Pedophilia, Minor-Attracted Persons, and the *DSM*: Issues and Controversies

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Symposium Proceedings

B4U-ACT, Inc.
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In Memoriam

Michael Melsheimer, 1942 – 2010
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Preface

B4U-ACT is a unique collaborative effort between minor-attracted people and mental health professionals to promote communication and understanding between the two groups. Our goal is to make effective and compassionate mental health care available to individuals who self-identify as minor-attracted and who want help dealing with challenging issues in their lives. We aim to give them hope for productive and fulfilling lives, rather than waiting for a crisis to occur.

One of the ways to accomplish this mission is to improve the accuracy of information about minor-attracted people that is available to mental health professionals. Inaccurate, negative stereotypes force minor-attracted people into hiding, leave young adolescents who are attracted to children hopeless with nowhere to turn, and do nothing to protect children. We have received emails from teenagers as young as 15 who were engaged in self-harming behavior or threatening suicide, and could talk to no one about it, because they were attracted to children.

Authoritative descriptions of the entire range of conditions that mental health professionals evaluate and treat are given by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) of the American Psychiatric Association. First published in 1952, it is now in its fourth major edition, with the fifth, the *DSM-5*, scheduled for release in 2013. There have been concerns raised in the past about the way pedophilia is addressed in the *DSM*. In addition, veteran psychiatrists and other experts have taken issue with changes proposed for the new edition, as related to pedophilia, as well as a great deal of other content. Controversy has arisen over scientific and conceptual issues, the purpose of the *DSM* (to promote mental health vs. social control), and consequences of the *DSM* entry on pedophilia for society and for people being diagnosed. Information about this controversy as it relates specifically to pedophilia can be found at:

- www.b4uact.org/science/symp/2011/refs.htm#crit and
- www.asexualexplorations.net/home/paraphilia_bibliography

On August 17, 2011, B4U-ACT brought together a selection of clinicians, researchers, academics, and minor-attracted people in Baltimore, Maryland to discuss these issues and controversies. The purpose of the meeting was to promote a more comprehensive and accurate *DSM* entry on pedophilia. This first symposium of its kind was a success, as 38 people heard and discussed stimulating presentations by nine distinguished speakers.

The foundation of the symposium was B4U-ACT's position that the *DSM* should be based on accurate information about minor-attracted people in the general population. It should be "sensitive to the needs of clinicians and their patients" (as advocated by the APA). Minor-attracted people should be involved in its revision (also advocated by the APA).

B4U-ACT believes that everyone benefits when a variety of reasoned perspectives is heard. Therefore, speakers were allowed to express their views freely and openly. B4U-ACT does not necessarily endorse all of the views expressed. Our policy of free and open expression is in support of the APA's position that *DSM* revisions should involve input from "diverse perspectives, disciplines, and areas of expertise," and that "patient and family" groups be involved. Speakers and attendees included specialists in psychiatry, psychology, philosophy, ethics, social work, linguistics, and gender studies. This is the kind of scholarly interaction necessary to resolve the numerous issues that have been raised by scholars, researchers, and minor-attracted people about the proposed *DSM* revisions.

Speakers addressed a diverse range of crucial issues related to the *DSM*, and discussion was lively. Keynote speaker **Dr. Fred Berlin** (of Johns Hopkins University) provided a conceptual overview of pedophilia from a psychiatric viewpoint, and argued in favor of acceptance of and compassion for people who are attracted to minors, while at the same time rejecting adult-minor sexual activity. **Dr. John Sadler** (University of Texas) argued that diagnostic criteria for mental disorders should not be based on concepts of vice since such concepts are subject to shifting social attitudes and doing so diverts mental-health professionals from their role as healers. **Dr. Nancy Potter** (University of Louisville) analyzed the concept of "uptake" — that is, genuine listening — and argued that by giving uptake to minor-attracted people, those revising the *DSM* would strengthen the *DSM-5* and contribute to more ethical

treatment, but that minor-attracted people must exhibit accuracy and sincerity in their testimony. **Dr. Lisa Cohen** (Albert Einstein College of Medicine) presented data on the psychological correlates of pedophilia based on forensic samples, and argued that use of non-forensic samples would help researchers separate factors related to feelings of attraction from those related to behavior, and support the development of improved diagnostic systems.

In the afternoon, **Dr. Renee Sorrentino** (Harvard Medical School) discussed legal, ethical, and medical consequences of the proposed *DSM-5* entry for pedohebephilia. **Andrew Hinderliter** (University of Illinois) argued that the medicalization of social deviance blurs the boundary between the helping professions and the criminal justice system, creating the potential for psychiatry to become a means of controlling undesirables, rather than an agent of healing. **Jacob Breslow** (London School of Economics and Political Science) challenged assumptions about minors and sexuality which currently underlie policymaking and the *DSM*. **Richard Kramer** (the only speaker representing B4U-ACT), analyzed sources of stigma in the *DSM*, presented survey data regarding MAPs' feelings of stigma, and provided recommendations for revising the *DSM* to reduce stigma.

We wish to thank all the speakers and participants in the symposium, as well as all the minor-attracted people and mental health professionals who have attended our workshops in the past or participated in or donated or contributed to our work in other ways. We are especially grateful to Dr. Fred Berlin for his keynote address that set the tone for the day, and to Russell Dick and the late Mike Melsheimer, whose vision as co-founders of B4U-ACT inspired this symposium.

For more information about the work of B4U-ACT or to become involved, see our website at www.b4uact.org.

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Opening Remarks

Russell A. Dick, LCSW

Co-Founder and Board Chair, B4U-ACT, Inc., Westminster, MD
Former Director of Social Work, Springfield Hospital Center, Sykesville, MD

Good morning! My name is Russell Dick, and I am the chairperson of the board of B4U-ACT and one of the co-founders. In my professional life I was the Director of Social Work at a state inpatient psychiatric hospital in Maryland, where I worked for 37 years until my retirement in June 2010. I also have had a private practice two evenings a week for 24 years. I'm also a husband and father, a gardener, jazz lover, bird watcher, walker/runner/bicycle rider, and have a variety of other roles and interests. While I, myself, am not a minor-attracted person, my late co-founder, Michael Melsheimer, when he was a volunteer at the hospital for many years, taught me to understand and appreciate what it is like to grow up to be a minor-attracted person.

B4U-ACT was established as a 501(c)(3) non-profit organization in 2003. Our goals are:

- To publicly promote services and resources for self-identified individuals (adults and adolescents) who are sexually attracted to children and adolescents and who seek such assistance,
- To educate mental health providers regarding the approaches helpful for such individuals,
- To develop a pool of providers in Maryland who agree to serve these individuals and abide by B4U-ACT's *Principles and Perspectives of Practice*[1], and
- To educate the citizens of Maryland regarding issues faced by these individuals.

There are a couple of important things to keep in mind throughout the day:

- None of the speakers on today's program speak for B4U-ACT, except for Richard Kramer, its director of operations. Statements made and opinions expressed here are those of the speakers, and not of B4U-ACT, and B4U-ACT does not endorse the statements or opinions of the speakers.
- There will be a variety of perspectives presented here today, some of which each of us may not agree with. We request, however, that everyone be respectful of people with different perspectives from their own.

You will notice that we are using the phrase "minor-attracted people" or "minor-attracted persons." This is part of our ongoing effort to promote communication. Some of the other terms or labels that are ascribed to the diverse population we are discussing today carry with them an accumulation of cultural meanings and impressions that can be misleading, prejudicial, and unintentionally (or intentionally) derogatory. A **Minor-Attracted Person** – or **MAP** – is a person whose primary emotional and sexual attraction is to children or adolescents younger than him or herself. Note that MAPs include adolescents primarily attracted to prepubescent children or to adolescents younger than themselves. This term refers to feelings of attraction only; it implies nothing about behavior. B4U-ACT uses this term because other terms call to mind inaccurate preconceptions.

