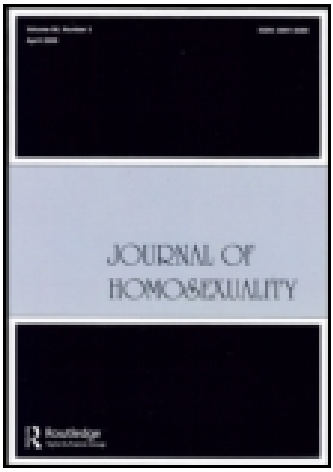

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The ICD Diagnoses of Fetishism and Sadomasochism

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The ICD Diagnoses of Fetishism and Sadomasochism

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SUMMARY. In this article we discuss psychiatric diagnoses of sexual deviation as they appear in the *International Classification of Diseases* (*ICD-10*), the internationally accepted classification and diagnostic system of the World Health Organization (WHO). Namely, we discuss the background of three diagnostic categories: Fetishism (F65.0), Fetishistic Transvestism (F65.1), and Sadomasochism (F65.5). Pertinent background issues regarding the above categories are followed by a critique of the usefulness of diagnosing these phenomena today. Specifically, we argue that Fetishism, Fetishistic Transvestism, and Sadomasochism, also labeled *Paraphilia* or *perversion*, should not be considered ill-

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nesses. Finally, we present the efforts of an initiative known as *ReviseF65,* which was established in 1997, to abolish these diagnoses.

KEYWORDS. Fetishism, Sadomasochism, Transvestism, sexual deviation, Paraphilia

The first version of the *International Classification of Diseases (ICD)* appeared in 1900. It was intended to classify deadly somatic diseases. The *ICD* has undergone various revisions, and the list of diseases (deadly or not) has increased continuously. Today, the *ICD* also serves as a classification manual of mental and behavioral disorders and is widely used among mental health professionals in Europe. Sexual deviation was introduced as a general classification in *ICD-6* (1948). Subdivisions of that category first appeared in *ICD-8* (1965), and have barely changed since. The next paragraphs elaborate on the diagnostic criteria and the category of sexual deviation.

In the *ICD-10* Classification of Mental and Behavioral Disorders the sexual deviation category is called Disorders of Sexual Preference (DSP) and given the code F65. The heading of the sexual deviation category is described (World Health Organization [WHO], 1992, p. 217) as "Disorders of Sexual Preference, Includes: paraphilias, Excludes: problems associated with sexual orientation." The category includes the following sub-categories: Fetishism, Fetishistic Transvestism, Exhibitionism, Voyeurism, Pedophilia, Sadomasochism, Multiple disorders of sexual preference, Other disorders of sexual preference (including, for example sexual activity with animals).

According to The *ICD-10* Classification of Mental and Behavioural Disorders, Diagnostic Criteria for Research (WHO, 1993, p.135), the above disorders are characterized by the following general criteria:

1. The individual experiences recurrent sexual urges and fantasies involving unusual objects or activities.
2. The individual either acts on the urges or is markedly distressed by them.
3. The preference has been present for at least 6 months.

In this article we focus on the diagnoses of Fetishism (F65.0), Fetishistic Transvestism (F65.1), and Sadomasochism (F65.5). The argument for selecting these diagnoses will be addressed. The next section further elaborates on these diagnoses, which appear in the *ICD* (WHO, 1992).

Fetishism is described (WHO, 1992, p. 218) as:

> Reliance on some non-living object as a stimulus for sexual arousal and sexual gratification. Fetishism should be diagnosed only if the fetish is the most important source of sexual stimulation or essential for satisfactory sexual response. Fetishistic fantasies are common, but they do not amount to a disorder unless they lead to rituals that are so compelling and unacceptable that they interfere with sexual intercourse and cause the individual distress.

Similarly, Fetishistic Transvestism is described (WHO, 1992, p. 218) as:

> The wearing of clothes of the opposite sex principally to obtain sexual excitement. This disorder is to be distinguished from simple fetishism in that the fetishistic articles of clothing are not only worn, but worn also to create the appearance of the opposite sex.

According to the diagnostic manual (WHO, 1992, p. 220) Sadomasochism is considered to be "A preference for sexual activity that involves bondage or the infliction of pain or humiliation. This category should be used only if sadomasochistic activity is the most important source of stimulation or necessary for sexual gratification."

