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Between DSM and ICD: Paraphilias and the Transformation of Sexual Norms

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Abstract The simultaneous revision of the two major international classifications of disease, the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Classification of Diseases*, serves as an opportunity to observe the dynamic processes through which social norms of sexuality are constructed and are subject to change in relation to social, political, and historical context. This article argues that the classifications of sexual disorders, which define pathological aspects of "sexually arousing fantasies, sexual urges or behaviors" are representations of contemporary sexual norms, gender identifications, and gender relations. It aims to demonstrate how changes in the medical treatment of sexual perversions/paraphilias passed, over the course of the 20th century, from a model of pathologization (and sometimes criminalization) of non-reproductive sexual behaviors to a model that reflects and privileges sexual well-being and responsibility, and pathologizes the absence or the limitation of consent in sexual relations.

Keywords Paraphilias · DSM-5 · ICD-10 · Sexual norms · Sexual behavior

Introduction

Beyond the scientific and technical interest in their construction and development, the international classifications of diseases are popular topics in the field of "science studies" (Bowker & Leigh Star, 1999; Young, 1995) and the philosophy of science (Demazeux, 2013). More specifically, the categories that take into account supposed pathological dimensions of sexuality (sexual dysfunction, sexual orientation, paraphilias, and gender identity disorders) constitute a research domain that is, more specifically, situated at the interface of history, sociology, and the anthropology of sexuality (Gagnon, 1975; Herdt, 1994), as well as sex research (Zucker, 2002). In the current context in which the two most important international disease systems of classifications, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) of the American Psychiatric Association (APA) and the *International Classification of Diseases* (*ICD*) of the World Health Organization (WHO) are undergoing revision, we are witnessing a revival in scientific research on the group of categories related to sexual function, dysfunction, paraphilias, and gender identity disorders (Angel, 2010, 2012, 2013; De Block & Adriaens, 2013; Drescher, Cohen-Kettenis, & Winter, 2012; Duschinsky & Chachamu, 2013; Giami, 2007; Graham, 2007; Hekma, 2011; Spurgas, 2013). A large number of these studies examine problems related to sexuality and gender identity in terms of gender stereotypes, that is to say, by attempting to identify, within these categories, the masculine and feminine specificities that they represent, as well as the gender power relations that are played out.

Drawing on recent literature published in this domain, this essay treats the classifications of sexual disorders which define pathological dimensions and aspects of "sexually arousing fantasies, sexual urges or behaviors" (APA, 2013) as representations of contemporary sexuality and gender relations. This type of analysis has previously been developed by historians of sexuality in relation to other topics, such as the medical and literary discourses of the modern age (Baldwin, 1994), medicine and psychiatry in the 19th century (Davidson, 1987; Foucault, 1988; Lanteri-Laura, 1979), and the relationship between pornography and medical discourse (Marcus, 1964). The analysis of the concepts developed to treat these "sexually arousing fantasies, sexual urges or behaviors" as pathological enables us to observe the separation

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between sexual normality and sexual deviation (pathological and/or criminal), as well as the social treatment of certain deviant sexual behaviors through the medicalization and pathologization of sexual deviation (Conrad, 2007; Tiefer, 1996). The introduction of Section 320.6: "Sexual deviation" in the ICD-6 in 1948 clearly illustrates the influence of cultural determinants in the construction of the category and the limits of social approval of sexual conduct. The notion of "sexual deviation" was defined explicitly in ICD-9 as: "the limits and features of normal sexual inclination and behavior have not been stated absolutely in different societies and cultures but are broadly such as serve approved social and biological purposes" (WHO, 1975). As we shall further argue, these systems of classifications are the result of controversies between the experts who developed them, particularly North-American experts in the case of the *DSM*, and more diverse and globalized panels in the case of the *ICD*, and not only the representation of a supposed nature of disease (Demazeux, 2013; Hacking, 1999). From this perspective, the study of medical categories and classifications enables us to understand the social, political, and ideological dimensions of sexuality that are implicated in the development of categories (*upstream)*, and the roles, relationships, and behaviors that are represented in them (*downstream)*.

Objectives

The simultaneous revision of the two major international classifications of disease serves as an opportunity to observe the dynamic processes through which social norms of sexuality are constructed, and are subject to change, through the process of pathologization or depathologization of specific "sexually arousing fantasies, sexual urges or behaviors." This essay focuses on the construction of the "paraphilia" categories designated as "sexual deviations" until 1975 and then as "sexual preference disorders" and "paraphilias" in the ICD-10 (1990).

The genealogy of the psychiatrization of sexual perversions has previously been analyzed in depth by Laws and O'Donohue (2008) and De Block and Adriaens (2013), among others, for the *DSM*. Important reviews have also been produced in the context of the Task Force of the DSM-5 (Zucker, 2010). In contrast, this essay centers mainly on the changes occurred in the WHO-ICD, which has been far less studied in the literature (Reiersøl & Skeid, 2006). Using a "symmetric approach" (Latour, 1993) and a historical perspective, this article presents the changes that occurred in this category through the various classifications systems that have been developed over the course of the 20th century. In the context of the *ICD*, these changes are marked by the progressive abandonment of the notion of "sexual perversion" and "sexual deviation" in favor of "paraphilia" and "sexual preference disorder," and with a more recent move endorsed by the publication of the DSM-5, with the introduction of "paraphilic disorder."

