

Podcast Recording:

d3ctxlq1ktw2nl.cloudfront.net/staging/2025-1-26/395554406-44100-2-8b52877ff2b5f.m4a

Annotated Bibliography

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). <https://doi.org/10.1176/appi.books.9780890425787>

While I researched the history of the changes made to previous editions of the DSM regarding 'sexual deviance' and paraphilias, I particularly looked into the latest version, the DSM IV to inform me of the current diagnostic criteria. This source was important for understanding how exactly paraphilias and paraphilic disorders are classified and diagnosed today. I used the information to differentiate between paraphilias and paraphilic disorders and define the specific types of paraphilias highlighted.

Shadow, S., & Girl, G. (2025, January 25). *The history of Kink and the DSM; The difference between Kink and Fetish*. KYNK 101. <https://kynk101.com/kink-bdsm-facts/dsm>

This source contained two different articles that were very informative about the history of classifying sexual behaviors in the DSM and differentiating between kinks, fetishes, paraphilias, and paraphilic disorders. I used this source as a base for how the DSM has changed the way psychologists diagnose variations in sexual behavior. I learned about how each DSM included updates in the sections on sexual deviances and paraphilias, and in what ways those were beneficial or not. Specifically, I realized the importance of the changes in the DSM III and IV that changed the language of talking about variations in sexual behavior from 'sexual deviance' to paraphilia and included the necessary criteria of personal distress and impairment for a diagnosis. While stigmas are hard to dismantle completely, the systematic change in the way psychologists view individuals and their sexual behavior helped to decrease the shame of having variations in sexual expression. Additionally, the more I

researched this topic, the more confused I became about the differences between kinks, paraphilias, and paraphilic disorders. This source included an article that talked in depth about the differences from the perspective of those in the community. This was important to understand the social, and real side of this topic compared to just getting information from the ‘science’ aspect.

Yakeley, J., & Wood, H. (2014). Paraphilias and paraphilic disorders: Diagnosis, assessment and Management. *Advances in Psychiatric Treatment*, 20(3), 202–213.

<https://doi.org/10.1192/apt.bp.113.011197>

This article was helpful in understanding the roots and the impact of the misconception that all paraphilias are harmful and dangerous. The authors made distinctions between paraphilias that are illegal if acted on compared to those that aren’t, and the idea that fantasies and urges themselves are not inherently illegal. I learned that not all sex offenders have paraphilias and most people with paraphilias do not commit offences. The impact of this misconception can include reluctance to search for treatment, which leads to most individuals with paraphilic disorders getting treatment after they have committed an illegal offense. This source also informed me of my last misconception, that individuals with this disorder do not choose to have these fantasies and urges. In most cases, some causes have been found to correlate with individuals with paraphilias and/or paraphilic disorders. These causes were informative for rebutting the last misconception I discussed in the podcast.

Yarber, W. L., & Sayad, B. W. (2022). *Human sexuality: Diversity in contemporary society*. McGrawHill.

This source was incredibly informative about all aspects of paraphilias, kinks, and paraphilic disorders. I used this textbook to get a good sense of what exactly paraphilias are along with a thorough description of each of the different categories of paraphilias and

paraphilic disorders. I learned a lot about the impact of stigma on individuals with diverse sexual behaviors, coercive versus non-coercive paraphilias, the necessity of personal distress for a diagnosis, frequency, and a little bit about the causes. I used some of this information in my podcast, however, a lot of it was used as a springboard to find other sources that went more in-depth about specific information mentioned. For example, the textbook addressed the idea that some paraphilias are relatively harmless, which led me to research more about the misconception that all paraphilias are criminal and dangerous.

Sampaio, M., Becher, G., Moraes, C., Luz, H., & Abdo, C. (2023). (442) the importance of understanding paraphilias and paraphilic disorders (PD) for General Health and Sexology. *The Journal of Sexual Medicine*, 20(Supplement_1).

<https://doi.org/10.1093/jsxmed/qdad060.415>

This source was very informative about the impacts that stigmas and stereotypes can have on individuals with paraphilias and paraphilic disorders. I learned that a majority of the research conducted in the field of human sexuality is focused on anatomy, sexual dysfunctions, pregnancy, and STIs. However, there is little funding and research for topics such as paraphilias. The impact of this is huge since many psychologists are not trained in how to counsel those with paraphilic interests. This lack of training then leads to more stigmatization, poor therapeutic alliances, and the pathologizing of unconventional or unusual sexual experiences. This helped me form the basis of my first misconception, that the lack of understanding of the distinctions between paraphilias, kinks, and paraphilic disorders leads to misdiagnosis, underdiagnosis, unnecessary pathologizing of sexual behaviors, moral judgments, and inadequate treatments. This article helped me understand the severity of addressing and learning about variations in sexual behavior.