FORMING SEXUAL DEVIATION DIAGNOSES: A HISTORICAL PERSPECTIVE

Influenced by psychiatric case studies as well as popular novels in the nineteenth century, early pioneers within the medical profession built a vocabulary and classification system of "unusual" sexual practices. On the one hand, the classification of sex practices was an innovative step forward. On the other hand, the use of diagnostic labeling established the persistent stigmatizing of individuals based on their sexual desires.

Given the scope of this article, we will not review the work of the early sexologists who made the first diagnoses during the period of approximately 1880-1930. In short, Krafft-Ebing (1903/1886), Ellis (1920), Stekel (1930), Hirschfeld (n.d.) and others originated the diag-

nostic terms of Fetishism, Transvestism, Sadism and Masochism. By the time Kinsey (1948) published *Sexual Behavior in the Human Male* these diagnoses were already well established. It was also in 1948 that the WHO assumed responsibility for the *ICD* and its further development. Although the exact inclusion process of these diagnoses in the *ICD* is not clear, it is well established that the American diagnostic system, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) published by the American Psychiatric Association, has influenced the *ICD* (and vice versa).

There have been few changes in the categories of sexual deviation in the last number of *ICD* revised manuals. For example, the spelling of "Transvestitism" in the *ICD-8* was changed to "Transvestism" in the *ICD-9* revision (WHO, 1978). Also, "Fetishistic Transvestism" was introduced in the *ICD-10* to distinguish that category from the Gender Identity Disorders (F64) diagnosis of "Dual role transvestism," categorized as F64.1 (WHO, p. 215). Despite these semantic changes to the categories, there seems to be no difference in the content of that diagnosis between *ICD-9* and *ICD-10*, and therefore no development. The same is true for Fetishism and Sadomasochism, which were originally classified in another subcategory (i.e., 302.8) in the *ICD-8* and *9* (WHO, 1978). In sum, there has been little development in the diagnostic criteria of sexual deviation disorders in the *ICD* over the past three revisions, and thus the impetus for the present article.

THE NEED TO REVISE F65

We propose that the diagnoses of Fetishism (F65.0), Fetishistic Transvestism (F65.1), and Sadomasochism (F65.5), which are included in the paraphilias, should be abolished. In this paper, we do not address other F65 diagnoses, although Moser (2001) has made a strong case for replacing the whole Paraphilia category of diagnoses in the *DSM*. In this article, we question the legitimacy of classifying sexual offences as sexual disorders.

Normative, Statistical and Empirical Reasons

There are several reasons for abolishing the diagnoses of Fetishism, Fetishistic Transvestism, and Sadomasochism. One reason is linked to statistical issues and normative issues, which influence inclusion/exclusion criteria in diagnoses. For example, the general criterion 1 is inaccu-

rately referring to "unusual objects and activities." From a statistical standpoint, unusual refers to rare and uncommon. However, "unusual" can also be understood as "weird" or "bizarre." That is, statistical criteria are being confounded at times with moral judgments. Viewing unusual objects or activities as immoral is archaic; there is no scientific basis for diagnosing individuals' sexuality when diagnostic criteria merely mask moral indignation. Furthermore, a variety of sexual practices that were previously considered non-normative are not currently regarded as pathological (for example, homosexuality, fellatio and anal sex). It is interesting to note what Kinsey (1953) said about fetishism:

> Persons who respond only or primarily to objects which are remote from the sexual partner, or remote from the overt sexual activities with a partner, are not rare in the population. This is particularly true of individuals who are erotically aroused by high heels, by boots, by corsets, by tight clothing, by long gloves, by whips, or by other objects which suggest sado-masochistic relationships, and which may have been associated with the individual's previous sexual activity. (pp. 678-679)

Behavior should not be diagnosed just because it is unusual. It is not unreasonable to assume that stamp collectors have an unusual interest, in the statistical sense. Few would argue the unusual inclination to philately should be considered a diagnosis. If this hobby is practiced in an extreme way and causes distress, an individual might be diagnosed with something, but it would not be seen as originating in philately. Our main point here is that sexuality should not be pathologized just because it is unusual just as other unusual characteristics or interests are free of psychiatric scrutiny. The diagnoses of fetishism or sadomasochism also should not apply just because a person feels distressed about his or her own interest in that kind of behavior. When sexual behavior is safe and consensual, there is nothing wrong with it from a clinical point of view.

It is possible, however, that some individuals may feel that there is something "wrong" with their sexual practices. Nevertheless, the diagnoses of Fetishism or Sadomasochism should not apply in such cases just because a person feels distressed about his or her own sexual interest. This kind of distress is often associated with feelings of shame rather than with maladaptive behavior per se. In fact, individuals are more likely to experience shame if the kind of sex they prefer is frowned upon, stigmatized or subject to diagnosis.

