

others. A paraphilia is a necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention.

In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia (e.g., an erotic focus on children or on exposing the genitals to strangers), and Criterion B specifies the negative consequences of the paraphilia (i.e., distress, impairment, or harm to others). In keeping with the distinction between paraphilic disorders and paraphilic foci, the term *diagnosis* should be reserved for individuals who meet both Criteria A and B (i.e., individuals who have a paraphilic disorder). If an individual meets Criterion A but not Criterion B for a particular paraphilia—a circumstance that might arise when a benign paraphilia is discovered during the clinical investigation of some other condition—then the individual may be said to have that paraphilia but not a paraphilic disorder.

It is not rare for an individual to manifest two or more paraphilic foci. In some cases, the paraphilic foci are closely related and the connection between the paraphilic foci is intuitively comprehensible (e.g., foot fetishism and shoe fetishism). In other cases, the connection between the paraphilic foci is not obvious, and the presence of multiple paraphilic foci may be coincidental or else related to some generalized vulnerability to anomalies of psychosexual development. In any event, comorbid diagnoses of separate paraphilic disorders may be warranted if more than one paraphilia is causing suffering to the individual or harm to others.

Because of the two-pronged nature of diagnosing paraphilic disorders, clinician-rated or self-rated measures and severity assessments could address either the strength of the paraphilia itself or the seriousness of its consequences. Although the distress and impairment stipulated in the Criterion B are special in being the immediate or ultimate result of the paraphilia and not primarily the result of some other factor, the phenomena of reactive depression, anxiety, guilt, poor work history, impaired social relations, and so on are not unique in themselves and may be quantified with multipurpose measures of psychosocial functioning or quality of life.

The most widely applicable framework for assessing the strength of a paraphilia itself is one in which examinees' paraphilic sexual fantasies, urges, or behaviors are evaluated in relation to their normophilic sexual interests and behaviors. In a clinical interview or on self-administered questionnaires, examinees can be asked whether their paraphilic sexual fantasies, urges, or behaviors are weaker than, approximately equal to, or stronger than their normophilic sexual interests and behaviors. This same type of comparison can be, and usually is, employed in psychophysiological measures of sexual interest, such as penile plethysmography in males or viewing time in males and females.

Voyeuristic Disorder

Diagnostic Criteria

302.82 (F65.3)

- A. Over a period of at least 6 months, recurrent and intense sexual arousal from observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, as manifested by fantasies, urges, or behaviors.
- B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The individual experiencing the arousal and/or acting on the urges is at least 18 years of age.

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in voyeuristic behavior are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Specifiers

The “in full remission” specifier does not address the continued presence or absence of voyeurism per se, which may still be present after behaviors and distress have remitted.

Diagnostic Features

The diagnostic criteria for voyeuristic disorder can apply both to individuals who more or less freely disclose this paraphilic interest and to those who categorically deny any sexual arousal from observing an unsuspecting person who is naked, disrobing, or engaged in sexual activity despite substantial objective evidence to the contrary. If disclosing individuals also report distress or psychosocial problems because of their voyeuristic sexual preferences, they could be diagnosed with voyeuristic disorder. On the other hand, if they declare no distress, demonstrated by lack of anxiety, obsessions, guilt, or shame, about these paraphilic impulses and are not impaired in other important areas of functioning because of this sexual interest, and their psychiatric or legal histories indicate that they do not act on it, they could be ascertained as having voyeuristic sexual interest but should *not* be diagnosed with voyeuristic disorder.

Nondisclosing individuals include, for example, individuals known to have been spying repeatedly on unsuspecting persons who are naked or engaging in sexual activity on separate occasions but who deny any urges or fantasies concerning such sexual behavior, and who may report that known episodes of watching unsuspecting naked or sexually active persons were all accidental and nonsexual. Others may disclose past episodes of observing unsuspecting naked or sexually active persons but contest any significant or sustained sexual interest in this behavior. Since these individuals deny having fantasies or impulses about watching others nude or involved in sexual activity, it follows that they would also reject feeling subjectively distressed or socially impaired by such impulses. Despite their nondisclosing stance, such individuals may be diagnosed with voyeuristic disorder. Recurrent voyeuristic behavior constitutes sufficient support for voyeurism (by fulfilling Criterion A) and simultaneously demonstrates that this paraphilically motivated behavior is causing harm to others (by fulfilling Criterion B).

