

19 - Paraphilic Disorders

Paraphilic Disorders

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Paraphilic Disorders Paraphilic disorders included in this manual are voyeuristic disorder (spying on others in private activities), exhibitionistic disorder (exposing the genitals), frotteuristic disorder (touching or rubbing against a nonconsenting person), sexual masochism disorder (undergoing humiliation, bondage, or suffering), sexual sadism disorder (inflicting humiliation, bondage, or suffering), pedophilic disorder (sexual focus on children), fetishistic disorder (using nonliving objects or having a highly specific focus on nongenital body parts), and transvestic disorder (engaging in sexually arousing cross-dressing). These disorders have traditionally been selected for specific listing and assignment of explicit diagnostic criteria in DSM for two main reasons: they are relatively common, in relation to other paraphilic disorders, and some of them entail actions for their satisfaction that, because of their noxiousness or potential harm to others, are classed as criminal offenses. The eight listed disorders do not exhaust the list of possible paraphilic disorders. Many dozens of distinct paraphilias have been identified and named, and almost any of them could, by virtue of its negative consequences for the individual or for others, rise to the level of a paraphilic disorder. In this chapter, the order of presentation of the listed paraphilic disorders generally corresponds to common classification schemes for these conditions. The first group of disorders is based on anomalous activity preferences. These disorders are subdivided into courtship disorders, which resemble distorted components of human courtship behavior (voyeuristic disorder, exhibitionistic disorder, and frotteuristic disorder), and algolagnic disorders, which involve pain and suffering (sexual masochism disorder and sexual sadism disorder). The second group of disorders is based on anomalous target preferences. These disorders include one directed at other humans (pedophilic disorder) and two directed elsewhere (fetishistic disorder and transvestic disorder). The term paraphilia denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners. In some circumstances, the criteria “intense and persistent” may be difficult to apply, such as in the assessment of persons who are very old or medically ill and who may not have “intense” sexual interests of any kind. In such circumstances, the term paraphilia may be defined as any sexual interest greater than or equal to nonparaphilic sexual interests. There are also specific paraphilias that are generally better described as preferential sexual interests than as intense sexual interests. Some paraphilias primarily concern the individual’s erotic activities, and others primarily concern the individual’s erotic targets. Examples of the former would include intense and persistent interests in spanking, whipping, cutting, binding, or strangulating another person, or an interest in these activities that equals or exceeds the individual’s interest in copulation or equivalent interaction with another person.

Examples of the latter would include intense or preferential sexual interest in children, corpses, or amputees (as a class), as well as intense or

F65.3 preferential interest in nonhuman animals, such as horses or dogs, or in inanimate objects, such as shoes or articles made of rubber. An individual's pattern of paraphilic interests is often reflected in his or her choice of pornography. 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 a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention. In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (i.e., distress, impairment, or harm to others). In keeping with the distinction between paraphilias and paraphilic disorders, the term diagnosis should be reserved for individuals whose paraphilic interests or behaviors meet both Criteria A and B (i.e., individuals who have a paraphilic disorder). If an individual's paraphilic interests or behaviors meet Criterion A but not Criterion B for a particular paraphilia—a circumstance that might arise when a benign paraphilia is discovered during the clinical investigation of some other condition—then the individual may be said to have that paraphilia but not a paraphilic disorder. It is not rare for an individual to manifest two or more paraphilias. In some cases, the paraphilic foci are closely related and the connection between the paraphilias is intuitively comprehensible (e.g., foot fetishism and shoe fetishism). In other cases, the connection between the paraphilias is not obvious, and the presence of multiple paraphilias may be coincidental or else related to some generalized vulnerability to anomalies of psychosexual development. In any event, comorbid diagnoses of separate paraphilic disorders may be warranted if more than one paraphilia is causing suffering to the individual or harm to others. Because of the two-pronged nature of diagnosing paraphilic disorders, clinician-rated or self-rated measures and severity assessments could address either the strength of the paraphilia itself or the seriousness of its consequences. Although the distress and impairment stipulated in the Criterion B are special in being the immediate or ultimate result of the paraphilia and not primarily the result of some other factor, the phenomena of reactive depression, anxiety, guilt, poor work history, impaired social relations, and so on are not unique in themselves and may be quantified with multipurpose measures of psychosocial functioning or quality of life.

Voyeuristic Disorder Diagnostic Criteria A. Over a period of at least 6 months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, as manifested by fantasies, urges, or behaviors. **B.** The individual has acted on these sexual urges with a nonconsenting person, or

the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. **C.** The individual experiencing the arousal and/or acting on the urges is at least 18 years of age. Specify if: In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in voyeuristic behavior are restricted. In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment. Specifiers The "in full remission" specifier does not address the continued presence or absence of voyeurism per se, which may still be present after behaviors and distress have

remitted. **Diagnostic Features** The diagnostic criteria for voyeuristic disorder can apply both to individuals who more or less freely disclose this paraphilic interest and to those who categorically deny any sexual arousal from observing an unsuspecting person who is naked, disrobing, or engaged in sexual activity despite substantial objective evidence to the contrary. If disclosing individuals also report distress or psychosocial problems because of their voyeuristic sexual preferences, they could be diagnosed with voyeuristic disorder. On the other hand, if they declare no distress, demonstrated by lack of anxiety, obsessions, guilt, or shame, about these paraphilic impulses and are not impaired in other important areas of functioning because of this sexual interest, and their psychiatric or legal histories indicate that they do not act on it, they could be ascertained as having voyeuristic sexual interest but should not be diagnosed with voyeuristic disorder. Nondisclosing individuals include, for example, individuals known to have been spying repeatedly on unsuspecting persons who are naked or engaging in sexual activity on separate occasions but who deny any urges or fantasies concerning such sexual behavior, and who may report that known episodes of watching unsuspecting naked or sexually active persons were all accidental and nonsexual. Others may disclose past episodes of observing unsuspecting naked or sexually active persons but contest any significant or sustained sexual interest in this behavior. Since these individuals deny having fantasies or impulses about watching others nude or involved in sexual activity, it follows that they would also reject feeling subjectively distressed or socially impaired by such impulses. Despite their nondisclosing stance, such individuals may be diagnosed with voyeuristic disorder. Recurrent voyeuristic behavior constitutes sufficient support for voyeurism (by fulfilling Criterion A) and simultaneously demonstrates that this paraphilically motivated behavior is causing harm to others (by fulfilling Criterion B). "Recurrent" spying on unsuspecting persons who are naked or engaging in sexual activity

