

# Summary of the most important changes in sexual dysfunction and sexual health introduced in the latest revision of the International Classification of Diseases and Related Health Problems ICD-11

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## ABSTRACT

### Aim

The aim of this publication is to review the changes introduced by the latest revision of the International Classification of Diseases and Health Problems, within sexual health and to compare them to the previously valid ICD-10.

### Method

This paper reviews both classifications and compares them with each other, presents diagnostic criteria for the most important changes within sexual dysfunctions, paraphilic disorders, gender non-conformity, sexual orientation and compulsive sexual disorders. The changes introduced in ICD-11 were proposed based on advances in research and clinical practice, as well as significant changes in social attitudes and human rights. This article describes and compares the main changes that have occurred in this area.

### Results

The World Health Organization has introduced far-reaching changes in the area of understanding and diagnosis of sexual dysfunctions by combining its psychological and physiological components, creating a bio-psycho-social model of sexual disorders. Another revolutionary change is the depathologisation and de-medicalisation of gender identity by

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introducing the term gender non-conformity and regrouping it from the previous category of personality and behavioural disorders to the newly created category of sexual health. ICD-11 also uses less oppressive and empowering terms. ICD-11 removed the category 'Mental and behavioural disorders related to sexual development and orientation', deeming it outdated and clinically irrelevant, and made significant changes to paraphilic disorders by excluding normative but atypical sexual behaviours such as fetishism, sadomasochism, fetishistic transvestism, and introducing diagnoses of dripping and compulsive sexual sadism. In the area of paraphilic disorders, a clear distinction is made between clinically significant and public health-relevant conditions and those that merely reflect private atypical sexual behaviour. The last significant change is the introduction of the category of compulsive sexual behaviour in the group of impulse control disorders.

**Keywords:** ICD-11, sexual dysfunctions, sexual incompatibility, compulsive sexual behaviour

## Introduction

The initial version of the 11th revision of the International Classification of Diseases and Related Health Problems (ICD-11) was published on 18 June 2018, followed by approval by the World Health Assembly on 27 May 2019. The transition process from ICD-10 to ICD-11 began on 1 January 2022.

The ICD is used to varying degrees by the 194 member states around the world. Poland, which uses an older version of the classification (ICD-10), has only begun the process of translating and implementing ICD-11. At the moment, ICD-11 is available in English, French, Spanish, Arabic and Chinese, and another 20 language versions are being prepared, including a Polish version. The new classification is already used by 35 countries worldwide.

The Polish version of ICD-11 is the responsibility of the Medical Centre for Postgraduate Education and the following stages of work on the classification are foreseen:

- Phase I Translation of the ICD-11 classification; March–August 2022;
- Phase II First revision of the translation by subject matter experts; September–November 2022;
- Stage III Verification and acceptance of the translation by national consultants; December 2022 – February 2023;
- Phase IV workshops and training on ICD-11; December 2022 – June 2023.

The WHO Department of Mental Health and Substance Abuse and the WHO Department of Reproductive Health and Research were responsible for creating the sexual health areas discussed in the ICD-11.

The Most Important Changes Concern:

- elimination of mind-body dualism in the area of sexual dysfunction (Sexual Dysfunction – SD), unification of SD classification and no division into organic and inorganic SD;
- the classification and naming of Paraphilic Disorders (PD), including the largely depathologised normative sexual practices of the KINK type and the recognition of Gender Sexual and Relationship Diversity (GSRD) as normative;

- removal of the categories of gender identity disorder and dual role transvestism; transgenderism has been replaced by the concept of gender non-conformity placed under the new category of sexual health;
- deletion of the category of mental and behavioural disorders linked to development and sexual orientation;
- the introduction of a new diagnostic category: Compulsive Sexual Behaviour Disorder (CSBD).

