

Is Pedophilia a Mental Disorder?

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Nearly 30 years ago, I was embroiled in the historic battle within the American Psychiatric Association (APA) over whether homosexuality *per se* was rightfully deemed a mental illness, as included in the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II; American Psychiatric Association, 1968). During the controversy, several topics were examined: historical and cross-cultural groundings in homosexual expression, associated psychiatric features accompanying a homosexual orientation, the emotional consequences to the homosexual of societal condemnation, and behaviors of other species. I argued vigorously for removal of homosexuality from the DSM (Green, 1972; see also Stoller, 1973). The Task Force on Nomenclature and Statistics voted to delete homosexuality. Ludicrously, that decision led to a shotgun marriage between science and democracy. It was put to popular vote—a referendum by the entire APA membership.

We cannot track precisely the 1970s model here. Consensual same-sex adult–adult sexuality does not suggest the element of harm to one participant as in child–adult sex or an age barrier to informed consent. But these concerns are within the domain of the law and penal enforcement. What follows here does not address whether pedophilia should be deemed criminal.

HISTORICAL AND CROSS-CULTURAL CONSIDERATIONS

Several quotes illustrate the range of acceptance of sexual contact between children and adults:

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The diversity of sexual behavior in a cross-cultural perspective is amazing to those who assume that their own society's moral standards are somehow laws of nature. Yet it is a fact that almost every sort of sexual activity . . . has been considered normal and acceptable in some society at some time. . . . Man-boy relationships are no exception to this rule of diversity. . . . Although they are roundly condemned by many segments of Western society as inherently abusive and exploitive, there have been (and still are) many societies that do not share this viewpoint. (Bauseman, 1997, p. 120)

Substantial differences are found between the legal, social, and biological definitions of pedophilia. In Western society, definitions of childhood have been based largely on arbitrary dates, milestones marking progress into adulthood. Biological change may not correspond closely to these, and are insignificant in social and legal definitions. (Howitt, 1998, p. 17)

At this point in our history, a very real conundrum exists for the researchers of adult/child sex. The problem is reflected in the question of what truly marks the point beyond which sexual interaction with a child is pathological and not just criminal. (Ames & Houston, 1990, p. 339)

In the DSM-IV (American Psychiatric Association, 2000), puberty is the boundary for pedophilia. The younger person is to be prepubertal. But, the designation of puberty as the bright line age boundary for erotic attraction to be a mental illness is arbitrary. It does not consider the mental development of the child. Further, puberty varies between individuals and may be changing over generations. And, for sexual proscription, it is not the marker necessarily grounded historically or cross-culturally.

Cross-Cultural Examples

Ford and Beach (1951) described cross-cultural examples of child–adult sex from the Human Relation Area files at Yale University. Among the Siwans (Siwa Valley, North Africa), “All men and boys engage in anal intercourse. Males are singled out as peculiar if they did not do

so. Prominent Siwan men lend their sons to each other for this purpose" (pp. 131–132). Among the Aranda aborigines (Central Australia), "Pederasty is a recognized custom. . . . Commonly a man, who is fully initiated but not yet married, takes a boy ten or twelve years old, who lives with him as his wife for several years, until the older man marries" (p. 132).

Diamond (1990) reviewed child–adult sex in Hawaiian history and Polynesia. In the eighteenth century, Cook (1773) reported copulation in public in Hawaii between an adult male and a female estimated to be 11 or 12 "without the least sense of it being indecent or improper" (cited in Diamond, 1990). Sexual interactions between adult and child were seen as benefitting the child, rather than as gratifying the adult. The sexual desire by an adult for a nonadult, heterosexual or homosexual, was accepted (Pukui, Haertig, & Lee, 1972, cited in Diamond, 1990).

