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LETTER TO THE EDITOR

Paraphilias and the ICD-11: Progress but Still Logically Inconsistent

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The Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH) is charged with reviewing and recommending changes for categories related to sexuality in the *International Classifications of Diseases and Related Health Problems* (ICD), published by the World Health Organization ([WHO]; Krueger et al., 2017). The WGSDSH proposed changing the name of the ICD-11 Section on "Disorders of Sexual Preference" to "Paraphilic Disorders." They also advocated for the removal of Fetishism, Fetishistic Transvestism, and Sadomasochism categories "as inconsistent with human rights principles endorsed by the UN and WHO" (Drew et al., 2011). The elimination of these diagnoses is a major step forward and a welcomed change.

WGSDSH still classifies Exhibitionism, Frotteurism, Pedophilia, and Voyeurism as mental disorders, renamed as Exhibitionistic, Frotteuristic, Pedophilic, and Voyeuristic Disorders (Krueger et al., 2017). They also suggest adding Coercive Sexual Sadism Disorder, Other Paraphilic Disorder Involving Non-Consenting Individuals, and Paraphilic Disorder Involving Solitary Behaviour or Consenting Individuals (PDISBCI). Except for the last diagnosis, all these diagnoses involve thoughts, fantasies, urges, or behaviors with nonconsenting individuals. Diagnostic criteria for all of these diagnoses include participating in the behavior *or* being markedly distressed by the nature of the arousal pattern.

It should be noted that Coercive Sexual Sadism Disorder is similar to Coercive Paraphilic Disorder (see Quinsey, 2010), which was proposed as both a mental disorder and as a condition for further study but rejected for inclusion in DSM-5 (American Psychiatric Association [APA], 2013). If there is any new research establishing an evidence basis for diagnosing this behavior as psychopathology, rather than as a crime, it is not known to the author or cited in Krueger et al. (2017).

My previous criticisms (see Moser, 2016a) have been acknowledged but not addressed. Krueger et al. (2017), the ICD-11 editors, and the WHO leadership might consider clarifying their thinking by answering a few questions:

(1) What distinguishes consensual sadomasochism (no longer a mental disorder under the current proposal) from PDISBCI? Previous attempts to delineate the differences between "healthy" and "unhealthy" sadomasochistic sexual practices have failed, and most health-care professionals do not have the cultural competence to make such determinations. What prevents clinicians who previously pathologized individuals with Sadomasochism from now diagnosing those same individuals with PDISBCI?
(2) Why are *possible* injuries sustained during *sex* (a proposed criterion for PDISBCI) seen as a criterion for diagnosis of a mental disorder while the *actual* injuries (often requiring surgery and some resulting in death) sustained by swimmers, football players, rock climbers, skiers, etc., are not an issue?
(3) What is the rationale for treating sex crimes differently from other crimes? There is no embezzlement disorder, identity theft disorder, or auto theft disorder. Committing a crime or even a pattern of crimes is not pathognomonic for a mental disorder in other sections of the ICD or DSM-5.
(4) Conversely, what is the rationale for *not* diagnosing psychopathology in individuals who persistently commit nonsexual acts which traumatize others (e.g., intimate partner abuse, child neglect)? This decision stands in stark con-

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trast to the proposal to diagnose a mental disorder in individuals who commit sexual acts which traumatize others. The flagrant lack of consistency in the application of the term "mental disorder" is glaring.

(5) What is the "demonstrable clinical utility…[and] legitimate mental health need" (Cochran et al., 2014, p. 674; cited in Krueger et al., 2017) for including the Paraphilic Disorder diagnoses in ICD-11? Currently, these diagnoses are used in the U.S. to support the indefinite internment of individuals in psychiatric hospitals, long after their sentences have been served. Whether or not the continued imprisonment of these individuals protects society, there is no indication that individuals who have been diagnosed with a Paraphilic Disorder are helped by or benefit from further incarceration.

(6) On what basis was the definition of a mental disorder expanded to include "some degree of harm…to others" (Krueger et al., 2017)? Even when civil commitments allow for the involuntary commitment of someone as a danger to others, that danger must be imminent and significant. As noted above, harming others in a nonsexual context does not count as a mental disorder.

(7) What is the rationale for diagnosing individuals distressed about their "atypical" sexual arousal with a Paraphilic Disorder, but not to diagnose individuals who are distressed about their homosexual or bisexual sexual orientation? Some definitions of sexual orientation do include the paraphilias (see Moser, 2016b).

(8) Is it appropriate that the same diagnosis encompasses individuals distressed about their atypical sexual arousal and individuals who have committed nonconsensual acts? Fantasizing about murdering someone is really quite different from murdering someone, even if most murderers fantasize about the murder before acting. Most fantasies of murder or nonconsensual sex acts are never acted upon.

(9) Are atypical sexual interests a sign of a mental disorder? One should remember that masturbation, homosexuality, heterosexual sodomy, and nonmarital sex were once seen as atypical and as evidence of a mental disorder.

There are some basic tenets of the ICD which seem to have been lost: Medicine is based on science; researchers and clinicians should acknowledge and try to minimize their biases; the patient—not society—is our focus; and we strive to apply the diagnosis of a mental disorder consistently, despite our own possible distaste for any associated behaviors. In the age of evidence-based medicine, we do not create diagnoses because experts, the lay public, or our political leaders think we should. We try to anticipate how these diagnoses can be misused and take steps to prevent that misuse. Although Krueger et al. (2017) appear to understand these challenges, their proposals do very little to prevent the misuse or abuse of these diagnoses. The leadership of WHO and the ICD-11 should demand answers to the questions above and clarify the purpose of including these diagnoses before codifying them in ICD-11.

The conflation of mental disorders and crimes is a human rights issue. People with paraphilias and Paraphilic Disorder diagnoses throughout the world experience major violations of their civil, cultural, economic, political, and social rights. We cannot protect their rights if we act as agents of social control or confuse crimes and moral beliefs with mental disorders.

To be crystal clear, the preceding comments should not be construed as supportive of any sexual activity involving nonconsenting individuals or those incapable of consenting. Any interpretation of my comments as supporting the decriminalization of nonconsensual sexual interactions is misguided and wrong.

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