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Evaluation and Treatment of Sexual Disorders: Frottage

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Frotteurism is a paraphilia which is defined in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association, 1994, p. 527). Diagnostic criteria include: "A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person"; and "B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."

The first mention that we can find of frotteurism occurs in Krafft-Ebing's *Psychopathia Sexualis* (1886/1965). He presented the cases of four frotteurs and writes: "The simplest explanation seems to be that 'frottage' is a masturbatorial act of a hypersexual individual who is uncertain about his virility in the presence of women. This would also explain the motive of the assault being made not anteriorly but posteriorly. . . ." (p. 351).

The *Oxford English Dictionary* (Burchfield, 1972) notes that the word "frottage" is adopted from the French word "frottage" meaning "rubbing" or "friction" and goes on to state: "The special perversion of frottage . . . consists in a desire to bring the clothed body, and usually though not exclusively the genital region, into close contact with the clothed body of a woman. . . . Like fetishism, too, frottage is evidently a morbid development of the normal sexual excitatory effects of touching or contact with the opposite sex" (p. 1168).

Frotteurism is among the more common paraphilias and has been viewed by prosecutors and judges as a "nuisance" paraphilia (Krueger & Kaplan, 1997). It is difficult to apprehend and prosecute individuals engaging in frotteurism, because it is usually committed in large cities against anonymous individuals where it is difficult to obtain witnesses. It has only rarely been the occasion for an initial presentation for treatment (most of our practice and referrals have been for individuals involved with other deviancies, such as exhibitionism, voyeurism, or pedophilia). Nevertheless, it occurs either by itself or in conjunction with other paraphilias and can be treated.

What follows is a presentation of several features of this disorder, a discussion of the methods of assessment of this disorder, treatment recommendations, several case studies, and a resource list containing bibliographic and other information, with annotations. It should be said at the outset that there is little available literature on frotteurism and that much of what can be said about its treatment derives from more general principles of assessment and treatment of the other paraphilias. We will use the masculine pronoun in discussing frotteurism. Although it is certainly conceivable that frotteurism could exist in a female, we have not seen this in our experience or in the literature.

CHARACTERISTICS AND EPIDEMIOLOGY

Freund, Seto, and Kuban (1997) suggest that frotteurism is a distortion of a hypothesized normal sequence of human sexual interactions. Freund and Kolarsky (1965) set forth such a sequence as consisting of four phases: "(1) a finding phase, consisting of locating and apprais-

ing a potential partner; (2) an affiliative phase, characterized by nonverbal and verbal overtures such as looking, smiling, and talking to a potential partner; (3) a tactile phase, in which physical contact is made; and (4) a copulatory phase, in which sexual intercourse occurs" (p. 113).

They hypothesize that a paraphilia involves the omission or distortion of one of these phases, and that a paraphilia would reflect the preference of the patient for a virtually instant conversion of sexual arousal into orgasm. Thus the absence, for instance, of a finding, affiliative, and/or copulatory phase would leave an individual fixated on the tactile phase and could explain his preference for strangers as targets (with no necessity for finding an affiliation) and with an indiscriminate choice of target with regard to attractiveness and age. In our experience, however, frotteurs, or others engaged in paraphilic activity such as exhibitionism or voyeurism, will have specific features that describe their preferred target, for instance desiring a large, middle-aged, well-dressed woman; this behavior does not usually involve contact with an individual known to the frotteur.

The epidemiology of the paraphilias is unknown. The very nature of this activity, that it is sexual and covert, and that it is illegal, would dissuade individuals from being willing to speak about it; there is thus no data that epidemiologists and sexologists have collected in randomized population surveys about the occurrence of any of the paraphilias.

Some data relevant to the incidence of the paraphilias may be gathered from data concerning childhood sexual abuse. Although not all child sexual abusers are necessarily paraphiles, such behavior reflects deviant sexual activity. Russell (1983) reported on the incidence and prevalence of sexual abuse of female children in San Francisco, finding that in a random sample of 930 adult women, 12% reported that they had been abused by a relative and 20% by a nonrelative before age 14. A national sample of 2,000 men and women in Great Britain reported that 12% of females and 8% of males reported some sort of "sexual abuse" before age 16, although intercourse was reported in only 5% of the abusive experiences (Baker, 1985).