Suggs (1966), studying Marquesan society, reported considerable childhood sexual behavior with adults (cited in Diamond, 1990). He reported many examples of heterosexual intercourse in public between adults and prepubertal children in Polynesia. The crews of visiting ships were typically involved and assisted by adult natives. Occasions were recorded of elders assisting youngsters in having sex with other elders. In many cultures of Oceania, prepubertal females were publicly sexually active with adults (Oliver, 1974). In Tahiti, in 1832, the missionary Orsmond observed that "in all Tahitians as well as officers who come in ships there is a cry for little girls" (Oliver, 1974, pp. 458–459, cited in Diamond, 1990).

Among the Etoro of New Guinea, from about age 10 years, boys would have regular oral sex with older men, swallowing their semen to facilitate growth (Bauserman, 1997). Among the neighboring Kaluli, when a boy reached age 10 or 11, his father would select a man to inseminate him for a period of months to years. In addition, ceremonial hunting lodges would be organized where boys could voluntarily form relationships with men who would have sexual relations with them (Bauserman, 1997).

These cross-cultural examples are not cited to argue for similar practices in Los Angeles or London. But are we to conclude that all the adults engaged in these practices were mentally ill? If arguably they were not pedophiles, but following cultural or religious tradition, why is frequent sex with a child not a mental illness under those circumstances?

For skeptics of the relevance of these cited exotic examples, for three centuries the age of sexual consent in England was 10. This was not in some loin cloth clad tribe living on the side of a volcano, but the nation that for six centuries was already graduating students from Oxford and Cambridge. Further, the time when age of consent was

10 was not in a period contemporaneous with Cromagnon Man, but continued to within 38 years of World War I. The impetus to raise the age of sexual consent in England from 10 years was fueled not by an outrage over pedophilia *per se* but concerns over child prostitution. Changes in employment law during the nineteenth century were protecting children from long hours of factory labor, leaving them more accessible for sexual service as the only means of support. Child prostitution was rampant (Bullough, 1990). Were all customers pedophiles? Were they all mentally ill?

Nonhumans

I will make one obligatory reference to nonhuman primates. Observations concern a near relative of Man, the bonobo, where these "pigmy chimps" are allowed free access to any other bonobo for sexual contact at the San Diego Zoo. Nonfertile combinations (same-sex or juvenile–adult combinations) were as frequent as potentially fertile, adult male–female combinations. Further, one third of sociosexual contacts by an adult with an infant were initiated by the infant (De Waal, 1990).

ASSOCIATED PERSONALITY FEATURES

A study of general personality features and concurrent psychopathology of pedophiles is hampered by sampling bias. Nearly all studies involve prisoners or those convicted of a criminal offence. These are doubtfully representative of all pedophiles who have contact with children and certainly not representative of pedophiles who confine their eroticism to fantasy and so do not break the law. Finkelhor et al. (1986) observed the following sampling bias in convicted sex offenders: "[They are] a small fraction of all offenders, the most flagrant and repetitive in offending, most socially disadvantaged, and least able to persuade criminal justice authorities to let them off" (p. 138).

Three studies of incarcerated offenders will be summarized and then one of nonincarcerated pedophiles. When imprisoned pedophiles were compared to nonsexually deviant psychiatric patients and controls, no differences were found in selected items of the Psychopathic Deviate scale of the MMPI (Johnston, French, Schouwiler, & Johnston, 1992). With pedophiles in residential or outpatient treatment, lifetime prevalence of mood disorder was found in two thirds, as well as anxiety disorder in two thirds. Cause and effect here is arguable between social consequences of pedophilia and psychiatric problems promoting pedophilia (Raymond, Coleman, Ohlerking, Christenson, & Miner, 1999). Incarcerated pedophilic

males were administered a test of state and trait anxiety and anger, a measure of self-esteem, and the MMPI. They were compared to offenders against adolescents and offenders against adults. Child offenders had higher scores on two of the three scales of the "neurotic triad," on three of the four scales on the "psychotic tetrad," and the scale Social Introversion. These reflect difficulties in interpersonal relations and social alienation. Pedophiles were higher in trait anxiety and anger and lower on self-esteem (Kalichman, 1991).

