

of the *DSM* and the only writer that I have come across to support his position with examples from the extant historical, cross-cultural, and clinical literatures. He reports that the process of reviewing such literatures was the same one that he and his colleagues used in the 1970s in their ultimately successful battle to have homosexuality removed from the *DSM*. One distinction that Green makes, however, between pedophilia and homosexuality is that adult-child sexuality should not be equated with mutually consenting adult-adult homosexuality, as the former involves children who cannot be considered consensual partners in sexual activities (a point echoing the central thesis of Schmidt's paper). Thus, a logical conclusion to Green's paper is that pedophilia should be removed from the *DSM* classification system in the same way that homosexuality was. If pedophilia should not be conceptualized as mental disorder, how should we view it, and what are the implications of adopting such a view?

One possible conceptualization of pedophilia is that it is a sexual orientation. This point of view appears to be consistent with Schmidt's reasoning. Although most researchers have tended to discuss sexual orientation in terms of the sexes or gender identities of the individuals involved (most likely assuming that the individual to whom one is attracted is of consenting age), there have been a growing number of researchers who have defined sexual orientation in much broader terms, which include pedophilia (e.g., Barbaree, Bogaert, & Seto, 1995; Berlin, 2000; Feierman, 1990; Laws & O'Donohue, 1997; Suppe, 1984). Barbaree et al. (1995), for instance, stated that "sexual orientation is defined by (1) the ability of a certain class of stimuli to evoke sexual arousal and desire in the individual, (2) the persons or objects toward which sexual behavior and activity are directed by the individual, and (3) the persons or objects depicted in fantasies and cognitions" (p. 358). Pedophilia certainly fits within this definition of sexual orientation. Furthermore, clinical evidence suggests that, similar to homosexual or heterosexual orientations, a pedophilic sexual orientation typically begins by early adolescence, tends to be lifelong, and is resistant to change (Abel & Osborn, 1995; Marshall, 1997), for as Schmidt states, it is part of the person's identity.

There are some who believe that, although pedophilia may represent a sexual orientation, it should still be classified as a mental disorder (Berlin, 2000; Laws & O'Donohue, 1997). At present, this might be the best policy. For instance, consider the fact that most comprehensive treatment programs for pedophiles currently involve some work on changing sexual responses to reduce sexual interest in children and/or increase sexual interest in adults, i.e., changing the pedophile's sexual orientation (Barbaree et al., 1995; McNulty, Adams, & Dillon,

2001; Marshall, 1997). It is possible that such practice could come under attack, if pedophilia was removed from the *DSM*. Basing their statements on reparative or conversion therapies for changing homosexual orientations, clinicians such as Haldeman (1994) have opined that it is unethical to treat a condition that is not considered to be an illness. A number of professional organizations, such as the American Academy of Pediatrics, the American Psychiatric Association, and the National Association of Social Workers, have also passed resolutions or adopted policy or position statements regarding treatments aimed at changing sexual orientations, which echo these sentiments. The American Psychiatric Association ("Position Statement," 1999, p. 1131), for instance, published a position statement on psychiatric treatment and sexual orientation, which concluded by stating

Therefore, APA opposes any psychiatric treatment, such as "reparative" or "conversion" therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation.

A similar statement was issued a year later ("Position Statement," 2000). We can be sure that there are many who would say that such statements could and logically should be applied to pedophilia if it is removed from the *DSM*.

Another possible implication of removing pedophilia from the *DSM* would be the effects it would have on research. Funding from agencies such as the National Institute of Mental Health would potentially become even more difficult to obtain. Clinical researchers would potentially not have access to research participants or may no longer conduct research in areas such as epidemiology and treatment of pedophilia.

I would like to conclude by stating that I believe that adopting a view of pedophilia as a sexual orientation can be very helpful in encouraging more scholarly discussion on this form of sexual behavior. I am, by no means, advocating that we retain pedophilia in the *DSM* because of the possible implications that I have outlined above. I merely believe that these issues should be considered before making a movement in that direction.

