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The DSM Diagnostic Criteria for Sexual Masochism

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Abstract I reviewed the empirical literature for 1900–2008 on the paraphilia of Sexual Masochism for the Sexual and Gender Identity Disorders Work Group for the forthcoming fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. The results of this review were tabulated into a general summary of the criticisms relevant to the DSM diagnosis of Sexual Masochism, the assessment of Sexual Masochism utilizing the DSM in samples drawn from forensic populations, and the assessment of Sexual Masochism using the DSM in non-forensic populations. I concluded that the diagnosis of Sexual Masochism should be retained, that minimal modifications of the wording of this diagnosis were warranted, and that there was a need for the development of dimensional and structured diagnostic instruments. It should be noted that this summary reflects my original literature review. Subsequently, interactions with other members of the workgroup and advisors have resulted in modification of these initial suggestions.

Keywords Paraphilia · Sexual sadism · Sexual masochism · Hypoxyphilia · DSM-V

Introduction

In contrast to the literature on Sexual Sadism (see Krueger, 2009), there are many fewer studies that have utilized the DSM in the assessment of Sexual Masochism. This article will review the evolution of the terminology of Sexual Masochism in the DSM, the existent studies that have offered critiques relevant to the diagnosis of Sexual Masochism, and the few studies that have used criteria from the DSM in both forensic and not clearly forensic populations. It will review other information obtained from community samples and then offer recommendations for the diagnostic criteria for DSM-V.

Further, for ease of reference, several tables have been developed. Table 1 contains criticisms relevant to Sexual Masochism, Table 2 lists studies that have utilized DSM-criteria on Sexual Masochism in exclusively forensic populations, and Table 3 contains studies that have been done using the DSM on mixed (consisting of both forensic and non-forensic) populations. Finally, an appendix listing all of the previous DSM criteria sets for Sexual Masochism (Appendix 1), along with ICD-9 (World Health Organization, 1989) and ICD-10 criteria (World Health Organization, 1992), and ICD-10 research criteria (World Health Organization, 1993) for sadomasochism are appended (Appendix 2).

Method

Consisted of a literature search by the librarian of the New York State Psychiatric Institute using the search terms of "sexual masochism," "sexual sadism," "sadomasochism," "domination," "bondage," "BDSM," "perversion," "paraphilia," "sexual homicide," "sexual murder," "lust murder," and "sex killer" of PubMed from 1966 through December 15, 2008, and of Psych Info from 1900 through December 15, 2008. Additionally, all of the prior *Diagnostic and Statistical Manuals* were consulted as well as ICD-9 and ICD-10. Articles were culled and attention was focused on articles using the DSM to make diagnoses of Sexual Masochism or offering critiques of the diagnostic criteria for Sexual Masochism or the paraphilias. Discussion of this literature and the diagnostic criteria was engaged in with colleagues.

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Table 1 Summary of criticisms relevant to the DSM diagnosis of sexual masochism