Today's symposium will facilitate the exchange of ideas among researchers, scholars, mental health practitioners, and minor-attracted persons who have an interest in critical issues surrounding the entry for pedophilia in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) of the American Psychiatric Association. The symposium will address critical issues in the following areas:

- Scientific and philosophical issues related to the *DSM* entry on pedophilia and/or hebephilia.
- Effects of the *DSM* entry on stigma, availability of mental health services, and research.

[1] *Principles and Perspectives of Practice*, B4U-ACT, Inc. www.b4uact.org/principles.htm

- Ways in which minor-attracted persons can be involved in the *DSM-5* revision process.

The workshop will be raising issues and questions, without necessarily achieving resolution. The various sections of the agenda are intended to help focus on a sampling of these issues, but will not allow time to address all of the issues.

Keynote: On the Paraphilias, including Pedophilia, from a Psychiatric Perspective

Fred S. Berlin, M.D., Ph.D.[1]

Associate Professor of Psychiatry and Behavioral Sciences
Johns Hopkins University School of Medicine, Baltimore, MD

A personal tribute

I'd like to start out by acknowledging one of the founding individuals of B4U-ACT, a gentleman named Michael Melsheimer, who passed away last year. I had known him for quite a long time, and found him to be one of the most courageous, decent, and honest people that I have come across. He was a man who never hesitated to speak his mind, and sometimes, in the face of very intense emotion, would try to have conversations of a very thoughtful and respectful nature. Mike would not mind me sharing some of the things I'm going to say, so I'm not talking about things that he wasn't talking about in public. He was a man who, in growing up, discovered himself to be attracted to young boys, and early in his life, this was very confusing for him. Certainly in his early years, he did not necessarily think there was anything wrong with acting on such attractions. Later on in his life, I've forgotten exactly when, perhaps in his 30s, he travelled to Thailand, and he was absolutely appalled by the way children were exploited sexually in child prostitution and so on. He came back to the United States looking at things rather differently than he had previously.

One of the things that he thought very strongly about, though, and which I think is one of the factors that led him to start B4U-ACT, is that he recognized that when he was younger, he had nobody to talk to about the fact that he was having such feelings. In fact, he was terrified to let anybody know he had these attractions, and he wanted to be able to encourage young people, who might be having similar feelings, to be able to come forward, and as the name of his organization suggests, before you act, to be able to talk, to be able to get help, to be able to figure out how not to cross the line and cause distress to others, and perhaps to cause tremendous disruption to one's own life. So that was one point: to encourage people to come in, not after they're in trouble, which is what so often happens, but before, to try to prevent that trouble from happening in the first place.

Beyond looking simply at how people are going to conduct themselves as far as behavior is concerned, Mike felt very strongly that people, who are having these attractions, should still feel good about themselves, particularly if they were being responsible about how they were dealing with them, and he felt very badly about the stigma that was tied to a label such as pedophilia, something that I'm going to talk about in some detail shortly. He wasn't advocating that it was okay to be sexual with children, but he had the understanding that simply having these attractions did not make one an evil person, and he wanted folks who were having these feelings to be able to walk in society feeling good about themselves.

As far as the *DSM* is concerned (it's a shame that he's not alive, and I have to speak for him on this), I think one of his major concerns was the stigma that's tied, oftentimes, to a psychiatric diagnosis. He felt that there is, in the minds of most people, an assumption that if there are people who experience these attractions, they must inevitably be acting upon them. Mike felt very strongly that the *DSM* needs in some way to acknowledge that that is not necessarily the case, and that was one of the reasons he wanted to talk about "minor-attracted persons." He felt that there were people out there who had these attractions and were trying very hard in a responsible way not to distress others or cause harm to themselves. Mike felt that the dehumanizing labels put on pedophiles — "scumbag" and such — were things he didn't want to see anymore. He was very active in his neighborhood, helping people with a variety of causes, and he told his neighbors about his background. He made it clear that he wasn't involved with children in

[1] Address correspondence to Dr. Fred S. Berlin, 104 E. Biddle Street, Baltimore, MD 21202, 410-539-1661.

the neighborhood, or with any children for that matter, but wasn't going to hide in shame of the fact he was a man who experienced these kinds of feelings.

Introduction

I will now move into talking a little bit, from the psychiatric perspective, about pedophilia. I'm not here to suggest what the *DSM* should or shouldn't do, but it's not unusual for people who have concerns about the *DSM* to want to advocate because of those concerns. People who are depressed often want to contact the subcommittee on affective disorders and make their thoughts known. People who have persons in their family with schizophrenia will often advocate and hope that they can have some input into the decisions made by the *DSM*. So, although I am not naïve about the differences here, given the public perspective on these matters, it is not unusual for people who feel that they are going to be affected by the *DSM* to want to have some input.

With that said, I'm going to go over how someone like myself, with a mental-health perspective, would look at a situation or a condition such as pedophilia. Because I don't want to simply do something that's "cookbook," I'm going to try to give a larger perspective, talking about how we evaluate, about differences in sexual makeup, and so on.

Let me outline the way in which I'm going to proceed here today. First of all, I want to talk about how someone like myself would evaluate an individual if there were concerns about trying to understand, or even intervene with, their sexual behavior. So I will explain the concept of *evaluation*.

Secondly, I want to talk about *etiology*, or cause, and here I will focus more specifically on pedophilia: What do we know, and what don't we know, about factors that might contribute to the development of that condition?

Thirdly, I want to talk about the *rationale for treatment*. We're in an area where many people, as most of you know, are skeptical about psychiatry. There are lots of folks who believe that psychiatrists are quick to excuse sin by relabeling it psychopathology. I happen, by the way, to agree that we have to be careful not to do that. There are people of sound mind who are misbehaving, and they shouldn't be excused and not held responsible by somehow dismissing their actions as being a manifestation of some sort of psychiatric condition. On the other hand, we don't want to simply assume that someone is of sound mind when their behavior is predisposed because of something relevant from a psychiatric perspective. If that's the case, then that relevancy needs to be factored into trying to decide how to deal with them. So as I said, I want to talk about why, from my point of view, many persons with pedophilia are actually helped by having that as a diagnosis, such as having availability of treatment.

I also want to make the point, since it's almost impossible to get into this area without talking about criminal justice, that I'm a physician. I'm going to approach this from the mental health point of view. My belief, just to state it upfront, is that we need to have both a criminal justice involvement and a public health perspective. I would make an analogy to alcoholism. We have to have laws against drunk driving — society has a right to protect itself — but it would be naïve to think that you are going to solve the problems of alcoholism simply by putting drunk drivers on a registry, and to think that we can punish and legislate the problem away. And yet, when it comes to this particular area, my sense is that society seems to have the idea that if we just pass one more law, or just be a little bit tougher, that's going to be a solution. But if the only thing we do for somebody with pedophilia, someone who is sexually attracted to children, is to send them to prison, nothing about that can either erase those attractions or enhance the capacity of such a person to successfully resist acting. Sooner or later, like it or not, most of these folks are back out on the street. I am not so naïve as to think that we can succeed as a society without having laws. But unless we begin to appreciate that people in many instances need to be helped, not punished and chastised, not only do we do such persons a disservice, I think we do a tremendous disservice to the community as well.

Evaluation

The first point I always make when it comes to evaluation is that people can behave in similar ways for a variety of reasons. So the first thing I do in evaluating a person, where there are any concerns at all about sexual behavior, is to ask, does this person have some sort of a psychiatric condition? Because, as I said a moment ago, there are plenty

of people who may be behaving in ways that are problematic sexually, but there is absolutely no basis for concluding that that's because there is some psychiatric problem. So that's question A: Do they, or do they not, have some sort of recognizable psychiatric condition?

If they do have a psychiatric condition, the second questions would be, is it one that involves some difference in sexual makeup? There are many people who, to use legal terminology, would commit sex offenses, but have perfectly conventional sexual interests. There is nothing different about their sexual makeup. I'm not going to spend a lot of time on this, but I want to give a couple of examples just to make it clear.