The impact of social norms on diagnostic considerations is illustrated in the case of homosexuality. Homosexuality was withdrawn from the disorders of sexual preference (DSP) category in the *ICD-10* (it was still listed in *ICD-9*). The removal of homosexuality from the DSP can be mainly attributed to homosexual individuals who were organized and applied political pressure on the psychiatric profession. They argued that there was no scientific basis for the inclusion of homosexuality as a mental disorder. Although *ICD* revisions should not be based on popular opinion, it is important to recognize that many psychiatric diagnoses reflect, to some extent, social norms. Thus, diagnosing Fetishism and Sadomasochism is no longer in line with the norms of diverse multicultural societies that value acceptance and tolerance.

As stated earlier, when sexual acts are safe and consensual, they should not be considered immoral and pathological. Yet, nonconsensual acts with the intent to hurt others must be addressed. If a person has an uncontrollable urge to do something that violates a partner's personal boundaries, or has an uncontrollable urge to do something that causes harm to himself or herself, these are issues that must be addressed. There is no reason, though, to diagnose such urges as sexual problems. Unfortunately many people violate others' rights or their own integrity, in ways that seem uncontrollable. That can involve any type of behavior, and may or may not have anything to do with sexuality. It can involve "normal" heterosexual behavior inappropriately imposed upon someone or acted out compulsively in ways that are unsatisfying. If such behavior requires diagnosis, nonsexual categories are available, including the *Personality disorders* (F60) and the *Habit and impulse disorders* (F63).

However, addressing ethical issues does not imply that a specific behavior should be considered as a sexual problem. Rather, sexual assault should be viewed as a criminal act. Nonetheless, if the behavior in question requires diagnosis, nonsexual categories are available, including personality disorders (F60) and the habit and impulse disorders (F63).

Another consideration for revising the diagnostic criteria for sexual deviation is linked to anecdotal data, methodological shortcomings and empirical research findings. Before Kinsey, data on sexual deviation were derived almost exclusively from fictional literature or from psychiatric case histories. Despite the obvious methodological limitations of such sources, these data are still used in the psychiatric community. For example, many cases were referred to psychiatrists, because individuals were in conflict with the law. The generalization of findings from those cases to the general population is questionable, due to

representability and generalizability limitations associated with external validity and sampling issues; it is impossible to generalize findings from the criminal population to the non-criminal population. Furthermore, Kinsey (1953) indicated that there is no reason to believe that fetishism leads to crime. Indeed, what do we know about law-abiding fetishists? In accordance with Kinsey (1953), demographic studies show that there are citizens in "good standing" who practice SM (Moser, 1995).

The psychoanalyst Robert Stoller (1991) conducted an extensive interview study of SM practitioners in the 1980s. His data indicated that there is no evidence for higher prevalence crime rates, psychoses or personality disorders among SM subjects in comparison to the general population. Stoller (1991, pp. 19-20) wrote:

> And these people, were one to try to apply character diagnoses to them, are as varied as I expect are the readers of this book. Most of my informants are stable in employment; most are college graduates or beyond, lively in conversation, with a good sense of humor, up-to-date on politics and world events, and not more or less depressed than my social acquaintances.

The fact that there are SM and fetish practitioners with psychiatric and/or criminal records does not warrant pathologizing these practices. One could pick any group with an arbitrary characteristic and, provided that the sample is big enough, find psychiatric and criminal cases among them. Thus, an arbitrary characteristic should not be used as a basis for psychiatric diagnosis. Correspondingly, sexual proclivities should not be used as the basis for psychiatric diagnosis.

Contemporary empirical research findings have had little impact on the diagnoses of Fetishism, Fetishistic Transvestism and Sadomasochism over the last 55 years in the *ICD*. The existing research over the past 60 years has not influenced the diagnostic thinking in the area of the Paraphilias. Nonetheless, there has been a substantial development in the diagnosis of other disorders. For example, the categories of neuroses and psychoses have been substantially refined over time. Surprisingly, the revision of *ICD-10* omitted *ICD-9*'s suggestion that "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, 1978, p. 40). This omission in the *ICD-10* seems to be a step backwards in the classification system.