Beyond the observation that the terms used have changed, as well as the contents of the categories, this article aims to demonstrate how changes in the social treatment of sexual perversions/paraphilias passed, over the course of the 20th century, from a model of pathologization (and sometime criminalization) of non-reproductive sexual behaviors (such as that developed in the end of the 19th century by authors such as Krafft-Ebing) to a model that pathologizes the absence or the limitation of consent in sexual relations. The centrality of the notion of consent between sexual partners has become the subject of a strong consensus among authors as widely differing as Hekma, Moser and Kleinplatz, and shared by authors of the revisions such as Krueger (2010a, b) and Långström (2010). This essay distinguishes itself from that of De Boeck and Adriaens (2013) in that it does not discuss the concept of mental illness, does not focus on the *DSM*, and subscribes to the perspective developed by feminist and other researchers which considers the discourses on sexual disorders and in particular female sexual dysfunction to represent gender roles (Angel, 2010, 2012, 2013; Fishman & Mamo, 2001; Giami, 2007; Spurgas, 2013; Tosh, 2011). The essay begins by presenting the historical context of the revision of the two major international classifications of disease, and by identifying the differences between the two organizations and Task Forces that were implicated in these revisions. It goes on to describe the principles that guided the work of each Task Force, before examining more specifically the changes in the definitions of paraphilias in the *ICD*, from a social historical perspective.

Method

This research draws on multiple sources. Firstly, I participated in a number of congresses and sessions in which the work of the task forces of both organizations was presented and discussed;[1] I was therefore able to observe the discussions and controversies that the process of revision provoked. Secondly, I also participated directly in these discussions as part of an NGO,[2] which offered suggestions with regard to the classification of paraphilias, and was invited to take part in a Task Force at the WHO in 2012 for the revision of the ICD-10. In this context, I was able to have informal conversations with sexologists and psychiatrists involved in the process of revision. Thirdly, I collected the different classifications of the WHO across history, since the 1948 ICD-6, as well as the comments and feedback which these had generated and I compared these data with the documents and discussions triggered by the *DSM* Task Force.

[1] Meeting of the American Psychiatric Association in San Francisco, CA, 2013; International Academy of Sex Research, Chicago, IL, 2013; World Association for Sexual Health, Porto Alegre, Brasil, 2013.

[2] I served as a member of the Advisory Committee of the World Association for Sexual Health and the UNESCO Chair in Sexual Health and Human Rights.

The APA and the WHO

The American Psychiatric Association (APA) and the World Health Organization (WHO) are two organizations that present important differences, though, interestingly, these are often exaggerated by their respective members. The APA was established in 1892 under the name American Medico-Psychological Association, before taking the name APA in 1921. It is a private, professional organization that brings together some 36,000 professionals in the field of psychiatry and mental health. While based in the United States, it exerts an international influence, notably through its network of publications. The publication of the *DSM* and its derivatives brings significant income to the APA. Some critical actors in the field, including professional organizations and patient and consumer associations, consider that the APA works in conjunction with the pharmaceutical industry, and that the construction of disease categories is to some extent influenced by the industry in the form of *disease mongering* (Cosgrove & Wheeler, 2013; Healy, 2002; Moynihan & Henry, 2006).

The WHO is a branch of the United Nations, established in 1948 in Geneva. With the input of a large network of public health services, expert, and national committees, it is responsible for developing the International Classification of Diseases (*ICD*), currently in its 10th edition. This classification was first published in its modern form in 1948 and was a continuation of the *International Classification of Causes of Death* (Jablensky, 1988). It is revised roughly every 20 years, with the aim of improving diagnosis and the establishment of public statistics, as well as facilitating access to health care, after a lengthy process involving consultations with experts and policy makers and clinical trials in the field. The revision of the *ICD* is validated by a Steering Committee and finally by the General Assembly of the member states of the WHO. With regard to the issues with which we are concerned here, the *ICD* has an advantage in that it is a classification that covers all diseases and disorders, including, since 1948, a specific chapter dedicated to mental disorders (in which sexual disorders and gender identity disorders are included), while the *DSM* only covers mental health disorders. This larger scope enables the WHO to keep some conditions and disorders as medicalized categories outside the field of mental disorders, in the form of somatic conditions or Z code categories (Giami, 2013). The political dimension of the *ICD* is more explicit than in the *DSM*, especially since the *ICD* is validated by political powers such as the General Assembly of the WHO, which include representatives of all member states. This means that, despite what is often claimed by members of these organizations, decisions regarding the promotion of any new system of classification are not solely and simply a matter of scientific evidence and clinical utility.

The Basic Principles of the Revision Process

In both cases, the process of revision is an international operation which takes place in consultation with experts, through the implementation of specialist working groups, reviews of the literature, as well as clinical trials in the field (Zucker, 2010). In the APA as well as the WHO, the protocol of the revision process is codified and systematic. Two main espoused principles guided the work of the experts appointed for developing the propositions for revision of these two systems of classification: the notions of clinical utility and scientific evidence.

> Clinical utility is the extent to which the classifications are supposed to assist clinical decision makers in fulfilling the various clinical functions of a psychiatric classification system. These functions include assisting clinicians and other users with the following: 1 Conceptualizing diagnostic entities; 2 Communicating clinical information to practitioners, patients and their families, and health care systems administrators; 3 Using diagnostic categories and criteria sets in clinical practice (including for diagnostic interviewing and differential diagnosis); 4 Choosing effective interventions to improve clinical outcomes; 5 Predicting future clinical management needs. Excluded from the concept of clinical utility are practical but nonclinical concerns, such as the effect of a change on insurance reimbursements. (First et al., 2004, p. 947)

This link between clinical utility and scientific evidence illustrates the changes that have occurred during the last 30 years in forms of diagnostic legitimization, which have come increasingly under the influence of researchers and epidemiologists, marking the decline of the relative influence of clinicians (Young, 1995).