Author	Source	Diagnostic criteria criticized	Comments/conclusions
Tallent (1977)	Peer reviewed article	Paraphilias	Paraphilias, like homosexuality, should be removed from the DSM; they represent value judgments only and not scientifically established criteria
Silverstein (1984)	Peer reviewed article	Paraphilias	Paraphilias, like homosexuality, should be removed from the DSM; they represent value judgments only and not scientifically established criteria
Suppe (1984)	Peer reviewed article	DSM-III and the paraphilias	Sexual deviation is not a diagnostic entity. Paraphilias should be removed from DSM. Burden of proof that these are personally or socially harmful rests with advocates of DSM: deletion may not change social attitudes
Grove et al. (1981)	Peer reviewed article	All DSM diagnoses	Diagnostic reliability had improved in psychiatry because of carefully constructed interview schedules and lists of diagnostic criteria, along with rigorous training of raters; much work remained undone
Kirk and Kutchins (1994)	Peer reviewed article	All DSM diagnoses	Reanalyzed data gathered in original DSM-III field trials and suggested that earlier claims of Interrater reliability were overstated
Gert (1992)	Peer reviewed article	DSM-III-R; all paraphilias	Liked definition of mental disorder; would change definition of paraphilia, specifically transvestic fetishism, to be consistent with definition of mental disorder
Schmidt (1995), Schmidt et al. (1998)	Book chapter	Broad discussion of all of DSM sexual disorders including paraphilias	Summarized that the literature reviews completed for DSM-IV revealed a paucity of data supporting the scientific conceptual underpinning of current diagnostic terminology regarding sexual psychopathology
Campbell (1999)	Peer reviewed article	All DSM diagnoses	Evidentiary reliability of DSM-IV consistently flounders because of lack of interrater reliability data. Later books suggested extended this to sex offender assessment
Campbell (2004)	Book		
Campbell (2007)	Book		
McConaghy (1999)	Peer reviewed article	Broad review of sexology; all of DSM	Suggested that the DSM-IV stated that the severity of sadistic acts increased over time; that while this may apply to serial or sadistic murderers, who were extremely rare, the lack of presentation for treatment of subjects who practiced S & M suggested that this was more benign. Said that this statement regarding progression was made towards sadism generally and was misleading. Suggested that, in view of the lack of a relationship of S & M with psychiatric pathology, as was the case with homosexuality, it would be reasonable that sadomasochism should also not be classified as a disorder
Moser (2001)	Book chapter	All of DSM paraphilias	Argues DSM "pathologizes" individuals who have nonstandard sexual interests despite a lack of research establishing difference in functioning; presents broad review and criticism; suggests the classification of "Sexual Interest Disorder"
Berner et al. (2003)	Peer reviewed article	ICD-10 and DSM-IV	Current studies on differently selected clinical samples reveal changed distribution with masochism prevailing in outpatient facilities and sadism in forensic settings; no survey data were presented to support this impression
Moser and Kleinplatz (2005)	Peer reviewed article	All, with focus on DSM-IV-TR	Asserted there were many factual mistakes in the text; that paraphilias were not mental disorders; that inclusion of paraphilias in the DSM facilitated discrimination and harm to people with variant sexual interests; and that, for consenting adults, it was not their sexual interests but the manner in which they were manifest that was a problem and more appropriate focus for therapy
Spitzer (2005)	Peer reviewed article	All, with focus on DSM-IV-TR	Contended that "medical disorder" could be applied to human behavior; said that Moser and Hill had not presented a single case (child or adult) of someone who had been harmed by being given a diagnosis of a paraphilia

Table 1 continued

Author	Source	Diagnostic criteria criticized	Comments/conclusions
Fink (2005)	Peer reviewed article	All with focus on DSM-IV-TR	Expressed that there must be some way of differentiating between the normal and abnormal ways in which people get aroused, excited, and fulfilled. Thought it was important to retain paraphilic diagnosis "in order to save some people from jail and others from themselves"
Kleinplatz and Moser (2005)	Peer reviewed article	All with focus on DSM-IV-TR	Maintained that Spitzer and Fink did not dispute their analysis of the problems with the DSM-IV-TR criteria for paraphilias and that conservative organizations flagrantly misrepresented their statements and intent of the symposium it was presented at and the APA. Stated that public opinion and not science were the main reason to keep the paraphilias in DSM
Reiersøl and Skeid (2006)	Peer reviewed article	ICD-10	The ICD diagnoses of Fetishism, Transvestic Fetishism, and Sadomasochism are outdated and not up to the scientific standards of the ICD manual. They stigmatize minority groups

Results

Summary of Evolution of Diagnostic Criteria for Sexual Masochism in the DSM

Masochism was not mentioned in DSM-I (American Psychiatric Association, 1952). It was added to DSM-II for use in the United States only (American Psychiatric Association, 1968) (Appendix 1).