Organization, Clarity and Cohesiveness

The F65 diagnosis appears to be disorganized. It combines disparate, unrelated items, which are being perceived as unusual phenomena. For example, it combines consensual and nonconsensual sexual behaviors. Nevertheless, they are all being diagnosed as DSP; ergo, they share maladaptive qualities. This grouping is inappropriate, because abusers and perpetrators are being classified and diagnosed in the same general category as individuals with non-abusive interests. The rationale for clustering these sexual behaviors in one category (i.e., F65) is based on moral and "normative" issues. Hence, both professionals and the public view these behaviors as pathological sexual interests. Consensual games that are called SM or domination and submission are not abusive and therefore should not be diagnosed at all, let alone clumped together.

There is sometimes a concern that SM practices such as spanking and whipping can cause bodily harm. Indeed, people can be damaged from being hit in uncontrolled ways. However, there are ways to give and receive strong stimulation, including pain, that are safe. Both partners need to take responsibility in such acts. People have to learn what is safe and what is not safe, whether they practice SM or any other kind of sex. There are certainly safety issues concerning individuals who practice conventional heterosexual acts, which, once violated, are not diagnosed as sexual disorders. By the same token, individuals who practice SM acts should not be diagnosed based on occasional and naïve safety violations. Nonetheless, it is important to note that safety rules should be taken seriously. We encourage individuals with psychological problems around risk-taking to seek professional help, whether their interests revolve around sexual acts, sports, workplace hazards, etc.

The category of Paraphilia is also outdated. It does not reflect the descriptions of the paraphilic variations observed and classified in the 1950s and later by John Money (1986). Furthermore, most types of Paraphilia are not mentioned in the F65. Given that several kinds of sexual abuse are diagnosed as DSP, it seems strange that rape is not recognized as a diagnosis in the category. Similarly, the practice of unsafe sex does not appear as a sexual disorder diagnosis. A diagnostic category, like the F65, needs more consistency, clarity and empirical basis in order to be legitimate. However, adding more non-abusive categories to the classification system may be as pejorative as the present F65 category. Thus, the most suitable solution to this problem is simply to eliminate the Fetish and Sadomasochism subcategories from the F65.

Traditional Viewpoints

The *ICD-10* presumes the importance of intercourse: "Fetishistic fantasies are common, but they do not amount to a disorder unless they lead to rituals that are so compelling and unacceptable as to interfere with intercourse and cause the individual distress" (WHO, 1993, p. 218). This interference is one of the central arguments for labeling fetishism as pathological. The importance of intercourse reflects a traditional attitude towards all kinds of sexuality that do not have procreation as their purpose.

Ideas about sexual pleasure have changed radically in Western societies over the decades. For example, today, psychiatric perspectives largely regard non-procreative sex as a healthy pursuit. Furthermore, mental health professionals no longer assume that sex results in intercourse, or that sex and intercourse are synonymous. As such, it is unclear why fetishism, due to its alleged interference with intercourse, is singled out as a disorder. A possible argument for including fetishism as a diagnosis would be the involvement of emotional distress. Yet, "traditional" intercourse may result in emotional distress as well. However, in such cases, the individual is not diagnosed with fetishism (but maybe with sexual dysfunction, F52). Hence, there is no need to diagnose a consensual act that involves mutual pleasure as a maladaptive sexual behavior.

"Fetishistic transvestism is distinguished from transsexual transvestism by its clear association with sexual arousal and the strong desire to remove the clothing once orgasm occurs and sexual arousal declines" (WHO, 1993, p. 218). Interestingly, the guidelines do not comment on a situation in which there is no desire to remove one's clothing once orgasm occurred. Some individuals like to relax after orgasm and do not have the desire to remove their clothes. Does that make them Transsexual Transvestites? What if a person wants to continue sexual activity in anticipation of another wave of arousal? Let us consider an example of a man who identifies as male and likes to wear women's lingerie while masturbating. He reports enjoying the experience of wearing lingerie while masturbating. The appearance of a female in his own mind is being facilitated when he wears women's lingerie and focuses on it. Once orgasm occurred, he does not want to take the lingerie off. Instead, he wants to wear it because it feels good. Would this example qualify as a case of Transsexual Transvestism? Or, would it fit the case of simple fetishism? It appears that the diagnostic criteria are neither suitable nor clear in this case. In this example, the sexual act does not include dis-

tress; rather, it illustrates feelings of pleasure. Moser and Kleinplatz (2002) have an excellent discussion of the *DSM-IV-TR* (2000) diagnosis of Transvestic Fetishism (which is essentially the same as Fetishistic Transvestism). In a lengthy example of a man wearing female clothing and feeling good about doing it, they ask, "Should this behavior, which can be regarded as adaptive rather than distressing, be construed as psychopathological? The rationale for pathologizing a coping skill is questionable" (Moser & Kleinplatz, 2002, pp.16-17).