“Recurrent” spying on unsuspecting persons who are naked or engaging in sexual activity (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 watching the same victim or if there is corroborating evidence of a distinct or preferential interest in secret watching of naked or sexually active unsuspecting persons. Note that multiple victims, as suggested earlier, are a sufficient but not a necessary condition for diagnosis; the criteria may also be met if the individual acknowledges intense voyeuristic sexual interest.

The Criterion A time frame, indicating that signs or symptoms of voyeurism must have persisted for at least 6 months, should also be understood as a general guideline, not a strict threshold, to ensure that the sexual interest in secretly watching unsuspecting naked or sexually active others is not merely transient.

Adolescence and puberty generally increase sexual curiosity and activity. To alleviate the risk of pathologizing normative sexual interest and behavior during pubertal adolescence, the minimum age for the diagnosis of voyeuristic disorder is 18 years (Criterion C).

Prevalence

Voyeuristic acts are the most common of potentially law-breaking sexual behaviors. The population prevalence of voyeuristic disorder is unknown. However, based on voyeuris-

tic sexual acts in nonclinical samples, the highest possible lifetime prevalence for voyeuristic disorder is approximately 12% in males and 4% in females.

Development and Course

Adult males with voyeuristic disorder often first become aware of their sexual interest in secretly watching unsuspecting persons during adolescence. However, the minimum age for a diagnosis of voyeuristic disorder is 18 years because there is substantial difficulty in differentiating it from age-appropriate puberty-related sexual curiosity and activity. The persistence of voyeurism over time is unclear. Voyeuristic disorder, however, per 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 spying on unsuspecting naked or sexually active persons. Therefore, the course of voyeuristic disorder is likely to vary with age.

Risk and Prognostic Factors

Temperamental. Voyeurism is a necessary precondition for voyeuristic disorder; hence, risk factors for voyeurism should also increase the rate of voyeuristic disorder.

Environmental. Childhood sexual abuse, substance misuse, and sexual preoccupation/hypersexuality have been suggested as risk factors, although the causal relationship to voyeurism is uncertain and the specificity unclear.

Gender-Related Diagnostic Issues

Voyeuristic disorder is very uncommon among females in clinical settings, while the male-to-female ratio for single sexually arousing voyeuristic acts might be 3:1.

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 secretly watching unsuspecting others who are naked or engaging in sexual activity should be lacking.

Substance use disorders. Substance use disorders might involve single voyeuristic episodes by intoxicated individuals but should not involve the typical sexual interest in secretly watching unsuspecting persons being naked or engaging in sexual activity. Hence, recurrent voyeuristic sexual fantasies, urges, or behaviors that occur also when the individual is not intoxicated suggest that voyeuristic disorder might be present.

Comorbidity

Known comorbidities in voyeuristic disorder are largely based on research with males suspected of or convicted for acts involving the secret watching of unsuspecting nude or sexually active persons. Hence, these comorbidities might not apply to all individuals with voyeuristic disorder. Conditions that occur comorbidly with voyeuristic disorder include hypersexuality and other paraphilic disorders, particularly exhibitionistic disorder. Depressive, bipolar, anxiety, and substance use disorders; attention-deficit/hyperactivity disorder; and conduct disorder and antisocial personality disorder are also frequent comorbid conditions.

Exhibitionistic Disorder

Diagnostic Criteria

302.4 (F65.2)

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

Specify whether:

Sexually aroused by exposing genitals to prepubertal children

Sexually aroused by exposing genitals to physically mature individuals

Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals

Specify if:

In a controlled environment: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to expose one's genitals are restricted.

In full remission: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment.

Subtypes

The subtypes for exhibitionistic disorder are based on the age or physical maturity of the non-consenting individuals to whom the individual prefers to expose his or her genitals. The non-consenting individuals could be prepubescent children, adults, or both. This specifier should help draw adequate attention to characteristics of victims of individuals with exhibitionistic disorder to prevent co-occurring pedophilic disorder from being overlooked. However, indications that the individual with exhibitionistic disorder is sexually attracted to exposing his or her genitals to children should not preclude a diagnosis of pedophilic disorder.