In ICD-10, the number of disorder groups was limited by the decimal coding system used in the classification, so that a maximum of ten major disorder groups could be created within a division. As a result, diagnostic groups were created that were not based on clinical utility or scientific evidence (e.g. anxiety disorders were included under neurotic, stress and somatoform disorders). ICD-11's use of a flexible alphanumeric coding structure allows for a much larger number of groups, enabling the creation of diagnostic groups more closely based on scientific evidence and clinical practice needs. The guiding principles of the ICD-11 organization attempt to organize diagnostic groups from a developmental perspective (e.g. neurodevelopmental disorders come first and neurocognitive disorders last) and based on presumed common aetiological and pathophysiological factors (e.g. specifically stress-related disorders) and shared phenomenology (e.g. dissociative disorders).

### **Clinical Descriptions and Diagnostic Guidelines (CDDG) in ICD-11**

ICD-11 is characterised by a shift towards a multidimensional classification, rather than a strictly categorical and fluid/time-varying classification. In addition, an important element of the change in the new classification is the introduction of Clinical Descriptions and Diagnostic Guidelines (CDDGs) for mental, behavioural and neurodevelopmental disorders containing detailed guidelines for clinical application by professionals worldwide. A particularly important feature of the CDDGs is the approach to describing key features of each disorder, which represent symptoms or features that a clinician would expect to see in all cases of the disorder. The lists of key features in the guidelines “at first glance” may resemble diagnostic criteria, but the ICD-11 avoids arbitrary cut-off values and precise requirements related to the number of symptoms and their duration, unless these have been established empirically in different countries and cultures or there is another compelling reason to include them.

The CDDG contains eight categories:

- 1) key (required) characteristics, e.g. temporal factors, whether SD is lifelong, i.e. the person has always experienced dysfunction since the start of the sexual activity in question, or acquired, i.e. the onset of sexual dysfunction occurred after a period when the person did not experience it;
- 2) additional clinical features, e.g. factors to indicate whether the dysfunction is generalised or situational, e.g. the desire disorder is only present in the relationship with the regular partner, regular partner but absent or reduced during viewing pornographic content and masturbation;

- 3) borderline with normality (threshold) e.g. factors related to lack of knowledge about own body, sexual functions and reactions etc;
- 4) course functions e.g. psychological or behavioural factors e.g. negative attitudes towards sexual activity, adverse past sexual experiences, poor sleep hygiene, overwork, relationship factors e.g. relationship conflict, lack of attachment;
- 5) developmental presentations, e.g. aetiological factors associated with a disease or disorder, e.g. diabetes, depressive disorders, hypothyroidism, multiple sclerosis;
- 6) culturally related factors (e.g. cultural inhibitions about expressing sexual pleasure, religious belief that one cannot feel desire without being married, etc.);
- 7) gender-related characteristics (e.g. differences between the sexual response cycle in women and men);
- 8) borderline with other conditions (differential diagnosis) e.g. SDs occur in combination with a drug or substance (e.g. SSRI, alcohol, amphetamine).

### **Diagnostic Instruments in ICD-11**

WHO is introducing four diagnostic instruments based on ICD-11: version 3 of the Schedules for Clinical Assessment in Neuropsychiatry (SCAN); the Composite International Diagnostic Interview (CIDI); The Structured Clinical Interview for ICD-11 (SCII-11) and FLII-11 is currently under development, it is a shorter interview with yes/no questions.

### **Elimination of Mind-Body Dualism in the Area of Sexual Dysfunctions**

The ICD-10 classification of sexual dysfunctions (F52) was based on the Cartesian separation of 'organic' and 'inorganic' states. ICD-10 strongly emphasised the dichotomy of sexual dysfunctions by dividing them into organic and inorganic. "Inorganic" sexual dysfunctions were included in the chapter on mental and behavioural disorders, while "organic" sexual dysfunctions were mostly listed in the chapter on genitourinary diseases. However, since the publication of ICD-10 in 1990, substantial evidence has accumulated indicating that the emergence and maintenance of sexual dysfunction often involves an interaction of physical and psychological factors. ICD-11 integrated the division between the body and psyche to create a chapter on conditions related to sexual health, which includes a unified classification of sexual dysfunctions and disorders associated with sexual pain, as well as changes in male and female anatomy.