A unique study at the Institute of Psychiatry of the Maudsley Hospital in London evaluated nonprisoner, non-patient pedophiles (Wilson & Cox, 1983). The men were obtained through the Pedophile Information Exchange. The psychometric instrument utilized, it being a Maudsley study, was the Eysenck Personality Questionnaire (EPQ). The EPQ is scored on three main axes of personality: extraversion, neuroticism, and psychoticism. There is also a "Lie Scale" to assess "faking good." A total of 77 pedophiles were studied, with an age range of 20–60. They were compared with 400 controls.

Pedophiles were significantly more introverted. Psychoticism, or thought disorder, was slightly elevated but not to a pathological level. Occupational groups with similar scores to the pedophiles are doctors and architects. Neuroticism scores were slightly higher than controls, but not clinically abnormal. Pedophile scores were similar to actors and students. The lie scales did not differ. Wilson and Cox (1983) concluded that

... the most striking thing about these results is how normal the paedophiles appear to be according to their scores on these major personality dimensions—particularly the two that are clinically relevant [neuroticism and psychoticism]... introversion... in itself is not usually thought of as pathological. (p. 57)

Another researcher, Howitt (1998), reached a similar conclusion: "The possibility of finding a simple personality profile that differentiates pedophiles from other men has appeared increasingly unrealistic as the research and clinical base has widened. Simplistic notions such as social inadequacy driving men to sex with children become unviable as highly socially skilled pedophiles are found" (p. 44).

NONPEDOPHILES: SELF-REPORT

How common is sexual interest or arousal in persons not known to be, or self-labeled as, pedophiles? In a sample of nearly 200 university males, 21% reported some sexual attraction to small children, 9% described sexual fantasies involving children, 5% admitted to having mastur-

bated to sexual fantasies of children, and 7% indicated they might have sex with a child if not caught (Briere & Runtz, 1989). Briere and Runtz remarked that "given the probable social undesirability of such admissions, we may hypothesize that the actual rates were even higher" (p. 71). In another sample with 100 male and 180 female undergraduate students, 22% of males and 3% of females reported sexual attraction to a child (Smiljanich & Briere, 1996).

NONPEDOPHILES: PENILE RESPONSIVITY

Laboratory researchers have validated physiologically the self-report studies of nonclinical, nonpedophile-identified volunteers. In a sample of 80 "normal" volunteers, over 25% self-reported some pedophilic interest or in the plethysmographic phase exhibited penile arousal to a child that equaled or exceeded arousal to an adult (Hall, Hirschman, & Oliver, 1995). In another study, "normal" men's erections to pictures of pubescent and younger girls averaged 70 and 50%, respectively, of their responses to adult females (Quinsey, Steinman, Bergersen, & Holmes, 1975). In a control group of 66 males recruited from hospital staff and the community, 17% showed a penile response that was pedophilic (Fedora et al., 1992).

Freund and Watson (1991), studying community male volunteers in a plethysmography classification study, found that 19% were misclassified as having an erotic preference for minors. Freund and Costell (1970) studied 48 young Czech soldiers who were shown slides of children between 4 and 10, both male and female, as well as adolescents and adults, male and female. Penile responsivity to female children, ages 4–10, was intermediate to adolescent and adult females and males in one scoring system. In the other scoring system, all 48 soldiers showed penile response to adult females, as did 40 of 48 to adolescent females, and notably, 28 of 48 showed penile response to the female children age 4–10.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

The evolution of pedophilia in the different editions of DSM is a trip through Alice's Wonderland. In the first edition of DSM-I (American Psychiatric Association, 1952), pedophilia was listed as one of the "sexual deviations." Pedophilia was labeled "sociopathic" because of its conflict with societal mores. In DSM-II (American Psychiatric Association, 1968), pedophilia remained a "sexual deviation," but "sociopathy" was gone and pedophilia fell into a group of "nonpsychotic mental disorders." Then, in DSM-III (American Psychiatric Association, 1980),

pedophilia was included in the group of paraphilias. It was diagnosed for sexual activity or fantasy of sex by an adult with a prepubescent child. The acts needed to range from “repeatedly preferred” to the “exclusive method of achieving sexual excitement” (p. 272). But “isolated sexual acts with children [did] not warrant the diagnosis” (p. 271). In DSM-III-R (American Psychiatric Association, 1987), the requirement was scuttled that sex with children needed to be “repeatedly preferred.” Pedophilia was diagnosable in persons who also had a sexual interest in adult–adult sex.