Specifiers

The "in full remission" specifier does not address the continued presence or absence of exhibitionism per se, which may still be present after behaviors and distress have remitted.

Diagnostic Features

The diagnostic criteria for exhibitionistic disorder can apply both to individuals who more or less freely disclose this paraphilia and to those who categorically deny any sexual attraction to exposing their genitals to unsuspecting persons despite substantial objective evidence to the contrary. If disclosing individuals also report psychosocial difficulties because of their sexual attractions or preferences for exposing, they may be diagnosed with exhibitionistic disorder. In contrast, if they declare no distress (exemplified by absence of anxiety, obsessions, and guilt or shame about these paraphilic impulses) and are not impaired by this sexual interest in other important areas of functioning, and their self-reported, psychiatric, or legal histories indicate that they do not act on them, they could be ascertained as having exhibitionistic sexual interest but *not* be diagnosed with exhibitionistic disorder.

Examples of nondisclosing individuals include those who have exposed themselves repeatedly to unsuspecting persons on separate occasions but who deny any urges or fan-

tasies about such sexual behavior and who report that known episodes of exposure were all accidental and nonsexual. Others may disclose past episodes of sexual behavior involving genital exposure but refute any significant or sustained sexual interest in such behavior. Since these individuals deny having urges or fantasies involving genital exposure, it follows that they would also deny feeling subjectively distressed or socially impaired by such impulses. Such individuals may be diagnosed with exhibitionistic disorder despite their negative self-report. Recurrent exhibitionistic behavior constitutes sufficient support for exhibitionism (Criterion A) and simultaneously demonstrates that this paraphilically motivated behavior is causing harm to others (Criterion B).

“Recurrent” genital exposure to unsuspecting others (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 exposure to the same victim, or if there is corroborating evidence of a strong or preferential interest in genital exposure to unsuspecting persons. Note that multiple victims, as suggested earlier, are a sufficient but not a necessary condition for diagnosis, as criteria may be met by an individual’s acknowledging intense exhibitionistic sexual interest with distress and/or impairment.

The Criterion A time frame, indicating that signs or symptoms of exhibitionism must have persisted for at least 6 months, should also be understood as a general guideline, not a strict threshold, to ensure that the sexual interest in exposing one’s genitals to unsuspecting others is not merely transient. This might be expressed in clear evidence of repeated behaviors or distress over a nontransient period shorter than 6 months.

Prevalence

The prevalence of exhibitionistic disorder is unknown. However, based on exhibitionistic sexual acts in nonclinical or general populations, the highest possible prevalence for exhibitionistic disorder in the male population is 2%–4%. The prevalence of exhibitionistic disorder in females is even more uncertain but is generally believed to be much lower than in males.

Development and Course

Adult males with exhibitionistic disorder often report that they first became aware of sexual interest in exposing their genitals to unsuspecting persons during adolescence, at a somewhat later time than the typical development of normative sexual interest in women or men. Although there is no minimum age requirement for the diagnosis of exhibitionistic disorder, it may be difficult to differentiate exhibitionistic behaviors from age-appropriate sexual curiosity in adolescents. Whereas exhibitionistic impulses appear to emerge in adolescence or early adulthood, very little is known about persistence over time. By definition, exhibitionistic disorder requires one or more contributing factors, which may change over time with or without treatment; subjective distress (e.g., guilt, shame, intense sexual frustration, loneliness), mental disorder comorbidity, hypersexuality, and sexual impulsivity; psychosocial impairment; and/or the propensity to act out sexually by exposing the genitals to unsuspecting persons. Therefore, the course of exhibitionistic disorder is likely to vary with age. As with other sexual preferences, advancing age may be associated with decreasing exhibitionistic sexual preferences and behavior.

Risk and Prognostic Factors

Temperamental. Since exhibitionism is a necessary precondition for exhibitionistic disorder, risk factors for exhibitionism should also increase the rate of exhibitionistic disorder. Antisocial history, antisocial personality disorder, alcohol misuse, and pedophilic sexual preference might increase risk of sexual recidivism in exhibitionistic offenders.