It was continued in DSM-III (American Psychiatric Association, 1980), where this diagnosis was made with either of the items: "(1) A preferred or exclusive mode of producing sexual excitement is to be humiliated, bound, beaten, or otherwise made to suffer, or (2) The individual has intentionally participated in an activity in which he or she was physically harmed or his or her life was threatened" (p. 274). Thus, an individual could have been diagnosed with this disorder only for participating in such activity with a consensual partner, if this was preferred or exclusive.

DSM-III-R (American Psychiatric Association, 1987) changed to require two criteria: "A. Over a period of at least six months, recurrent, intense sexual urges and sexually arousing fantasies involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer." And "B. The person has acted on these urges, or is markedly distressed by them." Here again, the occurrence of such urges or fantasies in an individual who was practicing S & M with a consensual partner was in itself considered pathological, providing substance to the claims by S & M practitioners that their particular behavior had been selected out as being pathological per se.

In DSM-IV (American Psychiatric Association, 1994), the A criterion was continued, substantially unchanged: "A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer." And the B criterion, as with the other paraphilias, was modified to incorporate elements of subjective distress or dysfunction: "B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning." Finally, DSM-IV-TR (American Psychiatric Association, 2000) made no changes in the criteria.

Review of Criticisms Relevant to Sexual Masochism

Many criticisms relevant to Sexual Sadism are also relevant to Sexual Masochism, and are contained in Table 1 and will not be repeated here (see Krueger, 2009). Generally, these indicate, among many concerns, that the paraphilias, or sadomasochism, should not be included in the DSM because they are not mental disorders, they are unscientific, they are unnecessary, and to do so pathologizes groups who engage in alternative sexual practices.

Table 2 Summary of studies involving assessment of sexual masochism utilizing the DSM in samples drawn from forensic populations

Study	Design	Number of and source of subjects	Diagnostic criteria used	Methods of diagnosis and data used	Results	Comments/conclusions
Raymond et al. (1999)	Interview of volunteers with pedophilia using, among other things, sexual SCID	45 males with pedophilia	DSM-IV	Interview; prospective study using structured diagnostic instruments	2 of 45 had sexual sadism; 0 had sexual masochism	Diagnosis of masochism was examined from the structured interview for sexual diagnoses which was used
Becker et al. (2003)	Legal files of 120 sexual offenders in Arizona	120	DSM-IV	Mental health professionals as part of commitment diagnoses	8.5% sexual sadism; 2% sexual masochism	
Hill et al. (2006, 2007, 2008)	Review of psychiatric court records	166 men who were sexual homicide perpetrators	DSM-IV	Diagnoses on the basis of review of written reports done by 20 forensic psychiatrists	36.7% received diagnosis of sexual sadism; 5.4% had sexual masochism 14.8% of those with sexual sadism also had sexual masochism	Conclude that DSM-IV diagnosis of sexual sadism was more useful and precise than the ICD-10 sadomasochism; however, follow-up for an estimated recidivism for 20 years at risk was not significantly related to diagnosis of sexual sadism

Indeed, Baumeister and Butler (1997) entitled their chapter in the edited volume *Sexual Deviance* as "Sexual Masochism: Deviance without Pathology," emphasizing that it was not pathological. In a recent chapter on Sexual Masochism, Hucker (2008) reviewed the literature. He wrote, addressing the call to remove the paraphilias from the DSM:

> On the other hand, the fact that a minority of sadomasochists do present with serious injuries or die during their activities (Agnew, 1986; Hucker, 1985) should make us consider seriously whether removing these behaviors from the domain of mental disorders is wise at the present time, especially as there is much room for more research on the topic. Kurt Freund (Freund, 1976) applied the term "dangerous" to the more extreme forms of sadism and masochism, and it would seem prudent at this stage in our knowledge to continue to refer to these more extreme cases by such a term, thereby distinguishing them from the more benign manifestations ("mild" masochism or erotic submissiveness) of what may well be a continuum of behaviors that merges with "normal" sexual expression. (pp. 260–261)

Review of Diagnostic Studies in Forensic Populations

Only three studies mention the diagnosis of Sexual Masochism based on the DSM in studies of forensic populations and these do not indicate a high occurrence of this diagnosis. In a study of 45 males with pedophilia using an unvalidated structured clinical interview for the sexual disorders, Raymond, Coleman, Ohlerking, Christenson, and Miner (1999) found that no subjects met criteria for sexual masochism, despite the discovery of numerous other paraphilias, in addition to pedophilia.