One of the things that we've done at Hopkins for many, many years, and I'm proud of it although it hasn't received much attention, is to try to assist mentally-retarded individuals in dealing with their sexual needs in an appropriate fashion. I suspect that most of us rarely take the time to think about what it would be like to have the mental age of an 8 year old, and yet the intensity of sexual desire that the rest of us experience as adults. Beyond that, if one does have the mental age of an 8 year old, how is one going to persuade an adult to become involved in an intimate situation? None of us wants to be intimate with someone who is that limited intellectually. So it's for this reason that, because of their limited coping skills and the lack of availability of an age-appropriate partner, some limited individuals will persuade, or even in some cases coerce, a child, who may be of exactly the same age mentally, into sexual activity. Now, what they are doing is wrong. I'm not trying to defend it, and if they are not so limited as to be seen as being "not criminally responsible," they could be prosecuted for having committed a sex offense. But the point that I want to make here is that they wouldn't be doing that because there is something different about their sexual makeup. They wouldn't be doing it because they have pedophilia. The example I'm giving you here is an example of someone who is engaging in an unacceptable sort of sexual behavior but for reasons that have nothing to do with an abnormality or difference in sexual makeup.

A second example of someone who could commit a sexual offense from the criminal justice perspective, but who does not have something different about their sexual makeup, might be that of a man who breaks into a home. He's looking to steal valuables, but he finds a woman home alone, and exploits the situation by sexually assaulting her. Again, there is no reason in this case to feel that he is doing this because he has some sort of a psychiatric illness, other than perhaps that he is just generally antisocial in his makeup. He may lack a sense of moral responsibility. He may be so stoned on drugs that he is disinhibited in his impulses and impaired in his judgment. But the major point I want to make here is that even though he is committing a very serious and violent sex offense, it has nothing to do with him having anything different in his sexual makeup from what exists for the majority of us.

So the first point is that there are people who engage in sexual behaviors that we might find to be unacceptable or problematic, but who have nothing different from the norm in terms of their sexual makeup.

The second point I want to make, and this will lay the groundwork for discussing how mental health looks at pedophilia, is that although we like to feel that we are all created equal, that's simply not true. We should all have equality of opportunity and in my judgment we are all equal in terms of moral worth, but if equal means being the same, we're not all equal. We differ from one another in a variety of ways, and one of the various ways in which we differ from one another is in our sexual makeup. And I'm going to name four ways that human beings differ from one another sexually and talk about how that's related to the various paraphilias that are listed in the *DSM*, pedophilia being one of those paraphilic disorders. So, those four ways that people differ sexually are:

- Behavior. The kinds of behaviors they either do or don't find to be erotically arousing.
- Partners. The kinds of partners they either do or don't find to be sexually attractive.
- Intensity of sexual desire they experience. For some people, sex is a pressing issue — it's on their minds a lot and they have a very pressing desire — but for others, it is less so.
- Attitudes they have about their own sexual desires. (Although this doesn't have to do with sexual makeup, *per se*, it is convenient to talk about it here.)

Now let me run through some of these, not in an exhaustive way, but to give you some flavor, since this is about the *DSM*, of how the *DSM* looks at some of this today.

Behavior. The first way in which I said people differ from one another sexually is with respect to the kinds of behaviors that either do, or do not, turn them on sexually. An example of that from the *DSM* would be a condition called transvestitic fetishism. To get away from the jargon, because I don't like psychiatric jargon, that means that the kind of behavior that arouses a person sexually is dressing in clothing of the opposite gender. Now in most instances, we are talking about a man who is very aroused by dressing up in female clothing. Normally, what we do in our society with such a situation is that we get very uncomfortable. We may joke about it or we sweep it under the rug, but for the person who experiences this desire, it can be anything but a laughing matter.

Many years ago, when I was just a young psychiatrist, a man came into the psychiatric unit of the hospital with clinical depression. He was a pediatrician who was well known in his local community and, in his early 70s, was still practicing. His wife of many years had found secreted in their closet a cache of female clothing. He had had to admit to her, in a very embarrassed way, that for many years he would put these clothes on in private. It would be very exciting for him and he would masturbate while dressed in this way. But because of the embarrassment and the shame that he felt, it was something that he thought he could never discuss with anyone. The reason that he was so clinically depressed as to require hospitalization was that he was very afraid that after all these years, his wife, whom he loved very much, might not be able to handle this, and that she would divorce him. He was also very worried about his reputation and his occupation. He was terrified that if people found out his secret, he would be forced out of his pediatric practice in disgrace. Now, this man did not have pedophilia. He was absolutely no threat to any of his young patients. But human beings respond emotionally, not just cerebrally. Many of us, on finding out that our child's pediatrician behaves in this way, for right or for wrong, would probably have reservations about sending the child back to him. So he was worried about his reputation, his career, and his family life. And even though he had all these fears of potentially dire consequences, the urge to dress up in this fashion was so strong that he was not certain he could refrain from doing so.

In the *DSM*, the current definition of a paraphilic disorder requires the individual in question to experience intense, recurrent, erotically-arousing (i.e., sexually-arousing) fantasies and urges about something, and in the case of transvestitic fetishism, that something is wearing clothes of the opposite gender.

Now, the average man does not experience fantasies and urges to dress up in female clothing. So when someone has intense, recurrent, sexually-arousing fantasies and urges of this sort, this is an example of how having something different about one's sexual makeup can cause a daily struggle to be in control sexually in a way that's very difficult for many of us to understand because most of us never experience those desires in the first place.

Another example of a paraphilic diagnosis based on an individual's sexual makeup including a craving to behave in a way that is different from the norm is exhibitionism. Now, again, the *DSM* does not diagnose a psychiatric disorder, a paraphilic disorder, based on behavior alone. The guy who gets drunk at a football game and "moons" the crowd can certainly be arrested for exposing himself in public. That does not mean that, from a psychiatric perspective as expressed in the *DSM*, he would qualify for a diagnosis of exhibitionism. Such diagnosis requires intense, recurrent, sexually-arousing fantasies and urges, to a point where it's an ongoing struggle to control himself.

I've been doing this work for over 30 years. We published a study several years ago of a hundred exhibitionist men. The total number of times that these men had exposed themselves was in the thousands, and most of them had had consequences. They'd stood before a judge, been embarrassed in front of their families and the public, and yet the recurrent urge to engage in this behavior was so severe that on their own, without help, many of these men were not able to bring this behavior under control. They weren't lacking in conscience. They certainly weren't self-defeating and wanting to go to prison or be punished. They were simply struggling because of the nature of their sexual makeup.

Partners. The second way that people differ from one another sexually is in terms of the kind of partners they either are, or are not, attracted to. For a teaching example, let's look at zoophilia, a paraphilic disorder in which the kind of partner that someone finds to be sexually arousing is an animal. Now the last thing that any of us experiences when I talk about animals is a sense of sexual excitement. What we experience are repulsion, disgust, and all sorts of negative feelings. So this is really the teaching point that I want to make: the kind of partner who for one individual may be a tremendous "turn off," may be for another person a tremendous "turn on," or *vice-versa*. This really shows what a tremendously broad spectrum of human sexuality there actually is.

When I would give this sort of a lecture years ago, I would talk about how unusual it must be for people to be recurrently attracted sexually to animals. But one of the things that has changed over the years has been the development of the Internet. Just as atomic energy can be used to light up the world or to blow up the world, so the Internet has both created certain problems and given us an opportunity to become more educated. One sort of website that has arisen with the development of the Internet is those that cater to people with a sexual interest in animals. It is absolutely astounding, even to someone like myself who has worked in this area for many years, to learn how many "hits" these sites get on a daily basis. The point is that we can be sitting next to each other, day in and day out, and we kind of get a sense of one another's character, temperament, and personality. You get to know if someone is honest, trustworthy, if they show up on time, and so on, but we don't have any sense of the private sexual makeup of the individual sitting next to us. So there is this tremendous spectrum, and I give this example for illustrative purposes, to show how large that spectrum can be.

Now let me get to the core of the issue of what we want to discuss today. A second example of people who have a paraphilic disorder based on erotic desires for a certain kind of partner that's different from the norm is pedophilia. Now, I want to be very clear about what a psychiatrist means by pedophilia.