The experts of the *ICD* consider that it has a clinical utility that encompasses not only clinical psychiatry, but mental health as a more comprehensive field. This perspective is based on the recognition that the majority of individuals with mental and psychiatric disorders, across the world, will not seek psychiatric help. In this way, the *ICD* can be seen to have a multidisciplinary dimension, and its usage concerns various professions beyond psychiatrists and psychologists. As the WHO psychologist Reed (2010) puts it:

> WHO views all health professionals who use the mental disorders classification as a constituency for its revision. This is reflected in the prominent representation in WHO's revision process of several international professional societies with a legitimate claim to global representation in their respective disciplines (e.g., psychology, social work, nursing, primary care medicine). (p. 460)

Beyond the principle of clinical utility, one expert participating in the revision of the ICD-10 highlighted certain underlying principles that guide the revision process, in particular in the field of sexual disorders. These include support for research and epidemiological surveillance in public health, but also the protection of individuals against violations of their human rights:

> All people, including lesbian, gay, bisexual and transgender (LGBT) persons, are entitled to enjoy the protections provided for by international human rights law, including in respect of rights to life, security of person and privacy, the right to be free from torture, arbitrary arrest and detention, the right to be free from discrimination and the right to freedom of expression, association and peaceful assembly (High Commissioner for Human Rights, United Nations Human Rights Council, 2011, quoted in Cochran, 2012).

As demonstrated through these differences in the founding principles by which the Task Forces undertaking each revision are guided, the two organizations do not prioritize the same criteria, and may not have the same objectives. However, it is important to bear in mind the criteria implemented in the revision of the general systems of classification in order to better understand whether the revision of paraphilias strictly follows these principles or whether, on the contrary, it reveals that other criteria and objectives are in play. The structural differences between the *ICD* and the *DSM* do not exclude the possibility that each could evolve in a different direction. For example, the structure of the *ICD*, by grouping together all diseases (mental and physical), does not exclude the possibility of declassifying gender identity disorders from the category of mental health disorders, and displacing them to a category describing somatic disorders (Drescher, 2014). Thus, this may allow some positive response to the demands of transsexual and transgender organizations and to the observations made by some European bodies that the psychiatric diagnosis of transsexualism can be considered as a violation of human rights (Hammarberg, 2009). Moreover, the *ICD* offers the possibility of including some non-medical conditions in a "Z code category" designated for "Factors Influencing Health Status and Contact with Health Services" on occasions when circumstances other than a disease or injury result in or are recorded by providers as problems or factors that influence care (Giami, 2013).

Critiques of the *DSM* and *ICD*

Although the work of the specific committees and task forces is based on the concepts of clinical utility and scientific evidence (First et al., 2004; Reed, 2010), the debates and controversies that were triggered by the revision of the categories of sexual and gender identity disorders implicate not only doctors and scientists, but also representatives of the pharmaceutical industry and of patient, activists, and human rights organizations.

Various observations made on the production of the classifications reveal that clinical utility and scientific evidence are not the only criteria taken into account in the formalization of these diagnostic criteria and, furthermore, that these concepts are used, to varying degrees, at an international level, depending on the health, political, and cultural context (Bowker & Leigh Star, 1999; Demazeux, 2013). Therefore, the medical and psychiatric categories of paraphilias combine medical and psychological aspects as well as moral aspects; these seem to reflect a combined legacy of a psychiatric past, factors related to access to health care in health insurance contexts, and also, less explicitly, references to legal systems and norms of sexual morality which they may either contradict or complement.

At the time of publication of the DSM-5 by the APA, a spokesperson from the National Institute of Mental Health (NIMH) published a communication in which he very strongly denounced the limitations of the scientific evidence of the DSM-5 and argued in favor of an epistemological shift towards the neurological sciences:

> (…) laying the groundwork for a future diagnostic system that more directly reflects modern brain science will require openness to rethinking traditional categories. It is increasingly evident that mental illness will be best understood as disorders of brain structure and function that implicate specific domains of cognition, emotion, and behavior. This is the focus of the NIMH's Research Domain Criteria project (Insel & Lieberman, 2013).

Another type of argument was developed by Frances, previously involved in the revision of the DSM-IV, who went so far as to recommend to clinical psychiatrists not to use the DSM-5. Frances (2010) considered that the *DSM* was badly written and inconsistent; that it would lead to an increase in false positive diagnoses, and to the pathologization of common behaviors and mental states. The arguments that were developed with regard to the revision of the ICD-10 are of a different nature, as they often emanate from international NGOs, which represent the interests of patients or users or adopt a human rights approach. These provide an opportunity for debates over the status of sexual and gender identity disorders as disorders, the need to retain or remove these from new classifications, the modification of clinical definition or, the inclusion of new clinical entities enabling their clinical diagnosis, epidemiological surveillance, and research (Drescher, 2014). These arguments have a significantly greater international dimension than those that arose around the *DSM*, which remain primarily located in the United States. They question the assignment of a status of disorder to "unusual sexual behavior" (Moser, 2009), since very little scientific evidence regarding the brain function and the epidemiology of these behaviors is available (Kafka, 2010; Långström, 2010). Yet, it is also the very nature of attributing the status of disorder to "unusual sexual behavior" which is subject to critique.