Talking Points

A. Introduction

a. History of conceptualizing and pathologizing 'sexual deviances'

- i. Specifically in regard to the DSM since it tends to reflect the social norms and values of the time, in this case distinguishing between what is 'ordinary' sexual behavior compared to behavior that is immoral, unethical, or illegal
- ii. DSM I (1952)
 1. Created a category called 'sexual deviation' which aimed to include cases that before the DSM had been categorized as 'psychopathic personality with pathologic sexuality'
 - a. antisocial, participated in sexual behaviors that deviated from the norm
 2. Sexual deviation - deviant sexuality that is not symptomatic of more extensive syndromes such as schizophrenia and obsessional reactions
 - a. Sexual behaviors that differed from the norms and were not a result of another psychological disorder
- iii. DSM II (1968)
 1. Included a guideline for psychiatrists in diagnosing 'sexual deviance'
 2. 'individuals whose sexual interests are directed primarily toward objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances such as necrophilia, pedophilia, sexual sadism, and fetishism'
- iv. DSM III (1980)
 1. Switch from 'sexual deviance' to paraphilias and psychosexual dysfunction
 2. Removal of homosexuality
 - a. Ego-dystonic homosexuality - people who have emotional pain or distress related to their sexuality
 3. Paraphilias - unusual or bizarre imagery or acts that are necessary for sexual excitement:
 - a. insistently and involuntarily repetitive
 - b. preference for the use of a nonhuman object
 - c. repetitive sexual activity with humans involving real or simulated suffering or humiliation
 - d. repetitive sexual activity with nonconsenting partners

4. EX: fetishism, transvestism, zoophilia, pedophilia, exhibitionism, voyeurism, sexual masochism, sexual sadism, atypical paraphilia
 - a. definitions and means for diagnosis
- v. DSM IV (1994)
 1. Significant change - criteria for diagnosis: ‘clinically significant distress or impairment’ within the context of social, occupational, or other important areas of functioning
 2. Specifically with a non-consenting person
- vi. DSM V (2013)
 1. Differentiated between a paraphilia and a paraphilic disorder
 - a. Paraphilia is a necessary but not sufficient condition for having a paraphilic disorder. A paraphilia by itself does not necessarily justify or require clinical intervention
 2. Diagnostic Criteria:
 - a. It lasts over a period of 6 months
 - b. Feels personal distress about their interest (not merely distress from society’s disapproval)
 - c. has a sexual desire or behavior that involves another person’s psychological distress, injury, or death, or a desire for sexual behaviors involving unwilling persons or persons unable to give legal consent

b. Issues with the past pathologizing of sexual behavior

- i. DSM follows the social norms at the time rather than empirical data or real science
 1. The idea of sexual deviance itself is a moral construct that opposes the values of the particular society or culture; it reflects the general perception of what should be normal rather than what people do
 - a. what is considered ‘deviant’ in Western culture is ‘normal’ in others
 2. Anything outside of heterosexual sex with the intent or possibility of reproduction was considered ‘atypical’ or ‘weird’
 - a. EX: anal and oral sex
 - i. “people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed”
 - b. EX: homosexuality
- ii. Key people who changed DSM:
 1. Alfred Kinsey - created Kinsey reports in the 1940s and 1950s that showed that people were doing a wide range of ‘unusual’ sexual practices and were much more common than previously acknowledged

2. Evelyn Hooker - groundbreaking research that showed that homosexuality was not a mental illness
- iii. While the diagnosing and distinction of paraphilias and paraphilic disorders have improved, there are still a lot of issues and stereotypes regarding the pathologizing of sexual behaviors
 1. “some mental health professionals believe that classifying some sexual behaviors as paraphilias is flawed and reflect a pseudoscientific attempt to judge, control, and medicalize sexuality’

B. Misconception #1: Misusing terms due to lack of information or misinformation about what they are (Kink, fetish, paraphilia, paraphilic disorder)

a. Root of misconception

1. Before the DSM V, which made a distinction between paraphilias and paraphilic disorders, any paraphilic behavior, interest, or fantasy was a disorder and was problematic.
- ii. Now, there is a distinction but the distinctions are not widely known

b. Definitions

- i. Kink - social category/term that describes any type of sexual behavior that falls outside of ‘mainstream’ sexual norms
- ii. Paraphilia - a clinical term used to describe atypical sexual interests that are typically more persistent, intense, and harmful than kinks
 1. DSM: “ any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature consenting partners”
 2. All paraphilias are kinks (atypical sexual interests) but not all kinks would be considered paraphilias
 3. Examples (in DSM)
 - a. Fetishism - sexual attraction to objects that become, for the person with the fetish, sexual symbols
 - b. Transvestism - cross-dressing in clothing of the other sex
 - c. Exhibitionism - exposing one’s genitals to an unsuspecting person
 - d. Sexual Masochism - being humiliated, beaten, bound or otherwise made to suffer
 - e. Sexual Sadism - inflicting psychological or physical suffering upon another person
 - f. Voyeurism - observing an unsuspecting person who is naked, disrobing, or having sex
 - i. Does NOT include sexually explicit books, internet sites, sexting, erotic dancing, recording partner for later viewing BC the observed person