Keep in mind that psychiatric diagnoses, although the public has unfortunately distorted this tremendously, are simply meant to be a short-hand way of conveying information. That's all that any medical diagnosis is. You say "diabetes," you say "lung cancer." To someone who is trained, those words convey a great deal of information that is important in understanding a particular condition. It might allow one to research and find out more about how the condition develops, to try to help people if that condition is creating problems, and so on. So when I use the term, "pedophilia," as a physician, I don't mean it as some sort of a demonizing pejorative.

The diagnosis of pedophilia does not necessarily apply to somebody who happens to be sexual with someone under the age of consent. For example, a man who gets involved sexually with his 13- or 14-year-old stepdaughter, who may look like she is 18 or 19, could be prosecuted for committing the crime of child sexual abuse, but he may not be doing that because there is something abnormal about his sexual makeup. Any man can find an attractive teenager to be appealing. That doesn't mean he's going to act on it, but that's not outside the range of what most individuals can find to be appealing. And the fact that he's engaging in this kind of behavior doesn't necessarily mean that he has the psychiatric disorder that we mean when we use the word, "pedophilia."

Every one of us could describe for others, if we wanted to do so, both the gender of partner, and the age range of partner, that we either are, or are not, attracted to sexually. These are very private and personal matters. If I started looking around the audience for volunteers, I could easily make you very uncomfortable, for understandable reasons, so I'm not going to do that. I'll instead take myself as an example.

If you ask me to tell you the gender of partner that I'm attracted to sexually, I would tell you that in my case, that happens to be female. I'm not making any value judgments. I'm not saying it makes me better or worse than anyone else. For whatever reason, that happens to be the gender of individual that I find to be appealing sexually. I can go beyond that, though, and I can tell you an age range of female that I either would, or wouldn't, be tempted by in a sexual way. At the upper end of the age range, and I always have to look around and be very careful not to offend anyone here, so I'll play it safe, I don't refrain from having sex with 90-year-old women because I'm a chauvinist who has something against the elderly. The fact of the matter is I'm simply not going to be very tempted to become involved sexually with a female of that age. Again, I don't mean to be offending anybody. At the lower end of the age range, though, and this is the much more important point, I don't refrain from having sex with six-, seven-, or eight- year-old children because I'm a moral person. I certainly hope I'm a moral person. But never in my life have I been tempted to be sexual with a child of that age. I have four children of my own. All of them are well past the ages I'm using in this example here. Like any father, when they were younger, I enjoyed expressing affection in a physical way: holding them and hugging them. But when I was doing that, at no time did I have to say to myself, "Be careful! Watch out for the feelings." There were no feelings. I didn't have to say, "Watch out. There are laws out there." It's irrelevant. I wasn't having any temptation at all about acting in such a fashion. That was simply an age range that was well below the age range that I, in particular, would find to be sexually appealing.

Now there are other people, when we ask them to define for us both the gender of partner, and the age range of partner, that they are attracted to sexually, who will say something entirely differently than what I just said, and we don't want to believe them, and in some cases we are going to find out that we should have listened because we find

out that they are acting in ways that many of us would find to be problematic. If an individual indicates that the age of individual that they are attracted to sexually is prepubescent, that is all that is meant diagnostically in the current *DSM* by the word, "pedophilia." As I said earlier, the diagnosis is meant to convey information, and when we use the word, "pedophilia," the information that is conveyed about an individual is that this is an individual who finds prepubescent children to be sexually appealing.

Now we can divide the cake up further. One of the ways in which we can divide the cake when it comes to pedophilia is with respect to the gender of the prepubescent child that the individual is attracted to in a sexual way. So assuming I am talking about a man attracted to little girls, that's opposite gender or heterosexual pedophilia. If it is a man attracted to boys, that is same gender or homosexual pedophilia. And if it's a man attracted to both boys and girls, the *DSM* would consider that to be bisexual pedophilia.

Another way of dividing the cake when it comes to pedophilia has to do with whether or not the individual in question is attracted sexually only to children, or whether that individual has some degree of attraction to adults, but in addition to being attracted to adults, he is much more strongly attracted to prepubescent children than are the rest of us. If the individual in question is attracted only to children, and not to adults, they are said to have the exclusive form of pedophilic disorder. If the individual in question is attracted both to adults and children, but is much more strongly attracted to children than are the rest of us, that is said to be the nonexclusive form of a pedophilic disorder.

Now the question sometimes comes up: Why, for God's sake, don't the individuals attracted both to adults and children simply do the moral thing and conform their behavior to the expectations of society? There are many answers to that question. I'm not going to cover all of them. But one of the points I want to make, which is relevant in terms of treatment, is that appetites have within them certain tastes. For example, I can finish a big turkey dinner and then I won't want any more turkey, but I might still crave a piece of strawberry shortcake for desert. That is the dilemma, not in terms of consequences obviously, but in terms of the mental experience faced by the person with the nonexclusive form of a pedophilic disorder. The fact that they're capable of interacting sexually with an adult doesn't erase the fact that they still may be having intense, recurrent, sexual cravings for children, and therefore, those cravings still need to be addressed from a psychiatric perspective in their own right.

Intensity. The intensity dimension has entered somewhat into what I've already discussed. Because time is limited, I am going to skip over going into more detail on that here.

Attitudes. The fourth way in which I said people differ from one another is in their attitudes about their own sexual desires. There are some people who are sexually attracted to prepubescent children and could be diagnosed with pedophilia, and those attractions are in no way whatsoever in conflict with their personal sense of right and wrong. Those individuals would believe, for example, that it is society that should change, and not themselves. There are organizations in this country, for example NAMBLA — the North American Man/Boy Love Association — that seem to believe that we are a very puritanical society, that children shouldn't be denied the pleasures of sex, and that it is society that needs to change, not themselves. I might say — there may be people who differ with me, I don't know — I don't agree with that at all. I don't think children are miniature adults. There's a maturation process. We don't let prepubescent children decide to sell the family home, or drive a car, or buy alcohol. Most of us as adults can have enough difficulty with intense sexual, emotional relationships, without thinking that an eight- or nine-year-old can engage in that kind of behavior with an adult without the risk of being exploited. But the point I'm making here is there are some people who are sexually attracted to children, and those attractions are not in conflict with their personal sense of right and wrong.

There are other people who are sexually attracted to children, and they may be struggling not to give in to temptation, but the attractions they experience are in conflict with their personal sense of right and wrong.

When the attractions that a person experiences for children are not in conflict with their personal sense of right and wrong, those desires are said to be egosyntonic. When the desires are in conflict with their personal sense of right and wrong, those desires are said to be egodystonic. One of the disservices that I think psychiatry has done to itself over the years is that it sounds like it is engaging in psychobabble and not making common sense. So I am giving you the jargon, but again, this is for the purpose of conveying information and trying to make some sense out of it.

So suppose I was presenting to you today a person whom I want to teach you something about, and whom I have diagnosed in the following way: "Here's this gentleman on whom I've done a thorough evaluation, and I have diagnosed him with homosexual pedophilia of the exclusive type that's egodystonic." It can sound like a lot of psychobabble, so let me break it down and explain it in everyday English.

First of all, I'm talking about a man. I said he has pedophilia. The information this conveys to you is that he finds prepubescent children to be sexually appealing. I said it was homosexual pedophilia. So I've told you that the kind of child that he finds to be sexually appealing is a boy. I've said that it is the exclusive form of homosexual pedophilia. So he's not attracted to little girls, he's not attracted to adult women, and —I think this is probably important — he's also not attracted to adult men. He is not gay. By definition, he has the exclusive form of homosexual pedophilia. And then in the diagnosis, I told you something about his attitude. I said it's egodystonic. So he's not arguing that he should be able to act on those attractions. He has them, they're strong, and it's a part of who he is as a human being, but he acknowledges that these are feelings that he ought not to be acting upon. All those words are not meant to demonize this man, but to convey a certain amount of information that can be helpful to others of us who are working in the mental health arena.

Observations related to evaluation of pedophilia. With that foundation on evaluation, I want to make a couple of observations and other points in terms of concepts and how they relate to the use of a term such as "pedophilia."