ICD: The Era of Sexual Deviations (1948–1990)

Many authors have written about sexual perversions and their conceptual transition into paraphilias and sexual disorders in the context of psychiatry, legal medicine, and sexology.[3] The notion of sexual disorders puts greater emphasis on sexual deficiencies and alterations such as erectile disorder or hypoactive sexual desire disorder. Disorders and problems related to sexuality first appeared in the ICD-6 in 1948, which included for the first time a large section for mental disorders. The category of "sexual deviation" appeared with the ICD-6, and continued with the ICD-7 (1955) and ICD-8 (1965), up until the publication of the ICD-9 (1990) which introduced the terms "disorders of sexual preferences" and "paraphilia," echoing the perspective developed in the DSM-III in 1980.

The category of "sexual deviation" first appeared in the ICD-6 as a sub-category of "Pathogenic personality." It regrouped a number of non-reproductive sexual behaviors including *Exhibitionism, Fetishism, Homosexuality, Pathologic sexuality, and Sadism*, and differentiated them from "disorders of sexual function" which were categorized as "psychogenic reactions affecting the genito-urinary system."[4] All these categories were directly influenced by the work of Krafft-Ebing (1895) and Ellis (Grosskurth, 1980). The difference between "sexual deviations" and "psychogenic reactions affecting the genito-urinary system" focused mainly on the etiology attributed to a "pathological personality," which would to some extent be a cause of the pathological behavior in the case of sexual deviations. For disorders of sexual function, by contrast, personality does not contribute to the etiology, which was generally considered somatic or functional, producing "distress" (even though that term was not in use yet).

The 1948 category of "sexual deviations" continued into the ICD-7, approved in 1955, and served as a conceptual model in the construction of the category of "sexual deviations" in the DSM-I (1952) and the DSM-II (1968) (De Block & Adriaens, 2013; Laws & O'Donohue, 2008). In 1965, the ICD-8 contained a modification in the structure of the themes that constituted sexual deviations. Homosexuality (male and female) constituted an extended specific category which included pedophilia, sodomy, exhibitionism, and other aspects such as transvestism and fetishism that would later be regrouped as gender identity disorders and separated from homosexuality. Homosexuality continued to make up the paradigmatic model of deviant sexual behavior as an enactment of non-reproductive behavior and it was associated to pathologies of personality. A second "other" category, including themes such as *Erotomania, Narcissism, Necrophilia, Nymphomania, Sadism,* and *Voyeurism,* which can be grouped in a category including the avoidance of reproductive coitus, or involving erotic attraction to "kinky sex" (Dreger, 2010), objects, and other situations that fall outside of the codes of heterosexual conjugal monogamy, was proposed. Limitations to the performance of sexual function (*Impotence, Frigidity, Dysmenorrhoea, Dyspareunia*) were classified as somatic disorders with a presumed psychogenic etiology. The question of the links between the *DSM* and *ICD* and the influence that each of these classifications exert on the other is still understood incompletely to date. The term "sexual deviation" gained a precise definition in 1975, with the publication of the ICD-9 (category 302):

> Abnormal sexual inclinations or behavior, which are part of a referral problem. The limits and features of normal sexual inclination and behavior have not been stated absolutely in different societies and cultures but are broadly such as serve approved social and biological purposes. The sexual activity of affected persons is directed primarily towards people not of the opposite sex, or towards sexual acts not associated with coitus normally, or towards coitus performed under abnormal circumstances. If the anomalous behavior becomes manifest only during psychosis or other mental illness the condition should be classified under the major illness. It is common for more than one anomaly to occur together in the same individual; in that case the predominant deviation is classified. It is preferable not to include in this category individuals who perform deviant sexual acts when normal sexual outlets are not available to them (WHO, 1975).

This definition clearly shows that the category of "sexual deviation" brings together sexual activities that do not have a reproductive function in terms of the gender of the partner, the nature of the acts, and the organs involved, or of coitus taking place in "abnormal circumstances." Moreover, while this category is filed under "Neurotic disorders, personality disorders and other non-psychotic mental disorders," the definition of sexual deviation implies that these behaviors do not serve the "approved biological and social purposes" (WHO, 1975) of "normal" sexual behavior. The definition of sexual deviation therefore constitutes a sort of intermediate disorder, falling between violations of the social order and moral faults and their pathologization attributed to non-psychotic forms of personality. However, this definition of sexual deviations had a short lifespan, disappearing with the arrival of the notion of paraphilia, first in the DSM-III and DSM-III-R, and subsequently in the ICD-10.

Paraphilia

The concept of paraphilia was first proposed by Stekel (1930) in his book *Sexual Aberrations*. In the preface, Stekel distinguished between "parapathia [which] stands for neurosis; paralogia for psychosis and paraphilia for perversion," thus separating paraphilias from other categories of mental disorder. "Sexual Aberrations" constructed the notion of paraphilias in two main domains: the first volume dealt with multiple aspects of fetishism,

[3] With regard to this point, see Béjin, 1982; Bland and Doan, 1998; De Block and Adriaens, 2013; Hekma, 2011; Oosterhuis, 2000.

