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DSM-5 paraphilic disorders criteria in the light of autoerotic asphyxiophilia and non-sexual form of oxygen restriction

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Summary

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders published in 2013 has proved to be particularly interesting in the field of sexuality. It introduced a number of significant changes in the definition of sexual norms, among them a widely discussed distinction between paraphilias and paraphilic disorders. The key criterion separating the abnormal sexual interests from the disordered ones is clinically significant distress resulting directly from sexual behavior and/or the risk of suffering or harm to another person as a result of one's sexual behavior. In the case of masochism – which addresses the phenomenon of suffering quite particularly – this distinction is troublesome. Using the example of autoerotic asphyxia – a behavior from the masochism spectrum – the authors critically examine the proposed DSM-5 method of defining the standards of sexual behavior. Interesting in this regard has been a comparison between autoerotic asphyxia and free diving – a nonsexual activity which, although also associated with possible loss of life by reduction of oxygen, has not been pathologized.

Key words: DSM-5, sexology, paraphilias

Introduction

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders was keenly awaited by psychiatrists, sexologists and mental health professionals interested in human sexuality. The Paraphilias sub-work group's contribution to DSM-5 was accompanied by a number of papers that suggested various improvements in the

diagnostic criteria for paraphilias, taking into consideration both their clinical and forensic utility [1–5]. The discussion on the place of atypical sexual preferences in DSM that emerged as a result of the work on and around DSM-5 has proven particularly interesting. Three years have passed and this discussion is ongoing [6–9], which reveals fundamental difficulty in achieving consensus on the definition of adequate criteria in the area of sexuality, with the most crucial issue whether the DSM should define sexual norms [6, 10].

In its final form, DSM-5 introduced a differentiation between paraphilias, which are now considered abnormal but non-disordered sexual variations, and paraphilic disorders. A paraphilic disorder is a paraphilia that is causes distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others [11].

At first glance, this reconceptualization seemed to be a substantial change – as DSM's website suggests – and a step forward in depathologizing alternative sexual fantasies, desires and behaviors. The mere fact of having an atypical sexual preference is no longer regarded as a disorder since the diagnosis is now based on clinical significance criterion [11]. However, what has been already noticed, that the mere alternative sexual drive is not considered a disorder since the fourth edition of the DSM, which appeared almost twenty years before the publication of DSM-5 [9]. From this perspective, the introduction of a distinction between paraphilias and paraphilic disorder seems only a superficial change, consisting in introduction of a new category of 'paraphilic disorder' rather than a thorough rewording of diagnostic criteria.

New definition of paraphilic disorder and resulting diagnostic criteria raise some doubts. The article discuses the most important ones using, among others, the example of autoerotic asphyxia – a phenomenon from the masochism spectrum, which, in accordance with this definition, absolutely maintains the status of paraphilic disorder. As an activity associated with the reduction of oxygen for sexual purposes, autoerotic asphyxia is a perfect counterpoint to certain non-sexual behaviors which, although they are also associated with threat to health and life, have not been pathologized. Analysis of similarities and differences between those phenomena reveals ambivalence towards sexual motivation. This ambivalence is not only cultural phenomenon, but it is also present among mental and sexual health professionals which seems to be mirrored in DSM-5 criteria for paraphilic disorder.

Definition by exclusion

One of the most interesting additions to DSM-5 is the new definition of paraphilia. Paraphilia has been defined as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with (a) phenotypically normal, consenting adult human partner" [12]. Given the criticism it had provoked before in the literature, it is a confusing improvement especially when one considers its practical implications [6, 10, 13]. Since the phenomenon that

is the subject of definition is defined here by exclusion, the 'normative' orientation of sexual preferences is more precisely defined in the first place. Everything that goes beyond the norm defined in this way becomes a paraphilia. This is a significant change because in earlier versions of the diagnostic manual paraphilias were defined solely by enumerating atypical objects or targets of sexual interest (a definition by concatenation) without making attempts to define normative sexual preference. In fact, it makes DSM-5 the first edition of the APA classification to define what normative sexual interests actually are and as a consequence alarmingly expands the spectrum of possible paraphilias and paraphilic disorders. It seems that DSM-5 not only fails to correct the asymmetry inherent in how various types of preferences are valued, but reinforces the asymmetry.