Becker, Stinson, Tromp, and Messer (2003) reported on a review of the legal files of 120 sexual offenders who were petitioned for civil commitment in Arizona. A total of 8.5% received a diagnosis of sexual sadism and only 2% sexual masochism.

Hill, Habermann, Berner, and Briken (2006) examined court reports on 166 men who had committed a sexual homicide in Germany. Psychiatric disorders were diagnosed by the raters according to DSM-IV. Sixty-one men (36.7%) received a diagnosis of Sexual Sadism, 5.4%. received a diagnosis of Sexual Masochism, and 14.8% of those with Sexual Sadism also had Sexual Masochism. Structured diagnostic instruments were used to make diagnoses of personality disorders, but not for the paraphilic disorders.

To summarize, only three studies have been conducted on forensic populations that mention Sexual Masochism diagnosed by the DSM, compared with a substantial volume of studies examining for Sexual Sadism. One of these studies reported no Sexual Sadism in a group of 45 males with pedophilia, one an occurrence of 2% out of 120 civilly committed sexual offenders, and one 5.4% in a group of 166 men who had committed a sexual

Table 3 Summary of studies with any mention of sexual masochism utilizing the DSM in samples that are not entirely forensic

Study	Design	Number of and source of subjects	Diagnostic criteria used	Methods of diagnosis and data used	Results	Comments/conclusions
Abel et al. (1987, 1988)	Prospective interview of 561 paraphiliacs	Prospective review of 561 paraphiliacs in Memphis Tennessee and in New York City; none were incarcerated; one-third referred from mental health; one-third from legal or forensic, and one-third other	DSM-II and DSM-II with some modification; deviant interest was not a necessary component of arousal	Structured clinical interview from 1 to 5 h	28 sadism, 17 masochism, 126 rapists	Most subjects reported sex crimes but had not been prosecuted for these
Kafka and Prentky (1994)	Prospective interview; 34 men in paraphilia group and 26 in the paraphilia related group	Some forensic	DSM-III-R	Structured interview and questionnaire	In the paraphilic group, 4 (12%) of 34 diagnosed with sadism and 3 (9%) diagnosed with masochism	Suggested structured diagnostic interviews and blind interviewing techniques for future studies
American Psychiatric Association (1999)	Chapter in book referenced as personal communication	2,129 patients with self-reported behavior at 140 sexual treatment clinics in North America	Unknown; presumably answers to the Abel Assessment For Sexual Interest Questionnaire Unknown DSM criteria	Not described; presumably the Abel Assessment of Sexual Interest	Sadism (2.3%) and masochism (2.5%)	
Kafka and Hennen (2002, 2003)	Prospective interview of 120 consecutive males presenting for treatment of paraphilias or paraphilia related disorders	120 total; 88 men with paraphlias, which included 60 sex offenders	DSM-IV	Structured interview and questionnaire	Sadism (4%) and masochism (11%)	Suggested use of structured diagnostic interviews in future with validated instruments

homicide. In this group, 14.8% of men who had Sexual Sadism also had Sexual Masochism. It is also not clear to what extent sexual masochism was contributory to any criminal behavior in these studies. Only one of these studies used structured diagnostic instruments to assess for paraphilic disorders.