is willing and the activities do not replace interpersonal sexuality

- g. Pedophilia - having a sexual focus on a prepubescent child
 - h. Others: necrophilia, telephone scatologia, zoophilia/bestiality
4. Paraphilic interest - the impulse for the behavior but does not declare personal distress, has no impairment in functioning, and no history of acting on this urge
- a. EX: Fetishism is a paraphilia until the person starts to feel distressed by it, their functioning is impaired, or there becomes the need for the item to be aroused
- iii. Paraphilic disorder - paraphilia that is causing distress or impairment or leads to personal harm, or a non-consenting person

c. Impact

- i. Stigmatization of non-harmful sexual interests - professionals, even those in the field of sexology - are not trained on the differences between the different categories
 - 1. People can be unjustly labeled as deviant or disordered - mislabeling of consensual activities as pathological
 - 2. Distress, shame, and reluctance to openly discuss or explore sexuality in healthy ways

C. Misconception #2: All paraphilias/paraphilic disorders are harmful/dangerous

- a. Roots in reality - exhibitionism, pedophilia
- b. Many individuals with paraphilic interests never act on their fantasies, and those that do might engage in them consensually
 - i. Not all sex offenders have paraphilias and most people with paraphilias do not commit offences
- c. Two different types of paraphilias:
 - i. Coercive - nonconsensual sexual activity
 - 1. Exhibitionism, voyeurism, pedophilia
 - 2. Illegal if enacted, but not to have fantasies or urges
 - ii. Noncoercive - relatively harmless, victimless, and only involves oneself or another consenting adult (fetishism, cross-dressing)
- d. Not everyone with a paraphilic interest requires treatment, only if:
 - i. paraphilic interests lead to personal distress
 - ii. causes harm or risk of harm to others
 - iii. individual struggles with impulse control or acts on their interests non-consensually
- e. **Impact**
 - i. The assumption that all paraphilias require intervention or disclosure to police
 - 1. Fear of legal consequences of disclosure (issues with mandated reporting)

- ii. Shame, guilt, and distress brought on by societal disapproval which fuels fear and discrimination
- iii. More challenging to seek help or guidance if needed
 - 1. It is more likely for people who receive treatment to be referred for legal reasons rather than presenting voluntarily which even then only constitutes a small proportion of individuals with paraphilic disorders
 - 2. Wait until something illegal has happened before getting treatment because of social stigma and shame that prevents someone from going to get treatment themselves
- iv. Unnecessary legal restrictions on non-harmful paraphilias
- v. Social alienation for those with harmless paraphilias while making it harder to identify those who genuinely need intervention.

D. Misconception #3: Having a paraphilic disorder/paraphilia is a choice

- a. While a lot of the research has been conducted on those who have committed an illegal offense, a common theme is that there are underlying causes that lead to the development of a paraphilia
- b. Causes**
 - i. Psychological comorbidity - higher rates with
 - 1. Personality disorders
 - 2. Mood and anxiety disorders
 - 3. Multiple paraphilias correlate with higher levels of psychiatric comorbidity
 - ii. Developmental/familial
 - 1. Attachment issues
 - 2. rejection or neglect from parents
 - 3. sexual abuse
 - iii. Behavioral/Emotional/Cognitive
 - 1. Social incompetence - intimacy and social skills deficits
 - 2. Emotional dysregulation
 - 3. Substance misuse
 - 4. Cognitive distortions or distorted sexual scripts
 - iv. Neurodevelopmental abnormalities
 - 1. Lower IQ
 - 2. impaired cognitive abilities
 - 3. neuroendocrine differences (serotonin)
 - 4. neuroradiological brain abnormalities (temporal and frontocortical regions)
- c. Sub-misconception:** Individuals who associate pain with sexual arousal are victims of childhood sexual abuse who developed psychological problems into adulthood
 - i. The proportion of pedophiles who report having been sexually abused in childhood by mature persons is larger than that of men who were not

charged for or accused of a sex offense against children even though the difference is relatively small (28 vs 14)

d. Impact

- i. Increased stigma and shame
 1. Blame and moral judgment
 2. Internalized shame, guilt, and distress
 - a. Anxiety, depression, self-hatred for feeling like their sexual preferences are 'wrong' or 'evil'
 - b. More likely to have been previously admitted to a hospital and have attempted suicide than patients without paraphilias
- ii. Misguided legal and social policies
 1. emphasis on punishment rather than rehabilitation
- iii. Less motivation to study the neurological, psychological, and developmental origins of paraphilias
 1. lack of specialized therapists and appropriate treatment programs

E. Conclusion

- a. Normalizing sexual variance