

# From Deviation to Disorder: the medicalization of sexuality in contemporary psychiatric classifications of disease

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## Sexuality, culture and politics A South American reader

Although mature and vibrant, Latin American scholarship on sexuality still remains largely invisible to a global readership. In this collection of articles translated from Portuguese and Spanish, South American scholars explore the values, practices, knowledge, moralities and politics of sexuality in a variety of local contexts. While conventionally read as an intellectual legacy of Modernity, Latin American social thinking and research has in fact brought singular forms of engagement with, and new ways of looking at, political processes. Contributors to this reader have produced fresh and situated understandings of the relations between gender, sexuality, culture and society across the region. Topics in this volume include sexual politics and rights, sexual identities and communities, eroticism, pornography and sexual consumerism, sexual health and well-being, intersectional approaches to sexual cultures and behavior, sexual knowledge, and sexuality research methodologies in Latin America.

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# From Deviation to Disorder: the medicalization of sexuality in contemporary psychiatric classifications of disease\*

Jane Araujo Russo\*\*

## 1. Introduction

In the final decades of the 20th century, the psychiatric field witnessed an important transformation. The psycho-social view of mental disorders, characterized in part by the hegemony of psychoanalytic interpretation and by a political and social critique of traditional psychiatric practices, gave way to a view that was strictly biological. A landmark in this transformation was the publication in 1980 of the third version of the *Diagnostic and Statistic Manual of Mental Disorders* (DSM-III) by the *American Psychiatric Association*. But this shift in the understanding of mental disorders—from psycho-sociological to biological—was not an isolated phenomenon. In fact, it was part of a larger process of the “re-biologization” of topics and debates, such as race and sexual difference, which were earlier reserved to the realm of political struggle.<sup>1</sup> Some authors claim that a model that has physics as scientific paradigm is giving way to a model of the organism grounded on biology.<sup>2</sup> In the midst of this trend towards biology, the so called neurosciences came to propose a radically materialist understanding of the human mind.<sup>3</sup> My objective is to examine this “biologization” of human experience from the perspective of psychiatry and neuroscience, focusing specifically on the classification and consequent definitions of mental disorders. The broader goal of my current research is to discuss to what extent the dominant mode of conceiving mental disorders reflects and produces rearrangements in the social representations of the Modern Self.

The change in terminology that occurred with the publication of DSM-III touched especially upon disorders/deviations related to sexuality and gender. A preliminary examination of the different versions of the manual can shed light on a disproportionate increase in the *number* of these disorders. Aside from this numerical change, one can

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<sup>1</sup> One example of this debate is *The Bell Curve – Intelligence and class structure in American life*, by R. J. Herrnstein and C. Murray. Published in 1994 in the United States, the book generated controversy by virtue of its authors’ renown and its reliance on genetic and racial determinism.

<sup>2</sup> For a discussion of this as a paradigm shift, see Bezerra Jr. (2000).

<sup>3</sup> See Russo & Ponciano (2002).

also perceive that new *types* of disorders/deviations were made part of the repertoire of psychiatric diagnoses. We intend to examine these questions—the quantitative increase and qualitative change of disorders—in light of broader changes witnessed in the ideology of contemporary psychiatry, keeping in mind the process of medicalization of areas previously interpreted psychologically and the ways in which this medicalization influences sexuality, specifically.

## 2. Sexuality as a field of psychiatric intervention

Historically, sexuality has constituted one of the fundamental thematic threads used to name and comprehend some of the most significant social processes in modern Western societies, especially those processes that result in the representation of an autonomous and singular subject that resists any type of social determinism.