Another traditional view held by psychoanalysts and others (e.g., Grønner Hanssen,1992; Money, 1986) proposes that Sadomasochism is caused by childhood trauma. This theory of etiology suggests that Sadomasochistic behavior is a manifestation of an underlying psychological problem and, hence, abnormal. However, there is no empirical evidence to support this commonly held etiological model. The occasional anecdotal finding, which suggests that there are individuals who seem to fit this kind of theory, is not sufficient to support a diagnostic category.

Diagnosing a phenomenon as an illness should not be based on a speculative theory. Some SM practitioners who incorporate spanking during their sexual acts were not spanked as children; at least we have not found any evidence of it. Others who clearly were traumatized as children have designed their SM games not only for pleasure but also as adaptive coping strategies. For example, a woman who practiced a masochistic game for many years stated that she had overcome her fear of sexual relationships with men by role-playing similar situations in the context of a safe setting with her husband, where she is in control. For her, the SM game has been adaptive, because she is no longer fearful of being abused, and because she is in complete control of her borders in sexual, erotic and intimate situations. Again, an effective healing strategy should not be diagnosed as a mental disorder.

SM and fetish interests are essentially normal variations. For example, some people are attracted to legs with stockings, others to feet with sexy shoes, etc. Similarly, the power dimension is usually present to some extent in "traditional" sexual activities, (e.g., who is on "top" and who is on the "bottom"). The interests are only suspect if there is a sense of "too much," but almost all behavior can be assessed as being "too much." If someone is compulsive about acting out his or her sexuality, no matter what kind of sexuality, he/she could be diagnosed with obsessive compulsive disorder (OCD). Hence, there is no more reason to single out "paraphilic OCDs" than to single out "philatelic OCDs" into

special diagnostic categories. In other words, there is no reason to make a diagnosis based on the person's sexual preference or practice, per se.

Many SM practitioners are not aware of the fact that they are subject to diagnoses. One reason for this lack of awareness is that people with SM and fetish interests do not usually seek therapy to change their sexuality, and, therefore, they do not come into contact with the diagnostic system. Another reason is that many mental health professionals currently do not think it would be appropriate or necessary to make such diagnoses. Like other individuals, SM and fetish practitioners would first have to experience emotional distress before seeking psychological services of their own accord. Most of those individuals who actually receive diagnoses are probably referred by others (e.g., the legal system) and thus constitute a highly biased sample of the sub-population.

Human Rights Issues

The effort to change F65 is also a human rights issue. Diagnosing individuals based on types of sexuality is as unjust as discriminating against people based on race, ethnicity, or religion. It is as absurd as diagnosing people for being "blue-eyed" or "old." Individuals should not be diagnosed for who they are, for the tastes they have, for their beliefs or interests, nor for the kinds of sexuality they prefer.

There are different reasons for keeping diagnoses like Sadomasochism and Fetishism in our society. For example, there is still a lot of respect for and belief in the medical diagnoses. Thus, some may use the diagnoses to legitimize discrimination. There are numerous cases in which individuals have been fired from their jobs because their employers had heard that they were practicing SM. There have also been cases in which men have been harassed and physically threatened out in the streets, in Norway, for wearing effeminate clothing.

The "deviants" all too often look upon themselves as less valuable. The experience of stigma is not an argument in and of itself for abolishing the diagnoses in question, but it is a significant rationale given the lack of evidence to support the notion that practicing SM and fetishism is an illness. Labeling and stigmatizing individuals must be avoided when neither physical nor psychological difficulties are evident.

Some individuals have needed long-term psychotherapy to overcome the negative impact of stigma. For example, a male fetishist tells us that he would enjoy his practice of fondling his partner's boots more if the question "Is this sick?" was not present in the back of his mind. Another male fetishist suffered from the stigma and consequently felt

inferior, because his wife regarded his preference to wear nylon stockings during intercourse as sick. She might be more comfortable with his wearing the stockings and enjoy the intercourse herself if she knew it was not an unhealthy practice.

