous brain development in people with paraphilia (Blanchard, Cantor, & Robichaud, 2006; Cantor, 2012); about comorbidity with other mental disorders, such as attention-deficit hyperactivity disorder and various affective disorders (Kafka & Hennen, 2002); and about the correlation between paraphilias and various medical conditions, such as brain tumors and multiple sclerosis (see, e.g., Gijs, 2008). It is very plausible that the objects of both strands of research really exist. As Money (1986) once noted:

> Some of the paraphilias are playful and harmless. Some are an unwelcome nuisance to a partner who does not share their fantasy content. Some are dangerous and destructive, even to a consenting partner. Some of those that are legally classified as sex offenses are violently dangerous, and some, like exhibitionism are harmless offenses against modesty. (p. 168)

The *DSM-5* seems keen on making this distinction between sexual deviance and mental disorder, or between harmless and harmful paraphilias, more explicit.[8] Early on in the process, the work group devoted to revising the subclass of the paraphilias in *DSM-5* announced a consensus that paraphilias are not ''*ipso facto* mental disorders'' and that by themselves they would ''not automatically justify or require clinical intervention'' (APA, 2012c; emphasis in original). Therefore, the work group proposed to differentiate between paraphilias and paraphilic disorders: ''A *Paraphilic Disorder* is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others in the past. A paraphilia is a necessary but not a sufficient condition for having a Paraphilic Disorder'' (APA, 2012c; emphasis in original). The distinction between paraphilias and paraphilic disorders may not be new, but it does emphasize that nonnormative sexuality need not necessarily be a mental disorder—an insight that, in earlier editions of the *DSM*, was often contradicted or blurred by the actual descriptions and diagnostic criteria relating to the paraphilias.

The work group indicated that implementing this distinction did not require ''making any changes to the basic structure of the diagnostic criteria as they had existed since DSM-III-R'' (APA, 2012c). This claim is only partly true. The *DSM-5* work group's wording of the diagnostic criteria for paraphilic disorders is nearly identical to the wording of the same criteria in *DSM-III-R* and *DSM-IV-TR* but not with *DSM-IV*'s rendering. As indicated, *DSM-IV* does not require an individual to act on his or her sexual urges or fantasies to be eligible for a diagnosis. The work group's proposal, however, does suggest that acting on sexual urges is relevant for psychiatric diagnosis: ''[A] paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others in the past'' is a paraphilic disorder. Hence, in some cases of pedophilia, sadism, voyeurism, exhibitionism, and frotteurism, the only difference between a nondisordered individual with a paraphilia and an individual with a paraphilic disorder is that the latter has had victims. The work group fails to explain, however, why and how harming others would amount to more than merely immoral or criminal behavior. In what way does exposing one's genitals to an unsuspecting stranger differ from exposing a gun to an unsuspecting stranger? It seems, then, that the work group on paraphilic disorders will have to further specify its criteria in order ''not to create medical conditions out of the full range of human behavior and emotions'' (APA, 2012a). The wording of the diagnostic criteria for paraphilic disorders, as well as the wording of the general definition of mental disorder on the *DSM-5* development website, is of course only provisional. The final version of the manual is expected to be published in May 2013 and will certainly differ from the draft online version available at the time of writing this article. As it is now, however, it seems that even after more than half a century of diagnosing the paraphilias, *DSM-5* will not have the final word on a topic that has been haunting psychiatry ever since the publication of *Psychopathia Sexualis*.

Conclusion

In the bulk of the historical literature about psychiatry's dealing with deviant sexuality, homosexuality has received the lion's share of the attention. Exhibitionism, sadism, fetishism, and other sexual deviations or paraphilias are only marginally touched on. The main reason for this discrepancy is that, historically, psychiatrists themselves have always been short of decent data about

[8]It is interesting to note that the *DSM-5* work group on ''sexual and gender identity disorders'' contains more nonpsychiatrists than any of the other work groups.

deviations other than homosexuality—partly because they are supposedly less common than homosexuality, and partly because the gay activist lobby has always been quite powerful. Thus, homosexuality has played an important part in the history of psychiatry, culminating in the 1974 APA referendum and the subsequent removal of homosexuality from the *DSM*. The controversy over homosexuality forced the APA to come up with a definition of mental disorder in *DSM-III*, which has since served as a touchstone to include or exclude many other disease categories. Yet somewhat ironically, many of the sexual deviations are still listed as mental disorders in recent editions of the manual.