Foucault (1988) observed that the development of sexuality is related to the very constitution of subjectivity in modern culture, involved in “knowing of the self”, “caring for the self” and “translating into discourse.” Sexuality becomes a parameter measurement of authentic human characteristics based upon the truth that we ascribe to it. This truth is constructed on the basis of a solution that addresses the dimensions of the body and mind. “Sexuality” was produced as a constitutive nucleus of truth about the subject within the liminal space between physicality and morality (both individual and social). In Christianity, we encounter a link between truth about human and corporeal/sexual desires. However, it is in the configuration of modern values that the representational focus is dislocated from the singular unit, the subject, creating the possibility of the production of a social world from the very self-definition of individuals (Cf. Foucault & Sennet, 1981). In this context, the topic of sexuality and its deviations and dysfunctions has occurred through two principal avenues: interiorization, in which sexuality (and its practices and associated discourses) has appeared as an expression of moral development of the singularity of subjects (as demonstrated in the artistic and literary production of the Marquis de Sade, Balzac and Jean Genet); and physicalization, in which sexuality has historically been related to ideas about the nervous system, dementia, and degeneration.

Scientific knowledge(s) appeared and developed within this second line of thought. Of these, biomedicine stands out as having played a predominant role in the production of sexuality as something that is essential to the subject. From the 19<sup>th</sup> century onward, it was primarily through biomedical discourse that the judgment of sexual **practices** considered to be licit or illicit (such as “sodomy”) transitioned to the judgment of **subjects** considered to be normal or abnormal (such as the “homosexual”). Within biomedicine, psychiatry was the specialty that most directly addressed the topic of sexuality, precisely because it was the field of knowledge whose object of study and intervention is individual behavior and its disorders. The attempt to establish sexology

as an autonomous discipline was only partially successful. As Carrara & Russo (2002) point out, the most renowned sexologists throughout the 19<sup>th</sup> and 20<sup>th</sup> century were doctors, a good portion of whom were psychiatrists. In 1846, it was already possible to find scientific publications discussing the topic of the pathologization of sexuality.<sup>4</sup> But it was with the first edition of *Psychopathia Sexualis* (1889) by the German psychiatrist Krafft-Ebing that so-called mental disorders linked to sexuality—the “perversions”—became widespread and established, both as part of the social imaginary of the era and of the repertoire of classifications of psychiatric disorders (Cf. Duarte, 1989).

Psychoanalysis, which emerged in the early 20th century, can be considered as a kind of sexology that worked. Despite not focusing its attention on perversions or sexual deviances per se, psychoanalytic theory broadened the concept of sexuality itself. It moved beyond a conception that referred to sexual practices *in stricto sensu* to one that affected the entire mental life of the subject. This broadened conception of sexuality involved the affirmation of infantile sexuality (the child as polymorphously perverse), the Oedipus complex (the desire of the child for the father or mother), the concomitant castration complex as a fundamental component of the socialization of the subject and, above all, the existence of infantile sexual desire as the source of dreams and neurosis.

The expansive diffusion of psychoanalysis in the field of psychiatry<sup>5</sup> had important implications for the classification of mental disorders. First and foremost, it meant a shift toward a *psychological* conception of mental disorders, in detriment to the physicalist vision that was hitherto predominant. With regard to sexuality, although there were no major changes in the nomenclature itself (the old designations of sexual perversions soldiered on), interpretations changed radically. Above all, psychoanalytic classification spoke of a new view of mental disorder. The term “neurosis”, for example, went beyond describing a determinant type of behavior or symptom, referring to a mechanism (or structure) underlying the observable disorder. This presupposes a certain theory of mental illness that revolves around infantile sexuality and its perils. Therefore, while sexual disorders occupy a secondary space in the classificatory process of psychology, sexuality is, indeed, everywhere in it.

### 3. The ideological/terminological revolution of the 1980s

During the last decades of the 20th century, the hegemony of psychoanalysis in American psychiatry (and later worldwide) came to an end. In 1980, the third version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) was published

<sup>4</sup> According to Foucault (1977), *Psychopatía Sexualis* was published by Henrich Kaan in 1846. This title, a popular phrase in the erudite media of the time, was also used by an Italian scientific journal: *Archivio delle Psicopatie Sessuali*.