Review of Diagnostic Studies in Non-Forensic Populations

Abel, Becker, Cunningham-Rather, Mittelman, and Rouleau (1988) and Abel et al. (1987) reported on an outpatient population of 561 men seeking voluntary evaluation and treatment for possible paraphilias in Memphis, Tennessee or in New York City. In the Memphis sample, all categories of paraphilias were evaluated; in the New York sample, mostly subjects with a diagnosis of rape or child molestation were seen. DSM-II and DSM-III criteria were used, with all subjects reporting recurrent, repetitive urges to carry out deviant sexual behaviors. Subjects were not included in the research solely because they had committed the paraphilic behavior. One-third of this sample was referred from legal or forensic sources, one-third from mental health sources, and one-third from other sources. Of these, 28 men were diagnosed with sadism and 17 with masochism. These disorders had occurred in the patient during his lifetime, and there was no indication as to which, if any, paraphilia was a focus of concern.

Kafka and Prentky (1994) collected data prospectively on 63 consecutively evaluated outpatient males. Three men were excluded. Thirty-four were seeking treatment for paraphilic disorders and 26 for paraphilia-related disorders. A questionnaire was used along with a structured interview to establish a diagnosis, which represented a lifetime diagnosis. It was not clear which paraphilia was the focus for treatment. Twelve percent of the paraphilic group was diagnosed with sadism and 9% with masochism. Kafka and Prentky recommended that future studies should utilize structured diagnostic interviews and blind interviewing techniques.

The American Psychiatric Association (1999) in a book called *Dangerous Sex Offenders* reported on some data given as a personal communication from Dr. Gene Abel on a sample of 2,129 patients evaluated at 140 sexual treatment clinics in North America, who presumably answered questions on the Abel Assessment of Sexual Interest (Fischer, 2000), although this was not explicitly stated. In this sample, 2.3 percent reported they had engaged in sadism and 2.5% in masochism, but the methods and criteria used to obtain this information were not described.

Kafka and Hennen (2002, 2003) reported on a population of 120 consecutively evaluated outpatient males with paraphilias ($N = 88$, including 60 sex offenders) or paraphilia-related disorders ($N = 32$). Structured interviews and DSM-IV criteria were used to make lifetime diagnoses. Eleven percent of the paraphilic sample had Sexual Masochism and 5% Sexual Sadism. They noted that there were no rating instruments with documented reliability and validity available to diagnose both paraphilias and paraphilia-related disorders. The index paraphilia for which treatment was sought was not specified.

The above four studies were the only ones I have found which apply DSM criteria for Sexual Masochism to populations that were not exclusively forensic, and at least three of these had a substantial component of forensic cases. This implies that researchers are not using criteria from the DSM to conduct research on Sexual Masochism and/or that individuals with Sexual Masochism are not presenting for treatment.

Review of Studies of Masochistic Behavior in the Community, in Treatment Populations, and with Regard to Harm

Incidence of Masochistic Behavior in the Community

Moser and Levitt (1987) reported that general population surveys had not established the proportion of the general population that identified as S/M and noted that it was not clear if any specific behaviors could be classified as S/M specifically. However, S & M behavior appears to be fairly common. Kinsey, Pomeroy, Martin, and Gebhard (1953, p. 678) reported that 26% of females and 26% of males reported a definite and/or frequent erotic response to being bitten. Hunt (1974), in a survey of sexual behavior in the United States involving 2,026 respondents in 26 cities, found that 4.8% of males and 2.1% of females reported ever having obtained sexual pleasure from inflicting pain, and 2.5% of males and 4.6% of females from receiving pain. A recent Australian study (Richters, Grulich, De Visser, Smith, & Rissel, 2003) utilizing a large telephone survey reported that 2.0% of men and 1.4% of women reported that in the preceding 12 months they had been involved in bondage and discipline, sadomasochism, or dominance and submission. In another article, Richters, De Visser, Rissel, Grulich, and Smith (2008) concluded that BDSM (referring to bondage and discipline, "sadomasochism" or dominance and submission) was simply a sexual interest and not a pathological symptom of past abuse or of difficulty with "normal sex."