Temperamental. Environmental. may be interpreted as requiring multiple victims, each on a separate occasion; this requirement for multiple victims on separate occasions is relevant because it increases the confidence in the clinical inference that the individual is motivated by voyeuristic disorder. Fewer victims can be interpreted as satisfying this criterion if there were multiple occasions of watching the same victim or if there is corroborating evidence of a distinct or preferential interest in secret watching of naked or sexually active unsuspecting persons. Note that multiple victims, as suggested earlier, are a sufficient but not a necessary condition for diagnosis; the criteria may also be met if the individual acknowledges intense voyeuristic sexual interest. Adolescence and puberty generally increase sexual curiosity and activity. To reduce the risk of pathologizing normative sexual interest and behavior during pubertal adolescence, the minimum age for the diagnosis of voyeuristic disorder is 18 years (Criterion C). **Prevalence** The population prevalence of individuals whose presentations meet the full criteria for voyeuristic disorder is unknown. Voyeuristic acts, however, are the most common of potentially law-breaking sexual behaviors. For example, in a Quebec Internet and phone survey sample, the lifetime prevalence of voyeuristic behaviors was reported to be as high as 34.5% (50.3% in men, 21.2% in women). Because this same study found that an "intense desire" and "persistent behavior" occur with much less frequency (9.6% and 2.1%, respectively), the prevalence of voyeuristic disorder is likely much lower. The ratio of voyeuristic behavior in men to women was approximately 2:1 in the Quebec sample and 3:1 in a Swedish general population sample. In a study determining which particular disorders were prevalent in individuals incarcerated for sexual offenses, a study of 1,346 incarcerated sex offenders from Austria found a prevalence of voyeuristic disorder of 3.7%. **Development and Course** Adult men with voyeuristic disorder often first become aware of their

sexual interest in secretly watching unsuspecting persons during adolescence. However, the minimum age for a diagnosis of voyeuristic disorder is 18 years because there is substantial difficulty in differentiating it from age-appropriate puberty-related sexual curiosity and activity. The persistence of voyeurism over time is unclear. With or without treatment of voyeuristic disorder, the subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness) or impairment from the disorder may change over time, as may a number of factors that may potentially affect the course of the disorder, such as psychiatric morbidity, hypersexuality, and sexual impulsivity. Thus, the severity and course may vary over time. As with other sexual preferences, advancing age may be associated with decreasing voyeuristic sexual preferences and behavior. Risk and Prognostic Factors Because voyeurism is a necessary precondition for voyeuristic disorder, risk factors for voyeurism should also increase the risk of voyeuristic disorder. Childhood sexual abuse, substance misuse, and sexual

Voyeurism. Manic episode, major neurocognitive disorder, intellectual developmental disorder, personality change due to another medical condition, substance intoxication, and schizophrenia. Conduct disorder and antisocial personality disorder. F65.2 preoccupation/hypersexuality have been suggested as risk factors, although the causal relationship to voyeuristic behavior is uncertain and the specificity unclear. Sex- and Gender-Related Diagnostic Issues Voyeuristic disorder is very uncommon among women in clinical settings, whereas the ratio in men to women for single sexually arousing voyeuristic acts is less extreme and may be 2:1–3:1. Differential Diagnosis Individuals with voyeurism experience recurrent, intense sexual arousal from the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity. Unless the individual acts on these urges with an unsuspecting person (e.g., surreptitiously peeping through a neighbor's window) or unless there is accompanying clinically significant distress or impairment in social, occupational, or other important areas of functioning, a diagnosis of voyeuristic disorder is not warranted. Individuals with a major neurocognitive disorder, intellectual developmental disorder, personality change due to another medical condition, or schizophrenia, or who are in a manic episode or experiencing substance intoxication, may become sexually disinhibited or have impaired judgment or impulse control and engage in voyeuristic behavior. Unless that behavior occurs at times other than in the context of one of these disorders, a diagnosis of voyeuristic disorder should not be made. Conduct disorder in adolescents and antisocial personality disorder would be characterized by additional norm-breaking and antisocial behaviors, and the specific sexual interest in secretly watching unsuspecting others who are naked or engaging in sexual activity will usually be lacking. Comorbidity Known comorbidities in voyeuristic disorder are largely based on research with males suspected of or convicted for acts involving the secret watching of unsuspecting nude or sexually active persons. Hence, these comorbidities might not apply to all individuals with voyeuristic disorder. Conditions that occur comorbidly with voyeuristic disorder include hypersexuality and other paraphilic disorders, particularly exhibitionistic disorder. Depressive, bipolar, anxiety, and substance use disorders; attention-deficit/hyperactivity disorder; and conduct disorder and antisocial personality disorder are also frequent comorbid conditions. Exhibitionistic Disorder Diagnostic Criteria

A. Over a period of at least 6 months, recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors. B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other

important areas of functioning. Specify whether: Sexually aroused by exposing genitals to prepubertal children Sexually aroused by exposing genitals to physically mature individuals Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals Specify if: In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to expose one's genitals are restricted. In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment. Subtypes The subtypes for exhibitionistic disorder are based on the age or physical maturity of the nonconsenting persons to whom the individual prefers to expose his or her genitals. The nonconsenting persons could be prepubescent children, adults, or both. This specifier should help draw adequate attention to characteristics of victims of individuals with exhibitionistic disorder to prevent co-occurring pedophilic disorder from being overlooked. However, indications that the individual with exhibitionistic disorder is sexually attracted to exposing his or her genitals to children should not preclude a diagnosis of pedophilic disorder. Specifiers The "in full remission" specifier does not address the continued presence or absence of exhibitionism per se, which may still be present after behaviors and distress have remitted. Diagnostic Features The diagnostic criteria for exhibitionistic disorder can apply both to individuals who more or less freely disclose this paraphilia and to those who categorically deny any sexual arousal from exposing their genitals to unsuspecting persons despite substantial objective evidence to the contrary. If disclosing individuals also report psychosocial difficulties because of their sexual attractions or preferences for exposing, they may be diagnosed with exhibitionistic

disorder. In contrast, if they declare no distress (exemplified by absence of anxiety, obsessions, and guilt or shame about these paraphilic impulses) and are not impaired by this sexual interest in other important areas of functioning, and their self-reported, psychiatric, or legal histories indicate that they do not act on them, they could be ascertained as having exhibitionistic sexual interest but not be diagnosed with exhibitionistic disorder. Examples of nondisclosing individuals include those who have exposed themselves repeatedly to unsuspecting persons on separate occasions but who deny any urges or fantasies about such sexual behavior and who report that known episodes of exposure were all accidental and nonsexual. Others may disclose past episodes of sexual behavior involving genital exposure but refute any significant or sustained sexual interest in such behavior. Since these individuals deny having urges or fantasies involving genital exposure, it follows that they would also deny feeling subjectively distressed or socially impaired by such impulses. Such individuals may be diagnosed with exhibitionistic disorder despite their negative self-report. Recurrent exhibitionistic behavior constitutes sufficient support for exhibitionism (Criterion A) and simultaneously demonstrates that this paraphilically motivated behavior is causing harm to others (Criterion B). "Recurrent" genital exposure to unsuspecting others may be interpreted as requiring multiple victims, each on a separate occasion; this requirement for multiple victims on separate occasions is relevant because it increases the confidence in the clinical inference that the individual is motivated by exhibitionistic disorder. Fewer victims can be interpreted as satisfying this criterion if there were multiple occasions of exposure to the same victim, or if there is corroborating evidence of a strong or preferential interest in genital exposure to unsuspecting persons. Note that multiple victims, as suggested earlier, are a sufficient but not a necessary condition for diagnosis, as criteria may be met by an individual's acknowledging intense exhibitionistic sexual interest with distress or impairment. Prevalence The population prevalence of individuals whose presentations meet the full criteria for exhibitionistic disorder is unknown,

although the disorder is highly unusual in women. Exhibitionistic acts, however, are not uncommon, and single sexually arousing exhibitionistic acts occur up to half as often among women compared with men. In a Quebec Internet and phone survey sample, lifetime prevalence of exhibitionistic behaviors was reported to be 30.9% (32.6% in men, 29.4% in women). Because this same study found that an “intense desire” and “persistent behavior” occur with much less frequency (4.8% and 0.8%, respectively), the prevalence of exhibitionistic disorder is likely much lower. For example, a Swedish study suggested that the lifetime prevalence of exhibitionistic disorder in the general population was 4.1% in men and 2.1% in women. Development and Course Adult men with exhibitionistic disorder often report that they first became aware of sexual interest in exposing their genitals to unsuspecting persons during adolescence, at a somewhat later time than the typical development of normative sexual interest in women or men. Although there is no minimum age requirement for the diagnosis of exhibitionistic disorder, it may be difficult to differentiate exhibitionistic behaviors from age-appropriate sexual curiosity in