The first point I want to make is that there have been a lot of theories out there about pedophilic behavior that are in many psychiatric textbooks. Since we are talking about the *DSM* and psychiatric books and so on, I want to address that issue. One of the theories that was out there, that I want to debunk, about pedophilic behavior is that it is not really so much about sex, but that it is about power and control. The second theory that has been out there is that pedophilic behavior is not really just about sex, but that these are men who lack social skills, don't know how to go about approaching an adult for sexual purposes, and therefore, because they are easier, turn to children.

Now what would not be explained by either the theory of power and control, or the theory of lacking social skills, when it comes to pedophilic behavior, is the man's erection. What do I mean by that? If a man with perfectly conventional sexual interests is alone, fantasizing about the kind of partner that he finds to be sexually appealing, fantasizing in a way that would cause him to get an erection, for the normal heterosexual man, what causes him to get an erection is fantasies about an adult woman. For the man with the exclusive form of homosexual pedophilia, who is alone and fantasizing about the kind of partner that causes him to get an erection, he is fantasizing about a prepubescent boy. That's not about power and control. That's not about lacking mature adult social skills. That's about a fundamental difference in sexual makeup. And if we fail to understand that, and think that all that we need to do for the person diagnosed with pedophilia is to teach them better social skills — and this is what was done for many years — all we've got when we are finished is a man who is still sexually attracted to children, but is probably better able than ever before to successfully approach a child in a sexual way. This, by the way, is why it is so important what we do with the *DSM*, because how we conceptualize things, how we think about things, has consequences, and if we don't think about them properly, it can lead to very dire experiences.

Years ago, psychiatrists were telling individuals that we could cure pedophilia, and we can't. That doesn't mean that we can't successfully treat it, or successfully help people, or that people can't successfully resist acting on certain temptations, but there is no cure. But psychiatrists back in the 60s, 70s, and 80s were telling individuals, including Bishops in the Church, that individuals with pedophilia had been cured. And if you are cured, you are no longer a threat to anyone, and so it's safe to put you back in a situation around children. If you talk about alcoholism, people can be successfully treated, and after successfully treating an alcoholic, we don't suggest that he should work in a bar, exposing him to a level of temptation he may not be able to handle. Again, I'm simply reinforcing the idea that I'm glad that people here want input into the *DSM* because the decisions that are made have consequences, and we want to make sure that they are going to be positive, rather than negative.

Now, the last point that I want to make is to ask, when I tell you that someone has been diagnosed with pedophilia, what else does that tell you about them as a person? What else does it tell you about their character, their temperament, their personality, and so on? And one of the reasons this is so important is an issue that I raised earlier: for the general community now, when you say the word, "pedophilia," they seem to think that this is about character, the essence of what someone is like, and their conscience. You hear these horrible words like "scumbag."

So, again, let me just try to put this into a common-sense perspective. When I tell you that my own sexual makeup is "heterosexual," what information does that convey about me as a person, and what information does it not convey? The answer is that it tells you that I am sexually attracted to women, and at my age, it's pretty safe to assume that I have acted on those attractions. But it doesn't tell you if I'm kind or cruel, caring or not caring, conscientious or lacking in conscience. Those are aspects of my makeup that need to be evaluated entirely in their own light. The early versions of the *DSM* confused that issue. In the early versions of the *DSM*, all of the differences in sexual makeup were classified as aspects of antisocial personality disorder, and back then, since homosexuality was considered a sexual disorder, that included homosexuality. I believe that the *DSM* — and I know some of you are quite critical of it, and that's fine — at least in this area, has come a long way. Because it now says that when there is something different about someone's sexual makeup, for example pedophilia, we put that in what is called Axis I of the *DSM*, but that does not say anything at all about what the *DSM* considers Axis II, which is personality. That has to be evaluated entirely in its own right.

The point here is that someone can be sexually attracted to children and it may be difficult for them, because of those attractions, to be in control of themselves. For others it isn't, and more power to them. But some people need help, and we want to assist them. The fact that they happen to be experiencing these attractions, and the fact that that means that they can be diagnosed with pedophilia, does not mean that they are characterologically flawed, that they are generally antisocial, or that they are morally corrupt. As a psychiatrist, I think that we want to support moral values. I am troubled by psychiatry that, as I said earlier, might excuse misconduct by labeling it psychopathology, but I also want to recognize that when someone is different through no fault of their own, and struggling and needing help, that I don't simply label them as a "pervert" or see them as somehow less than a human being, as less deserving of understanding and compassion.

I don't find anything incompatible between that and wanting to protect the community. I think one can be very concerned with protecting people, and not wanting them to be harmed, and can at the same time have compassion and concern for people who are struggling, and want to assist them. If we help a person who is having these feelings to live life as a safe and productive individual, it's a "win-win." The community is better off and the individual is better off. I don't see in this a conflict in any way whatsoever.

Etiology

What is the etiology of a condition such as pedophilia? Perhaps the most important point here is what pedophilia (as well as other sexual differences) is ***not*** due to, and that is a voluntary choice. To put it into an every-day context, let's realize that while research is important, we also have to sometimes bring our own life experiences into it. In looking at my own life experience, and you can all do the same, was there ever a time, when as a little child, I said to myself, "look, you're going to be growing up, and you've got some choices to make. You've got to decide: do you want to grow up to be attracted to women? Oh I don't know. Do I want to grow up to be attracted to men? Do I want to grow up to be attracted to boys, or to girls?" At no time in my life, as a young child, did I sit down, reflect on the options, and decide that I was going to grow up to be attracted to women. I can tell you that discovering that I'm attracted to women, in our society, made my life much easier than it might otherwise have been, but I discovered those attractions in growing up. I didn't weigh the options, think about it, and decide.

I've worked with many men who have the exclusive form of homosexual pedophilia. None of them, I would argue, ever decided to grow up to be attracted exclusively to prepubescent children. These men, in growing up, discovered that they experience those attractions, and in our society, these are attractions that can make life very different and very problematic for them in a way that most of us would find difficult to understand.

I will digress for a moment, and talk again about a man whom personally I liked to think of as my friend, among other things, Michael Melsheimer. He felt strongly that he discovered as a young boy growing up that he was attracted to boys, and he was confused. He didn't know who to talk to, hearing the words and the language — the "pervert" and so on. This was a time when even if you grew up discovering that you were attracted to the same gender, you didn't dare speak about it. And one of the reasons he felt this organization, B4U-ACT, is so important is that there are, as I'm standing here speaking today, numbers of 17-year-old youngsters privately becoming aware of the fact, discovering that, rather than being attracted to other youngsters their own age, they're attracted to 6, 7, and 8 year olds. The last thing that they are going to do in our society, as it stands now, in my judgment, is to raise their

hand, acknowledge that, and ask for help. B4U-ACT wants our society to become one that makes that possible, and I want to completely support that goal of B4U-ACT. I'm trying to explain here one of the reasons why I think that it is absolutely so important and so vital.

To finish my first point then about etiology, it's not a person's fault that he has pedophilia, but it is going to be his responsibility to do something about it. If he can do something about it on his own, more power to him. But if he needs some professional help in dealing with it, then I as a psychiatrist want to make that help available to individuals who may be struggling.

Now the other two things that we are trying to understand in terms of pedophilia is the role played by nature and nurture. And again, as I said earlier, I know that there are people, probably in this room, who experience attractions to young people, and that's perfectly fine. I freely subscribe to the idea that you are decent people. I'm not looking to stigmatize you. I'm not going to use these awful terms, but some of you might even agree with me that if, as a little child, somehow you could have chosen, maybe you wouldn't have wanted to choose, given the realities of this world, to be attracted to minors. So one of the things that we want to understand in terms of pedophilia is what are the factors that contribute to it, because it might be that, if we could prevent it for some future generations, some folks might be better off, and have an easier life, as a result of that having happened.