<sup>5</sup> We refer to the psychiatric method of the core countries of the so called Western world. This diffusion took place especially in the United States and France (although at different moments), later spreading to peripheral countries such as Brazil.

by the *American Psychiatric Association*.<sup>6</sup> The publication of DSM-III signaled a radical terminological change in psychiatric classifications and, more importantly, an internal diversification of classificatory logic. DSM-III proclaimed itself to be an atheoretical manual, based solely on the principles of testability and verification, in which a disorder is identified by accessible criteria subject to observation and empirical measurement. This insistence upon the objectivity of the new categories and their descriptive character was a critique of the previous method of classification, founded on an *etiological* pretense regarding mental disorders; in other words, on unconscious processes, *inferred* by clinicians and not subject to rigorous empirical observation.

Under this radical rupture in terminology, however, there was also a radical departure from a certain theory about mental disorders, a theory which pointed to *mental* (or *psychological*) processes as underlying the disorders. In American psychiatry, the new manual represents the so called neo-Kraepelinian revolution—in reference to Emil Kraepelin, the important German psychiatrist of the late 19th century, representative of the organist theory of mental disorders. In truth, this shift did not signal the end of *any* etiological theory: only of a specific (specified) etiological theory. The empiricist assumption implied an “atheoretical,” and therefore objective, position that signaled the adoption of a physicalist view of mental disorders without any possibility for alternative interpretations. The *empirical* objectivity of signs and symptoms corresponds ideally to the *empirical* objectivity of the physical substrate: in other words, the objectivity of psychiatric diagnosis is the same as the objectivity of the physiological and organic substrate. In this sense, “atheoreticism” is in fact the adoption of a specific theory regarding disorders. It distances itself from psychoanalysis and a psychological reading of mental illness and returns psychiatry back to the heart of medicine.<sup>7</sup>

Comparing the three earlier versions of the manual, one immediately notes a marked difference in the method by which symptoms are conceived. In DSM-I and II, symptoms were polymorphic expressions of underlying processes. The same symptom, or a determined group of symptoms, could refer to different mechanisms in different cases. The borders between diagnostic categories were reasonably fluid. For the authors of DSM-III, there is a clear and discernible boundary between the ill and the normal and between different mental illnesses. In DSM-III, it is necessary to rigorously define those boundaries.

<sup>6</sup> The first version of the Diagnostic and Statistical Manual of Mental Disorders—DSM I—was published in 1952 and was strongly driven by the psychodynamic strand of psychiatry inspired by psychoanalytic theory. This orientation remained in the second edition of the manual—DSM II—published in 1968. In 1974 the American Psychiatric Association initiated the revision of the DSM-II, justified due to the revision of the 8th edition of the International Classification of Diseases (ICD-8) that the World Health Organization (WHO) was then undertaking and the 1968 agreement between the government U.S. and WHO about the need to match nomenclatures in WHO manuals and the APA's publications. After many debates and controversies, the revision and update of DSM II was completed in 1980 with the publication of DSM III. In 1987, this DSM III was updated (DSM III-R) and in 1994 the fourth version (DSM IV) was published.

<sup>7</sup> For an account of this process, see Wilson (1993); Skodol, Spitzer & Williams (1981); Skodol & Spitzer (1982); Shorter (1997, and Young (1995). For a discussion about the relationship between this transformation and the modern conception of the self, see Russo & Henning (1999).

This need to delimit clear boundaries between different disorders resulted in over-specification and led to an exponential increase in the number of categories listed in the manual. To illustrate this point, DSM-II (which was already larger in relation to the DSM-I) listed 180 categories while DSM-III listed 295. In the DSM-IV, however, the number of disorders reached 350. Beyond the mere numerical increase, the method by which the categories were “organized” was also completely modified.

One of the central modifications in the structure of the manual was in respect to the abandonment of the old hierarchy between organic and non-organic disorders. In the introduction of DSM-I, the authors state:

The basic division in this nomenclature is between those mental disorders associated with organic brain disturbances and those occurring without such primary disturbance of brain functions, and not into psychoses, psychoneuroses and personality disorders. (DSM I, Introduction)

In DSM-III, this division is no longer considered fundamental:

Differentiation of Organic Mental Disorders as a separate class does not imply that nonorganic (“functional”) mental disorders are somehow independent of brain processes. On the contrary, it is assumed that all psychological processes, normal and abnormal, depend on brain function. (DSM III, Introduction)

In DSM-IV, we are informed that the group of “Organic Mental Disorders”—still present in DSM-III—no longer exists, since the use of the expression presupposed the incorrect idea that other mental disorders present in the manual did not have a biological basis. In other words, the division that was fundamental to DSM-I simply ceases to operate in DSM-IV.