One of the key tenets of ICD-11 is the definition of sexual response, which is described as an interaction of psychological, interpersonal, social, cultural, physiological and gender-related factors. The substrate of SD (sexual dysfunction) may be each of these separately or a specific compilation of several or all of them simultaneously. SD encompasses all levels at which people may have difficulties

in experiencing satisfying sexual behaviour, and may involve dysfunctions in experiencing, obtaining or maintaining: sexual arousal and desire, orgasmic dysfunction, ejaculatory dysfunction and other specific sexual dysfunctions. A separate category of SD is disorders associated with sexual pain. The ICD-11 tries to emphasize the similarities in dysfunctions experienced on a binary level by women and men, while not neglecting the gender differences associated with different clinical symptoms, e.g. sexual excitement dysfunctions in women may be manifested by lubrication disorders, while in men by erectile dysfunctions, but desire disorders regardless of gender will be manifested similarly, e.g. by weakened or lack of fantasy. However, disorders of desire regardless of sex will be manifested similarly, e.g. by weakened or absent sexual fantasies, lack of desire for sexual activity with a partner, weakened or absent masturbatory activity with simultaneous lowering of mood for this reason and feeling it as distress. In the ICD-11 approach to SD, a greater role than before is attributed, shared regardless of sex assigned/self-identified, to pathways of nervous system activation and deactivation, neurotransmitter activity, neuroplasticity, modulating and reinforcing SD through behaviours and experiences in the life course.

The diagnostic criteria for SD are:

- 1) persistence or recurrence of symptom(s) for at least several months, but if there is an immediate cause of the symptom, e.g. erectile dysfunction due to spinal cord injury, then the time criterion does not apply;
- 2) the symptom(s) is/are frequent, although it may be of variable severity;
- 3) the presence of the symptom(s) is associated with clinically significant distress.

Changes in the area of SD also include a new classification of sexual pain. ICD-11 provides the opportunity to identify specific types of pain syndromes without excluding those in which another condition is thought to be the cause.

## **Paraphilic Disorders**

Of particular importance in ICD-11 is the approach and understanding of the 'normativity' of sexual behaviour. This revision emphasises that there is no normative standard for sexual activity, and that what is satisfactory or unsatisfactory is defined from the point of view of the individual and what is satisfying to them, regardless of whether their pattern of experiences, manner or form of sexual activity is satisfying to other people or what is considered normative in a given culture. The only necessary criterion is consensuality and informed consent of all those involved in the activity.

Paraphilic Disorders (PD) in ICD-11 replace the group of sexual preference disorders in ICD-10. The key element around which this diagnosis oscillates is the achievement of sexual arousal accompanied by a lack of informed consent of the persons (or objects) involved. PD, unlike other sexual difficulties, was not included in the category of 'sexual health conditions' but remained in the category of 'mental disorders, behavioural disorders and neurodevelopmental disorders'. This decision was dictated by the fact that:

- non-consensual sexual behaviour may occur in the context of certain psychiatric and behavioural disorders, such as manic episodes or dementia disorders, or in the context of substance intoxication – not meeting the diagnostic criteria for a paraphilic disorder.
- the diagnosis and treatment of paraphilic disorders are often linked to legal proceedings, as in many countries PD are criminal behaviours, punishable by law, moreover they require specialist knowledge of mental health, especially psychology, psychiatry, sexology, endocrinology and law and are sometimes associated with the use of controversial pharmacotherapy (e.g. anti-androgen treatment) opting for the so-called “lesser evil policy” and the protection of potential victims. The legislation of some countries, including Poland, allowing, in a preventive system, the forced detention of these persons, e.g. in Poland in the National Centre for the Prevention of Dissocial Behaviour, after serving a mandatory sentence of imprisonment, in order to proceed therapeutically and minimise the risk to the community in which these persons would be detained, was also significant. In this situation, the constitutional law of the countries concerned and Human Rights law do not allow the threat of danger to be a sufficient basis for the continued deprivation of liberty of persons who have already served their sentence, but the presence of a mental disorder that renders the person unable to control his or her dangerous behaviour does. It was largely legal considerations that decided to leave PD in this category.