A Favorable View of the *DSM-IV* Diagnosis of Pedophilia and Empathy for the Pedophile

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We disagree with much of what Green sets forth as reasoning, which allows him to conclude that pedophilia is not a mental disorder. First, the acceptance of man–boy sexual relations in other cultures or at other historical times does not mean that pedophilia may not be considered to be a mental disorder. Alcohol dependence, schizophrenia, obsessive-compulsive disorder, and other mental disorders have all existed in various cultures over time, but have not been identified as mental disorders until recognized and categorized as such. Second, his description of the occurrence of adult–infant sexual relations in bonobos could also be argued as illustrating that a model for such behavior exists in primates. Third, it is well known that there are few, if any, psychopathological or other variables that differentiate individuals with pedophilia or paraphilias from those without, and any such distinction would support the consideration of such individuals as constituting a separate group. Finally, the demonstration of sexual arousal to children or the self-reported sexual interest in children cited are in samples who have not reported pedophilic behavior and thus who would not be considered pedophiles.

In the *DSM-IV* (American Psychiatric Association, 2000), “each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom” (p. xxxi). The newly modified criteria for pedophilia that “the person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty” (p. 572) seems to us a valid and appropriate way of diagnosing pedophilia and of limiting its diagnosis.

Many individuals with pedophilia, or others with paraphilias, including exhibitionism, voyeurism, or frotteurism, require acting out on such fantasies or urges in order to develop dysfunction or require the intervention of the legal system to set conditions to create an awareness and acknowledgment of wrongdoing and to motivate individuals for continued treatment. Others will experience interpersonal difficulty (inability to develop or maintain romantic relationships) or dysfunction (loss of income or jobs because of time involved with the activity). If an individual with pedophilic arousal has not acted on his or her arousal, has no interpersonal difficulty, or is not distressed by it, then we would not consider that individual to have pedophilia and not consider him or her to be in need of treatment. In our combined 40 years of experience in treating such populations, we have, however, yet to encounter such an individual. Something has to bring

an individual in for evaluation and treatment; otherwise, they are not seen.

The questions raised by Green are even more crystallized by the suggestion of the entity “hypersexual disorder” for the *DSM* by Stein, Black, and Pienaar (2000) with the following diagnostic criteria: (1) the existence of recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors that persist over a period of at least 6 months and do not fall under the definition of paraphilia; (2) the fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; (3) the symptoms are not better accounted for by another Axis I disorder (e.g., manic episode, delusional disorder, erotomanic subtype); (4) the symptoms are not due to the direct physiologic effects of a substance (e.g., a drug of abuse or a medication) or a general medical condition. A similar concept of “sexual addiction” was considered in the *DSM-IV* Sourcebook (Wise & Schmidt, 1996) but was not felt to be appropriate for inclusion. However, this newly proposed entity seems more neutral and is not encumbered by the term “addiction” and it seems to meet a need that we have found for individuals presenting with complaints of compulsive masturbation, compulsive engagement in the use of internet pornography, and/or compulsive telephone sex (sometimes 10 or 12 hr per day). Here, the nature and aim of an individual’s sexual interest pattern are conventional but the acting out of this sexual behavior pattern has become excessive, dysfunctional, and a source of distress.

Paradoxically, if one examines the history of the development of the concept of disease in the field of drug dependence, it has been a long struggle to have society and medicine conceptualize drug dependence as being a disorder or disease, rather than a moral or criminal problem, and this conceptualization has led to the development of more understanding and tolerance, better criteria for the development of research, and a search for more effective treatments (Acker, 1993). It would be our hope that similar results could attend to the use of the pedophilic and paraphilic diagnostic entities in the *DSM-IV*.

Regarding Schmidt’s article, we would like to state that we are in agreement with his eloquent presentation of the moral dilemma and tragedy of the pedophile. Unfortunately, some of the effective pharmacotherapeutic treatments available at this time involve a suppression of total sexual interest and do not differentially target sexual interest towards children, thus limiting solutions to this dilemma (Rosler & Witztum, 2000). Overall, we have found that individuals who are pedophiles have been, and continue to be, subject to great condemnation and discrimination by society, and any work that would enhance

understanding, treatment, and tolerance of them is most welcome.