If one then focuses on the occurrence of frotteurism within the universe of paraphilias, one discovers that it is relatively common. Abel et al. (1988) reported on a group of 561 nonincarcerated paraphiliacs who responded to advertising in the local paper. These researchers interviewed appropriate respondents under a federal certificate of confidentiality which guaranteed complete confidentiality. They identified 17 categories of paraphilic behavior; frottage was sixth in terms of frequency as was voyeurism, as far as the number of individuals who reported at least one paraphilia (most individuals in this sample reported multiple paraphilias). Of 516 individuals interviewed, 62, or 10%, of this sample received a diagnosis of frotteurism. Similarly, Bradford, Boulet, and Pawlak (1992) reported on a sample of 443 adult males who were consecutively admitted to the Sexual Behaviours Clinic at the Royal Ottawa Hospital; 58, or roughly 14%, of these individuals admitted to frotteurism.

It is also notable that frotteurism very frequently occurs in conjunction with other paraphilias. Abel et al. (1988) reported that of the 62 subjects diagnosed with frotteurism, only 21% had frotteurism as a sole diagnosis, and that there was an average number of paraphilias of 3.8 per frotteur. Bradford et al. (1992) reported that of the individuals reporting frottage, 24% also reported heterosexual pedophilia; 35% heterosexual hebephilia (defined as a sexual preference for peri- and postpubertal victims, 12 to 16 years of age); 21% homosexual pedophilia; 17% homosexual hebephilia; 17% cross-dressing; 65% voyeurism; 29% scatologica (lewdness); 31% attempted rape; 16% rape; and 31% exhibitionism.

ASSESSMENT

Informed Consent and Forensic Considerations

It is recommended that any assessment begin by informing clients that we are mandated reporters of ongoing child sexual abuse, and that if the individual reveals any information that allows us to identify a child who is at risk for being or is being abused, then we have to notify the respective child welfare authorities. With frotteurs, because their targets usually involve

adults in subways who are not identifiable, a notification is not mandated unless the individual admits to some other paraphilia with an identifiable child as a target. Informed consent should be obtained and explained prior to doing an assessment. The elements of the information given involve an explanation of the nature and purpose of the interview, and what will be done with the information (i.e., a report will be issued to an attorney, judge, or licensing authority, or no report will be issued). Furthermore, if there are specific tests or instruments, such as the Abel Assessment (Abel, 1994), or the Adult Sexual Interest Cardsort (Abel, 1984), then information regarding the risks and benefits of this assessment or test should be given and consent obtained.

There is no duty that we are aware of to report past crimes. We would add that laws vary according to the state and country that an individual is practicing in, and that clinicians should familiarize themselves with local laws.

Following the initial consultation, if it is determined that the frotteur is out of control, then it seems to us that the clinician would have some duty to protect, and that this in some fashion would require actions to protect both the patient and the public, which might include emergency initiation of antiandrogen medications; hospitalization; or the establishment of a contract with the patient to avoid public places and not to engage in such actions until the next meeting. It would devolve to the clinician to use whatever clinical judgment and skill he or she has to treat the frotteur and choose the appropriate course of action among these alternatives.

It is also important to discuss confidentiality of medical records. In our experience there is no absolute confidentiality of medical records. An evaluation requested by an attorney in writing adds attorney-client privilege to the doctor-patient privilege. However, records can be obtained by medical licensing authorities (only with the patient's consent, but this consent could be insisted upon as a condition of licensure or regaining one's license), or by other parties (such as in child custody disputes or otherwise).

Initial Clinical Interview

It is important to establish the source of the referral and the referral question. If an individual were to come with some fear of arrest, then the clinician might at the outset suggest that this individual engage an attorney. If the person has been arrested and/or prosecuted, it is important to request all available written information concerning this individual and his history, including victims' statements, arrest reports, psychological or psychiatric evaluations, and records of treatment. It is particularly important to obtain information regarding the individual's frotteurism from sources other than the patient, because paraphiliacs are notoriously unreliable historians.

Regardless of whether the individual has been arrested or not, it is important to begin with a very thorough and detailed clinical history and mental status examination. It is also important to establish whether there are any comorbid diagnoses such as major psychiatric syndromes, personality disorders, or medical problems.

A detailed history of the patient's sexual functioning and any paraphilic sexual interests or behaviors follows. Given the reported occurrence of multiple paraphilias in the same individual, when one interviews a frotteur, one should inquire carefully about other paraphilias.