Being Diagnosed and Its Aftermath

Individuals may believe they are ill because medical authorities said so; a diagnosis can often become a self-fulfilling prophecy. For example, a 52-year-old businessman had been distressed for many years because he was under the impression that he was sick. It started in adolescence when he felt an irresistible urge to wear a garter belt and sheer nylon stockings. After secretly masturbating while wearing his sister's nylons, he experienced feelings of shame. Soon thereafter he started reading about perversions in popular publications devoted to sexual education. He read that Transvestism and Fetishism were labeled perversions and were not normal behaviors, but rather were perceived as psychiatric illnesses. His feelings of shame were exacerbated after realizing that having that kind of illness was a psychiatric issue as well as a sexual disorder. Consequently, he tried to fight the recurrent urge to wear nylons as best as he could. He was popular with girls and when he reached the age of 17 he started having intercourse, which he enjoyed. He used to think that when he met the right girl, he would be so much in love with her that he would not think about wearing nylons anymore. That happened when he was 25 years old. He married and did not think about wearing stockings for a time. After a year of being married the urge came back and he could not resist doing it. So he resumed wearing stockings, but still in secret. He went for psychotherapy and was told that his urge to cross-dress was an illness to be treated. After 4 years in psychotherapy he was not "cured"; on the contrary, he felt even worse about himself. Finally, he decided to tell his wife about the reason he had sought therapy and about his "terribly sick" fetish. His wife accepted him and his urge to wear stockings as normal behavior. The couple incorporated his nylon stockings into their sex life together. That was the end of his psychotherapy and concluded many years of suffering. Previously, he had been distressed to the extent that he was on the verge of suicide a couple of times. Now he and his wife have a satisfactory sex life together and the distress is gone. The loving relationship between them has deepened. His pain would have been avoided if Fetishism and Fetishistic Transvestism had not been diagnosed as illnesses.

Negative self-image and low self-esteem from the stigma attached to the diagnoses can affect people severely. This may result in obsessions and compulsions, such as alcoholism, drug abuse or workaholism. Other possible results are suicide or suicidal gestures and other kinds of self-destructive behaviors (e.g., self-mutilation and passivity). For example, a middle-aged, gay man, with a rubber fetish and masochistic inclinations, has been looking down on himself for most of his adult life because of his "perversions." Currently, he is engaging in psychotherapy and is successfully overcoming his deep shame about himself and his sexuality. As in the previous example, in his youth he had read about "perversions" (including homosexuality) and therefore thought he was ill. The negative self-image led to severe, chronic, recurrent, major depression. He is now in a good relationship with his partner, who is also into SM and leather. Given that the impact of the stigma has been mitigated, he is living a much happier and more fulfilling life than before. His psychotherapist supported his belief that the rubber fetish and masochism are not sick. His therapist's encouraging words about his sexual choices have been essential for his recovery. Perhaps the most fulfilling aspect of his life is the love he shares with his partner. This satisfying relationship is worth commenting on, as intimacy problems are quite prevalent among both "normal" and paraphilic individuals. But, in the case of paraphilic individuals, psychiatry is quick to attribute such problems to deviant sexuality. It would be more appropriate to examine problems of intimacy in interpersonal relationships per se, rather than automatically conceptualizing the "paraphilic" behavior as a sexual deficit.

POLITICAL EFFORTS TO REVISE F65

In this section we will outline some of the incidents leading up to the establishment of the ReviseF65 group in 1997 (also known as "The Forum"). We also refer to some of the Forum's efforts inside and outside the lesbian and gay movement.

The organized gay and lesbian movement was established in 1950, and later called Landsforeningen for Lesbisk og Homofil frigjøring (LLH), the National Organization of Lesbian and Gay Liberation. Over the last fifty years in Norway, leaders in the gay movement have had SM interests. The gay community has always been a catalyst for gay leather men and women, galvanizing their self-expression and SM lifestyle. Yet due to prejudice, most gay leather and SM individuals

had–and still have–to live closeted in the gay community, just as gays and lesbians in general have done in the rest of society. There have also been conflicts between gay leather individuals and other homosexuals about SM and fetish practices.

The group *Lesbians in Leather* founded in 1993, was a precursor of *Smia,* founded in 1995, a human-rights group for lesbian, bisexual, gay, and transgendered people. All these groups, namely Lesbians in Leather, Smia and ReviseF65 are subsidiaries of LLH, and were founded by Svein Skeid.

In 1997, the ReviseF65 Forum was formed by Smia, individual transgender people, and mental health professionals. The LLH gave the ReviseF65Forum a mandate to abolish Fetishism, Transvestism and Sadomasochism as psychiatric diagnoses from the *ICD*. The Norwegian gay leather men's organization Scandinavian Leather Men (SLM-Oslo), established in 1976, and the heterosexual SM organization "SMil," founded in 1988, joined the Forum in 1998; thus, the coalition continued to grow.