Yes, Virginia, There Are Real Pedophiles: A Need to Revise and Supervise, Not Eliminate, *DSM*

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Green concluded that pedophilia is not a mental illness "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*."

I disagree with Green for two main reasons. First, *DSM* should be revised, not eliminated, from consideration in addressing the definition and criteria for pedophilia. Green notes the inadequacies of the *DSM* criteria for pedophilia as have others (O'Donohue, Regev, & Hagstrom, 2000). Of course, *DSM* never claimed to be more than a guide for clinical, educational, and research purposes and specifically warns about treating its contents as a cookbook (American Psychiatric Association, 2000). The expectation of its developers is that it will evolve with time and new information. Behind Green's attack on *DSM* is a more fundamental question: What is a mental disorder? *DSM* does not provide even a clear definition of the main theme of their classification system, acknowledging that "No definition adequately specifies precise boundaries for the concept of 'mental disorder.' The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations" (American Psychiatric Association, 2000, p. xxi).

DSM has been particularly dismissive of mental disorders that have a neurological, endocrine, or other physical basis. For example, it dropped Organic Personality Syndrome in *DSM-IV*. It frequently has as exclusion criteria "Due to a medical condition" and the terms endocrine, neurologic, and genetic do not even appear in the *DSM-IV* index. Based on the current logic of *DSM*, one may expect that were a physical basis for schizophrenia found, this diagnosis would no longer appear in *DSM*. In short, *DSM* tends to dismiss an area of knowledge wherein the etiology of sexual disorders, including pedophilia, as well as many other mental health problems, may lie. Psychoses and neuroses are not at the heart of sexual disorders. Even unreliably diagnosed personality disorders are not key. However, endocrine (Bain et al., 1988; Gaffney & Berlin, 1984) and neurological findings (Hucker, Langevin, Wortzman, Bain, & Handy, 1986) seem to be the logical avenue to

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explore in understanding the etiology of pedophilia and the persistence of this sexual preference pattern throughout the life span. *DSM* should be focused more on describing mental symptoms and conditions associated with physical conditions that play a major role in the mental manifestations of the disorders rather than eliminating them. The false compartmentalization of knowledge between professions, such as neurology, endocrinology, and psychiatry, has led to ignoring the interface of mental and physical conditions in sexual disorders as well as in other areas, such as diabetes, thyroid disorders, and brain damage and insult.

A second reason for disagreeing with Green is his overgeneralization of our Western society's view of pedophilia to other cultures. His "many cultures" and "much of the past" is presented in terms of a few examples. He does not tell us that 10% or 50% or 80% of cultures allowed the practice of pedophilia as we know it. Moreover, it is important not to take examples from other cultures and times out of context as Green has done. He provides examples of adult-child contacts at other times and in other cultures without a full description of context. One senses that there are conditions in his examples (noted by my italics) that may not parallel the contemporary definition of pedophilia as an enduring sexual preference for children.

Green notes, "Among the Aranda aborigines of Central Australia for example men *who are fully initiated but not yet married*, takes a boy of 10 or 12 . . . and Captain Cook (1773) . . . reported copulation *in public* in Hawaii between an adult male and a female estimated to be 11 or 12 . . ." As an example, without doing any reading of cultural anthropology, I wonder what the life expectancy was in 1773; it certainly was not the 75-80 years an individual in Western society can expect today. Did the youth marry at 15 and were they dead by 30? Did the public copulation have religious, social, or political significance that separated it from rape or sexual assault? And most important, can you show that the examples reflect the current meaning of pedophilia as a sexual preference for minors over adults? For example, did the men carrying out this public copulation have a life long sexual preference for children? Would they be allowed to copulate with 11- or 12-year-old girls at any time in their life or only at times of rites of passage? Would they copulate with female minors in preference to adult females? Given the examples, these questions may be unanswerable, but they illustrate the difficulty of generalizing to other cultures and other times.

Even if we assume that there is an exact parallel between adult-child sexual contacts in other cultures and our own, does that make it acceptable? Cultural relativism can