The practice of distinguishing the normative orientation of sexual preferences from the paraphilic one seems all the more surprising that both these phenomena belong to the spectrum of the norm. What some readers may find particularly interesting, is that before the definition of paraphilia entered DSM-5, the original wording proposed by author had been as follows: “A paraphilia is any powerful and persistent sexual interest other than sexual interest in copulatory or pre-copulatory behavior with phenotypically normal, consenting adult human partners” [14].

The critics of the current paraphilia definition also point to the problematic implications of the particular wordings. The term 'consenting' unquestionably has a strong justification for legal purposes [7, 8] but does not necessarily provide a credible ground for distinguishing 'normal' from 'abnormal' with respect to mental health. In this context, it should be considered whether undertaking non-consensual sexual behaviors (although morally reprehensible and/or illegal) necessarily constitutes evidence of mental disorder and, inversely, whether any consensual sexual activity is consistent with sexological definitions of the norm. Another issue is whether having an interest in other types of genital stimulation is an indicator of a mental disorder and whether sexual activity with others should determine the sexual norm. Moreover, when is someone 'phenotypically normal'? One could also ask what, precisely, sexual activity with another person is and whether sexual contacts facilitated by media count as such? These questions are hard to answer, especially when we consider that a number of common sexual activities would not fit proposed criteria.

It appears that paraphilic preferences are no longer sufficient for a diagnosis under certain conditions, yet they continue to be situated somewhere between what is normal and abnormal in the area of sexuality. It is somewhat surprising as APA has never justified, based on clinical evidence or research data, why it considers some nonstandard sexual interests as paraphilic disorder and hence requiring at least some sort of clinical vigilance [9].

Distress and impairment

The distinction made between paraphilias and paraphilic disorders was motivated by the desire to reduce the number of false positive diagnoses based only on the content criterion of the atypical orientation of sexual preferences as opposed to the criterion of clinical significance [11]. By acknowledging at least the last decade of studies on individuals practicing paraphilic sexual behaviors in a consensual manner without any distress or psychosocial impairment experienced [15–17]. It may be then worth giving some thought to the question of whether any consensual and atypical sexual preference, which is associated with individual distress, should be the basis for diagnosis without considering the source of this suffering.

Although DSM-5 clearly states that the distress and impairment described in Criterion B are distinctive in being the immediate or ultimate result of the paraphilia, and not primarily the result of some other factor such as the disapproval of society [11, 18], this distinction creates serious difficulties. Internalized distress, socially induced guilt and shame must be distinguished from internal distress and discomfort, but how? It is very doubtful that it is possible to distinguish 'internal' from 'internalized' distress, and it is equally doubtful whether such distinctions actually even exist. Individuals practicing bondage, discipline (or domination), sadism and masochism (BDSM) can suffer impairment in their social and occupational lives because their sexual preferences do not meet current societal standards. They may also have difficulty finding a partner who reveals complementary preferences. These considerations are particularly important in the case of those forms of paraphilia, which according to DSM-5 can be diagnosed as paraphilic disorders only because of the distress that accompanies them. If, despite this type of doubt, we decide to make a diagnosis of a paraphilic disorder, another question emerges: what sort of clinical intervention is appropriate?

The manner in which the preface to the paraphilic disorders chapter of DSM-5 is currently phrased leaves the reader with two contrary but justified interpretations: conversion or affirmation. There are many ways a person can pursue therapy for his/her sexual interest, but there are two main ones: a therapy can be either aimed at changing unwanted sexual behavior, or aimed at helping a client to be more comfortable with the behavior thereby alleviating the stress. If the preference itself – paraphilia – is no longer problematic as far as a person's mental health is concerned, the DSM should probably also include the affirmative approach. Changing the course of a preference that is no longer considered disordered seems pointless.

It is impossible to overlook the resemblance between the way in which the diagnosis of paraphilic disorder is currently formulated and the category of ego-dystonic homosexuality and the discussion on the legitimacy of using reparative therapies for homosexual people experiencing suffering due to their sexual orientation. As in the case of ego-dystonic homosexuality, which was eventually removed from the DSM, also in the context of at least some paraphilic disorders (e.g., fetishism or transvestism) it should be stressed that continuing to list them in the DSM gives implicit permission

for harmful psychiatric and psychological treatment. Readers interested in complex analysis of theoretical background, methodology and efficacy of activities aimed at changing sexual orientation from homo – or bisexual towards heterosexual, may find the report of the American Psychological Association [19] particularly beneficial.