[4] Although it had been included in DSM-I and DSM-II, pedophilia was not included in the ICD-6.

seen as a continuation of the notion of "Impulsive Conduct," while the second focused on sadism and masochism. For Stekel, homosexuality belonged to a different category altogether, named "parapathias," which originated in the social repression of attraction to men (Stekel, 1951). The term "paraphilia" was later taken up and popularized by the American sexologist Money in a non-pejorative sense to designate "unusual sexual interests" defined as "a sexo-erotic embellishment or an alternative to the official ideological norm" (Money, 1990, p. 139). In his popular book *Love Maps*, Money (1993) developed a whole typology of paraphilias according to their characteristics, but considered that these resulted from a profound dissociation between sexual pleasure and love. Money's definition is of interest because it takes place in the context of the modernization of sexuality (Robinson, 1976), in which the line separating normality from pathology is no longer grounded in the distinction between reproductive and non-reproductive sexuality, but clearly in a distinction between "normal" and "unusual" ways of doing things founded upon a dissociation between love and pleasure. Thus, Money's "unusual sexual interests" are "unusual" in that they are not exclusively focused on heterosexual coitus and do not fit the heteronormative norm; moreover, they do not fit with the standard of a loving or romantic reciprocal relationship. Sexual health, such as it was defined by Money, rests on a strong association between sexual pleasure and love. Money therefore established a dichotomy between "healthy" and "unhealthy" forms of erotic non-reproductive sexual activity, while for Krafft-Ebing all non-reproductive sexual activity was considered *Psychopathia Sexualis*. The American psychoanalyst Stoller (1991) considered hatred or desire to harm as at the root of all sexual excitement, not only that which is associated with "perverse" sexual activity and, inversely, that love was the best antidote to sex. Thus, the most important theorists of sexual perversions and paraphilias in the twentieth century had already argued that the criterion of sexual reproduction (the enclosure of sexual normality in the sphere of reproductive heteronormativity or "repronormativity" (Franke, 2001) was no longer sufficient for understanding the economy of "unusual" sexual behaviors, and that it was necessary to introduce other criteria such as "personal distress," hatred, the desire to harm (oneself or others), or a criminal dimension.

Broadly, in the 1980s, the introduction of the category of paraphilias and the change of meaning of these behaviors reflected in some way the social and political movements of the 1960s and 1970s and the sexual liberation that legitimized a non-reproductive and non-marital sex life. It focused on well-being and a closer social proximity between partners, allowing for democratic and egalitarian interaction (Hekma & Giami, 2014). We can therefore presume that this movement also contributed to the recognition of non-reproductive sexual practices and sexual diversity. This recognition concerned, firstly, the sexual behaviors of heterosexuals outside of procreation, thanks to the development of hormonal contraception, and outside of marriage (McLaren, 1999); secondly, the depathologization of homosexuality by the American Psychiatric Association (1973), which was now recognized as a lifestyle and social identity (Bayer, 1981; Silverstein, 2008). Similarly, masturbation became a symbol of a sexual practice enabling a better understanding of one's erotic body, and later, with the arrival of the HIV epidemic, the paradigm of a safe sex practice recommended to gay men (Laqueur, 2003). In the context of these shifts and changes in the social norms of sexuality, the issues of well-being and consent became central as a form of social regulation of sexual acts. This observation of the logic of changes in the *ICD*, marked by suppressions, additions, and reformulations of pathological sexual activities enables us to explore this hypothesis by identifying the different ways in which paraphilias have been defined in the recent versions of the *ICD*.

Paraphilias From DSM-III-R to ICD-10: 1990

The appearance of the concept of paraphilia in the ICD-10 in 1990 formed part of a new evolution of the classifications in which the work of the *DSM* and notably the "revolution" of the DSM-III published in 1980 and of the DSM-III-R published in 1987 started to influence the construction of the ICD-10 in the domain of "mental disorders" and in particular "sexual disorders." The gap between the agendas of revision of these two classifications modified the order of reciprocal revisions, giving a certain primacy to the *DSM*. The term paraphilia was introduced in the DSM-III (1980) as a subcategory of the new category: "Psychosexual disorders." The category of paraphilias was renewed in the DSM-III-R with some modifications as compared to the previous edition*: Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual sadism, Sexual masochism,* and *Atypical paraphilias*. "Zoophilia" was moved to the sub-category NOS (not otherwise specified) with Telephone scatology, Necrophilia, Partialism, Coprophilia, Klismaphilia, and Urophilia. "Transvestism" was changed into "Transvestic fetishism" and "Frotteurism" was added to this list (Milner & Dopke, 2008).

The category paraphilia subsequently entered the ICD-10 as a sub-section of the category F60-F69 "Disorders of adult personality and behavior," named "F65: Disorders of sexual preference." It fell between two other categories: "F64: Gender identity disorders" and "F66: Psychological and behavioral disorders associated with sexual development and orientation." As in the *DSM*, sexual dysfunctions were separate from mental disorders, appearing in section "F50-F59: Behavioral syndromes associated with physiological disturbances and physical factors" in the category: "F52 Sexual dysfunction, not caused by organic disorder or disease" (WHO, 1990).