And what happened to neurosis, the psychological disorder par excellence? The exclusion of the term “neurosis” in DSM-III was at the core of a sharp conflict between the psychoanalytic *establishment* and the task force in charge of producing the new manual. The defeated psychoanalysts obtained a small victory by guaranteeing the inclusion of the term “neurosis” in parentheses alongside the new categories. This victory was not long lived, however, as the 1987 revised version of DSM-III—known as DSM-III-R—dropped the use of parentheses (and, along with them, the term neurosis).

In the new “architecture” of DSM-III, the group of “neuroses”—present in DSM-I and II—disappeared, breaking down into at least three categories with a total of 18 disorders. In DSM-IV, the three categories are maintained, but the number of disorders rises to 24. In truth, this “dissolution” and redistribution of the old disorder can be considered as even larger still if we add in other groups, such as “Factitious Disorders,” “Disorders of Impulse Control Not Elsewhere Classified,” or “Adjustment Disorders.” In these, the

term “neurosis” was not added in parentheses, but it could be recognized as a type of disorder (such as “factitious disorder with psychological symptoms” or “pathological gambling”) that in other eras would have been considered as part of a neurotic disorder or even as a form of neurosis.

To the extent that the manual was transformed, the recognition of what used to be called “neurosis” became increasingly difficult. As already stated, the transformation is not simply in one of terminology. The dissolution of the boundary between the organic and non-organic, so dear to the authors of DSM-I, indicates the medicalization of what was once considered to be psychological. Disorders that were before amenable to differentiated—psychological—treatment transform into disorders which, defined in strictly medical terms, ought to be treated just like any other disease; that is, medically. This brings us to the strong relationship DSM III maintains with psychopharmacology.

In truth, it is impossible to understand the intense diffusion of the new manual in the international psychiatric world without considering this relationship. In fact, DSM-III rapidly became a kind of psychiatric bible. The first two versions of the manual were administrative codes prepared by a small and obscure committee without any scientific pretense. It was crafted during the epoch of the great textbooks of psychiatry, in more or less eclectic fashion, incorporating diverse tendencies and modes of conceiving of diagnosis and psychiatric practice. DSM-III would turn into a bible and lead to the globalization of North American psychiatry. Adherence to DSM-III is encouraged in many different ways. In the first place, there is an affinity between the diagnostic format (through a list of clearly identified symptoms, creating clear criteria for inclusion and exclusion in these categories) and the randomized clinical trial; that is, experimental research. The pharmaceutical industry, interested in research in the efficacy of new medications to be placed on the market, heavily financed the randomized clinical trials. Traditional clinical case studies—favored by the logic of psychoanalysis, in which a case is examined and discussed in depth—would gradually be replaced by multicentered studies involving large numbers of patients, according to the parameters of the experimental clinical trial and meeting the requirements imposed by the *U.S. Food and Drug Administration* (FDA) for the release of new psychiatric medications. The FDA requires that laboratories present study results that can be replicated in order to prove their validity. This requirement reinforces the need for diagnostic criteria (with clearly defined boundaries, criteria for inclusion and exclusion, etc). In other words, it enforces **a standardization** of diagnostic procedure. Thus, the interests of large pharmaceutical laboratories on the one hand and the requirements of an American regulatory agency on the other disseminate and practically impose the diagnostic logic of DSM-III worldwide (Cf. Healy, 1997; and Valenstein, 1998). Since large pharmaceutical laboratories are always seeking registration in the American market, which is the biggest in the world, the diagnostic criteria of DSM-III ends up being adopted by the rest of the world, particularly in specialized scientific journals that publish the results of these studies. In 1993, even the International Classification of Diseases (ICD, published by the World

Health Organization) incorporated the classification of DSM-IV in its chapter on mental disorders.<sup>8</sup>

Therefore, it is possible to affirm that the significant changes in terminology produced in 1980 by the publication of DSM-III and its diffusion in the international psychiatric world resulted in a major transformation both in prevailing conceptions of mental illness and in the ways mental disorders are treated. This transformation moved in the direction of the medicalization of old neuroses, which resulted in the abandonment of the very term “neurosis” itself in favor of a multiplicity of highly specified classificatory categories, with clearly defined boundaries established between each category (favoring the generic designation “disorder”). Within this multitude of categories, the impressive increase in the number of disorders related to gender or sexuality deserves our attention.