Temperamental. Environmental. Exhibitionism. Manic episode, major neurocognitive disorder, intellectual developmental disorder, personality change due to another medical condition, substance intoxication, and schizophrenia. Conduct disorder and antisocial personality disorder. adolescents. Whereas exhibitionistic impulses appear to emerge in adolescence or early adulthood, very little is known about persistence over time. With or without treatment of exhibitionistic disorder, the subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness) or impairment from the disorder may change over time, as may a number of factors that may potentially affect the course of the disorder, such as psychiatric morbidity, hypersexuality, and sexual impulsivity. Thus, the severity and course may vary over time. As with other sexual preferences, advancing age may be associated with decreasing exhibitionistic sexual preferences and behavior. Risk and Prognostic Factors Because exhibitionism is a necessary precondition for exhibitionistic disorder, risk factors for exhibitionism should also increase the risk of exhibitionistic disorder. Antisocial history, antisocial personality disorder, alcohol misuse, and pedophilic sexual preference might increase risk of sexual recidivism in exhibitionistic offenders. Hence, antisocial personality disorder, alcohol use disorder, and pedophilic interest may be considered risk factors for exhibitionistic disorder in men with exhibitionistic sexual preferences. Childhood sexual and emotional abuse and sexual preoccupation/hypersexuality have been suggested as risk factors for exhibitionism, although the causal relationship to exhibitionism is uncertain and the specificity unclear. Differential Diagnosis Individuals with exhibitionism experience recurrent, intense sexual arousal from the act of exposing their genitals to an unsuspecting person. Unless the individual acts on these urges with an unsuspecting person (e.g., exposing his genitals to riders on a train) or unless there is accompanying clinically significant distress or impairment in social, occupational, or other important areas of functioning, a diagnosis of exhibitionistic disorder is not warranted. Individuals with a major neurocognitive disorder, intellectual developmental disorder, personality change due to another medical condition, or schizophrenia, or who are in a manic episode or experiencing substance intoxication, may become sexually disinhibited or have impaired judgment or impulse control and engage in exhibitionistic behavior. Unless that behavior occurs at times other than in the context of one of these disorders, a diagnosis of exhibitionistic disorder should not be made. Conduct disorder in adolescents and antisocial personality disorder would be characterized by additional norm-breaking and antisocial behaviors, and the specific sexual interest in exposing the genitals will usually be lacking. Comorbidity Known comorbidities in exhibitionistic disorder are largely based on research with individuals (almost all men) convicted for

criminal acts involving genital exposure to nonconsenting persons. Hence, these comorbidities might not apply to all individuals who qualify for a

F65.81 diagnosis of exhibitionistic disorder. Conditions that occur comorbidly with exhibitionistic disorder at high rates include depressive, bipolar, anxiety, and substance use disorders; hypersexuality; attention-deficit/hyperactivity disorder; other paraphilic disorders; and antisocial personality disorder. Frotteuristic Disorder Diagnostic Criteria A. Over a period of at least 6 months, recurrent and intense sexual arousal from touching or rubbing against a nonconsenting person, as manifested by fantasies, urges, or behaviors. B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if: In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to touch or rub against a nonconsenting person are restricted. In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment. Specifiers The “in remission” specifier does not address the continued presence or absence of frotteurism per se, which may still be present after behaviors and distress have remitted. Diagnostic Features The diagnostic criteria for frotteuristic disorder can apply both to individuals who relatively freely disclose this paraphilia and to those who firmly deny any sexual arousal from touching or rubbing against a nonconsenting person regardless of considerable objective evidence to the contrary. If disclosing individuals also report psychosocial impairment because of their sexual preferences for touching or rubbing against a nonconsenting person, they could be diagnosed with frotteuristic disorder. In contrast, if they declare no distress (demonstrated by lack of anxiety, obsessions, guilt, or shame) about these paraphilic impulses and are not impaired in other important areas of functioning because of this sexual interest, and their psychiatric or legal histories indicate that they do not act on it, they could be ascertained as having frotteuristic

sexual interest but should not be diagnosed with frotteuristic disorder. Nondisclosing individuals include, for instance, individuals known to have been touching or rubbing against nonconsenting persons on separate occasions but who contest any urges or fantasies concerning such sexual behavior. Such individuals may report that identified episodes of touching or rubbing against an unwilling individual were all unintentional and nonsexual. Others may disclose past episodes of touching or rubbing against nonconsenting persons but contest any major or persistent sexual interest in this. Since these individuals deny having fantasies or impulses about touching or rubbing, they would consequently reject feeling distressed or psychosocially impaired by such impulses. Despite their nondisclosing position, such individuals may be diagnosed with frotteuristic disorder. Recurrent frotteuristic behavior constitutes satisfactory support for frotteurism (by fulfilling Criterion A) and concurrently demonstrates that this paraphilically motivated behavior is causing harm to others (by fulfilling Criterion B). “Recurrent” touching or rubbing against a nonconsenting person may be interpreted as requiring multiple victims, each on a separate occasion; this requirement for multiple victims on separate occasions is relevant because it increases the confidence in the clinical inference that the individual is motivated by frotteuristic disorder. Fewer victims can be interpreted as satisfying this criterion if there were multiple occasions of touching or rubbing against the same unwilling individual, or corroborating evidence of a strong or preferential interest in touching or rubbing against nonconsenting persons. Note that

multiple victims are a sufficient but not a necessary condition for diagnosis; criteria may also be met if the individual acknowledges intense frotteuristic sexual interest with clinically significant distress and/or impairment. Prevalence The population prevalence of individuals whose presentations meet the full criteria for frotteuristic disorder is unknown, but frotteuristic acts, including the uninvited sexual touching of or rubbing against another individual, may occur in up to 30% of adult men in the U.S. and Canadian general population. Prevalence of frotteuristic disorder is certainly much lower, considering the finding that "intense desire" and "persistent behavior" were reported infrequently (3.8% and 0.7%, respectively). In outpatient settings for men with paraphilic disorders and hypersexuality, approximately 10%–14% have a presentation that meets diagnostic criteria for frotteuristic disorder. Prevalence among women is likely lower. Development and Course Adult men with frotteuristic disorder often report first becoming aware of their sexual interest in surreptitiously touching unsuspecting persons during late adolescence or emerging adulthood. However, children and adolescents may also touch or rub against unwilling others in the absence of a diagnosis of frotteuristic disorder. Although there is no minimum age for the diagnosis, frotteuristic disorder can be difficult to differentiate from conduct-disordered behavior without sexual motivation in individuals at younger ages. The persistence of frotteurism over time is unclear. With or without treatment of frotteuristic disorder, the subjective distress (e.g., guilt,