The impetus behind the F65 Repeal Movement was the flourishing of SM pride, with fetish men and women parading through the streets during Gay Pride week. Leather people were tired of being object of derision in the tabloids and being characterized by Norwegian psychiatrists as "violent" and anti-social individuals. The members of Smia also suffered from the effects of this prejudice. A celebratory attitude that started in a lighthearted way suddenly became deadly earnest, when everybody at a board meeting turned the palms of their hands upwards simultaneously. Scars on the wrists indicated that several of the people present had attempted suicide because of harassment or persecution within their own communities. As with other forms of assault, women were the chief victims; they were isolated because of their SM orientation or preference.

For several years, The Norwegian Board of Health (a part of the central health administration) has supported Smia's work financially to strengthen the self-esteem and identity of gay leather men as part of strategies to prevent sexually transmitted diseases including HIV. Stigmatizing fetish and SM practices amounts to an insult against healthy leather-people and, therefore, runs counter to effective public health and safer sex education efforts. It seemed like a paradox that the same official health authorities who grant money to LLH and Smia, who encourage a positive identity for fetishists and SM participants, also represent the agencies that employ discriminatory and stigmatizing diagnoses of these practices.

Another historic event that has had a great impact on the mobilization for SM human rights in general, and the F65 Repeal Movement in particular, is the British Spanner trial (1987-1997). During this trial process, several hundred gay leather men were questioned. Twenty-six men were cautioned and sixteen charged with mutual piercing, spanking and branding, that is, with consensual activities that are legal in other European countries, like Norway. Not only homosexual individuals were targeted, imprisoned and lost their jobs. The safer sex meeting places and magazines of straight SM people were also raided and shut down by police in the wake of the Spanner verdict (dissenting 3:2) by the House of Lords in 1993. The consenting SM men lost the Spanner case when it was appealed to the European Commission of Human Rights (dissenting 11:7). The Strasbourg human rights court affirmed the verdict in 1997.

Even though the case was lost, and the Spanner Verdict made some SM play illegal in the UK, it was inspiring for Smia and SLM-Oslo to be part of a worldwide movement in support of the Spanner defendants. For the growing SM human rights movements, the word "Spanner" attained as much significance as the Stonewall riot did in 1969 for the gay and lesbian movement. In Norway, a fund-raising campaign had the moral support of the lesbian and gay movement, human-rights groups, trade unions, women's organizations, and a variety of political organizations that included several hundred thousand members from both right and left political wings. In 1995 an official British law commission ("Consent in the Criminal Law," 1995) gave the fetish/SM/leather communities considerable support and argued that SM should no longer be considered a criminal offence in Great Britain.

The LLH-leader, Gro Lindstad, expressed strong support for SM human rights. In late June of 1994, her future, registered partner, Bente Vinæs, returned with good news from the International S/M-Leather-Fetish Celebration in New York City. The conference material she brought home stated: "For the first time, the leather-s/m-fetish community's style of sexuality is no longer considered necessarily pathological. . . . The new DSM-IV language means that we will no longer be considered sick unless our erotic play causes 'clinically significant distress or impairment in social, occupational or other important areas of functioning'" (Bannon, 1994). Project Coordinator Race Bannon (1994) described this as "a terrific development for the leather-s/m-fetish community!" Later, the ReviseF65 group contacted American mental health professionals who admitted that the *DSM-IV* (1994) was obviously an improvement, but by no means perfect.

Repeal of Sadomasochism Diagnoses in Denmark

In 1995, the Danish newspaper "*Politiken"* reported that "Sadomasochism is not a disease" in Denmark ("Sadomasochisme er ingen sygdom," 1995).

A letter from the SM organization "Det sorte Selskab" (The Black Society) demanded the removal of the diagnosis, and the Health Ministry issued a recommendation to remove the diagnosis of Sadomasochism from the Danish version of the ICD. "I agree with you that sexual preference is a completely private affair," wrote Yvonne Herlov Andersen, the Minister of Health, in her personal communication to the leader of The Black Society ("Sadomasochisme er ingen sygdom," 1995). "The acceptance of people with a different sexuality has increased, and in this area Denmark is a pioneer country," she wrote ("SM diagnosis withdrawal in Denmark," 1995).

These changes sparked debates in Norway. For example, psychologist Grønner Hanssen, author of a book on SM (see Grønner Hanssen, 1992), debated with health authorities on a radio show about the possibility of Norway following Denmark's lead. Grønner Hanssen reasoned that the stigma, prejudice, and misconceptions related to being diagnosed caused personal strain. Marit Kromberg, Department Manager of the Norwegian Board of Health, argued for retaining the diagnosis. She indicated that what people do in private is not the business of the Norwegian authorities, but if a person seeks treatment, it is the physician's responsibility to diagnose the problem correctly.