Crépault and Couture (1980), using a semistructured interview and a self-administered questionnaire, reported on the erotic fantasies of 94 men occurring during heterosexual activity; 11.7% reported that they had had a fantasy of being humiliated, and 5.3% where they were beaten up. A recent systematic review of the research literature on women's rape fantasies (Critelli & Bivona, 2008) reported that between 31 and 57% of women had fantasies in which they were forced into sex against their will and that for 9–17% of women these were a frequent or favorite fantasy experience.

Thus, although there is not a lot of survey information on sexual masochistic or sadomasochistic behavior, it has been reported in from 1 to 5% of the U.S. and Australian population. Sadomasochistic sexual fantasies during sexual intercourse

were reported by 10% of men in a Canadian study and a large percentage of females (from 31 to 57%) were reported to have rape fantasies in a recent review of the literature.

Presentation of Patients with Sadomasochism or Masochism for Treatment

Freund, Seto, and Kuban (1995) reported on a group of 54 male masochists seen at their sexology clinic. They reported that masochistic patients appeared to be relatively rarely seen in a sexology clinic and that, in contrast to individuals who had presented for treatment of other paraphilias, their masochistic patients were predominately self-referred and rarely got into legal trouble because of their paraphilia.

Spengler (1977, 1983), in a survey of 245 manifestly sadomasochistic West German men, reported that 20% rejected their sadomasochistic orientation, 70% accepted it, and 9% "didn't know." Ninety percent had never visited a doctor, psychiatrist, or psychologist because of their sadomasochistic deviation, but 10% reported doing this at least once. Moser and Levitt (1987) reported on the results of a questionnaire given to 178 men self-defined as S & M. Most respondents were satisfied with the S & M part of their sexuality, but 6% expressed distress concerning their behavior and 16% had sought help from a therapist for their S & M desires. Thus, according to the above studies, patients with Sexual Masochism infrequently see mental health professionals for concerns about this behavior.

Is There Evidence of Harm from Sadomasochistic or Masochistic Behavior?

Most studies of individuals practicing sadomasochism in the community have shown evidence of good psychological and social function, as measured by higher educational level, income, and occupational status compared with the general population (Breslow, Evans, & Langley, 1985; Moser & Levitt, 1987; Sandnabba, Santtila, & Nordling, 1999; Santtila, Sandnabba, & Nordling, 2000). Weinberg (2006) concluded his review of the social and psychological literature by saying that "…sociological and social psychological studies see SM practitioners as emotionally and psychologically well balanced, generally comfortable with their sexual orientation, and socially well adjusted" (p. 37). A recent study by Sagarin, Cutler, Cuther, Lawler-Sagarin, and Matuszewich (2009) examining hormone levels and psychological measures of relationship closeness in subjects before and after participating in sadomasochistic activities reported reductions in physiological stress as measured by cortisol and increases in relationship closeness among participants who reported their SM activities went well.

Hypoxyphilia, or the production of sexual excitement by asphyxia, has been reported in several studies of Sexual Masochism (Alison, Santtila, Sandnabba, & Nordling, 2001; Freund et al., 1995; Santtila, Sandnabba, Alison, & Nordling, 2002). Studies of survivors of this practice indicate that nearly all individuals fantasize about masochistic scenarios as they engage in it (Hucker, 2008). Fifty fatalities yearly from this activity are reported in the United States (Litman & Swearingen, 1972) and case reports of death from electrocution during other autoerotic procedures exist (Cairns, 1981).

Thus, studies which have been done show generally good psychological and social functioning compared with the general population and that sadomasochistic activity may be associated with reductions in physiological stress and increase in relationship closeness. There are, however, case reports of injury or death associated with masochistic activity, and evidence that most individuals who engage in or die during erotic or autoerotic asphyxiation have masochistic fantasies.

Misuse of DSM in Child Custody Proceedings and Discrimination

Klein and Moser (2006) described the case of the misuse by forensic professionals of the DSM criteria in a child custody suit, suggesting that these not infrequent cases should be an impetus to the editors of the DSM to reevaluate its classification of atypical sexual behavior as pathological and to strengthen its warnings against misuse. Wright (2006) presented information on violence and discrimination against SM-identified individuals; of 1017 SM individuals surveyed, 36% had suffered some sort of violence or harassment because of their SM practices, and 30% had been victims of job discrimination.