The list of paraphilias (disorders of sexual preference) also excluded any disorders that directly concerned homosexuality and problems related to or resulting from sexual orientation. These joined the category F66: "Psychological and behavioral disorders associated with sexual development and orientation," before being completely deleted in the proposal for the ICD-11 (Cochran et al., 2014). Category F65 included the following themes:

Fetishism, Fetishistic transvestism, Exhibitionism, Voyeurism, Pedophilia, Sadomasochism, Multiple disorders of sexual preference, Other disorders of sexual preference, and Disorder of sexual preference, unspecified." The category "other disorders of sexual preference" included activities that are supposed to be "too rare or idiosyncratic to justify a separate term for each":

> …activities [such] as making obscene telephone calls, rubbing up against people for sexual stimulation in crowded public places (frotteurism), sexual activity with animals, use of strangulation or anoxia for intensifying sexual excitement, and a preference for partners with some particular anatomical abnormality such as an amputated limb….Erotic practices are too diverse and many too rare or idiosyncratic to justify a separate term for each. Swallowing urine, smearing feces, or piercing foreskin or nipples may be part of the behavioral repertoire in sadomasochism. Masturbatory rituals of various kinds are common, but the more extreme practices, such as the insertion of objects into the rectum or penile urethra, or partial self-strangulation, when they take the place of ordinary sexual contacts, amount to abnormalities. Necrophilia should also be coded here. (WHO, 1990, p. 172)

What is most interesting in this list of paraphilia is that in most cases they are restricted to behaviors per se and that the category or the experience of distress is not mentioned as a dimension of the diagnostic guidelines. Paraphilias become pathological when they become a substitute to coital sexual activity and, to some extent, exclusive and obsessive practices. Fetishism is the only category for which distress is mentioned as a dimension to be taken into account, but only when the frequency of fetishistic behaviors begins to interfere negatively with the individual's social life and causes them distress. The majority of paraphilias that were retained concerned only male behavior. This suggests a gender bias: "kinky" behaviors are perceived as an attribute or tendency of men.

The absence of the concept of "distress" as a qualifying criterion for a paraphilia to attain the status of disorder does, however, pose a logical problem, insofar as the ICD-10 defines disorders as being characterized by symptoms associated with *distress*:

> The term "disorder" is used throughout the classification, so as to avoid even greater problems inherent in the use of terms such as "disease" and "illness." "Disorder" is not an exact term, but it is used here to imply the existence of a clinically recognizable set of symptoms or behavior associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here (World Health Organization, 1990, p. 11).

In summary, the ICD-10, in resonance with the DSM-III and the DSM-III-R, excluded homosexuality from its classification of paraphilia. It retained other non-reproductive behaviors, some of which are associated with gender identity (Fetishistic transvestism); others with behaviors which may involve other persons (Exhibitionism, Voyeurism, Pedophilia, Sadomasochism); others that become problematic only when they become substitute to coital sexual activities and when they are related to harm; and others that are "rare" or "idiosyncratic."

From Paraphilia to Paraphilic Disorder: DSM-5 and ICD-11

The *DSM* continued to take the lead in the revision process. The DSM-5 was published in May 2013 at the 166th Congress of the APA in San Francisco, and led to numerous controversies outlined in the introduction to this essay. The composition of the Task Force of the APA and the WHO were made public, enabling the observation that some of the members of the APA Task Force were also members of the WHO Sexual Disorders and Sexual Health Working Group, notably one member in the area directly related to paraphilias. The term "paraphilic disorder" was coined during the work of the DSM-5 Task Force around 2009–2010 (Zucker, 2010). The American psychiatrist Krueger, a renowned specialist of paraphilias and their treatment, participated in both groups (Krueger & South, 2009). In the Task Force of the DSM-5, he was responsible for the preparation of the categories Sexual Sadism and Sexual Masochism (Krueger, 2010a, b), while in the revision group of the ICD-11, he coordinated the entire subgroup on paraphilias. The influence of the DSM-5 is very clear; however, it could be suggested that the ICD-11 proposal, which has not yet been approved by the WHO General Assembly, could already serve as a form of early revision or refinement of the DSM. The similarity between the DSM-IV and the ICD-9-CM is largely a result of the American Psychiatric Association's close work with the National Center for Health Statistics (NCHS) over a long period of time, to promote consistency between DSM-IV and ICD-9-CM (Reed, 2010; Spitzer, 1988). More than 90 % of diagnostic categories are shared by the two systems of classifications (Demazeux, 2013), and working groups in the revision steps are more and more connected and coordinated (Spitzer, 1988); one form of connection and coordination being to recruit the same experts.

In an oral presentation at the APA congress in San Francisco, Krueger recalled the definitions that he proposed for "paraphilic disorders" in the ICD-11:

> A paraphilic disorder involves a persistent and intense pattern of atypical sexual arousal, which is manifested by sexual thoughts, fantasies, urges, and/or behaviors. If the focus of the arousal pattern involves others whose age or status renders them unwilling or unable to consent (e.g., pre-pubertal children, an unsuspecting individual being viewed through a window, an animal), a disorder is diagnosed if the person has acted on the arousal pattern and/or is markedly distressed

by it. In arousal patterns that involve consenting adults or solitary behavior, a disorder may be diagnosed only if 1) the person is markedly distressed by the nature of the arousal pattern and the distress is not simply a consequence of rejection or feared rejection of the arousal pattern by others; or 2) the nature of the paraphilic behavior involves significant risk of injury or death (e.g., asphyxophilia). An arousal pattern that does not involve individuals who are unwilling or unable to consent, and is not associated with marked distress or significant risk of injury or death, is not considered a disorder. ICD-11 will include absence of consent, distress, and harm as constitutive dimensions (Krueger, 2013).