On the nurture side, one of the factors that can predispose an individual to the development of pedophilia is having been sexually abused as a child, particularly for a boy. Now, as you all know, these are very emotional issues, and I understand that. People are concerned about their children, and they should be. Sex is a very emotional issue. These things can be difficult to talk about. But the fact that if someone has been sexually abused as a child, that's a predisposing factor, and the reason that I was getting to the emotion of it is that there are people who will say, "That's just the abuse excuse. I know lots of people who have been sexually abused. They don't develop pedophilia. This is an excuse. It's not true. I don't buy it."

What is the kind of evidence that allows one to say whether something is or isn't a risk factor in the development of a particular condition? Let me talk, for example, about cigarette smoking and lung cancer. For many years, the cigarette companies made the point that if you look at most people who smoke, and followed them over time, the overwhelming majority of smokers do not get lung cancer. It may surprise you to hear, but that's true; that's a fact. On the other hand, if you look at individuals with lung cancer, particularly the most common kind, and ask how many are smokers, over 90 to 95% of individuals with the most common form of lung cancer are cigarette smokers. So when you put it all together, statistically, there is absolutely no doubt that cigarette smoking is a risk factor for the development of lung cancer. Why some people who smoke were immune to the smoke to the point that it didn't cause them to develop lung cancer is something that we'd like to learn more about, but the fact that some individuals weren't damaged in that way by smoking doesn't mean that other individuals weren't indeed so affected.

Now to come back to this issue of pedophilia and being abused as a child, there was a large study that was done by Rind, which was very much criticized around 2000, that looked at large numbers of people who had been sexually abused as children. This was a "meta-analysis" that looked at them in adulthood and discovered that many were leading productive and healthy lives. I remember at the time, thinking to myself, "What wonderful news to tell the parents of a child who has been involved sexually with an adult: that there is reason to be hopeful, that your child hasn't been given a life sentence, and that your child has a good chance of being okay." Yet there were people who criticized this study and said that it was going to encourage pedophilia. Now if I can use the bully pulpit here, I think that what people misunderstood was that there is a difference between saying that something is right or wrong — and in my opinion, it is wrong for an adult to have sex with a child — versus asking if the behavior is damaging or not, and what the degree of damage is. If some kids, thank God, have been through this experience and turn out to be productive, healthy adults, isn't that wonderful news? And so, to finish my point, the overwhelming majority of kids who have been sexually abused do not end up with pedophilia, but in most of the studies that have been done, if you look at people who do have pedophilia, very significant numbers of them as children were sexually abused. So I'm not saying that <u>the</u> cause of pedophilia is being sexually abused. Many people with it were never abused sexually, but I am saying it's a risk factor. And one of the tragedies in all of this is that in many instances, when one is looking at an adult with pedophilia, one is looking at a former victim grown older where that victimization hadn't been appreciated in a timely way. Again, that doesn't mean that I think it excuses being sexual with a child, but to ignore the fact that someone may be struggling because their own sexuality was warped by this kind of an early life experience would be to ignore a reality that I think should not be ignored.

Let me talk quickly about the biological side of etiology. We are now doing a lot of research to try to see whether we might be able to correlate some differences in the kinds of sexual desire people experience, some differences in their sexual makeup, at least in some instances, with differences at the biological level. All of us are interested in having sex because we are biological in our makeup. There are certain genes and hormones and chromosomes that play into it. We don't have to read a book and think about it and decide to be sexual. It's just something that God or nature programmed into us for a very important reason. While I won't go into detail here, in some instances we can now show that people who are different in their sexual makeup seem to also, in some cases, have differences at the biological level that may be playing a contributory role.

Now, to sum up etiology, I'm not saying the cause of pedophilia is having been sexually abused. I'm not saying the cause is having some sort of a biological abnormality. I am saying that both of those sorts of factors can act as predisposing factors to the development of pedophilia. But perhaps most importantly, I am making the argument that it is not someone's fault they have the disorder. It's not because they are evil individuals, who have sat down, thought about it, and decided to experience a different mental makeup.

Rationale for treatment

I do some forensic psychiatric work, so I'll put on my forensic coat. Society assumes that all of us can conform our behavior to the required standards simply through the application of willpower alone. And society makes that assumption for the very important reason that if we didn't, we would have absolute anarchy. The common thief could stand in front of a judge and say, "You know, your Honor, I know other people steal, and they belong in prison, and they should be punished, but I have these overwhelming and recurrent feelings of greed, and I understand that the University of Maryland and Hopkins now have a greed clinic, and I have a greed disorder, and they're going to put it in the *DSM*, and I need to be in treatment, your Honor. I'm not really a bad guy who deserves to be punished." So I'm being a bit facetious, but you can see where we would be if society didn't make the assumption that we make choices, we're capable of controlling our behavior, and if we don't control it, we have to live with the consequences.

Now let me put on my white coat here for a moment and, as a physician, ask the question: What is the evidence, particularly when it comes to behaviors that are energized by powerful, biologically-based appetites, that people can invariably control their behavior simply through the application of willpower alone? I'm going to start with the appetite for food, and then I'm going to make my point about sex.

Americans spend literally millions of dollars a year trying to diet, trying to lose weight. As a consequence, various doctors have come on board: we have the Pritican diet, the Atkins diet, you name it. And so here I am with the bully pulpit today, and you're very lucky. I'm going to give you the Dr. Fred Berlin, 100% guaranteed way to diet successfully and lose weight: Eat a little bit less every day. It is literally no more difficult than that. You do that, and you're going to lose weight. But the power of a biological-based appetite is such that, for some people, something that seems so simple on the surface can be incredibly problematic.

What's the mental phenomenon of the would-be dieter? You all know this, but just to drive it home, let's say it's New Year's Eve, 2011, time to make a New Year's resolution. This is it: I'm going to take off 20, maybe 30, pounds. I just had a big meal so I'm absolutely convinced I'm going to be able to do it, and I know I'm going to succeed. Well, what happens? It's the nature of drives, of appetites, that they're cyclical. I begin to get hungry, and for the person who is watching me, all that they're going to see is something that looks on the surface like sneaky, secretive, premeditated behavior. What are they going to see? They're going to see me getting up out of bed, going downstairs, opening the refrigerator, and so on. In other words, I've never seen a case where the refrigerator walks itself up to the bedroom. I've got to go and do something. And it's probably going to be in secret. I told the wife; I told the kid. They don't need to know. And I promise myself, "It's just going to be a little bit. I just want a little snack." And of course, it isn't. I gorge myself. I stuff myself. And as soon as I'm done, I'm sorry. I'm really sorry. I mean it. I want to lose this weight. I promise, never again. And then as the cycle repeats, I tend to repeat the pattern. Not everybody, but I think you can agree that many good people trying to do their best on their own aren't able to succeed.

Now, to come to my concluding point, people could argue that that's not fair. You have to eat to live, but you don't have to have sex. But let's step back and look at the bigger picture. God or nature put the sex drive into each

and every one of us for a very important reason, and that is literally the preservation of the human species. It's true that if I don't eat, I die. It is equally true that if we all stop having sex, we all die. And when that very powerful, strong, sexual drive, that recurrently wants to be satisfied, gets misdirected, for lack of a better word, aimed, for example, towards desires to repeatedly expose or to cross dress or to be intimate sexually with children, that desire still repeatedly craves to be satisfied. I don't think it takes a mental health expert to appreciate how problematic a situation that can be, and why some people may need help.

I think that one of the purposes of B4U-ACT is to make the point in the *DSM* that not everyone needs help, that some people, on their own, have figured out how to live responsibly in society, and that people don't want the *DSM* to automatically have people assuming that if you make a diagnosis such as pedophilia, it means that someone inevitably is being irresponsible. I agree with that, but I hope you also agree with me that for those people who do need help, it may be useful to have psychiatry involved so that we can assist them. Because I want the community to be safe and I want fundamentally decent people to have a life for themselves.