Hypoxyphilia

The DSM-V paraphilias workgroup discussed this entity and decided, because of the dangerousness of this activity and its appearance as a clinical syndrome, that this might merit inclusion as a separate paraphilic disorder. An advisor to the subworkgroup has prepared an analysis of the literature (Hucker, 2009). Hucker recommended the use of the term "asphyxiophilia" given the observation that it appeared that individuals engaging in this behavior primarily obtained sexual arousal through restriction of breathing rather than the subjective experience of oxygen lack. He also recommended keeping this diagnosis under the general rubric of Sexual Masochism.

Relationship and Cultural Context

Mitchell and Graham (2008) raised the issue that relationship influences are not considered in the diagnosis of sexual disorders and Tiefer (2004) and Tiefer, Brick, and Kaplan (2003) noted that both relationship and cultural context are important in assessing and treating sexual disorders. Given that Sexual Masochism is one of the paraphilias that could occur in the context of a relationship (along with Transvestic Fetishism, and perhaps some of the other unnamed paraphilias), it might make sense to consider

adding a specification as to whether Sexual Masochism occurred in the context of a relationship.

Recommendations and Discussion

Should Sexual Masochism Be Retained in the DSM?

Yes, for the following reasons:

1. While masochistic and/or sadomasochistic behavior occur with some frequency in the population and is associated with generally good psychological or social functioning, there are a very small number of cases where masochistic fantasy and behavior result in severe harm or even death. These cases clearly indicate a sexual interest pattern that has become pathological. Since so little is know about this behavior, further research is indicated, and inclusion in the DSM would facilitate this.
2. Although there are only a small number of studies that report on the occurrence of sexual masochism in forensic populations, one of these (Hill et al., 2006) reported that, of 166 sexual murderers, 5.4% received a diagnosis of sexual masochism, and 14.8% of those with sexual sadism also had sexual masochism. Further, because of the association of sadism with masochism, and because the studies of forensic populations did not use structured diagnostic inventories, the occurrence of sexual masochism in forensic populations could be substantially higher. In my opinion, retention of the diagnosis of Sexual Masochism in the DSM would allow for further research to be done on Sexual Masochism in forensic populations.
3. The current criteria for Sexual Masochism in the DSM do not apply to the vast majority of individuals who are practicing this behavior. There clearly are some individuals who present for treatment for Sexual Masochism, where such behavior has become out of control and a source of distress or dysfunction, and the current diagnostic criteria are appropriate for these individuals.
4. Some of the concerns of those in the S & M community regarding the misuse of the DSM to diagnose them could be addressed by strengthening caveats circumscribing the appli cation of the DSM in clinical or in forensic matters, particularly as regards S & M.

Should There Be Any Change in the Diagnostic Criteria?

Yes. Please see Table 4 for the change I am recommending and the reason for it. Otherwise, I think that the current criteria do a good job of defining Sexual Masochism that has become pathological and should not be changed. Further, the paraphilias subgroup will be discussing dimensional assessment, and this may afford the opportunity to depict Sexual Masochism on some continuum, or to qualify this disorder as mild, moderate, severe, or extreme.