Temperamental. Frotteurism. Manic episode, major neurocognitive disorder, intellectual developmental disorder, personality change due to another medical condition, substance intoxication, and schizophrenia. Conduct disorder and antisocial personality disorder. shame, intense sexual frustration, loneliness) or impairment from the disorder may change over time, as may a number of factors that may potentially affect the course of the disorder, such as psychiatric morbidity, hypersexuality, and sexual impulsivity. Thus, the severity and course may vary over time. As with other sexual preferences, advancing age may be associated with decreasing frotteuristic sexual preferences and behavior. Risk and Prognostic Factors Nonsexual antisocial behavior and sexual preoccupation/hypersexuality might be nonspecific risk factors, although the causal relationship to frotteurism is uncertain and the specificity unclear. However, because frotteurism is a necessary precondition for frotteuristic disorder, risk factors for frotteurism should also increase the risk of frotteuristic disorder. Differential Diagnosis Individuals with frotteurism experience recurrent intense sexual arousal from the act of touching or rubbing against a nonconsenting person. Unless the individual acts on these urges with a nonconsenting person (e.g., rubbing his genitals against a passenger on a crowded subway car) or unless there is accompanying clinically significant distress or impairment in social, occupational, or other important areas of functioning, a diagnosis of frotteuristic disorder is not warranted. Individuals with a major neurocognitive disorder, intellectual developmental disorder, personality change due to another medical condition, or schizophrenia, or who are in a manic episode or experiencing substance intoxication, may become sexually disinhibited or have impaired judgment or impulse control and engage in frotteuristic behavior. Unless that behavior occurs at times other than in the context of one of these disorders, a diagnosis of frotteuristic disorder should not be made. Conduct disorder in adolescents and antisocial personality disorder would be characterized by additional norm-breaking and antisocial behaviors, and the specific sexual interest in touching or rubbing against a nonconsenting person will usually be lacking. Comorbidity Known comorbidities in frotteuristic disorder are largely based on research with men suspected of or convicted for criminal acts involving sexually motivated touching of or rubbing against a nonconsenting person. Hence, these comorbidities might not apply to other individuals with a diagnosis of frotteuristic disorder

based on subjective distress over their sexual interest. Conditions that occur comorbidly with frotteuristic disorder include hypersexuality and other paraphilic disorders, particularly exhibitionistic disorder and voyeuristic disorder. Conduct disorder, antisocial personality disorder, depressive disorders, bipolar disorders, anxiety disorders, and substance use disorders also co-occur.

F65.51 Sexual Masochism Disorder **Diagnostic Criteria** A. Over a period of at least 6 months, recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors. B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if: With asphyxiophilia: If the individual engages in the practice of achieving sexual arousal related to restriction of breathing. Specify if: In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in masochistic sexual behaviors are restricted. In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment. **Diagnostic Features** The diagnostic criteria for sexual masochism disorder are intended to apply to individuals who freely admit to having such paraphilic interests. Such individuals openly acknowledge intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors. If these individuals also report psychosocial difficulties because of their sexual attractions or preferences for being humiliated, beaten, bound, or otherwise made to suffer, they may be diagnosed with sexual masochism disorder. In contrast, if they declare no distress, exemplified by anxiety, obsessions, guilt, or shame, about these paraphilic impulses, and are not hampered by them in pursuing other personal goals, they could be ascertained as having masochistic sexual interest but should not be diagnosed with sexual masochism disorder. The term bondage-domination-sadism-masochism (BDSM) is broadly used to refer to a wide range of behaviors that individuals with sexual masochism and/or sexual sadism (as well as other individuals with similar sexual interests) engage in, such as restraints or restriction, discipline, spanking, slapping, sensory deprivation (e.g., using blindfolds), and dominance-submission roleplay involving themes such as master/enslaved person, owner/pet, or kidnapper/victim. **Associated Features** The extensive use of pornography involving the act of being humiliated, beaten, bound, or otherwise made to suffer is sometimes an associated feature of sexual masochism disorder.

Those who engage in sadomasochistic sexual behavior may experience a hyposensitivity to pain, although it is unknown whether this finding applies to those with sexual masochism disorder. Additionally, although it is often assumed that individuals with masochistic sexual interest have a history of childhood sexual abuse experiences, there is insufficient evidence to support this association. **Prevalence** The population prevalence of individuals whose presentations meet the full criteria for sexual masochism disorder is unknown. In Australia, it has been estimated that 2.2% of men and 1.3% of women had been involved in BDSM behavior in the past 12 months. **Development and Course** Individuals with paraphilias living in the community have reported a mean age at onset for masochism of 19.3 years, although earlier ages, including puberty and childhood, have also been reported for the onset of masochistic fantasies. Very little is known about persistence over time. With or without treatment of sexual masochism disorder, the subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness) or impairment from the disorder may change over

time, as may a number of factors that may potentially affect the course of the disorder, such as psychiatric morbidity, hypersexuality, and sexual impulsivity. Thus, the severity and course may vary over time. As with other sexual preferences, advancing age may be associated with decreasing sexual masochistic preferences and behavior. Culture-Related Diagnostic Issues It is important to distinguish self-harming behaviors that occur during collectively accepted religious and spiritual practices from sadomasochistic behavior conducted for sexual arousal. For example, collective rituals in various religions and societies include suspension from hooks, selfflagellation, self-mortification, and other painful ordeals. The role of sexual arousal or pleasure in these practices remains unknown. Association With Suicidal Thoughts or Behavior Association of sexual masochism disorder with suicidal thoughts or behavior is unknown. However, a study of 321 adults who endorsed BDSM involvement found an association of stigma-related shame and guilt with suicidal ideation. Functional Consequences of Sexual Masochism Disorder The functional consequences of sexual masochism disorder are unknown. Individuals reporting sexual interest in asphyxiophilia seem to experience more sexual distress and psychological maladjustment than the general population. Individuals engaging in masochistic behavior are at risk for accidental death while practicing asphyxiophilia or other autoerotic procedures. However, the proportion of these decedents whose sexual interests and behavior fulfill diagnostic

Sexual masochism. F65.52 criteria for sexual masochism is unknown. Differential Diagnosis Individuals with sexual masochism experience recurrent, intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer. Unless the sexual urges, fantasies, or behaviors involving being humiliated or made to suffer are accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning, a diagnosis of sexual masochism disorder is not warranted. Comorbidity Known comorbidities with sexual masochism disorder are largely based on individuals in treatment. Disorders that occur comorbidly with sexual masochism disorder typically include other paraphilic disorders, such as transvestic fetishism. There is some indication of an association of sexual masochism disorder with borderline personality disorder (based on data from a small clinical sample of women with and without borderline personality disorder). Sexual Sadism Disorder Diagnostic Criteria A. Over a period of at least 6 months, recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors. B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if: In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in sadistic sexual behaviors are restricted. In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment. Diagnostic Features The diagnostic criteria for sexual sadism disorder are intended to apply both to individuals who freely admit to having such paraphilic interests and to those who deny any sexual interest in the

physical or psychological suffering of another individual despite substantial objective evidence to the contrary. Individuals who openly acknowledge intense sexual interest in the physical or psychological suffering of others are referred to as “admitting individuals.” If these individuals also report psychosocial difficulties because of their sexual attractions or preferences for the physical or psychological suffering of another individual, they may be diagnosed with sexual sadism disorder.