Decriminalizing mental disorder concepts-
Pedophilia as an example

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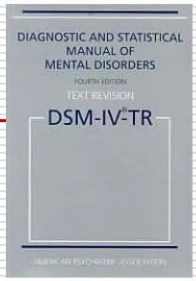
Overview

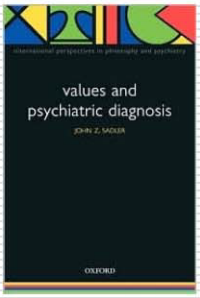
- I. Context & prior work on "vice" in the DSMs
- II. Vice-laden diagnostic criteria
- III. Pedophilia as a vice-laden diagnostic concept
- IV. Rethinking vice-laden diagnostic criteria
- V. Questions about Pedophilia as a diagnostic construct
- VI. Questions and Discussion

2

I. The context of "vice"

- My scholarly research focuses on philosophical approaches to conceptual problems in psychiatry.
- My major work to date is a book that analyzes the varieties of value commitments manifested in the DSMs (*Values & Psychiatric Diagnosis* Oxford, 2005).
- Currently I'm working on a followup entitled *Vice & Psychiatric Diagnosis*.





3

I. The context of "vice"

- Drawing upon some classical work in moral philosophy (Putnam, Mackie) I define values as ideas or dispositions that are action-guiding and susceptible to praise or blame.
  - Values: good/bad, beautiful, useful, rigorous, comprehensive, precise, sloppy, etc.
- Values come in different kinds, just like facts do. The "kinds" of values of interest today include:
  - Non-moral values
  - Moral values

4

I. The context of "vice"

- A few comments on the distinction between "word" and "concept"
  - Concept: an idea, given in thought
  - Word: the name or signification of the concept, part of language
  - Different words can refer to the same concept:
    - Blue (English) Bleu (French)
    - Car – Automobile
  - Different concepts can use the same word:
    - John - can be an English proper name for a man, a client of a sex worker, or a toilet
  - Concepts often, even usually, require many words to understand
    - "philosophy" "paraphilia" "democracy"

5

I. The context of "vice"

- All kinds of values can be positive (good/desirable) or negative (bad/undesirable)
- Values are subject to diverse social opinion about whether they are desirable or good/bad. What is good for some may be bad for others.
- Generally societies come to a broad consensus about the goodness or badness of a value – reflected in cultural norms and laws.
- In any case, values are subject to cultural change, though many don't change much (e.g. murder is wrong, theft is wrong)

6

I. The context of "vice"

- Moral values are ones associated with rightful or wrongful thought and conduct – "good", "bad", "evil", "virtuous", etc.
- Non-moral values are all the other kinds of philosophical values –
  - Aesthetic values – whether a painting is beautiful or ugly.
  - Practical values – how something might be useful to us – "effective", "efficient", "profitable".
  - Epistemic values – how we decide if our knowledge is worthy – "clarity", "comprehensive", etc.

7

I. The context of "vice"

- "Vice", in my usage, is defined as wrongful or criminal thought and/or conduct.
- By definition, "vice" always reflects moral values, and moral values that are negative, disvalued, or otherwise socially undesired.
- Needless to say, in individual practice, vicious conduct has always been a part of human history.
- What counts as "vice" has varied considerably over history and across cultures.

8

II. Vice-laden diagnostic criteria

- "Vice-laden" means that a concept requires wrongful or criminal content in its meaning.
  - If you remove "wrongfulness" in defining "robbery" you no longer have a concept that reflects what people mean by "robbery".
  - Vice-laden means the concept is, by definition, wrongful.
- Some DSM diagnostic categories are "vice-laden" -- the criteria involve one or more examples of undesirable moral evaluations.

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II. Vice-laden diagnostic criteria

- Some examples of vice-laden diagnostic criteria:
  - DSM-IV- TR Conduct disorder: "has been physically cruel to people", "often lies to obtain goods or favors or to avoid obligations"
  - DSM-IV-TR Intermittent Explosive Disorder: "Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property."
  - DSM-IV-TR Narcissistic Personality Disorder: "is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends"
  - DSM-IV-TR Pedophilia: "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)."

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II. Vice-laden diagnostic criteria

- "Vice" judgments are social, and are subject to change. Whether a given behavior of vicious or virtuous depends upon prevailing social opinion, though many philosophers would argue that some acts are intrinsically wrongful, while others would argue that some acts have proven wrongful by historical and cultural experience.
- The question I want to raise in my presentation today is "Do vice-laden criteria and concepts of disorder belong in medicine?

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III. Pedophilia as vice-laden

- I've already identified DSM-IV-TR Pedophilia as vice-laden:
  - DSM-IV-TR Pedophilia: "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)."
- Red indicates vice-laden "content"

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III. Pedophilia as vice-laden

- Things don't change too much with DSM-5 proposals:
  - *Pedohebephilic Disorder:*
    - *A. Over a period of at least six months, one or both of the following, as manifested by fantasies, urges, or behaviors: (1) recurrent and intense sexual arousal from prepubescent or pubescent children (2) equal or greater arousal from such children than from physically mature individuals.*
    - *B. One or more of the following signs or symptoms: (1) the person has clinically significant distress or impairment in important areas of functioning from sexual attraction to children (2) the person has sought sexual stimulation, on separate occasions, from either of the following: (a) two or more different children, if both are prepubescent (b) three or more different children, if one or more are pubescent (3)* repeated use of , and greater arousal from, *pornography depicting prepubescent or pubescent children than from pornography depicting physically mature persons, for a period of six months or longer*
    - *C. The person is at least age 18 years and at least five years older than the children in Criterion A or Criterion B.*
    - *Specify type: Pedophilic Type/Hebephilic Type/Pedohebephilic Type—Sexually Attracted to Both*

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III. Pedophilia as vice-laden

- Since the Enlightenment, Anglo-American law has generally recognized the distinction between wrongful acts and wrongful thoughts.
  - Generally, only wrongful *acts* are criminal and subject to arrest and punishment.
- However, large portions of Anglo-American culture still recognizes wrongful thoughts as "morally wrong" or "sinful". As such, wrongful thoughts → vice-ladenness.
  - For many Americans, fantasies of adult-child sexual contact are still morally wrong.
  - For these collectives, even the "cognitive criteria" for Pedophilic/Pedohebephilic disorders constitute wrongfulness in thought.
  - Even "pedophilia" (no disorder) is still vice-laden.

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IV. Rethinking vice-laden diagnostic criteria

- The problems with vice-laden categories & criteria for mental disorders
  - 1. Typical medical diseases and injuries are non-moral in value-content. Vice-laden categories are confined to the domain of mental disorders and make "mental illness" subject to shifting sociomoral attitudes.
  - 2. Vice-laden diagnoses transform mental health clinicians into regulators of moral deviance – akin to the police.
  - 3. Vice-laden diagnosis undermines psychiatry's claims that mental disorders are "just like physical disorders"

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IV. Rethinking vice-laden diagnostic criteria

- The problems with vice-laden categories & criteria for mental disorders
  - 4. Vice-laden diagnosis perpetuates stigma for all mental illnesses.
  - 5. Vice-laden categories introduce all kinds of confusion when mental health, penal, and criminal justice systems design services.

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IV. Rethinking vice-laden diagnostic criteria

- What to do?
  - The example of delirium
    - Delirium is a complication of a medical or surgical illness characterized by a disturbance in sleep/wake cycle, psychomotor behavior, cognitive function, and sensory experiences.
    - Delirium is commonly associated with "antisocial" acts e.g., assaults on staff or other helpers.
    - Yet violent delirium is not "morally wrong". Reasons?
      - The delirious patient is "not responsible" for actions.
      - More importantly for this discussion, the concept of "delirium" does NOT include vice-laden diagnostic criteria.
      - Assaultive behavior is not part of the diagnostic criteria – not a core symptom of the delirium condition.

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IV. Rethinking vice-laden diagnostic criteria

- What to do?
  - My position:
    - mental disorder concepts should not be built around vice-laden (morally wrongful) symptoms.
    - Instead, mental disorder concepts should ALWAYS include core (essential) features that are NON-MORAL in their values
      - Just like in physical diseases
    - This means that some vice-laden criteria are permissible in psychiatric categories, but the categories should not DEPEND upon vice-laden criteria – as is the case of current notions of Pedophilia.