#### 4. From deviance to disorder: sexuality in DSM-IV

In DSM-I, the subcategory “Sociopathic Personality Disorder”—classified within the group of Personality Disorders—introduces the classification of “Sexual Deviation.” The text of the manual provides the following specification: “The diagnosis will specify the type of pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation” (p.39).

In DSM-II, the so-called “sexual deviations” are once again classified within the group Personality Disorders and Other non-Psychotic Mental Disorders. In lieu of the simple classification “sexual deviation,” present in DSM-I, nine categories are listed with their respective descriptions:

“Homosexuality”

“Fetishism”

“Pedophilia”

“Transvestism”

“Exhibitionism”

“Voyeurism”

“Sadism”

“Masochism”

“Other sexual deviations”

In DSM-III, the old sexual deviations are no longer part of the group of “Personality

<sup>8</sup> The ninth edition of the International Classification of Diseases (ICD-9) published in 1975 was by 1978 effectively implemented as a manual for diagnostic orientation in various countries of the world. However, in 1979 the *American Psychiatric Association* and other medical entities of the United States edited a modified version of ICD-9, called ICD-9 Clinical Modification (ICD-9 CM). It included results of studies already conducted for DSM-III, at the time a work in progress. The allegedly “atheoretical” North American psychiatric paradigm was adopted in the modified version of ICD-9 and later, in 1993, in the tenth edition of the ICD (ICD-10). For more information, see Venâncio (1998).



Disorders.” Instead, they constitute a separate group called “Psychosexual Disorders.” In the nine “Sexual Deviations” of DSM-II, one finds 22 “Psychosexual Disorders,” subdivided into four categories (Gender Identity Disorders, Paraphilias, Psychosexual Dysfunctions and Other Psychosexual Disorders). The expansion of sexual disorders continues in DSM-IV. In this latest version, this type of disorder is entitled “Sexual and Gender Identity Disorders,” and comprises 27 disorders (several which have more than one subdivision), grouped into “Sexual Dysfunctions,” “Paraphilias” and “Gender Identity Disorders” (see Appendix).

When one compares the three nomenclatures, it quickly becomes clear that the so-called “Paraphilias” recover the DSM-II category of “Sexual Deviations”, which are in fact the old “perversions” traditionally considered to be internal disorders by the field of psychopathology. Of these, the old “transvestism” stands out, now constituting a subdivision of the so called “Gender Identity Disorders.” Here one perceives a modernization of the nomenclature, with the use of the term “gender-identity” being much to the taste of feminist and homosexual movements, as well as gender studies in the social sciences. Beyond this shift in terminology, an important innovation introduced by DSM-III and later versions is an “overflow” of traditional classifications with the inclusion of new disorders represented by the category “Sexual Dysfunctions.” Here, we encounter disorders which were earlier very well defined as symptoms of some other disorder, or were external to the field of mental disorders.

Here one perceives an “autonomatization” of the theme of sexuality, which removes itself from the other diagnostic categories and now defines a specific class of disorders. At the same time, one can confirm the growth of the concept of “deviance” (now labeled “dysfunction”). Until DSM-II, following the tradition inaugurated in the 19<sup>th</sup> century, only the sexualities considered “deviant” were incorporated into the “menu” of psychopathological disorders. In other words, this meant those sexualities which deviated from what was seen as normal (heterosexual genital relations between adults). These deviations from “normal” sexuality were understood as part of a set of more general disorders of the self (such as neurosis). They did not constitute a specific class of disorders. From DSM-III forward, however, the dismantlement and fragmentation of the old neuroses led to the delimitation of a series of new disorders of “normal” sexuality.