Paraphilic disorders in ICD-11 include:

- a) exhibitionist disorder;
- b) viewing disorder (voyeurism);
- c) paedophilic disorders;
- d) frotteuristic disorders (frotteurism – an additional separate diagnostic category, previously it was in the group of so-called other paraphilias);
- e) compulsive sexual sadism syndrome (this is a new diagnostic category);
- f) and other paraphilic disorders.

The novelty of the ICD-11 is the exclusion of fetishism, transvestic fetishism and sadomasochism from the category of disorders and the depathologisation of these sexual behaviours. The sex-positive community has long called for these sexual behaviours to be treated as KINK and included in the normative group Gender Sexual and Relationship Diversity (GSRD).

Paraphilias that are not PD, e.g. sexual masochism, fetishistic behaviour or transvestic behaviour in the ICD-11 can be diagnosed under so-called other paraphilic disorders, even if they take place alone or with the consent of the persons involved, only if they are associated with significant suffering or a significant risk of injury or death (e.g. asphyxiophilia) or are associated with significant stress for the person involved (but this stress must not be due to the consequences of rejection by others or fear of rejection by the partner due to the pattern of sexual arousal used).

The WHO, in arguing for this change, has not only noted the cultural and social changes in this area but has also drawn attention to the important distinction

between conditions which are relevant to public health and indicate a need for health services and those which are simply private behaviours of healthy people and which have no impact on public health and whose treatment is neither indicated nor sought. The Working Group on Sexual Disorders and Sexual Health working on this category rightly points out that moral, religious and cultural norms, in different societies, are not and cannot be a public health concern or health classification.

It was also significant that ICD-10, in this category, described only sexual behaviours, e.g. “fetishism is the use of non-personal (usually inanimate) objects (with or without the presence of a personal partner)”, without using the criterion of suffering or functional impairment, and without reference to public health. It is also worth noting that these behaviours had no clinical relevance. Therefore, specific patterns of sexual arousal, even if they are atypical for a particular society or culture, but do not involve suffering, dysfunction or harm to the individual or others, cannot be treated or diagnosed as mental disorders.

The basic diagnostic criteria for paraphilic disorder are:

- 1) a persistent, concentrated and intense pattern of sexual arousal – manifested by persistent sexual thoughts, fantasies, desires or behaviours – which includes people who do not consent or whose age or status does not allow them to give such consent in an informed way (e.g. children before puberty, people with intellectual disabilities, people who do not suspect such behaviour e.g. a person looking through a window, an animal, etc.);
- 2) the person has acted on these thoughts, fantasies or urges, or is visibly distressed by them.

ICD-11 drops the requirement for duration of PD, the importance of which has not been confirmed by research. The persistence of the pattern of arousal, its intensity, is much more important in the diagnosis than its duration. It is very important that a single instance of paraphilic behaviour is not sufficient to make a diagnosis of PD.

The ICD-11 introduces another very important change in the context not only of PD but also of other mental disorders, namely that functional impairment is no longer a required diagnostic criterion and should only be used when necessary to distinguish the disorder from normativity.

It is also worth noting that there is no requirement in the ICD-11 diagnostic guidelines for the relevant arousal pattern to be exclusive or preferential.

In view of the pattern of sexual arousal common among sex offenders and in order to clearly distinguish from normative sadomasochistic behaviour that does not involve significant harm or risk, a new diagnostic category was created in this area – compulsive sexual sadism disorder, it is defined as a persistent, constant and intense pattern of sexual arousal that involves inflicting physical or psychological suffering on a non-consenting person.

In addition, from the group of other paraphilic disorders, frotteuristic disorder has been identified, which is defined as a persistent, repeated and intense pattern of sexual arousal that involves touching or rubbing against a non-consenting person, usually in public places. The motivation to identify this pattern was that it is a serious problem in some countries and its prevalence is high.

