Hence, antisocial personality disorder, alcohol use disorder, and pedophilic interest may be considered risk factors for exhibitionistic disorder in males with exhibitionistic sexual preferences.

Environmental. 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.

Gender-Related Diagnostic Issues

Exhibitionistic disorder is highly unusual in females, whereas single sexually arousing exhibitionistic acts might occur up to half as often among women compared with men.

Functional Consequences of Exhibitionistic Disorder

The functional consequences of exhibitionistic disorder have not been addressed in research involving individuals who have not acted out sexually by exposing their genitals to unsuspecting strangers but who fulfill Criterion B by experiencing intense emotional distress over these preferences.

Differential Diagnosis

Potential differential diagnoses for exhibitionistic disorder sometimes occur also as comorbid disorders. Therefore, it is generally necessary to evaluate the evidence for exhibitionistic disorder and other possible conditions as separate questions.

Conduct disorder and antisocial personality disorder. 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 should be lacking.

Substance use disorders. Alcohol and substance use disorders might involve single exhibitionistic episodes by intoxicated individuals but should not involve the typical sexual interest in exposing the genitals to unsuspecting persons. Hence, recurrent exhibitionistic sexual fantasies, urges, or behaviors that occur also when the individual is not intoxicated suggest that exhibitionistic disorder might be present.

Comorbidity

Known comorbidities in exhibitionistic disorder are largely based on research with individuals (almost all males) convicted for criminal acts involving genital exposure to nonconsenting individuals. Hence, these comorbidities might not apply to all individuals who qualify for a 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 **302.89 (F65.81)**

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 attraction from touching or rubbing against a nonconsenting individual regardless of considerable objective evidence to the contrary. If disclosing individuals also report psychosocial impairment due to their sexual preferences for touching or rubbing against a nonconsenting individual, 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 individuals 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 individuals 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 individual (i.e., multiple victims, each on a separate occasion) may, as a general rule, be interpreted as three or more victims on separate occasions. 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 individuals. 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.

The Criterion A time frame, indicating that signs or symptoms of frotteurism must persist for at least 6 months, should also be interpreted as a general guideline, not a strict threshold, to ensure that the sexual interest in touching or rubbing against a nonconsenting individual is not transient. Hence, the duration part of Criterion A may also be met if there is clear evidence of recurrent behaviors or distress over a shorter but nontransient time period.

Prevalence

Frotteuristic acts, including the uninvited sexual touching of or rubbing against another individual, may occur in up to 30% of adult males in the general population. Approximately

10%–14% of adult males seen in outpatient settings for paraphilic disorders and hypersexuality have a presentation that meets diagnostic criteria for frotteuristic disorder. Hence, whereas the population prevalence of frotteuristic *disorder* is unknown, it is not likely that it exceeds the rate found in selected clinical settings.

Development and Course

Adult males 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. Frotteuristic disorder, however, by definition requires one or more contributing factors that may change over time with or without treatment: subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness); psychiatric morbidity; hypersexuality and sexual impulsivity; psychosocial impairment; and/or the propensity to act out sexually by touching or rubbing against unconsenting persons. Therefore, the course of frotteuristic disorder is likely to vary with age. As with other sexual preferences, advancing age may be associated with decreasing frotteuristic sexual preferences and behavior.

Risk and Prognostic Factors

Temperamental. 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, frotteurism is a necessary precondition for frotteuristic disorder, so risk factors for frotteurism should also increase the rate of frotteuristic disorder.

Gender-Related Diagnostic Issues

There appear to be substantially fewer females with frotteuristic sexual preferences than males.

Differential Diagnosis

Conduct disorder and antisocial personality disorder. 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 individual should be lacking.

Substance use disorders. Substance use disorders, particularly those involving stimulants such as cocaine and amphetamines, might involve single frotteuristic episodes by intoxicated individuals but should not involve the typical sustained sexual interest in touching or rubbing against unsuspecting persons. Hence, recurrent frotteuristic sexual fantasies, urges, or behaviors that occur also when the individual is not intoxicated suggest that frotteuristic disorder might be present.

Comorbidity

Known comorbidities in frotteuristic disorder are largely based on research with males suspected of or convicted for criminal acts involving sexually motivated touching of or rubbing against a nonconsenting individual. 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. Potential differential diagnoses for frotteuristic disorder sometimes occur also as comorbid disorders. Therefore, it is generally necessary to evaluate the evidence for frotteuristic disorder and possible comorbid conditions as separate questions.

Sexual Masochism Disorder

Diagnostic Criteria **302.83 (F65.51)**

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 last 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 Criterion A time frame, indicating that the signs or symptoms of sexual masochism must have persisted for at least 6 months, should be understood as a general guideline, not a strict threshold, to ensure that the sexual interest in being humiliated, beaten, bound, or otherwise made to suffer is not merely transient. However, the disorder can be diagnosed in the context of a clearly sustained but shorter time period.

Associated Features Supporting Diagnosis

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.

Prevalence

The population prevalence of sexual masochism disorder is unknown. In Australia, it has been estimated that 2.2% of males and 1.3% of females had been involved in bondage and discipline, sadomasochism, or dominance and submission in the past 12 months.

Development and Course

Community individuals with paraphilias 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. Sexual masochism disorder per definition requires one or more contributing factors, which may change over time with or without treatment. These include subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness), psychiatric morbidity, hypersexuality and sexual impulsivity, and psychosocial impairment. Therefore, the course of sexual masochism disorder is likely to vary with age. Advancing age is likely to have the same reducing effect on sexual preference involving sexual masochism as it has on other paraphilic or normophilic sexual behavior.

Functional Consequences of Sexual Masochism Disorder

The functional consequences of sexual masochism disorder are unknown. However, masochists are at risk of accidental death while practicing asphyxiophilia or other autoerotic procedures.

Differential Diagnosis

Many of the conditions that could be differential diagnoses for sexual masochism disorder (e.g., transvestic fetishism, sexual sadism disorder, hypersexuality, alcohol and substance use disorders) sometimes occur also as comorbid diagnoses. Therefore, it is necessary to carefully evaluate the evidence for sexual masochism disorder, keeping the possibility of other paraphilias or other mental disorders as part of the differential diagnosis. Sexual masochism in the absence of distress (i.e., no disorder) is also included in the differential, as individuals who conduct the behaviors may be satisfied with their masochistic interest.

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.

Sexual Sadism Disorder

Diagnostic Criteria **302.84 (F65.52)**

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.