In contrast, if admitting individuals declare no distress, exemplified by anxiety, obsessions, guilt, or shame, about these paraphilic impulses, and are not hampered by them in pursuing other goals, and their self-reported, psychiatric, or legal histories indicate that they do not act on them with nonconsenting persons, then they could be ascertained as having sadistic sexual interest but their presentation would not meet criteria for sexual sadism disorder. Examples of individuals who deny any interest in the physical or psychological suffering of another individual include individuals known to have inflicted pain or suffering on multiple victims on separate occasions but who deny any urges or fantasies about such sexual behavior and who may further claim that known episodes of sexual assault were either unintentional or nonsexual. Others may admit past episodes of sexual behavior involving the infliction of pain or suffering on a nonconsenting person but do not report any significant or sustained sexual interest in the physical or psychological suffering of another person. Since these individuals deny having urges or fantasies involving sexual arousal to pain and suffering, it follows that they would also deny feeling subjectively distressed or socially impaired by such impulses. Such individuals may be diagnosed with sexual sadism disorder despite their negative self-report. Their recurrent behavior constitutes clinical support for the presence of the paraphilia of sexual sadism (by satisfying Criterion A) and simultaneously demonstrates that their paraphilically motivated behavior is causing clinically significant distress, harm, or risk of harm to others (satisfying Criterion B). "Recurrent" sexual sadism involving nonconsenting others may be interpreted as requiring multiple victims, each on a separate occasion; this requirement for multiple victims on separate occasions is relevant because it increases the confidence in the clinical inference that the individual is motivated by sexual sadism disorder. Fewer victims can be interpreted as satisfying this criterion, if there are multiple instances of infliction of pain and suffering to the same victim, or if there is corroborating evidence of a strong or preferential interest in pain and suffering involving multiple victims. Note that multiple victims, as suggested earlier, are a sufficient but not a necessary condition for diagnosis, as the criteria may be met if the individual acknowledges intense sadistic sexual interest. The term bondage-domination-sadism-masochism (BDSM) is broadly used to refer to a wide range of behaviors that individuals with sexual masochism and/or sexual sadism (as well as other individuals with similar sexual interests) engage in, such as restraints or restriction, discipline, spanking, slapping, sensory deprivation (e.g., using blindfolds), and dominance-submission roleplay involving themes such as master/enslaved person, owner/pet, or kidnapper/victim. Associated Features The extensive use of pornography involving the infliction of pain and suffering is sometimes an

Sexual sadism. associated feature of sexual sadism disorder. **Prevalence** The population prevalence of individuals whose presentations meet the full criteria for sexual sadism disorder is unknown and is largely based on individuals in forensic settings. Among civilly committed sexual offenders in the United States, less than 10% have sexual sadism disorder. Among individuals who have committed sexually motivated homicides, the proportion of sexually sadistic behavior is about one-third. Individuals with sexual sadism disorder in forensic samples are almost exclusively men, but a representative sample of the population in Australia reported that 2.2% of men and 1.3% of women said that they had been involved in BDSM behavior in the previous year. In a population-based sample in Finland, the lifetime prevalence for sexually sadistic behavior was 2.7% among men and 2.3% among women. **Development and Course** Information on the development and course of sexual sadism disorder is extremely limited. Whereas sexually sadistic preferences per se are probably a lifelong characteristic, sexual sadism disorder may fluctuate according to the individual's subjective distress or his or her propensity to harm nonconsenting others. As with other

sexual preferences, advancing age may be associated with decreasing sexually sadistic preferences and behavior. Regarding sexually sadistic preference, many individuals who engage in BDSM behavior became aware of their corresponding interest in their teenage years.

Culture-Related Diagnostic Issues

The legal status of sexually sadistic behavior ranges across countries and societies, suggesting the potential for variation in distress (because of variation in cultural acceptance) and functional impairment (because of legal status).

Association With Suicidal Thoughts or Behavior

Association of sexual sadism disorder with suicidal thoughts or behavior is unknown. However, a study of 321 adults who endorsed BDSM involvement found an association of stigma-related shame and guilt with suicidal ideation.

Differential Diagnosis

Individuals with sexual sadism experience recurrent, intense sexual arousal from the physical or psychological suffering of another person. Unless the sexual urges to make another person suffer physically or psychologically are acted on with a non-consenting person, or unless there is accompanying clinically significant distress or impairment in social, occupational, or other important areas of functioning, a diagnosis of sexual sadism disorder is not warranted. The majority of individuals who are active in community networks that practice sadistic and masochistic behaviors do not express any dissatisfaction with their sexual interests, and their

Infliction of physical or psychological suffering during the commission of a sex crime. Conduct disorder and antisocial personality disorder. F65.4 behavior would not meet DSM-5 criteria for sexual sadism disorder. Individuals who commit rape or other sexual assaults might inflict pain on their victims as a result of the act of rape, or in the course of subduing victims or restraining them to commit the sexual assault. Such instrumental infliction of pain should not be considered to be indicative of sexual sadism disorder unless there is evidence that the individual is deriving pleasure from the infliction of pain and the resulting suffering of the victim (e.g., admission of specifically being aroused by the pain, evidence of a preference for pornography involving themes of sexual sadism, excessive use of pain-inducing violence that goes beyond what might be necessary in the course of committing the sexual assault). Individuals with conduct disorder and antisocial personality disorder may be physically cruel to people and force others to engage in sexual activity. Coercive or sadistic sexual behaviors that occur in the context of conduct disorder or antisocial personality disorder but that do not reflect an underlying pattern of sexual arousal from the physical or psychological suffering of another person should not be used as a basis for diagnosing sexual sadism disorder. In cases in which the diagnostic criteria are met for both sexual sadism disorder and conduct disorder/antisocial personality disorder, both disorders may be diagnosed.

Comorbidity

Known comorbidities with sexual sadism disorder are largely based on individuals (almost all men) convicted for criminal acts involving sadistic acts against nonconsenting victims. Hence, these comorbidities might not apply to all individuals who never engaged in sadistic activity with a nonconsenting victim but who qualify for a diagnosis of sexual sadism disorder based on subjective distress over their sexual interest. Disorders that are commonly comorbid with sexual sadism disorder include other paraphilic disorders. According to a population-based study in Finland, individuals who had engaged in sexually sadistic behavior had also engaged in other types of paraphilic behavior, namely (in descending order of co-occurrence) masochism (68.8%), voyeurism (33.3%), transvestic fetishism (9.2%), and exhibitionism (6.4%).

Pedophilic Disorder Diagnostic Criteria

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger). B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal

difficulty.