The ICD-11 also proposes the use of the category “other paraphilic disorder”, which includes behaviours towards persons/objects who do not or cannot give consent but a specific pattern of sexual arousal does not fit into any of the available categories or is not common enough or well researched (e.g. patterns of arousal involving dead people or animals).

## **Gender Non-Conformity**

Gender Identity Disorder present in ICD-10 has been removed and a new term “gender non-conformity” has been introduced in ICD-11. This is a step further than the DSM-V, using the term “gender dysphoria”, the term dysphoria implies suffering or impairment in daily life as a criterion for diagnosis, and not all transgender people experience suffering or impairment in daily life. Gender non-conformity is therefore a neutral term, assuming the incompatibility of the sex assigned at birth with the sex experienced regardless of the suffering or lack of suffering experienced. Gender non-conformity has therefore been moved from the chapter on mental disorders to the new chapter on sexual health, meaning that transgenderism is no longer considered and cannot be treated as a mental disorder. Gender non-conformity has not been completely eliminated from the ICD-11 because in many countries access to health services is dependent on a qualifying diagnosis e.g. access to hormone therapy, mastectomy procedures, penile plastics, vaginal plastics etc. It is important to note that the guidelines clearly and unambiguously state that self-identification and gender-related behaviours are not sufficient for a diagnosis of gender non-conformity.

Over recent times, many civil society organisations, WHO member governments as well as the Parliament of the European Union have called on the WHO to remove categories related to transgender identity from the classification of diseases and disorders. One of the most important motivations for these calls was to end the stigmatisation of transgender people. Unfortunately, ‘just’ stigmatisation was not a sufficient reason to remove transgenderism from the list of mental disorders, despite the fact that numerous studies have indicated that there is a strong link between the stigmatisation of this group and their mental health status, raising questions about the extent to which the conceptualisation of transgender identity as a mental disorder supports the WHO’s constitutional aim of identifying people in need of mental health care and in selecting appropriate methods and treatments. Unfortunately, the status of transgender people in the ICD-10 has contributed to the deterioration of their mental health, legal doubts about their status in the process of correction, incorrect diagnostic, therapeutic and pharmacological procedures and violations of Human Rights, e.g. the so-called “real life test” required in the process of correction and opinion-forming in Poland until recently.

Therefore, the Working Group on Sexual Disorders and Sexual Health recommended retaining gender non-conforming diagnoses in ICD-11 to preserve access to health services, but removing these categories from the chapter on mental and behavioural disorders.



Diagnostic criteria for gender non-conformity in adolescence and adulthood include the continuous presence for at least several months of at least two of the following symptoms:

- 1) strong aversion to or discomfort caused by the presence of primary or secondary sex characteristics due to incompatibility with the sex experienced;
- 2) a strong desire to rid oneself of some or all of one's primary or secondary sex characteristics (or, at puberty, a desire to prevent the development of a predicted secondary sex characteristic);
- 3) a strong desire to possess the primary or secondary characteristics of the experienced/preferred sex;
- 4) a strong desire to be treated, to live and to be accepted as a person of the experienced gender.

Furthermore, a diagnosis of gender non-conformity cannot be made before the onset of puberty. Another very important change of the ICD-11 in this area is the change of the oppressive vocabulary for transgender people and the discontinuation of terms such as 'opposite sex', 'anatomical sex' considering the division of sex on the binary continuum as insufficient and the introduction of terms such as 'experienced sex' and 'assigned sex'. ICD-11 also does not assume that all transgender people seek or desire services related to the transition process.

The ICD-11 diagnostic criteria for childhood gender non-conformity are more stringent to avoid, as much as possible, the diagnosis of children whose gender is fluid for developmental reasons. All three of the following criteria must be present simultaneously to diagnose gender nonconformity in children:

- 1) a strong desire or claim that the child is experiencing an alternative gender, compared to the one assigned at birth;
- 2) a strong aversion to the child's own sexual anatomy or anticipated secondary sexual characteristics, or a strong desire to possess the sexual anatomy or anticipated secondary sexual characteristics of the desired sex;
- 3) creating appearances or fantasies in games or playthings typical of the sex experienced rather than of the sex assigned.

