Development and Course

Individuals with sexual sadism in forensic samples are almost exclusively male, but a representative sample of the population in Australia reported that 2.2% of men and 1.3% of women said they had been involved in bondage and discipline, "sadomasochism," or dominance and submission in the previous year. Information on the development and course of sexual sadism disorder is extremely limited. One study reported that females became aware of their sadomasochistic interest as young adults, and another reported that the mean age at onset of sadism in a group of males was 19.4 years. Whereas sexual sadism per se is 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. Advancing age is likely to have the same reducing effect on this disorder as it has on other paraphilic or normophilic sexual behavior.

Differential Diagnosis

Many of the conditions that could be differential diagnoses for sexual sadism disorder (e.g., antisocial personality disorder, sexual masochism disorder, hypersexuality, substance use disorders) sometimes occur also as comorbid diagnoses. Therefore, it is necessary to carefully evaluate the evidence for sexual sadism disorder, keeping the possibility of other paraphilias or mental disorders as part of the differential diagnosis. 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 behavior would not meet DSM-5 criteria for sexual sadism disorder. Sadistic interest, but not the disorder, may be considered in the differential diagnosis.

Comorbidity

Known comorbidities with sexual sadism disorder are largely based on individuals (almost all males) 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.

Pedophilic Disorder

Diagnostic Criteria **302.2 (F65.4)**

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. 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 individuals. If individuals also complain that their sexual attractions or preferences for children are causing 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.

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. Since 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).

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.

The Criterion A clause, indicating that the signs or symptoms of pedophilia have persisted for 6 months or longer, is intended to ensure that the sexual attraction to children is not merely transient. However, the diagnosis may be made if there is clinical evidence of sustained persistence of the sexual attraction to children even if the 6-month duration cannot be precisely determined.

Associated Features Supporting Diagnosis

The extensive use of pornography depicting prepubescent children is a useful diagnostic indicator of pedophilic disorder. This is a specific instance of the general case that individuals are likely to choose the kind of pornography that corresponds to their sexual interests.

Prevalence

The population prevalence of pedophilic disorder is unknown. The highest possible prevalence for pedophilic disorder in the male population is approximately 3%–5%. The population prevalence of pedophilic disorder in females is even more uncertain, but it is likely a small fraction of the prevalence in males.

Development and Course

Adult males with pedophilic disorder may indicate that they become aware of strong or preferential sexual interest in children around the time of puberty—the same time frame in which males 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, the course of pedophilic disorder may fluctuate, 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 a pedophile. Advanced age is as likely to similarly diminish the frequency of sexual behavior involving children as it does other paraphilically motivated and normophilic sexual behavior.

Risk and Prognostic Factors

Temperamental. There appears to be an interaction between pedophilia and antisociality, such that males with both traits are more likely to act out sexually with children. Thus, antisocial personality disorder may be considered a risk factor for pedophilic disorder in males with pedophilia.

Environmental. Adult males with pedophilia often 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.

Genetic and physiological. 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.

Gender-Related Diagnostic Issues

Psychophysiological laboratory measures of sexual interest, which are sometimes useful in diagnosing pedophilic disorder in males, are not necessarily useful in diagnosing this disorder in females, even when an identical procedure (e.g., viewing time) or analogous procedures (e.g., penile plethysmography and vaginal photoplethysmography) are available.

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 from one site to another. *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. Mental health professionals in the United States, however, should be aware that possession of such visual stimuli, even for diagnostic purposes, may violate American law regarding possession of child pornography and leave the mental health professional susceptible to criminal prosecution.

Differential Diagnosis

Many of the conditions that could be differential diagnoses for pedophilic disorder also sometimes occur as comorbid diagnoses. It is therefore generally necessary to evaluate the evidence for pedophilic disorder and other possible conditions as separate questions.

Antisocial personality disorder. This disorder increases the likelihood that a person who is primarily attracted to the mature physique will approach a child, on one or a few occasions, on the basis of relative availability. The individual often shows other signs of this personality disorder, such as recurrent law-breaking.

Alcohol and substance use disorders. The disinhibiting effects of intoxication may also increase the likelihood that a person who is primarily attracted to the mature physique will sexually approach a child.

Obsessive-compulsive disorder. There are occasional individuals who complain about ego-dystonic thoughts and worries about possible attraction to children. Clinical interviewing usually reveals an absence of sexual thoughts about children during high states of sexual arousal (e.g., approaching orgasm during masturbation) 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).

Fetishistic Disorder

Diagnostic Criteria **302.81 (F65.0)**

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 fetishes 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 their 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 primary elements associated with sexual arousal (Criterion A). A diagnosis of fetishistic disorder must include clinically significant personal distress or psychosocial role impairment (Criterion B). Common fetish objects include female undergarments, male or female footwear, rubber articles, leather clothing, 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 a paraphilia not otherwise specified disorder, 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 fetish 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 Supporting Diagnosis

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. Some individuals may acquire extensive collections of highly desired fetish objects.

Development and Course

Usually paraphilias have an onset during puberty, but fetishes 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.

Gender-Related Diagnostic Issues

Fetishistic disorder has not been systematically reported to occur in females. In clinical samples, fetishistic disorder is nearly exclusively reported in males.

Functional Consequences of Fetishistic Disorder

Typical impairments associated with fetishistic disorder include sexual dysfunction during 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.

Although fetishistic disorder is relatively uncommon among arrested sexual offenders with paraphilias, males with fetishistic disorder may steal and collect their particular fetishistic objects of desire. Such individuals have been arrested and charged for nonsexual antisocial behaviors (e.g., breaking and entering, theft, burglary) that are primarily motivated by the fetishistic disorder.

Differential Diagnosis

Transvestic disorder. 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).

Sexual masochism disorder or other paraphilic disorders. Fetishes can co-occur with other paraphilic disorders, especially "sadomasochism" 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, the diagnosis of sexual masochism disorder should be made.

Fetishistic behavior without fetishistic disorder. Use of a fetish object for sexual arousal 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 **302.3 (F65.1)**

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 female.

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.