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Table 4 Comparison of DSM-IV-TR and proposed DSM-V diagnostic criteria for sexual masochism

DSM-IV-TR	Proposed for DSM-V
Sexual Masochism	*Sexual Masochism*
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer	A. Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of being humiliated, beaten, bound, or otherwise made to suffer
B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning	B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
	C.
	Specify if:
	With Asphyxiophilia (Sexually Aroused by Asphyxiation)

Note: I concluded that sexual masochism should be retained in the DSM-V, and that the phrase "real, not simulated" should be deleted from the A Criterion as this did not appear to add any real distinction and because I could find no explanation for the continued inclusion of this phrase was found in the literature. The DSM paraphilias subworkgroup discussed hypoxyphilia and asked Dr. Steven Hucker to prepare an analysis of the literature and his recommendations for suggested diagnostic criteria, which he did (Hucker, 2009). Hucker, arguably the foremost authority on sexual masochism and on hypoxyphilia, argued convincingly to the paraphilias workgroup that it was not clear in this disorder that sexual arousal was, in fact, a result of oxygen deprivation; rather, it appeared that individuals would primarily obtain sexual arousal by restricting their breathing which secondarily resulted in the subjective experience of oxygen deprivation. He suggested that the term asphyxiophilia, coined previously by Money (1986) was more accurate and should be used. He also suggested that the available research did not provide sufficient evidence for making asphyxiophilia a separate category or code, and that it should be retained, but under the main diagnosis of sexual masochism as a specifier

Appendix 1: Sexual Masochism in the DSM

Diagnostic Criteria for Sexual Masochism from DSM-I to DSM-IV-TR.

DSM-I (American Psychiatric Association, 1952)

There is no mention of Sexual Masochism in DSM-I.

DSM-II (American Psychiatric Association, 1968)

The only mention of Masochism occurs under the categorization of Sexual Deviations (302.7):

Sexual Deviations. This category is for individuals whose sexual interests are directed primarily towards objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them. This diagnosis is not appropriate for individuals who perform deviant sexual acts because normal sexual objects are not available to them. (p. 44)

DSM-III (American Psychiatric Association, 1980)

Sexual masochism is classified as one of the paraphilias, with one of the following criteria necessary for the diagnosis:

(1) A preferred or exclusive mode of producing sexual excitement is to be humiliated, bound, beaten, or otherwise made to suffer.
(2) The individual has intentionally participated in an activity in which he or she was physically harmed or his or her life was threatened, in order to produce sexual excitement.

DSM-III-R (American Psychiatric Association, 1987)

The diagnostic criteria for sexual masochism were revised as follows:

A. Over a period of at least six months, recurrent intense sexual urges and sexually arousing fantasies involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.
B. The person has acted on these urges, or is markedly distressed by them.

DSM-IV and DSM-IV-TR (American Psychiatric Association, 1994, 2000)

See Table 4.

Appendix 2: Sexual Masochism in the ICD

The ICD-9 and ICD-10 Criteria for Sexual Sadism and Sexual Masochism and the ICD-10 Diagnostic Criteria for Research for Sadomasochism

The ICD-9-CM Diagnostic Criteria for Sadism and Masochism (World Health Organization, 1989) (p. 229) are:

302.8 Other specified psychosexual disorders
302.83 Sexual masochism
302.84 Sexual sadism

The ICD-10 International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (World Health Organization, 1992) (p. 367) criteria are:

F65 Disorders of sexual preference
Includes: Paraphilias
F65.5 Sadomasochism
A preference for sexual activity which involves the infliction of pain or humiliation, or bondage. If the subject prefers to be the recipient of such stimulation this is called masochism; if the provider, sadism. Often an individual obtains sexual excitement from both sadistic and masochistic activities.
Masochism
Sadism

The ICD-10 Classification of Mental and Behavior Disorders Diagnostic criteria for research (World Health Organization, 1993) are:

F65.5 Sadomasochism (p. 137)

A. The general criteria for disorders of sexual preference (F65) must be met.
B. There is preference for sexual activity, as recipient (masochism) or provider (sadism), or both, which involves at least one of the following:
   (1) pain;
   (2) humiliation;
   (3) bondage.
C. The sadomasochistic activity is the most important source of stimulation or is necessary for sexual gratification.

F65 Disorders of sexual preference (p. 135)

G1. The individual experiences recurrent intense sexual urges and fantasies involving unusual objects of activities.
G2. The individual either acts on the urges or is markedly distressed by them.
G3. The preference has been present for at least 6 months.

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