C. The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A. Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old. Specify whether: Exclusive type (attracted only to children) Nonexclusive type Specify if: Sexually attracted to males Sexually attracted to females Sexually attracted to both Specify if: Limited to incest Diagnostic Features The diagnostic criteria for pedophilic disorder are intended to apply both to individuals who freely disclose this paraphilia and to individuals who deny any sexual attraction to prepubertal children (generally age 13 years or younger), despite substantial objective evidence to the contrary. The age guideline of 13 or younger is approximate only, because the onset of puberty varies from person to person, and there is good evidence the average age at onset of puberty has been declining over time and differs across ethnicities and cultures. Examples of disclosing this paraphilia include candidly acknowledging an intense sexual interest in children and indicating that sexual interest in children is greater than or equal to sexual interest in physically mature persons. If individuals also complain that their sexual attractions or preferences for children are causing marked distress or psychosocial difficulties, they may be diagnosed with pedophilic disorder. However, if they report an absence of feelings of guilt, shame, or anxiety about these impulses and are not functionally limited by their paraphilic impulses (according to self-report, objective assessment, or both), and their self-reported and legally recorded histories indicate that they have never acted on their impulses, then these individuals have a pedophilic sexual interest but not pedophilic disorder. When trying to differentiate child offenders with pedophilic disorder from child offenders without pedophilic disorder, factors that suggest a diagnosis of pedophilic disorder in the offender include self-reported interest in children, use of child pornography, a history of multiple child victims, boy victims, and unrelated child victims. Examples of individuals who deny attraction to children include individuals who are known to have sexually approached multiple children on separate occasions but who deny any urges or fantasies about sexual behavior involving children, and who may further claim that the known episodes of physical contact were all unintentional and nonsexual. Other individuals may acknowledge past episodes of sexual behavior involving children but deny any significant or sustained sexual interest in children. Because these individuals may deny experiences, impulses, or fantasies involving children, they may also deny feeling subjectively distressed. Such individuals may still be diagnosed with pedophilic disorder despite the absence of self-reported

distress, provided that there is evidence of recurrent behaviors persisting for 6 months (Criterion A) and evidence that the individual has acted on sexual urges or experienced interpersonal difficulties as a consequence of the disorder (Criterion B). Behaviors include sexual interactions with children, whether or not they involve physical contact (e.g., some pedophilic individuals expose themselves to children). Although the use of sexually explicit content depicting prepubescent children is typical of individuals with pedophilic sexual interests and thus might contribute important information relevant to the evaluation of Criterion A, such behavior in the absence of the individual's sexual interactions with children (i.e., acting on these sexual urges in person) is insufficient to conclude that Criterion B is met. Presence of multiple victims, as discussed above, is sufficient but not necessary for diagnosis; that is, the individual can still meet Criterion A by merely acknowledging intense or preferential sexual interest in children. Associated Features Individuals with pedophilic disorder may experience an emotional and cognitive affinity with children, sometimes referred to

as emotional congruence with children. Emotional congruence with children can manifest in different ways, including preferring social interactions with children over adults, feeling like one has more in common with children than with adults, and choosing occupations or volunteer roles in order to be around children more often. Studies show that emotional congruence with children is related to both pedophilic sexual interest and the likelihood of sexually reoffending among individuals who have sexually offended. Prevalence The population prevalence of individuals whose presentations meet the full criteria for pedophilic disorder is unknown but is likely less than 3% among men in international studies. The population prevalence of pedophilic disorder in women is even more uncertain, but it is likely a small fraction of the prevalence in men. Development and Course Adult men with pedophilic disorder may indicate that they became aware of strong or preferential sexual interest in children around the time of puberty—the same time frame in which men who later prefer physically mature partners became aware of their sexual interest in women or men. Attempting to diagnose pedophilic disorder at the age at which it first manifests is problematic because of the difficulty during adolescent development in differentiating it from age-appropriate sexual interest in peers or from sexual curiosity. Hence, Criterion C requires for diagnosis a minimum age of 16 years and at least 5 years older than the child or children in Criterion A. Pedophilia per se appears to be a lifelong condition. Pedophilic disorder, however, necessarily includes other elements that may change over time with or without treatment: subjective distress (e.g., guilt, shame, intense sexual frustration, or feelings of isolation) or psychosocial impairment, or the propensity to act out sexually with children, or both. Therefore,

Temperamental. Environmental. Genetic and physiological. the course of pedophilic disorder may fluctuate, or the intensity might increase or decrease with age. Adults with pedophilic disorder may report an awareness of sexual interest in children that preceded engaging in sexual behavior involving children or self-identification as an individual with pedophilia. Advanced age is as likely to similarly diminish the frequency of sexual behavior involving children as it does other paraphilically motivated and nonparaphilic sexual behavior. Risk and Prognostic Factors There appears to be an interaction between pedophilia and antisocial personality traits such as callousness, impulsivity, and a willingness to take risks without adequate regard for the consequences. Men with pedophilic interest and antisocial personality traits are more likely to act out sexually with children and thus qualify for a diagnosis of pedophilic disorder. Thus, antisocial personality disorder may be considered a risk factor for pedophilic disorder in males with pedophilia. Adult men with pedophilia sometimes report that they were sexually abused as children. It is unclear, however, whether this correlation reflects a causal influence of childhood sexual abuse on adult pedophilia. Since pedophilia is a necessary condition for pedophilic disorder, any factor that increases the probability of pedophilia also increases the risk of pedophilic disorder. There is some evidence that neurodevelopmental perturbation in utero increases the probability of development of a pedophilic interest. Sex- and Gender-Related Diagnostic Issues Laboratory measures of sexual interest, in terms of psychophysiological responses to sexual stimuli depicting children, which are sometimes useful in diagnosing pedophilic disorder in men, are not necessarily useful in diagnosing this disorder in women because there has been very limited research on the assessment of pedophilic sexual interest in women. Diagnostic Markers Psychophysiological measures of sexual interest may sometimes be useful when an individual's history suggests the possible presence of pedophilic disorder but the individual denies strong or preferential attraction to children. The most thoroughly researched and longest used of such measures is penile plethysmography, although the sensitivity and specificity of diagnosis may vary across sites, which frequently use different stimuli,

procedures, and scoring. Viewing time, using photographs of nude or minimally clothed persons as visual stimuli, is also used to diagnose pedophilic disorder, especially in combination with self-report measures. U.S. clinicians, however, should be aware that possession of visual sexual stimuli depicting children, even for diagnostic purposes, may violate American law regarding possession of child pornography and leave the clinician susceptible to criminal prosecution. The option exists to use audio stimuli describing sexual interactions in penile plethysmography. Across psychophysiological methods, the diagnostic marker is relative sexual response to stimuli