Based upon the description of new disorders in the most recent version of the manual (DSM-IV), I raise two questions that certainly deserve a more careful discussion than I am capable of providing here. The first is with respect to the underlying conception of “normal sexuality”; the second inquires as to the very conception of the self that permeates the entire manual.

In the text of DSM-IV, we are informed that a sexual dysfunction “is defined by a disorder in the processes that characterize the cycle of sexual response or by pain associated

with sexual intercourse” (p. 467). The cycle of sexual response, in turn, is comprised of the following phases: desire, arousal, orgasm and resolution. Each phase refers to a specific disorder. We thus encounter “Sexual Desire Disorders,” “Sexual Arousal Disorders,” “Orgasmic Disorders” and, obviously, “Sexual Pain Disorders.” There are two “Disorders of Sexual Desire” listed. The first is “Hypoactive Sexual Desire Disorder,” which is characterized by a “deficiency or lack of sexual fantasies and desire to have sexual activity” (p. 470). The other is the “Sexual Aversion Disorder”, characterized by “aversion and active avoidance of sexual genital contact with a partner” (p. 472).

Immediately, our attention is drawn to the question of is it possible to come up with an entirely objective definition of “*deficiency of fantasies*” or “*low desire*.” Such an evaluation implies an underlying affirmation that there is an objectively verifiable, normal level of fantasies and sexual desires. From another viewpoint, the two disorders detected by this pretense of a “normal level” indicate the existence of a lack (of fantasy or of desire).<sup>9</sup> Apparently, either the possibility of excess is not considered to be a disorder, or it does not exist. In other words, an excess of fantasies or a high level desire are both within the parameters of what the DSM takes to be normality.

We thus see that, in regards to sexuality, the “objectivity” of the new manual suggests an acceptance of the modern injunction that “more sex is better.” Aside from the “shifting” of sexual terms from those used to describe the old perversions, we also thus encounter the belief that a “deficiency” of sexuality is pathological. This “descriptive neutrality” thus buys into and, indeed, naturalizes the contemporary values regarding a sexually active life.

To understand the conception of the self that permeates the manual, it is necessary that we return to the classificatory logic introduced in DSM-III, which implies a clear and rigorous demarcation of different disorders. Earlier, I demonstrated that this classificatory logic is in opposition to the old “dimensional” diagnostic inspired by psychoanalysis, which saw symptoms as “polymorphous expressions of underlying processes.” In other words, the combination of visible and delineable symptoms points to something beyond: an “underlying structure,” unknown to the subject themselves and which, in some way, compromises the whole. To arrive at this “underlying structure,” this invisible level, is implicit a kind of voyage to the center of one’s self, a journey of self-discovery in search of “self-actualization.”

I believe that the clear delineation of disorders using demarcated combinations of objectifiable symptoms and the consequent disproportional increase in the number of possible disorders indicates not so much an increase in the scientific capacities of psychiatry, but rather the imposition of a different kind of psychiatric practice.

<sup>9</sup> Similarly, the two other types of Sexual Disorders, Sexual Arousal Disorder and Orgasmic Disorders (each with two subtypes, feminine and masculine) are also understood to be disorders of deficiency and not excess.

The professional capable of guiding the subject in a “voyage to the center of one’s self” is substituted by a strictly medical professional who focuses on circumscribed and localized disturbances, offering treatments that are equally circumscribed and localized. In this respect, the inclusion of “sexual desire disorders” and “sexual arousal disorders” in a psychiatric manual are part of the movement described above. That which could previously be interpreted as part of a greater psychological dimension does not disappear: it is, instead, transformed and objectified so that it can be described, interpreted and medically treated. The fragmentation and specification of disorders of “normal” sexuality are part of this broader process, which points to the very objectification and fragmentation of the “self, “subject” and “person” concepts.