We also do a thorough nondeviant, as well as deviant, sexual history and inquire about the occurrence of any history of sexual or physical abuse. We routinely use the two forms on pages 194 and 195 as an aid in obtaining a sexual history in an ordered way and to survey for a variety of deviant sexual behaviors.

It is important to obtain as detailed a picture of the individual's pattern of behavior as possible. This would include the age of onset; the frequency of occurrence (oftentimes, frotteurism is a high frequency deviant behavior, occurring several times per day); the usual place or places that the frotteur chooses (e.g., subways, buses, dance floors, crowds); the usual targets (male or female, age, appearance); the cognitions that accompany the act ("She is frightened, but can't move"; "She is really enjoying it"; "I don't even think she was aware of anything"; "She knew just what I was doing"); the time of day and the circumstances of the frottage (in the morning on the way to work, or in the evening on the way from work); what is

worn; and whether a change of clothes is brought. Discovering the cognitions could offer the clinician some therapeutic advantage because removing or correcting them could increase the frotteur's awareness and motivation for change. If he can be convinced that, contrary to what he thinks, the woman might be frozen in surprise or fear, or find such activity almost unbelievable and disgusting, then he might become much less ready to engage in such activity. In the back of the assessing clinician's mind is always the possibility that in some fashion the information acquired could be used to intervene in a therapeutic way.

Antecedents to the behavior are particularly important to assess, as these offer possible areas that the clinician or a family member might be able to use to help the individual control his behavior. Is the behavior more likely to occur if the individual is angry? Intoxicated? Has had a bad day? How calculated is the behavior? How impulsive?

It is important to assess the individual's sense of control over himself. To assess this we ask "How much in control of your behavior are you?" We present a line indicating 0% control on one end and 100% control on the other and ask an individual to put a mark on the line that represents the percent of control that they think they have, from 0%, or no control at all, to 100%, or absolute control. We pose a hypothetical situation in which there is a high likelihood of not being apprehended for the act. For example, for a pedophile, one might ask what might he do if a young child were to approach him in a park with no one around. How much control would he have over any impulses or thoughts of abusing this child? For a frotteur, one might ask: "In a large crowd, with no police around, with several women in front of you focused on a parade and many people pressing forward, how much control might you have over any impulse to engage in frotteurism?"

Subjective and Objective Instruments

Several instruments are available to assess sexual functioning. One routinely used in addition to the preceding interview is the Derogatis Sexual Functioning Inventory (Derogatis, 1980; Derogatis & Melisaratos, 1979). This is a 258-item, self-administered instrument which presents questions in 10 areas of sexual functioning: information, experience, drive, attitudes, psychological symptoms, affects, gender role definition, fantasy, body image, and satisfaction. Scores are then derived for each of these categories and for overall sexual functioning. A major advantage is its comprehensiveness; a major disadvantage is its complexity. A computerized version is available.

The Clarke Sexual History Questionnaire for Males (Paitich et al., 1977) is another available instrument. This is a 190-item sexual history questionnaire which presents questions regarding a variety of deviant sexual behaviors in males, inquiring about the frequency and age of occurrence of a broad range of sexual behaviors, including the paraphilias. A computerized version is currently under development.

Another instrument routinely used is the Adult Sexual Interest Cardsort (Abel, 1984). It presents 75 items which are statements depicting various sorts of sexual activity. An individual is asked to rate whether each item seems to him extremely sexually repulsive, neutral, or extremely sexually arousing. This offers some indication of the individual's sexual preferences.

Sex offenders are notorious for being poor at self-report (Kaplan et al., 1990), and this has given rise to attempts to assess an individual's sexual preference objectively. One such measure is penile plethysmography (Abel, Blanchard, & Barlow, 1981; Pithers & Laws, 1988). This involves measuring penile tumescence as various stimuli are presented to the patient by having the patient put a mercury strain gauge around his penis as he sits in a separate room or behind a partition, and then presenting various stimuli to him. The Association for the Treatment of Sexual Abusers (ATSA, 1993) has a set of audiotapes for sale, as do other vendors. A problem that exists is that there is no generally accepted set of standardized stimuli. It should be noted that plethysmographic assessment should only be used as an aid in treatment, such as for pre- and postassessment, and not to establish guilt or innocence.