Risky behaviors and harm criterion

It seems that the most debatable criterion that separates paraphilias from paraphilic disorders is personal harm and/or the risk of harm to others. It raises doubts, among others, because the analogous criterion is not formulated in relation to non-sexual activities that may involve threat of severe personal harm, including participation in extreme sports like base jumping, free-riding, scuba diving at depth (SD), and free diving (FD), which are not included in any of existing classifications of mental disorders. FD is particularly interesting as it involves potentially fatal breath control, making it very similar to autoerotic asphyxiophilia (AA).

Erotic asphyxiation, is an intentional restriction of oxygen to the brain for the purpose of sexual arousal. Although induced asphyxia has been used to enhance sexual excitement for several centuries, it entered the modern English literature on psychiatry, legal medicine, and forensic pathology at the beginning of 20th century [20–22]. It is not identical with asphyxiophilia, which signals orientation of sexual preferences as opposed to the practice itself (asphyxia). Acknowledging the possible fatal consequences of such behavior, Dietz [23] proposed a diagnostic category that was introduced in the sexual masochism spectrum. Enhancing sexual arousal by oxygen deprivation was, however, included only in the third, revised edition of the DSM [24] under the term ‘hypoxyphilia’, which was later relabeled ‘asphyxiophilia’ [11].

When oxygen is self-restricted it is called autoerotic asphyxiophilia, which poses risk of harm to no one but the person holding his/her breath. AA and other accidental deaths in some way related to solitary sexual activity were described by Hazelwood, Dietz and Burgess [25] and their *Autoerotic fatalities* from 1983 is one of the first studies on this subject [see 26–31]. The vast majority of the findings on the characteristics of AA come from post-mortem forensic and medical examinations [31, 32] and living breath-practitioners seldom present themselves to psychiatrists or reveal their preferences. Individuals can be accessed via Internet communities of people with atypical sexual preferences (e.g., fetlife.com), which can be helpful for determining the scale of this particular interest [29]. Lack of precision in defining whether it is the practice itself or the orientation of preferences, makes it difficult to interpret these estimates later. The rate of death in this population has been estimated by some researchers, but the estimates vary substantially [25, 30, 31, 33] and there are numerous cases when AA-related death has either been mistaken for suicide or deliberately staged as such by relatives.

Being seen as a severe form of masochism – “masochists are at risk of accidental death while practicing asphyxiophilia or other autoerotic procedures” [11, p. 695] –

that potentially results in death, AA is regarded as a disorder [29]. Nevertheless, it is not the imminent risk of death which seems to be crucial here. We have decided to compare AA with other activity, similar in terms of risk and oxygen restriction – free diving (FD). One could ask why should it be relevant when diagnosing paraphilic disorders? To us, it definitely should, even if indirectly. This analogy reveals unconscious, not verbalized, cultural suppositions linked with sexuality, present not only in conversational thinking but also in diagnostic proceedings.

Free diving, also known as breath-hold diving, is an underwater activity without the use of scuba or a surface-supply of oxygen. It has been growing in popularity as an underwater activity with numerous sub-disciplines. Apart from being a recreational activity, it is also treated as an official competitive sport governed by two worldwide associations: the International Association for Development of Apnea (AIDA International) and the World Underwater Federation (CMAS). According to the AIDA International, there are currently nine FD categories, but the main aim in all of them is for competitors to attempt to attain great depths, times or distances using a single breath. Due to numerous serious injuries and deaths accompanying this sport, various organizations have been taking steps to increase divers' awareness of the dangers. Divers Alert Network – the largest association dedicated to diving safety – have been developing a database on FD accidents since 2004, in which cases are identified through automated keyword internet searches and voluntary submissions. A review of FD accident cases from 2006 to 2011 showed that 308 out of 417 reported cases were fatal [34]. Most victims (86%), as in AA, were men. It should be added that during free diving and autoerotic asphyxiophilia, even brief apnea may lead to impairment of neuropsychological and motor functioning, and repetitive restriction of oxygen may cause neurological symptoms, and even permanent brain injury [35].

When one compares FD with autoerotic asphyxiophilia, they are found to be very much alike, especially with respect to the mechanism underlying the possible injuries and the potential risk. The essential difference between the two (except for the obvious characteristics of the practice itself) is found in their motivation; generally individuals who perform AA do so to achieve sexual pleasure, whereas those who participate in FD – as in the case of other extreme sports – are driven by a desire to compete and a desire to cross the boundaries of the human body. Both of them are associated with experiencing euphoria. Nevertheless, judgements about AA and FD are axiologically different. So where does this difference come from?