A 1994 national survey was conducted among the 2000 lesbian and gay members of LLH. Despite negatively slanted questions the respondents rejected discrimination against leather, SM and transgendered practitioners, and judged this diversity as a valuable resource. The September 1994 issue of *Blikk*, the Norwegian gay and lesbian newspaper, featured a spokesman of the Norwegian Board of Health, who asserted erroneously that Sadomasochism would be removed from *ICD* in 1996 ("SM-ere friskmeldt," 1994). In the January 1996 issue, readers were told that Fetishism and Sadomasochism were still classified as psychopathology in Norway ("SM-sex fremdeles en sykdom," 1996). The presence of Fetishism and Sadomasochism as diagnoses in 1996 created a great deal of confusion and frustration among gay rights activists. Following a proposal from LLH-Oslo, the biennial National Convention of LLH in May 1996 approved a long-term national and international project to remove Fetish and Sadomasochism diagnoses. LLH leader Gro Lindstad sent a letter to The Norwegian Board of

Health requesting copies of *ICD-10*, which at that time was being translated into Norwegian. LLH wanted to influence the translation process, so that Fetishism and SM would no longer be regarded as diseases. The request was rejected. Later it turned out that the Norwegian version contained the same F65 diagnoses as the international one.

The ReviseF65 group tried to follow Denmark's 1995 strategy. Unfortunately, the project was shelved soon after the Christian Conservative Government took over. The work of the Forum was resumed in 1998 with a new mandate from LLH that was renewed in 2000.

Surprisingly, prior to the National Convention of May 2002, LLH proposed to remove the ReviseF65 project from the organization's working plan, describing this worldwide endeavor as merely "a detail." After the vigorous intervention of the Forum and allies within LLH-Oslo, the convention decided to retain the mandate of the ReviseF65 project. This incident highlighted the importance of keeping steady contact with the mother organization. The work in favor of Fetish/SM human rights has to be fought continuously on different fronts, within as well as outside the gay/lesbian movement.

European Support

SM human rights leaders in SLM-Oslo have promoted the democratic revision of the rules and policies of the European Confederation of Motorcycle Clubs (ECMC) in order to address issues of sexual politics. In 2000, more than 50 ECMC member clubs, following a proposal by SLM-Oslo, decided to support the ReviseF65 effort. The European division of the International Lesbian and Gay Association (ILGA) issued a statement at its conference in Pisa, Italy (1999), supporting efforts to remove the diagnoses from the ICD.

During the lesbian and gay Europride 2002 in Cologne, more than one million people were confronted with the slogan "SM is healthy–Remove SM and fetish diagnoses!" during the parade. Conversations during Europride 2002 with representatives from German, heterosexual, SM organizations contributed to a change in strategic thinking. The ReviseF65 group has spent considerable time encouraging mental health professionals to address themselves directly to the WHO and initiate dialogue with WHO-collaboration centers.

Current efforts involve mobilizing support from the national professional organizations of sexologists, psychologists and psychiatrists. In this way, we are working to build a professional foundation for an initiative by the health authorities to remove the diagnoses. The ReviseF65

group is interested in participating in relevant, international, professional conferences to discuss the F65 Paraphilias. The Web site of the ICD project (ReviseF65, 2002), along with the corresponding mailing list, has facilitated national and international networks. The Web site, which is published in several languages (i.e., Norwegian, English, German and Portuguese), has given the Forum a good opportunity to disseminate a range of material about its work.

CONCLUSIONS

The ICD diagnoses of Fetishism, Transvestic fetishism and Sadomasochism are outdated and not up to the scientific standards of the *ICD* manual. Their contents have not undergone any significant changes for the last hundred years. They are at best completely unnecessary. At worst, they are stigmatizing to minority groups in society. There are people who are suffering from stigma and emotional distress because of the diagnoses.

The purpose of this article has been to get SM groups and kinky-friendly mental health professionals all over the world to join us in the effort to repeal the diagnoses. Specific strategies should be determined at the local and national levels, depending on the professional and political situation in each country. The support and work of leather men and women, SM community-leaders and organizations are crucial in order to reach this goal. The initiative of individuals is always welcome. Furthermore, formation of local and national working groups can be immensely effective, because they are able to approach the professionals in question. We encourage activists and kink-aware people of professional status everywhere to visit our Web site (www.reviseF65.org) and to join our discussion group (Yahoo! Groups, 2000).

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