Another way of trying to objectively assess sexual interest relies on visual reaction time, and is marketed as The Abel Assessment (Abel, 1994). This consists of two parts. The first presents a very detailed set of questions which explore an individual's sexual history and in-

terests. The second presents several series of slides which use models to depict images that a paraphile might find arousing. Although there is support to the use of reaction time in assessing sexual interest patterns, and Dr. Abel has data to support his instrument, the validation of this assessment by other objective sources has yet to be done (Krueger, Bradford, & Glancy, 1998).

In our experience there is great utility to presenting questionnaires and to making an objective assessment of sexual interest patterns, as well as relying on clinical interviewing, as individuals frequently are more honest and complete in answering questions provided by questionnaires or computers than they are in face-to-face interviews.

TREATMENT RECOMMENDATIONS

Cognitive and Behavioral Interventions

At the outset, it is important to establish what resources and supports a frotteur or paraphile might have which could aid in his treatment. If he has a significant other or wife or parent, has he informed that individual of his problem? It might be advantageous to have the patient inform this individual, in order to recruit that individual to aid in the patient's treatment, as well as to inform that individual of the nature of the treatment (family members or significant others oftentimes have many questions). We would, if indicated, then have a meeting with the patient and with his family member or significant other to identify ourselves as his caregiver, to introduce ourselves, to explain something of the nature of the disorder and the nature of the treatments available, including risks and benefits, and to try and recruit the parent or significant other into being a treatment ally and a part of the treatment. This is for several reasons. First, it helps to have someone who would have some day-to-day contact with the patient to be able to report if that individual may have relapsed (for instance, that the individual cannot account for the time from which he left work until he came home, or if he has in fact admitted a relapse to the significant other). Second, the presence of an observing family member can itself have a dissuading effect on aberrant behavior. Third, frequently there are dynamic issues that emerge between the offender and his significant other that can be helped by therapeutic intervention.

Cognitive-behavioral techniques have been widely used in the treatment of the paraphilias and have been described in several reviews (Abel et al., 1992; Abel, Rouleau, & Cunningham-Rathner, 1986; Hawton, 1983). Such treatment usually involves group therapy and a number of behavioral techniques. One of these is masturbatory satiation, which has the goal of trying to decrease an individual's arousal to deviant fantasy and stimuli. Typically, an individual is instructed to, in the privacy of his home, masturbate to a nondeviant scenario, achieving ejaculation within a brief period of time, usually 5 to 10 minutes. Then he is asked to continue to masturbate to fantasies of his deviant behavior for an additional 50 minutes. This with time becomes boring and aversive. Patients are asked to record the verbalizations of their fantasies on a tape recorder for review by their therapist at a later date and also to rate their experience of the session as to how aversive or boring they found it. Typically patients finish a specified number of sessions, usually 20, in a course of therapy. With time many subjects report a decrease in the strength and attraction of their deviant fantasies. This is a technique, once learned, which a patient can use again and again in the future should he experience an emergence of his deviant interests or impulses.

Another behavioral technique is covert sensitization, which attempts to associate negative consequences with the individual's deviant behavior and with antecedents to that behavior. Typically, an individual is asked to initially write out what a typical episode of behavior might be and to look carefully for any recurrent antecedents to this behavior. For instance, a frotteur might have a hard day at work, then have a drink or two at a bar before getting on a subway and engaging in such behavior. We would have the frotteur verbalize over a period of 5 minutes or so his feelings about frustrations at work, perhaps his preparation for frottage, such as putting on extra underwear at work, his walking to the subway, and his movements in the subway toward a victim, and his beginning to be aroused. We would then ask him to inter-

rupt this narration and to verbalize the negative consequences of his actions, preferably those that have already been experienced or, if not, imagined consequences. For instance, if a frotteur has been arrested as a negative consequence, we would have him verbalize the detailed process of the arrest, including being apprehended by police, being led away in handcuffs, having his employer or family members find out, being in a jail cell and identified as a sex offender, and/or being threatened by other inmates, and his feelings during this. We would then have him verbalize a brief "escape scene" such as lying on a beach, in order to get out of the set of negative experiences and emotions. All of these verbalizations are done on a tape, which the therapist then listens to and offers feedback about.

Olfactory aversion (Laws, Meyer, & Holmen, 1978) is another technique in which the subject verbalizes the antecedents to and progression of his deviant behavior and then pairs this with the periodic wafting of a noxious olfactory stimulant, such as ammonia. We have found that individuals who can successfully learn this technique can then carry ampules of ammonia (smelling salts) with them which they can step aside and break and waft should they catch themselves in a progression toward offending.