Investigating the history of how and why psychiatrists, sexologists, and other mental health professionals delineated sexual pathology from normal sexuality and/or criminal behavior, current historians have to engage with 19th- and 20th-century theories about the etiology, diagnosis, classification, and treatment of sexual deviance. Underneath the various disagreements in the field, for example, about the complex relations between personality, identity, and sexual deviance (Crawford, 2006; Downing, 2010), and about the extent to which medical science has contributed to the self-understanding of patients (Foucault, 1976; Oosterhuis, 2000), historians of sexuality overwhelmingly agree (and sometimes deplore; see, e.g., Bullough, 2003) that the role of theory in guiding sex research has changed throughout the past 150 years. The grand theorizing of Krafft-Ebing and Freud has gradually been replaced by a more piecemeal, quantitative, and data-driven approach to sexual deviance (Waters, 2006).

In the psychiatric diagnosis of sexual abnormality, this change has concurred with a more symptom-based and nontheoretical approach, an approach that is especially prevalent in the more recent editions of the *DSM*. Still, even in the nontheoretical psychiatric approaches to sexual abnormality, a theory is needed to distinguish normal from abnormal varieties. Why is a stable and exclusive sexual desire for blonde women not considered to be pathological, while a similarly stable and exclusive desire for prepubescent children tends to be seen as a disease? This question is not easy to answer, and the present review shows how different canonical authors, associations, and publications have tried to solve the issue. Some of them, most notably Kinsey, straightforwardly argued that sexual perversions were not diseases, a position that is now held by such scholars as Charles Moser. By contrast, Krafft-Ebing and Kraepelin argued that paraphilias are biologically abnormal and hence diseases. Today, Blanchard and many other sexologists defend an updated version of this biomedical view, by arguing that genetic or brain defects cause paraphilias (Gijs, 2008).

The fact that the problem of distinguishing between sexual deviance and mental disorder keeps on haunting the literature has little to do with the scientific status of sexology, psychology, or psychiatry but rather with the hard-to-crack philosophical problem of defining (mental) disease and (mental) health. Basically, there are three approaches to this issue: a naturalistic position that aims to provide a value-free definition; a normativist position that claims that all medical judgments are value judgments; and a hybrid position, like Wakefield's, that seeks to solve the problem by combining naturalist and normativist aspects. Each of these positions has its problems (Ereshefsky, 2009), and there is no orthodox position in philosophy of medicine or philosophy of psychiatry.

The problem of defining mental health and disorder is probably not insurmountable for prototypical mental disorders such as major depressive disorder and schizophrenia (Lilienfeld & Marino, 1995). After all, very few psychiatrists and laypersons would deny that these conditions represent true mental disorders. The problem is more pressing, however, for conditions that are less obviously pathological. An important part of the history we have sketched underscores that paraphilias are among the conditions which are not unambiguously normal or disordered. Given that we are still far removed from a universally accepted definition of mental disorder (and even further removed from a workable operationalization of such a definition), we cannot expect a clear and intellectually satisfying answer to the question of whether the paraphilias are genuine diseases.

Failing such an answer, we think the following two options are worth considering. The first option has been proposed by Ereshefsky (2009). In his view, the distinction between health and disease should not be a central concern for medicine or psychiatry. In fact, it distracts from the really relevant issues. According to Ereshefsky, the central medical or psychiatric concerns should be what the particular physiological and psychological states are and how we value or disvalue them. Hence, rather than calling a sexual fantasy or behavior healthy or disordered, we should both describe the psychological states and make value judgments about these states: "Is it a desirable condition for the person/for his or her environment/for society? Why (not)?" Both judgments are medically relevant, but it is medically speaking equally important to treat the value judgment and the descriptive judgment as distinct kinds of judgment.

Of course, not everyone will agree with Ereshefsky's position. Diagnostic manuals of mental disorders, for example, seem to be built on the distinction between health and disease. They simply cannot do without a definition of mental disorder. In those cases, and this is the second option, we think it recommendable to use only one concept of mental disorder, to be explicit about it, and to be explicit about the reasons why a condition is thought to fulfill this concept's definitional criteria. While this solution will not lead to a closing of the debates on the pathological nature of the paraphilias, it

will add clarity and coherence to the positions in these debates. In this context, the APA's decision to include a definition of mental disorder in *DSM-III* and all consecutive editions was certainly laudable. Applying this concept coherently throughout the manual proves to be much more difficult, however, as is illustrated by the paraphilias' quirky history in recent psychiatric classification. Though the upcoming publication of the latest edition of the *DSM* will likely not resolve all inconsistencies or end all debate on this subject, we hope the brief history of the paraphilias provided in this article will allow readers to reflect more thoughtfully and with greater interest on the changes made to the paraphilias and paraphilic disorders sections when the *DSM-5* becomes available in 2013.

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