These features must be present in the child before puberty for at least two years, which means that the diagnosis cannot be made until around 5 years of age.

The diagnosis of dual role transvestism has been removed from the ICD-11, due to lack of public health relevance and lack of clinical significance.

## **Mental and Behavioural Disorders Related to Sexual Development and Orientation**

The category was removed altogether. The Working Group felt that the category of developmental and sexual orientation disorders combined normative developmental patterns observed in non-heteronormative people with psychopathological processes which cannot be the case in today's society. The concept of egodystonic homosexuality was part of a compromise recognising that homosexuality is not a disorder but can still form the basis of a psychiatric diagnosis when a person

suffers because of it. Today we know that non-heteronormative people are more likely than heteronormative people to report higher levels of suffering, but this is strongly linked to experiences of social rejection, stigma and the resulting minority stress experienced. Suffering related to a person's social perception cannot be an indicator of an individual's mental disorder, as an individual cannot be responsible for a sick part of society (sick in the context that homophobia is a type of disorder).

Similarly, the category of difficulties in intimate relationships of non-heteronormative people has been removed from the ICD-11. Difficulties in relationships are common, occur for many reasons and have nothing to do with psychosexual identity. Non-heteronormative people use mental health services for the same reasons as heterosexual people therefore retaining this category was unwarranted.

### **Compulsive Sexual Behaviour Disorder (CSBD)**

The emergence of this category and the move away from dualism in SD removed the category of excessive sexual desire in ICD-10 by introducing the category of CSBD.

In clinical practice, whether sexological, psychological or psychiatric, we relatively often encounter the problem of loss of control over various forms of sexual activity (i.e. compulsive use of pornography, compulsive masturbation, risky sexual contacts with many partners). Despite constant research, we are still not sure what the underlying cause of these disorders is.

CSBD is a diverse and controversial clinical phenomenon with a highly inconsistent picture. Nowadays, it can be said with high probability that the same clinical symptoms, similar and similar sexual behaviours have different etiologies. Determination of the substrate, mechanisms and function of CSBD is necessary for a proper treatment process and therapeutic management (Smaś-Myszczyszyn, 2019).

Despite the growing number of scientific papers on CSBD, we still do not know the answer to the mechanisms behind the loss of control over sexual behaviour. Looking through the available literature, one can find terms such as sexual addiction, sex addiction, hypersexuality, compulsive sexual disorder, paraphilic disorder, sexual impulsivity, nymphomania and satyriasis, loss of control over sexual behaviour or compulsive sexual behaviour. The compromise on nomenclature seems to reflect the ICD-11 criteria by introducing the term compulsive sexual behaviour disorder.

Large epidemiological studies estimating the incidence of CSBD are still lacking. Available studies suggest that 3–6% of the population suffers from CSBD. Research conducted by Grant's team in 2005 among psychiatric patients on the prevalence of various types of impulsive disorders indicates a prevalence of CSBD in this group of 4.4%. Those seeking treatment for CSBD are predominantly males whose loss of control over sexual behaviour began in childhood or late adolescence (Smaś-Myszczyszyn, 2019).

Impulsivity, compulsivity, attachment style disorder and addiction are cited as the main constitutive factors of the disorder.

At the neurobiological level, CSBD involves three central regulatory mechanisms leading to compulsive sexual dysfunction:

- a) increase in reward system reactivity;
- b) increased reactivity to anxiety stimuli;
- c) weakened inhibition mechanisms.