Biological Therapies

Biological therapies of the paraphilias have consisted mainly of the use of antidepressant agents and antiandrogen agents. Stein et al. (1992) have suggested a possible relationship between the paraphilias and obsessive-compulsive disorder. Indeed, particularly with some of the high-frequency behaviors such as exhibitionism or frotteurism, there are many similarities. Patients report obsessions with sexual thoughts and behaviors and a compulsion to engage in them. However, these sexual thoughts and compulsions for the most part are experienced as ego-syntonic (willful, pleasurable, and agreeable) rather than ego-dystonic or alien, as in the obsessive-compulsive disorders.

A number of case reports and some smaller, more controlled trials have suggested that antidepressants, and in particular the serotonin-reuptake inhibitors (SRIs), have efficacy in the paraphilias (Gijs & Gooren, 1996). Whether this is because of the efficacy of these agents against obsessive-compulsive disorder, or because of the sexual side effects of these medications, which include a decrease in libido, retardation of orgasm or ejaculation, and/or a diminution in the deviant sexual interest or activity itself, is unknown.

Antiandrogen agents, with more profound effects on libido, sexual functioning, and side effects, have probably been studied more. Most work on the paraphilias has involved the use of depot or oral Provera in the United States or cyproterone acetate in Canada (Cooper, 1986). These appear to be highly effective. Recently attention has shifted to the use of luteinizing-hormone releasing hormone agonists, such as triptorelin outside of the United States or leuprolide in the United States. These agents work by lowering the secretion of the gonadotropic hormones, luteinizing hormone and follicle-stimulating hormone, which act on the testes to produce testosterone (Bradford, 1998; Rosler & Witztum, 1998). Because these agents result in an initial increase in these gonadotropic hormones, and thus testosterone, it is important to also treat the patient with a testosterone antagonist, such as Flutamide, for several weeks at the inception of treatment until testosterone levels drop. These agents have been highly effective at decreasing deviant arousal and behavior. Because these agents have such a profound effect on sexual functioning, and because they have substantial side effects, such as weight gain, gynecomastia, and osteoporosis, to name some of them, a careful medical evaluation prior to the initiation of treatment, which would include a physical examination and laboratory screen, including chemistries, white count, and sexual hormones (testosterone, luteinizing hormone, and follicle-stimulating hormone), and bone density studies is recommended. It is important to point out that the effects of these agents are reversible, with sexual functioning returning when these agents are stopped. Furthermore, these agents are available in depot form, in which an individual may take an injection once a month or once every 3 months rather than daily. These agents also have many fewer side effects than Provera or cyproterone acetate.

Typically an assessment is conducted to establish how much control the frotteur or paraphile has. This might also include an assessment of other behaviors or fantasies which the

frotteur might disclose, such as rape fantasies or an interest in children. If the patient is felt to be dangerous or to have poor control, then antiandrogen medication might be recommended initially. If, however, an individual had some degree of control and could contract not to engage in such acts, then behavioral treatments or SRI medications might be used. In our experience, individuals can use the antiandrogen medications to obtain control and a respite from their struggle, so to speak, and during this time learn behavioral or other techniques or otherwise engage in therapeutic changes that afford them more control until control is established, and then, when these agents are discontinued, experience a continued sense of control.

Relapse Prevention Therapies

Relapse prevention strategies, developed first for individuals with substance abuse problems, have been employed for years for paraphiliacs (Freeman-Longo & Pithers, 1992; Pithers, 1990). This therapeutic modality helps an individual to identify a chain of precursors or a cycle to his deviant behavior and gives him a strategy to interrupt this chain before actually engaging in the offending behavior. For instance, a frotteur might disclose that "early warning signs" of prior relapses have involved feelings of depression, use of alcohol, fatigue, and exhaustion, and would know to seek help from his clinician before relapsing. Other treatments, such as the use of 12-step meetings to abstain from alcohol, or the use of antidepressants, could be used to prevent relapse.