As we can see in this definition proposed by Krueger for the ICD-11, paraphilic disorders should be characterized by the presence of three criteria: the absence of consent, which may concern a child, an animal or an inanimate human corpse; the distress felt by the individual; and the hurt or harm caused to oneself and/or one's partner. This definition marks a change in the direction of a greater tolerance of sexual thoughts, fantasies, urges, and/or behaviors which used to be considered as "unusual." In the case of situations which do not involve "others whose age or status renders them unwilling or unable to consent," the paraphilic disorder could be diagnosed only in the case of distress or risk to life to the individual or their partner. This *ICD* definition is, however, less explicit than that given in the DSM-5, which posits that:

> 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. A paraphilia is a necessary but not sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention (American Psychiatric Association, 2013, p. 686).

Table 1 shows a central core of paraphilic disorders that represent pathologies related to lack of consent or coercion (*Voyeuristic Disorder, Exhibitionistic Disorder, Frotteuristic disorder, Pedophilic disorder*), in that they involve others who are not in a position to give their consent; a point which remains common to both classifications. The *ICD* goes further in the pathologization of these kinds of behaviors, however, in that it proposes to include "Coercive sexual sadism disorder." This category was not included by the authors of the DSM-5, and is the subject of vehement critiques from feminist researchers who are not in favor of the pathologization of rape, preferring it to remain clearly a crime to be treated in the criminal arena (Quinsey, 2010; Tosh, 2011).

Table 1 Paraphilias retained in the DSM-5 and in propositions for the ICD-11

DSM-5 (May 2013)	ICD-11 (proposal)
Similar	
Voyeuristic disorder	Voyeuristic disorder
Exhibitionistic disorder	Exhibitionistic disorder
Frotteuristic disorder	Frotteuristic disorder
Pedophilic disorder	Pedophilic disorder
Different	
Sexual masochism disorder	Coercive sexual sadism disorder
Sexual sadism disorder	
Fetishistic disorder	
Transvestic disorder	
Other specified paraphilic disorder	
Unspecified paraphilic disorder	
Removed from ICD-10	
	F65.0 fetishism
	F65.1 fetishistic transvestism
	F 65.5 sadomasochism

Controversies Around the Status of Paraphilias

The proposed revisions of the *ICD* seem to respond to critiques from those who consider that the practices and culture of BDSM are not pathological, insofar as they are based on free will and consent on the part of the protagonists (Moser & Kleinplatz, 2005; Reiersøl & Skeid, 2006). In contrast to the DSM-5, Fetishism, Fetishistic transvestism, and Sadomasochism are excluded from the *ICD* list of paraphilic disorders in that they are not necessarily characterized by any of the criteria retained for labeling paraphilic disorders as disorders, in particular the absence of partner consent. However, while the DSM-5 no longer considers that the existence of a behavior in the absence of distress would be sufficient to characterize a disorder, the preparatory documents for the revision of the ICD-11 do not demonstrate the same degree of tolerance towards the remaining paraphilic behaviors. The DSM-5 marks the end of the consideration of certain sexual behaviors as pathological in themselves, and labels them as pathological only when they involve any distress for the person. Interviewed by the philosopher Dreger on his work in the revision group for the DSM-5, Blanchard proposed a hierarchy to distinguish between different types of paraphilia as a function of their degree of harm: "We tried to go as far as we could in depathologizing mild and harmless paraphilias, while recognizing that severe paraphilias that distress or impair people or cause them to do harm to others are validly regarded as disorders" (Dreger, 2010). The ICD-11 draft proposes to retain a smaller number of paraphilic behaviors, mainly those that involve lack of consent on the part of the partner. In these cases, the behavior is considered paraphilic in its very nature, whether or not it includes distress on the part of the person and/or the partner. In summary, the *ICD* does not depathologize the behaviors themselves, but only those that involve a consensual partner or no partner at all.

Liberal critics, that is to say, those who support the depathologization of paraphilia, particularly BDSM and other forms of voluntary

sadomasochistic relations, argue that a large number of behaviors considered as paraphilias or sexual deviations in earlier classifications (*DSM* and *ICD*) are based on reciprocal consent, not harmful, and the expression of forms of sexual diversity. For example, the Dutch historian of sexuality Hekma (2011) rejects the pathological character of sexual perversions by arguing that "no sexual relation is morally wrong as long as it is not abusive, which means that it does not go against the wishes of the partner" (p. 81). Moreover, Shindel and Moser (2011) consider that:

> these diagnoses have caused harm, been misused, and lack the scientific basis for designating these interests as pathological. The resistance to removing diagnoses which have significant negative effects, no clear positive effects, and no established utility in patient management, is bewildering. Therefore, the APA should remove sexual masochism and consensual sexual sadism from DSM-5. Based on the same logic, the other non-criminal paraphilias (transvestism, fetishism, partialism) should also be removed. (p. 928)

Shindel and Moser authors argued that there is a lack of scientific evidence in the foundations of the construction of the disorders, and of epidemiological data that could provide an estimate of the prevalence of these behaviors. This lack of data is confirmed by the research of specialists on this topics who have worked within the Task Force of the DSM-5 (Kafka, 2010; Krueger, 2010a, b; Långström, 2010), and would justify the exclusion of paraphilias from systems of classification of mental disorders. These comments are also in line with statements by representatives of the National Institutes of Mental Health (NIMH), who have made some strong critiques of the DSM-5 because of its supposed lack of scientific foundation in the domain of neuroscience (Insel & Lieberman, 2013).