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## List of sexual deviances/disorders in three versions of the DSM (II, III, and IV)

### DSM-II

#### PERSONALITY DISORDERS AND OTHER NON PSYCHOTIC MENTAL

##### SEXUAL DEVIANCES

- Homosexuality
- Fetishism
- Pedophilia
- Transvestism
- Exhibitionism
- Voyeurism
- Sadism
- Masochism
- Other sexual deviances

### DSM III

#### PSYCHOSEXUAL DISORDERS

##### GENDER IDENTITY DISORDERS

- Transsexualism,*
- Gender identity disorder of childhood*
- Atypical gender identity disorder*

##### PARAPHILIAS

- Fetishism*
- Transvestism*
- Zoophilia*
- Pedophilia*
- Exhibitionism*
- Voyeurism*
- Sexual masochism*
- Sexual sadism*
- Atypical paraphilia*

##### PSYCHOSEXUAL DYSFUNCTIONS

- 302.71 *Inhibited sexual desire*
- 302.72 *Inhibited sexual excitement*
- 302.73 *Inhibited female orgasm*
- 302.74 *Inhibited male orgasm*
- 302.75 *Premature ejaculation*

- 302.76      *Functional dyspareunia*  
 306.51      *Functional vaginismus*  
 302.70      *Atypical psychosexual dysfunction*

#### OTHER PSYCHOSEXUAL DISORDERS

- 302.00      *Ego-dystonic homosexuality*  
 302.89      *Psychosexual disorder not elsewhere classified*

### DSM IV

#### SEXUAL AND GENDER IDENTITY DISORDER

##### SEXUAL DYSFUNCTIONS

*The following specifiers apply to all primary Sexual Dysfunctions:*

Lifelong Type/Acquired Type/ Generalized Type/ Situational Type/ Due to Psychological Factors/ Due to Combined Factors

##### \*Sexual Desire Disorders

- 302.71      Hypoactive Sexual Desire Disorder  
 302.79      Sexual Aversion Disorder

##### \*Sexual Arousal Disorders

- 302.72      Female Sexual Arousal Disorder  
 302.72      Male Erectile Disorder

##### \*Orgasmic Disorders

- 302.73      Female Orgasmic Disorder  
 302.74      Male Orgasmic Disorder  
 302.75      Premature Ejaculation

##### \*Sexual Pain Disorders

- 302.76      Dyspareunia (Not Due to a General Medical Condition)  
 306.51      Vaginismus (Not Due to a General Medical Condition)

##### \*Sexual Dysfunction Due To A General Medical Condition

- 625.8      Female Hypoactive Sexual Desire Disorder Due to ....  
 608.89      Male Hypoactive Sexual Desire Disorder Due to ...  
 607.84      Male Erectile Disorder Due to ...  
 625.0      Female Dyspareunia Due to ...  
 626.0      Male Dyspareunia Due to ....  
 625.8      Other Female Sexual Dysfunction Due to Other Male Sexual Dysfunction Due to ...  
 \_\_\_\_\_.      Substance-Induced Sexual Dysfunction

*Specify if:* With Impaired Desire/ With Impaired Arousal/ With Impaired Orgasm/  
With Sexual Pain

*Specify if:* With Onset During Intoxication  
302.70 Sexual Dysfunction NOS (Not otherwise specified)

#### PARAPHILIAS

302.4 Exhibitionism

302.81 Fetishism

302.89 Frotteurism

302.2 Pedophilia

*Specify if:* Sexually Attracted to Males/Sexually Attracted to Females/Sexually  
Attracted to Both

*Specify if:* Limited to Incest

*Specify type:* Exclusive Type/Nonexclusive Type

302.83 Sexual Masochism

302.84 Sexual Sadism

302.3 Transvestic Fetishism

*Specify if:* With Gender Dysphoria

302.82 Voyeurism

302.9 Paraphilia NOS

#### GENDER IDENTITY DISORDERS

302.xx Gender Identity Disorder

.6 *in Children*

.85 *in Adolescents or Adults*

*Specify if:* Sexually Attracted to Males/Sexually Attracted to Females/Sexually  
Attracted to Both/ Sexually Attracted to Neither

302.6 Gender Identity Disorder NOS

302.9 Sexual Disorder NOS