CASE STUDIES

The number of case reports that we have been able to find in the literature is small. These include the four cases described earlier by Krafft-Ebing (1886/1965) and a case of a man who engaged in obscene telephone calls and practiced frotteurism and was treated successfully with psychoanalysis (Myers, 1991). The treatment method of psychoanalysis is not considered to be the current standard for the treatment of the paraphilias; rather cognitive-behavioral therapy, medication therapy, and/or relapse prevention therapy are. However, psychotherapy, couples therapy, and even psychoanalysis, in addition to a whole plethora of other therapies, may be concurrently indicated for treatment of comorbid problems, such as depression, personality disorders, or couples problems.

Case Study A

Mr. A* at the time of our initial evaluation was a 58-year-old male, never married, referred as a condition of probation after he had pled guilty to misdemeanor charges of assault. He gave a history of, at the age of 15 while attending a Fourth of July picnic with his parents, rubbing up behind an adult female with his erect penis, as everyone was watching an event. He reported becoming very sexually excited by this. The patient recalled that rapidly his frotteuristic activity escalated in his later teens to include activities sometimes three or four times per day, usually on the way to or from school or, later, work, where he would rub up against unsuspecting females in subways or buses. He estimated he engaged in this behavior 200 days out of 365 days per year. He also engaged at night in "dirty dancing" at various discos where he would rub up against women who he asked to dance with him. He estimated that he did this perhaps 100 nights out of the year. He also described anticipating holidays in which there would be large crowds of people and parades, such as on St. Patrick's day or other holidays, in which he would engage in such activity. Interestingly, he reported that over the years, particularly on holidays, he witnessed other men who he would recognize through the years as also engaging in frotteuristic activity. He continued this activity throughout his adulthood with only two arrests and no convictions until the episode that mandated him to obtain treatment. By calculation he had, over a 40-year career, engaged in approximately 20,000 acts of frotteurism. He had no other paraphilias. He had a history of being both physically and sexually abused and of being socially phobic at his workplace. He had more than a thousand

*Names and identifying characteristics in all case examples have been disguised thoroughly to protect privacy.

female sexual partners. He had had in the 1980s treatment from two therapists, a social worker and a psychologist, with the treatment focus being his difficulties in heterosexual relationships. He reported that he had not revealed his history of frotteurism to either of these therapists. He had throughout his history maintained an excellent work history and had had no other major *DSM-IV* psychiatric syndromes. He acknowledged problems with intimacy and was distressed that he had been unable to marry and have children.

Treatment consisted of the imparting of masturbatory satiation to decrease his deviant arousal and covert sensitization to associate negative consequences with engaging in such acts. It also included insight-oriented therapy to help him examine his pattern of relationships with women and issues of intimacy and commitment. He did not agree to take antidepressant medication to treat his social phobia, which was suggested. In treatment, following his arrest, his engagement in frotteuristic activity dramatically decreased and he reported no episodes in the year that he was in treatment. After a year of therapy, he reported absolute control over his frotteurism but would not agree to continue in relapse prevention. Had his probation so mandated it, he undoubtedly would have.

This case illustrates the high frequency of frotteuristic activity and the necessity to have some hold over an individual, such as therapy being mandated by probation, in order to treat him; the tendency that such individuals might have to conceal such activity from a therapist who might not know or ask specifically about a paraphilic history; and the existence of other personality issues.

Case Study B

Mr. B. was a 34-year-old physician who was single and in private practice. He ultimately pled guilty to felony counts of sexual assault involving over 30 women over a several-year period for charges that he engaged in the rubbing and manipulation of patients' clitoris during unchaperoned pelvic examinations. His license was withdrawn and, following a prison term, he joined a group of professionals who had engaged in professional sexual misconduct of some form. He initially denied that he had engaged in anything inappropriate, but with the confrontation and support of the group admitted to wrongdoing. He had no other paraphilic or psychiatric history, and by all appearances his relationships and sexual life were normal during this activity.

This case indicates a different form of frotteurism, that propagated by a professional in the course of his professional duties which consisted of the inappropriate and nonconsensual touching of an unsuspecting female for purposes of sexual gratification. This touching did not involve the perpetrator's penis but rather consisted of manipulation by his hands and occurred during the course of professional activity. It was treated with a suspension of his practice.