Pedophilia. Other paraphilic disorders. Antisocial personality disorder. Substance intoxication. Obsessive-compulsive disorder. depicting children compared with stimuli depicting adults, rather than absolute response to child stimuli. Differential Diagnosis Individuals with pedophilia experience recurrent, intense, sexually arousing fantasies or sexual urges involving sexual activity with a prepubescent child or children. Unless the individual has acted on these sexual urges with a prepubescent child or unless the sexual urges or fantasies cause marked distress or interpersonal difficulty, a diagnosis of pedophilic disorder is not warranted. Sometimes individuals present with a different paraphilic disorder but are referred for an evaluation regarding possible pedophilic disorder (e.g., when an individual with a diagnosis of exhibitionistic disorder exposes himself to children as well as adults). In some cases, both diagnoses may apply, whereas in others, it may be the case that one paraphilic disorder diagnosis is sufficient. For example, an individual who exposes himself exclusively to prepubescent children may have both exhibitionistic disorder and pedophilic disorder, whereas another individual who exposes himself to victims, irrespective of the victims' age, may be considered to have only exhibitionistic disorder. Some individuals with antisocial personality disorder sexually abuse children, reflecting the fact that the presence of antisocial personality disorder increases the likelihood that an individual who is primarily attracted to mature persons will approach a child sexually, on the basis of relative access to the child. An additional diagnosis of pedophilic disorder should only be considered if there is evidence that over a period of at least 6 months, the individual has also had recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child. The disinhibiting effects of substance intoxication may also increase the likelihood that an individual who is primarily attracted to mature persons will sexually approach a child. There are occasional individuals who complain about egodystonic thoughts and worries about possible attraction to children. Clinical interviewing usually reveals an absence of positive feelings about these thoughts, no connection between these thoughts and sexual behavior (e.g., masturbating to these thoughts), and sometimes additional ego-dystonic, intrusive sexual ideas (e.g., concerns about homosexuality). Comorbidity Psychiatric comorbidity of pedophilic disorder includes substance use disorders; depressive, bipolar, and anxiety disorders; antisocial personality disorder; and other paraphilic disorders. However, findings on comorbid disorders are largely among individuals convicted for sexual offenses involving children (almost all males) and may not be generalizable to other individuals with pedophilic disorder (e.g., individuals who have never approached a child sexually but who qualify for the diagnosis of pedophilic disorder on the basis of subjective distress).

F65.0 Fetishistic Disorder Diagnostic Criteria A. Over a period of at least 6 months, recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on nongenital body part(s), as manifested by fantasies, urges, or behaviors. B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. C. The fetish objects are not limited to articles of clothing

used in cross-dressing (as in transvestic disorder) or devices specifically designed for the purpose of tactile genital stimulation (e.g., vibrator). Specify: Body part(s) Nonliving object(s) Other Specify if: In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in fetishistic behaviors are restricted. In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment. Specifiers Although individuals with fetishistic disorder may report intense and recurrent sexual arousal to inanimate objects or a specific body part, it is not unusual for non-mutually exclusive combinations of fetishistic sexual interests to occur. Thus, an individual may have fetishistic disorder associated with an inanimate object (e.g., female undergarments) or an exclusive focus on an intensely eroticized body part (e.g., feet, hair), or his or her fetishistic interest may meet criteria for various combinations of these specifiers (e.g., socks, shoes, and feet). Diagnostic Features The paraphilic focus of fetishistic disorder involves the persistent and repetitive use of or dependence on nonliving objects or a highly specific focus on a (typically nongenital) body part as a primary element associated with sexual arousal (Criterion A). A diagnosis of fetishistic disorder must include clinically significant personal distress or impairment in social, occupational, or other important areas of functioning (Criterion B). Common fetish objects

include women's undergarments, men's or women's footwear, rubber articles, leather clothing, diapers, or other wearing apparel. Highly eroticized body parts associated with fetishistic disorder include feet, toes, and hair. It is not uncommon for sexualized fetishes to include both inanimate objects and body parts (e.g., dirty socks and feet), and for this reason the definition of fetishistic disorder now re-incorporates partialism (i.e., an exclusive focus on a body part) into its boundaries. Partialism, previously considered in DSM-IV-TR to be a paraphilia not otherwise specified, had historically been subsumed in fetishism prior to DSM-III. Many individuals who self-identify as fetishist practitioners do not necessarily report clinical impairment in association with their fetish-associated behaviors. Such individuals could be considered as having a fetishistic sexual interest (i.e., a recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on a nongenital body part, as manifested by fantasies, urges, or behaviors), but not fetishistic disorder. A diagnosis of fetishistic disorder requires concurrent fulfillment of both the behaviors in Criterion A and the clinically significant distress or impairment in functioning noted in Criterion B. Associated Features Fetishistic disorder can be a multisensory experience, including holding, tasting, rubbing, inserting, or smelling the fetish object while masturbating, or preferring that a sexual partner wear or utilize a fetish object during sexual encounters. It should be noted that many individuals with fetishistic sexual interests also enjoy sexual experiences with their partner(s) without using their fetish object. However, it should also be noted that individuals with a fetishistic sexual interest often find that sexual experiences that involve their fetish object are more sexually satisfying than sexual experience without it. And for a minority of people with a fetishistic sexual interest, their fetish object is obligatory to becoming sexually aroused and/or satisfied. Some individuals may acquire extensive collections of highly desired fetish objects. Development and Course Usually paraphilias have an onset during puberty, but fetishistic sexual interests can develop prior to adolescence. Once established, fetishistic disorder tends to have a continuous course that fluctuates in intensity and frequency of urges or behavior. Culture-Related Diagnostic Issues Knowledge of and appropriate consideration for normative aspects of sexual behavior are important factors to explore to establish a clinical diagnosis of fetishistic disorder and to distinguish a clinical diagnosis from a socially acceptable sexual behavior. Sex- and Gender-

Related Diagnostic Issues Fetishistic behaviors have been reported more in men, but also occur in women. This gender difference is smaller for fetishistic fantasy than for actual fetishistic behavior. In clinical samples, fetishistic disorder is nearly exclusively reported in men. **Functional Consequences of Fetishistic Disorder** Typical impairments associated with fetishistic disorder include sexual dysfunction during

Transvestic disorder. Sexual masochism disorder or other paraphilic disorders. Fetishism. F65.1 romantic reciprocal relationships when the preferred fetish object or body part is unavailable during foreplay or coitus. Some individuals with fetishistic disorder may prefer solitary sexual activity associated with their fetishistic preference(s) even while involved in a meaningful reciprocal and affectionate relationship. **Differential Diagnosis** The nearest diagnostic neighbor of fetishistic disorder is transvestic disorder. As noted in the diagnostic criteria, fetishistic disorder is not diagnosed when fetish objects are limited to articles of clothing exclusively worn during cross-dressing (as in transvestic disorder), or when the object is genitally stimulating because it has been designed for that purpose (e.g., a vibrator). Fetishistic disorder can co-occur with other paraphilic disorders, especially sadomasochistic behavior or interests and transvestic disorder. When an individual fantasizes about or engages in “forced cross-dressing” and is primarily sexually aroused by the domination or humiliation associated with such fantasy or repetitive activity, and experiences distress or functional impairment, the diagnosis of sexual masochism disorder should be made. Use of a fetish object for sexual arousal (fetishism) without any associated distress or psychosocial role impairment or other adverse consequence would not meet criteria for fetishistic disorder, as the threshold required by Criterion B would not be met. For example, an individual whose sexual partner either shares or can successfully incorporate his interest in caressing, smelling, or licking feet or toes as an important element of foreplay would not be diagnosed with fetishistic disorder; nor would an individual who prefers, and is not distressed or impaired by, solitary sexual behavior associated with wearing rubber garments or leather boots. **Comorbidity** Fetishistic disorder may co-occur with other paraphilic disorders as well as hypersexuality. Rarely, fetishistic disorder may be associated with neurological conditions. **Transvestic Disorder Diagnostic Criteria** A. Over a period of at least 6 months, recurrent and intense sexual arousal from cross-dressing, as manifested by fantasies, urges, or behaviors. B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Specify if:

With fetishism: If sexually aroused by fabrics, materials, or garments. With autogynephilia: If sexually aroused by thoughts or images of self as a woman. Specify if: In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to cross-dress are restricted. In full remission: There has been no distress or impairment in social, occupational, or other areas of functioning for at least 5 years while in an uncontrolled environment. **Specifiers** The presence of fetishism decreases the likelihood of gender dysphoria in men with transvestic disorder. The presence of autogynephilia increases the likelihood of gender dysphoria in men with transvestic disorder. **Diagnostic Features** The diagnosis of transvestic disorder does not apply to all individuals who dress as the opposite sex, even those who do so habitually. It applies to individuals whose cross-dressing or thoughts of cross-dressing are always or often accompanied by sexual excitement (Criterion A) and who are emotionally distressed by this pattern or for whom it impairs their social or interpersonal functioning (Criterion B). The cross-dressing may involve only one or two articles of clothing (e.g., for men, it may pertain

only to women's undergarments), or it may involve dressing completely in the inner and outer garments of the other sex and (in men) may include the use of women's wigs and makeup. Sexual arousal, in its most obvious form of penile erection, may cooccur with cross-dressing in various ways. In younger men, cross-dressing often leads to masturbation, following which any women's clothing is removed. Older men often learn to avoid masturbating or doing anything to stimulate the penis so that the avoidance of ejaculation allows them to prolong their cross-dressing session. Men and women sometimes complete a crossdressing session by having intercourse with their partners, and some have difficulty maintaining sufficient sexual arousal for sexual activity without cross-dressing (or having private fantasies of cross-dressing). Clinical assessment of distress or impairment, like clinical assessment of transvestic sexual arousal, is usually dependent on the individual's self-report. The pattern of behavior "purging and acquisition" often signifies the presence of distress in individuals with transvestic disorder. During this behavioral pattern, an individual (usually a man) who has spent a great deal of money on women's clothes and other apparel (e.g., shoes, wigs) discards the items (i.e., purges them) in an effort to overcome urges to cross-dress, and then begins acquiring a woman's wardrobe all over again.

Associated Features Transvestic disorder in men is often accompanied by autogynephilia (i.e., a man's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman). Autogynephilic fantasies and behaviors may focus on the idea of exhibiting female physiological functions (e.g., lactation, menstruation), engaging in stereotypically feminine behavior (e.g., knitting), or possessing female anatomy (e.g., breasts).

Prevalence The prevalence of transvestic disorder is unknown; however, it appears to be much more prevalent in men than in women. Fewer than 3% of Swedish men report having ever been sexually aroused by dressing in women's attire. The percentage of individuals who have crossdressed with sexual arousal more than once or a few times in their lifetimes would be even lower.

Development and Course In men, the first signs of transvestic disorder may begin in childhood, in the form of strong fascination with a particular item of women's attire. Prior to puberty, cross-dressing produces generalized feelings of pleasurable excitement. With the arrival of puberty, dressing in women's clothes begins to elicit penile erection and, in some cases, leads directly to first ejaculation. In many cases, cross-dressing elicits less and less sexual excitement as the individual grows older; eventually it may produce no discernible penile response at all. The desire to cross-dress, at the same time, remains the same or grows even stronger. Individuals who report such a diminution of sexual response typically report that the sexual excitement of cross-dressing has been replaced by feelings of comfort or well-being. In some cases, the course of transvestic disorder is continuous, and in others it is episodic. It is not rare for men with transvestic disorder to lose interest in cross-dressing when they first fall in love with a woman and begin a relationship, but such abatement usually proves temporary. When the desire to cross-dress returns, so does the associated distress. Some cases of transvestic disorder progress to gender dysphoria. The men in these cases, who may be indistinguishable from others with transvestic disorder in adolescence or early childhood, gradually develop desires to remain in the woman's role for longer periods and to feminize their anatomy. The development of gender dysphoria is usually accompanied by a (selfreported) reduction or elimination of sexual arousal in association with cross-dressing. The manifestation of transvestism in penile erection and stimulation, like the manifestation of other paraphilic as well as nonparaphilic sexual interests, is most intense in adolescence and early adulthood. The severity of transvestic disorder is highest in adulthood, when the transvestic drives are most likely to conflict with performance in heterosexual intercourse and desires to marry and start a family. Middle-age and older men with a history of

transvestism are less likely to present with transvestic disorder than with gender dysphoria.

Functional Consequences of Transvestic Disorder

Transvestism. Fetishistic disorder. Gender dysphoria. Engaging in transvestic behaviors can interfere with, or detract from, heterosexual relationships. This can be a source of distress to men who wish to maintain conventional marriages or romantic partnerships with women.

Differential Diagnosis Individuals with transvestism experience recurrent and intense sexual arousal from cross-dressing. Unless the fantasies, sexual urges, or behaviors involving cross-dressing are accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning, a diagnosis of transvestic disorder is not warranted. This disorder may resemble transvestic disorder, in particular, in men with fetishism who put on women's undergarments while masturbating with them. Distinguishing transvestic disorder depends on the individual's specific thoughts during such activity (e.g., are there any ideas of being a woman, being like a woman, or being dressed as a woman?) and on the presence of other fetishes (e.g., soft, silky fabrics, whether these are used for garments or for something else). Individuals with transvestic disorder do not report an incongruence between their experienced gender and their assigned gender or a desire to be of the other gender; and they typically do not have a history of childhood cross-gender behaviors, which would be present in individuals with gender dysphoria. Individuals with a presentation that meets full criteria for transvestic disorder as well as gender dysphoria should be given both diagnoses.

Comorbidity Transvestic disorder is often found in association with other paraphilias. The most frequently cooccurring paraphilias are fetishistic sexual interests or behavior and masochistic sexual interests or behavior. One particularly dangerous form of masochistic sexual interests or behavior, autoerotic asphyxia, is associated with transvestic sexual interests or behavior in a substantial proportion of fatal cases.

Other Specified Paraphilic Disorder F65.89 This category applies to presentations in which symptoms characteristic of a paraphilic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the paraphilic disorders diagnostic class. The other specified paraphilic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific paraphilic disorder. This is done by recording "other specified paraphilic disorder" followed by the specific reason (e.g., "zoophilia").

Examples of presentations that can be specified using the "other specified" designation include, but are not limited to, recurrent and intense sexual arousal involving telephone scatologia (obscene phone calls), necrophilia (corpses), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), or urophilia (urine) that has been present for at least 6 months and causes marked distress or impairment in social, occupational, or other important areas of functioning. Other specified paraphilic disorder can be specified as in remission and/or as occurring in a controlled environment.

Unspecified Paraphilic Disorder F65.9 This category applies to presentations in which symptoms characteristic of a paraphilic disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the paraphilic disorders diagnostic class. The unspecified paraphilic disorder category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific paraphilic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis.

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