Among other reasons to exclude paraphilias from pathologization, Moser and Kleinplatz (2005) developed the idea of a strong distinction between normal variation in behavior, non-pathological paraphilia, and crimes, in particular pedophilia:

> We wish to clarify that our suggestion to remove the paraphilias, which includes pedophilia, from the *DSM* does not mean that sexual acts with children are not crimes. We would argue that the removal of pedophilia from the *DSM* would focus attention on the criminal aspect of these acts, and not allow the perpetrators to claim mental illness as a defense or use it to mitigate responsibility for their crimes. (p. 105; see also Fink, 2005)

Yet the proposal that deviant behaviors that cause harm to partners or that take place in the absence of consent should be treated in a criminal context has not been followed. This refusal to exclude paraphilias from the classifications appears, in part, based on non-scientific and non-clinical criteria:

> What are the consequences if we go the route that Drs. Moser and Kleinplatz suggest and remove the paraphilias from the DSM? First of all, it is not going to happen because it would be a public relations disaster for psychiatry. (Spitzer, 2005, p. 115)

Both the WHO and experts involved in the *DSM* enterprise do not develop their argument solely on the grounds of scientific evidence but rather on a moralistic basis and political perspective. It would seem therefore that retaining paraphilias in these classifications may serve to preserve the morality and the credibility of these institutions.

In addition to arguments that paraphilias are not mental disorders, some critics advocate that BDSM activities are not only non-pathological, but that they are based on protective ethical principles and therefore can fall into the category of safer sex. In the wake of the AIDS epidemic, the New York gay SM group "Gay Male S/M Activists" (GMSMA) coined the phrase "safe, sane, consensual" for the very first time, in 1983. Since then, "safe, sane, and consensual" has become one of several recognized moral ethical principles and cornerstones of SM activity (Reiersøl & Skeid, 2006). Advocates of the cause and the BDSM community therefore go so far as to consider that the practice of certain paraphilias, based on the consent of the individuals involved, has some educational value, and requires mental and moral competencies centered around strong self-control. A similar argument was developed by the artist Ungerer (2000) in his book "S.M." illustrated with his drawings. On the basis of his ethnographic study of dominatrix female sex workers in a German city, Ungerer argued that they had developed practical knowledge and techniques that enabled them to inflict pain without causing harm.

Conclusion

An analysis of the changes which occurred in the category of sexual deviation (paraphilia) in the *ICD* over the course of the second half of the 20th century shows a slow evolution that has seen the progressive abandonment of the psychiatric and medical model of the 19th century, in which sexual normality was based on the model of heterosexual coitus within heterosexual marriage, and where "deviations from the reproductive instinct" were seen as mental illnesses (Lanteri-Laura, 1979). The change introduced in the DSM-III, which first excluded homosexuality from the domain of mental and sexual disorders, reflected the wider change in social norms of sexuality that has been called the sexual revolution (Allyn, 2000; Hekma & Giami, 2014), as well as changes in the relationship between medicine and sexuality (Soble, 1987). Medicine has gradually legitimized non-reproductive sexual activity through the development of hormonal contraception, depathologization of homosexuality, participation in the legalization of abortion in the majority of Western countries, and the development of a sexual medicine which recognizes erotic sexual activity for pleasure as at least as important for one's health as procreation. With the development

of contraception and the emergence of HIV, sexual activity has come to be considered as a democratic activity that needs to be negotiated between equal partners. The negotiation of the health risks incurred through sexual activity (pregnancy or infection) has been placed at the center of relationships, and is now seen as key to well-being and love. The emergence of the concepts of sexual health (Giami, 2002) and sexual rights (Petchesky, 2000) has reinforced the democratic normative model of sexual activity grounded in individual responsibility, communication, love, well-being, and respect for others. From this cultural perspective, the abandonment of moral references associated with the concept of perversion, the introduction of the question of love and positive emotions between partners into sexological considerations, and the creation of the term paraphilia have displaced the notion of sexual normality centered on the equation of sexual with reproductive life, towards a framework based on communication, individual freedom, well-being, and equality. Against this backdrop, consent became the key criterion for distinguishing normal sexual activity and its variations from pathological and criminal forms. The difficulty now lies, therefore, in distinguishing between pathological forms of sexual deviation, and those which should fall within the criminal justice system. However, in both cases, a distinction is drawn between the normal and the pathological, and the range of acceptable (but not necessarily encouraged) forms of sexual practices.

The introduction of the axis of distress as a necessary condition for a "behavior, urge or fantasy" to be recognized as pathological also reflects changes seen in sexual normality and its association with well-being. "Normal" sexual activity as framed and encouraged by public health policies, sex therapists, and even representatives of certain religions (Herzog, 2008) should aim at the attainment of well-being. From this perspective, it appears altogether logical to pathologize sexual behaviors that inflict distress or even harm on the self and/or the partner. However, the ideology of well-being does not seem to be taken up in the same way by the *DSM* and the *ICD*, since the criterion of distress was not recognized as a necessary condition in the *ICD*. The classification of some behaviors as pathological in and of themselves, even in the absence of distress, reveals an underlying moral conception that continues to sanction socially reprehensible behaviors, pathologizing these as a way of maintaining/protecting public morality.

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