Case Study C

Mr. C. was a 30-year-old Caucasian male with a history of pedophilic arousal to both prepubescent males and females, but with no attempts at sexual touching of children or solicitation of them. He also had a history of exhibitionism, consisting of exposing himself in convenience stores, around his apartment building, and in public at night. He had a history of manic-depressive disease and was on therapeutic doses of lithium and sertraline. Despite these, and despite intensive cognitive-behavioral treatment which included 2 months of inpatient treatment and intensive weekly outpatient treatment over the course of a year, he still reported high deviant arousal, in particular to the fantasies of touching children around his neighborhood on their arms or legs with his fingers or rubbing up against them in crowds with his clothed penis. He finally agreed to a course of antiandrogens and was given depot leuprolide acetate and flutamide, with a dramatic decrease in his sexual interest and behavior. He continued on this for an 8-month period, then stopped, and had a recurrence of his deviant interest. He then availed himself of 12-step groups for addictive sexual behavior on a frequent basis, but, when he was still not able to control himself, requested and was given another course of depot leuprolide acetate, with similar beneficial results.

This case illustrates the occurrence of frotteurism and pedophilia, and the great difficulty in control that can be experienced by an individual with these disorders. It also indicates the dramatic effects that antiandrogen medications can have on sexual arousal and behavior.

Case Study D

Mr. D. was a 26-year-old male, single at the time of his initial evaluation. He had a history of profound social phobia and obsessive-compulsive disorder and had managed to slowly progress toward leaving his parents' home, living by himself, and attending classes through a variety of treatments including cognitive-behavioral and supportive treatment for his social phobia, and a variety of antidepressant medications including monoamine oxidase inhibitors, tricyclics, and buproprion (which he was on at the time of his evaluation). He was evaluated for what he had self-identified as frotteuristic activity and he also indicated that he had never revealed this activity to any of his therapists. He reported that for the 4 years prior to his evaluation he would periodically travel in subways and would target an adult female in the same subway car. He would then sit next to her without touching her. If she did not move away (and sometimes the subway car would be empty), he would deliberately drop something on the floor in front of the woman. He would then, with his fingers, appear to inadvertently brush against her hip or leg, and apologize. He would in his mind find such activity highly sexually exciting; this behavior was accompanied by an erection. He did not ejaculate at this time and he never tried to press his penis against a female in the usual fashion of a frotteur. He would masturbate several times per evening with his masturbatory fantasies including memories or thoughts of the most recent episode of touching or prior episodes of touching. He said that medications had had no effect on this behavior. He had no other paraphilias. He had had one brief sexual experience with a woman who lived in his building, but otherwise was sexually naïve. Following our initial evaluation, he decided not to accept the recommended treatment for this condition, which was cognitive-behavioral therapy to try and decrease his deviant arousal and supportive and informational therapy to try and help him develop a relationship with a woman.

This case illustrates a somewhat atypical presentation of a frotteur, in which an individual intensely sexualizes what appears to be an innocent and accidental contact with a woman; it also indicates the difficulty that some individuals have in agreeing to therapy for this disorder and comorbid personality issues and other syndromes.

Overall, it may be said that frotteurism is one of the more common paraphilias, and that with current cognitive-behavioral and medical treatments there is much reason to be optimistic that such behavior can be successfully controlled. However, research is needed on the incidence and prevalence not only of frotteurism but of all of the paraphilias, along more scientific assessments of treatment efficacy and outcome.

Nondeviant Sexual History

1. Age reached puberty _____
2. Age 1st ejaculation occurred _____
3. By what means? _____
4. Age of 1st crush _____
5. Age of 1st date _____
6. Age of 1st nongenital touching (petting) _____
7. Age of 1st genital experience _____
8. Age of 1st masturbation _____
9. Masturbation frequency _____
10. Number of sexual partners (female) _____

    (male) _____
11. Sexual orientation _____
12. Sexual imagery _____
13. Masturbation fantasy _____
14. History of physical abuse _____
15. History of sexual abuse _____
16. Sexual dysfunction _____

Paraphilic History

For each reported fantasy, ask age when fantasy first began, number of lifetime acts, and percent of current control over acting on the fantasies.

Paraphilia	Fantasies	Age of Occurrence	Number of Acts
Exhibitionism			
Public Masturbation			
Fetishism			
Frotteurism			
Pedophilia			
Rape			
Sexual Masochism			
Sexual Sadism			
Transvestic Fetishism			
Transexualism			
Voyeurism			
Necrophilia (corpses)			
Zoophilia (animals)			
Coprophilia (feces)			
Urophilia (urine)			
Klismaphilia (enemas)			
Scatalogia (telephone)			
Partialism			

0% Control Over Deviant Urges **100% Control Over Deviant Urges**

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