An early critique of DSM and pedophilia concluded that “[Inclusion] of the so-called ‘sexual paraphilias’ in DSM has reinforced the suspicion that they are not, *per se*, mental disorders, but rather constitute conflicts between an individual and society . . . psychiatry has resorted to the codification of social mores while masquerading as an objective science” (Suppe, 1984, p. 26).

We live now with DSM-IV and its revised text edition (American Psychiatric Association, 2000). The criteria for pedophilia are shown in Table I. How do they fit in with the general DSM criteria for a mental disorder? The DSM-IV criteria require their association with “present distress . . . or disability (i.e., impairment in one or more important areas of functioning) or a significantly increased risk of suffering . . . an important loss of freedom” (p. xx). But DSM also states that “Neither deviant behavior (e.g., . . . sexual) nor conflicts that are primarily between the individual and society [which can certainly result in loss of freedom to the convicted pedophile] are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual . . .” (p. xxii). Thus, the pedophile who is not distressed over being a pedophile except in response to public condemnation would not qualify for disorder. But, elsewhere in DSM-IV, this loophole appears to be covered:

Because of the ego-syntonic nature of Pedophilia, many individuals with pedophilic fantasies, urges, or behaviors do not experience significant distress. It is important to understand that experiencing distress about having the fantasies, urges, or behaviors is not necessary for a diagnosis of Pedophilia. Individuals who have a pedophilic arousal pattern and act on these fantasies or urges with a child qualify for the diagnosis . . . (American Psychiatric Association, 2000, p. 571)

So what then of the pedophile who does not act on the fantasies or urges with a child? Where does the DSM leave us? In Wonderland. If a person does not act on the fantasies or urges of pedophilia, he is not a pedophile. A person not distressed over the urges or fantasies and who just repeatedly masturbates to them has no disorder. But a person who is not distressed over them and has sexual contact with a child does have a mental disorder.

Table I. DSM-IV-TR Diagnostic Criteria for Pedophilia

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- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).
- B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.
- C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.
- Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.
- Specify if:
- Sexually attracted to males
 - Sexually attracted to females
 - Sexually attracted to both
- Specify if:
- Limited to incest
- Specify if:
- Exclusive type (attracted only to children)
 - Nonexclusive type
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The APA position with its DSM catalogue is logically incoherent. Confronted with the paradox that in contrast to other conditions designated a mental disorder, such as with persons who hand wash to the point of bleeding and can’t touch a door knob, or who are harassed by voices threatening their personal destruction, many pedophiles are not distressed by their erotic interest, aside from the fear of incarceration. Some celebrate their interests, organize politically, and publish magazines or books. So to deal with this paradox, DSM dug itself deep into a logical ditch. If a person’s erotic fantasies are primarily of children and masturbatory imagined partners are children, that person does not have a mental illness, without more. Never mind these mental processes, those readers of DSM who are psychiatrists and treaters of the disordered mind. These people with these fantasies do not have a mental disease unless that person translates thought into action. This turns psychiatry on its head. Certainly a society can set rules on sexual conduct and proscribe child–adult sex and invoke sanctions for transgressors. But that is the province of the law and the penal system. The DSM should not provide psychiatry with jurisdiction over an act any more than it should provide the law with jurisdiction over a thought.

CONCLUSION

Sexual arousal patterns to children are subjectively reported and physiologically demonstrable in a substantial minority of “normal” people. Historically, they have been common and accepted in varying cultures at varying times.

This does not mean that they must be accepted culturally and legally today. The question is: Do they constitute a mental illness? Not unless we declare a lot of people in many cultures and in much of the past to be mentally ill. And certainly not by the criteria of DSM.

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