Diagnostic criteria for CSBD include:

- 1) A persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in failure to control repetitive sexual behaviour, manifested by one or more of the following:
  - a) Involvement in repeated sexual activities has become the focal point of a person's life, resulting in neglect of health and personal areas and/or neglect of other interests, activities or responsibilities;
  - b) The person has made numerous unsuccessful attempts to control or significantly reduce sexual behaviour;
  - c) Person continues to engage in repeated sexual behaviour despite negative consequences (e.g. repeated interruption of relationships, occupational consequences, negative health impacts);
  - d) The person continues to engage in repeated sexual behaviour, even if they derive little or no satisfaction from it.
- 2) The pattern of failure to control intense, sexual impulses or urges and the resulting lack of control of repetitive sexual behaviour is evident and continues over time.
- 3) A pattern of repeated sexual behaviour causes significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Although there is no consensus on the origin of this disorder, its inclusion in the ICD-11 under the heading of impulse control disorders was intended to meet the needs of patients seeking treatment, as well as to reduce the feelings of shame and guilt associated with seeking help among those experiencing distress because of it.

The most common cause of CSBD (Smaś-Myszczyszyn, 2022b):

- 1) Patients who masturbate and compulsively watch pornography have obsessive-compulsive disorder;
- 2) in patients with casual sexual contacts are relationship disorders;
- 3) patients who compulsively masturbate and have casual sexual contacts at the same time have impulse control disorders.

## Summary

ICD-11 introduces a chapter on factors that affect health and cause contact with health services but are unrelated to illness. These factors give rise to clinical, therapeutic and sexological encounters and include:

- 1) guidance on sex education and attitudes;
- 2) counselling related to the sexual behaviour and relationships of the patient;
- 3) counselling relating to the couple's sexual behaviour and sexual relations.

Table 1

*Tabular summary of changes in ICD-11 compared to ICD-10 in the area of sexual health and gender identity*

Division in ICD-11	Group in ICD-11	Diagnosis in ICD-11	ICD-11 code	Division in ICD-10	Group in ICD-10	Diagnosis in ICD-10	ICD-10 code
sexual health conditions	sexual dysfunctions	hypoactive sexual desire disorder	HA00	mental and behavioural disorders	sexual dysfunctions not caused by organic lesions or somatic disease	lack or loss of sexual needs	F52.0
idem	idem	item deleted		idem	sexual dysfunctions not caused by organic lesions or somatic disease;	sexual aversion	F52.1
idem	idem	sexual arousal disorders in women	HA01.0	idem	sexual dysfunctions not caused by organic lesions or somatic disease;	no genital response; no sexual arousal	F52.2
idem	idem	erectile dysfunction	HA01.1	as above + diseases of the genitourinary system	sexual dysfunctions not caused by organic lesions or somatic disease; genitourinary diseases	lack of genital response; erectile dysfunction; psychogenic impotence and impotence of organic origin	F52.2 N48.4
idem	idem	orgasmic disorders	HA02	idem	sexual dysfunctions not caused by organic lesions or somatic disease;	orgasmic disorders; orgasmic inhibition; psychogenic anorgasmia	F52.3
idem	idem	early ejaculation	HA03.0	idem	idem	premature ejaculation	F52.4
idem	idem	delayed ejaculation	HA03.1	idem	idem	orgasmic disorders	F52.3

continuation of Table 1

Division in ICD-11	Group in ICD-11	Diagnosis in ICD-11	ICD-11 code	Division in ICD-10	Group in ICD-10	Diagnosis in ICD-10	ICD-10 code
idem	idem	other specified sexual dysfunctions	HA0Y	as above + the genitourinary system	sexual dysfunctions not caused by organic lesions or somatic disease; diseases of the genitourinary system;	other sexual dysfunctions without organic or pathological cause; other penile disorders; other non-inflammatory vulvar and perineal disorders; intermenstrual pain	F52.8 N48.4 N90.9 N94.1 N94.2
		item deleted		idem	sexual dysfunctions not caused by organic lesions or somatic disease;	excessive sexual desire	F52.7
idem	Sexual pain disorders	sexual pain disorders during penetration	HA20	idem	idem	inorganic vaginosis; organic vaginosis; inorganic dyspareunia	F52.5 F52.6
idem	gender incompatibility	gender non-conformity in adolescence and adulthood	HA60	idem	adult personality and behaviour disorders; subgroup: Gender Identity Disorder	transsexual-lysm	F64.0
		item deleted		idem.	idem	transvestite-type double role	F64.1
idem	idem	Sexual incompatibility during childhood	HA61	idem	idem	gender identity disorder in childhood	F64.2