The source of this difference can be traced, for example, in a perception of the degree of control over own corporality and driveability, which is highly valued in the Judaeo-Christian culture of the West. According to Wright [4], a person diagnosed with paraphilia is perceived as one who does not control his or her urges. Extreme sports provoke different associations, in which control takes the extreme form of transgression of the most basic limitations resulting from corporeality. However, there is no credible evidence that AA or any other paraphilic behaviors are controlled to a lesser extent than FD, base jumping, or any other forms of pleasurable and risky activities.

Another issue involves the circumstances in which AA and FD are practiced. Diving entails a public and well-structured environment, which offers the possibility of minimizing risk, for example, by providing timely cardiopulmonary resuscitation. In contrast, AA is most often practiced in solitude, which substantially increases the risk of harm. It is worth emphasizing, however, that the use of mechanisms and strategies aimed at increasing safety is often raised not only by the divers, but also individuals who perform AA and BDSM [33]. It is worth asking whether the use of safety mechanisms to decrease the risk while practicing asphyxia should be taken into account by the clinicians making the diagnosis. However, DSM-5 does not include such a possibility and does not differentiate between these two situations. Readers interested in the great diversity of safety measures for AA may refer to Uva [33].

Why are there differences in assessment?

Although autoerotic asphyxia is undoubtedly a hazardous practice (as is free diving), pathologizing it does not seem to bring sexologists and psychiatrists any closer to understanding this phenomenon, examining its mechanisms, or finding ways to minimize the damage it can cause. It does not contribute to designing and implementing effective prevention programs, increasing public awareness of the possible consequences of such practices, or minimizing their risk.

There are also no clear reasons why autoerotic asphyxia – in contrast to free diving – is pathologized, although it is associated with an analogous risk to health or life. Therefore, the difference in attitude towards these similar behaviors seems mainly to lie in their motivation. FD practitioners are regarded as daredevils trying to test the boundaries of their own bodily abilities (which in Western mythologies is a praiseworthy effort), whereas AA practitioners are regarded as pursuing body pleasures, which in Western culture does not involve anything sublime. The foundations of such reasoning can be traced way back to St. Augustine whose views on sexuality shaped Western ambivalence for corporality, and apparently the DSM is not free from it.

Compared with the urge to compete or the drive to push the boundaries of mankind's limits − no matter how potentially lethal they may be, which brings associations with extreme asceticism − a desire for sexual pleasure is considered disadvantageous and diminished in value and thus insufficient to justify the willingness to bear the highest risk. Thus, it seems that not only motivation to undertake an activity is important but primarily, its social valorization and ethical assessment of pleasure it brings. Those are the crucial factors deciding that regardless of how great the health risk is when engaging in sports that involve oxygen restriction, such activities are perceived as not only normal, but also marveled at. The crucial difference in the evaluation of these two types of activities is not based on clinical or medical grounds, but rather on cultural and customary ones. As a result, AA practitioners cause vigilance among mental health professionals and DSM authors, whilst those engaging in potentially

more harmful activities – given the number of fatalities – e.g., FD, base jumping, are seldom present in psychiatric discussion. This carries a number of consequences, which do not narrow down only do diagnostics, but also impact the delicate sphere of corrective and therapeutic interventions, because to some extent it shapes attitudes and affects the procedural directives; moreover, it leaves the specialist a large field of arbitrariness in this area. Maybe there is a need for a thorough looking through criteria of differentiating norm from dysfunction in the area of human sexuality in order to determine to what extent cultural aspects are present in those criteria. It seems that the mere awareness of this dependence should allow the therapist to be more reflective and conscious in relation to patients/clients practicing AA, even if their initial assessment of these behaviors does not change.

Concluding remarks

Mental health practitioners wishing to treat DSM-5 as a handbook must be aware that it is they who ultimately will have to decide what kind of therapeutic intervention to choose when meeting a client or patient whose sexual interests or behaviors cause harm or distress. A professional must also recognize that a client's decision whether to 'treat him or herself' might be made not on the grounds of moral guilt, shame or social exclusion, but simply as a result of a conscious decision about whether they wish to live 'on the edge', or not. While it may be well recognized that therapeutic work in sexuality is an ethical minefield, at the same time, the reasons for this seem to be ignored. They consist of both internally contradictory assessments of various aspects of sexuality in contemporary societies as well as individual determinants (beliefs and experiences) of the therapist in this area. It seems, therefore, that this delicate issue should be taken into account in the process of education of practitioners to a greater extent than before, to make them aware of the dependencies existing in this area.

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