continuation of Table 1

Division in ICD-11	Group in ICD-11	Diagnosis in ICD-11	ICD-11 code	Division in ICD-10	Group in ICD-10	Diagnosis in ICD-10	ICD-10 code
		item deleted		idem	idem.	other gender identity disorders	F64.8
		item deleted		idem	idem	gender identity disorder, not specified	F64.9
mental, behavioural and neurodevelopmental disorders	paraphilic disorder	exhibitionist disorder	6D30	idem.	adult personality and behavioural disorders; subgroup: sexual preference disorders	exhibitionism	F65.2
idem	idem	viewing disorders	6D31	idem	idem	watching	F65.3
idem	idem	paedophilic disorders	6D32	idem	idem	paedophilia	F65.4
idem	idem	compulsory sexual sadism	6D33			does not contain	
idem	idem	frotteuristic disorders	6D34			does not contain	
		item deleted		idem	idem	sadomaso-chism	F65.6
		item deleted		idem	idem	fetishism	F65.0
		item deleted		idem	idem	transvestite-fetishism	F65.1

continuation of Table 1

Division in ICD-11	Group in ICD-11	Diagnosis in ICD-11	ICD-11 code	Division in ICD-10	Group in ICD-10	Diagnosis in ICD-10	ICD-10 code
		item deleted		idem	idem	complex sexual preference disorder	F65.6
idem	idem	other paraphilic disorders that occur without informed consent	6D35			does not contain	
idem	idem	other paraphilic disorders occurring alone or with consent	6D36			does not contain	
		item deleted		idem	idem	other sexual preference disorders	F65.8
		item deleted		idem	idem	sexual preference disorder, not specified	F65.9
		item deleted		idem	adult personality and behavioural disorders; Subgroup: psychological and behavioural disorders related to development and sexual orientation	sexual maturation disorders	F66.0
		item deleted		idem	idem	sexual orientation incompatible with the ego (ego-dys-tonic)	F66.1

continuation of Table 1

Division in ICD-11	Group in ICD-11	Diagnosis in ICD-11	ICD-11 code	Division in ICD-10	Group in ICD-10	Diagnosis in ICD-10	ICD-10 code
		item deleted		idem	idem	sexual relationship disorders	F66.2
		item deleted		idem	idem	other disorders arising from psychosexual development	F66.8
		item deleted		idem	idem	disorders of psychosexual development, not specified	F66.9
mental, behavioural and neurodevelopmental disorders	impulse control disorders	compulsive sexual behaviour	6C72			does not include	

Source: own study based on Reed & Drescher et al. (2016); Reed & First et al. (2019); ICD-11 guidelines.



These categories address the need for health services, including mental and sexual health services, that can be provided in the absence of diagnosable disorders. This category is one of the efforts to depathologise and de-medicalise sexual health and gender identity in the therapeutic process.

The last two decades have seen major societal changes, a huge increase in scientific and clinical understanding in the field of sexual health, a significant depathologisation of normative sexual behaviour, and the recognition of sexual and gender diversity. Viewing sexuality in binary, zero-one and black-and-white categories does not work in today's society, contributes to the suffering of many people and violates human rights. Inclusion of diversity is necessary and the change introduced in this area within ICD-11 seems to be an attempt to keep up with the changing society and reality. What has been collectively agreed has been reflected in ICD-11, which is clearly different from the descriptions of categories related to sexuality and gender identity in ICD-10. The emerging ICD-11 definitely addresses sexual health and gender identity more broadly and in a more integrated way in clinical practice. The ICD-10 classification was outdated, did not relate to today's knowledge, was dichotomous, separated the *body* from the *psyche*, did not take into account the latest research and scientific reports, and pathologised normative states and behaviours related to sexuality. The ICD-11 seems to address at least some of these areas.

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