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IV. Rethinking vice-laden diagnostic criteria

- What to do?
  - Current pedophilia proposals do little to introduce non-moral "bads" into diagnostic criteria
    - Pain, incapacity, suffering, impairment, loss of function criteria are largely absent
  - Two options:
    - "rehabilitate" the Pedo(hebe)philia concept through research identifying the non-moral negative values that make the "evaluation" of the condition largely nonmoral.
    - If there are no non-moral problems associated with the Pedo(hebe)philia condition, then it should be removed as a diagnostic category.

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IV. Rethinking vice-laden diagnostic criteria

- What to do?
  - The problem with "rehabilitating pedo(hebe)philia" as a diagnostic concept is we know little about the nonmoral "bads" associated with the condition.
  - Scientists should be looking for underlying dysfunctions or abnormalities in areas not involving moral judgments.
  - The DSM diagnostic criteria are "impoverished" – they are little more than restatements of the same vice-laden syndrome. Consider the DSM-IV-TR diagnostic criteria for Schizophrenia:

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IV. Rethinking vice-laden diagnostic criteria

- **DSM-IV-TR Diagnostic criteria for Schizophrenia** (American Psychiatric Association 2000, p. 312-313)
- A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
- (1) delusions
- (2) hallucinations
- (3) disorganized speech (e.g., frequent derailment or incoherence)
- (4) grossly disorganized or catatonic behavior
- (5) negative symptoms, i.e., affective flattening, alogia, or avolition
- Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.
- B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).
- C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).
- D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.
- E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
- F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).
- [EXTENSIVE SUBTYPING]

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IV. Rethinking vice-laden diagnostic criteria

- What to do?
  - DSM categories should be richly described in multiple phenomenological domains, with little to no semantic overlap between kinds of symptoms.
    - E.g. "hallucinations" is a distinct, discrete phenomenon, separate from "grossly disorganized behavior".
  - Not the case with the paraphilias.
  - The paraphilia literature is redolent with descriptions of "comorbidities", raising the question of whether a more fundamental, "underlying" condition is operative, with the sexual symptoms simply one of many outward manifestations.

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V. Questions about Pedophilia as a diagnostic construct

- (1) Should Pedophilia be considered a mental disorder at all, if it is based primarily upon fantasied or actual criminal conduct?
- (2) If Pedophilia and related categories are to be preserved as legitimate, nonmorally value-laden disorders, then they require a preponderance of nonmorally-value-laden diagnostic descriptors in their diagnostic criteria.
- (3) Will the scientists pursue this route?

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VI. Questions and Discussion

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Is Anybody Out There? Testimony of Minor-Attracted Persons and Hearing versus Listening to their Voices

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Statement of the problem

Among clinicians, there is a widespread view that self-reporting is particularly unreliable in pedophiliacs (Blanchard 2009). There may be reasons for such unreliability: as Michael First says, sex offenders are not necessarily rewarded for being truthful about pedophilic impulses (First 2010, 1241, quoting Blanchard 2010). Truth-telling thrives best when an environment of **trust** exists and when speakers are confident that their offerings will be given **uptake**. And those virtues are hard to come by in dialogue that involves—or should involve— minor-attracted persons. This paper is, therefore, undergirded by the idea that the virtues are tied to scientific knowledge in particular ways.

The scientific knowledge we are querying is that episteme that forms the *DSM*. The influence of the *DSM* cannot be overstated. It:

- Is a quick and easy way to share information among clinicians.
- Provides a common focus and language for researchers to organize and conduct studies.
- Carries legitimacy in granting agencies so its categories are more readily funded.
- Provides a language within clinical encounters for communication and understanding.
- Has categories that are recognized by insurance companies so patients' diagnoses are more likely to be covered (Kamens 2011).

In other words, the *DSM* carries a significant degree of epistemic and ethical responsibility for its classificatory system. As Karen Franklin comments, the construct of the paraphilias in general is explicitly based on cultural notions of normalcy. The concept is widely critiqued as lacking in scientific validity (Franklin 2010). But the development of the *DSM* relies on **evidence**, and so it is crucial to determine what counts as appropriate, necessary, and sufficient evidence.

One kind of evidence about pedophilia comes from the voices and experiences of minor-attracted persons—i.e. **testimony**. This paper argues that we are doing what Sandra Harding (1986) calls "bad science" when we fail to attend to those voices and that the *DSM-5*'s classification of this part of the paraphilias will be scientifically inadequate if the practice of neglecting the voices of minor-attracted persons continues. As one blogger wrote, "Is it just me, or is placing the role of defining the whole of normative sexual behaviour in our society in the hands of a workgroup that only references three sources (all written by the work group head) a problem?" (Mercedes, 2010, para. 5, quoted in Kamens 2011). Kramer reasons that involving minor-attracted people in research and collaborative efforts to produce knowledge for the *DSM* would increase understanding of some of the paraphilias and lead to solutions to ethical problems. Yet, contrary to APA guidelines, no patients or family groups have had workgroup representation (Kramer 2011, 234).The result is distorted beliefs that are treated as knowledge but actually fall short of it. Paraphrasing Julia Serrano (2009), I suggest that clinicians may see themselves as experts on paraphilias and so cannot comprehend that service users, too, have profound experiences and insights into desire, action, and the will that clinicians could learn about by a certain kind of listening. But appropriate listening is difficult to do because the kind of knowledge we are talking about is normative—in terms of desire-based knowledge—and philosophical—in terms of action and the will. (I come back to this point shortly.)

I. Testimony and testimonial injustice

Testimony is a kind of evidence, and so it must be evaluated in terms of the credibility of the speaker (Root 2001, 19). The generally accepted criteria for credibility are that (a) the speaker's point has general plausibility, (b) the speaker is in a position to be a knower with respect to that point, and (c) the speaker does not have an interest in deceiving or misleading the listener. In other words, the speaker must have the virtues of accuracy and sincerity (Fricker 2007, ch 5), an issue I take up in § III.)

For example, suppose the person sitting next to you exclaims, "There is a bat flying around in this room!" Your job is first to assess the general plausibility of the statement. (Let's say it is possible, although unlikely.) Second, you ask yourself whether or not your seat-mate is in a position to know that a bat is flying around. Is she sighted? Does she need glasses and is she wearing them? Is she facing the right direction to be able to see? (Let's say the answers to these questions are "yes.") Finally, does she have any reason to be deceiving or misleading you? Could she be pulling your leg? Does she know what a bat looks like? Is she planning ultimately to disrupt the conference with a cry of "bat on the loose"? The less plausible the speaker's claim, the more the listener will need to rely upon the speaker's position as a potential knower on this subject and his or her character.

These criteria are objectively grounded, meaning that the evaluation of them relies on an assumption that there are facts of the matter that would make those conditions more or less likely to be fulfilled.

But as listeners, we often fail to be objective in our assessments, and this leads to what Miranda Fricker (2007) calls **epistemic injustice**. Epistemic injustice is when the listener's response to the speaker impedes the emergence of knowledge-claims due to *hearing, but not properly listening to*, the speaker. It is an ethical as well as an epistemological problem but first I focus on the epistemological. To be epistemically unjust means that the listener could have done otherwise and that his or her failure to appropriately attend to the speaker results in distorted beliefs. It occurs when the listener holds biases and prejudices that influence his or her assessment of the speaker's telling. The listener doesn't accord the speaker the credibility that is warranted.

In our case, we have already seen that service users are viewed as deceitful. This means that the listener distrusts the speaker's message. It is true that shame, social stigma, and fear of legal consequences prevent people from being open about "non-normative" desire (Kamens 323). But lack of openness is part of a dynamic in which being open has high costs for the speaker. Andrew Hinderliter also notes that the paraphilia diagnoses create an environment where patients feel they cannot be honest with clinicians. He points out that this distrust seriously draws into question the therapeutic value of these diagnoses (Hinderliter 2010). I would add that it seriously draws into question their scientific legitimacy as well. This accounts for a second reason that the voices of service users are not heard.

Briefly, scientific legitimacy relies on a philosophical model of knowledge that is rooted in an outdated positivism. As Lorraine Code (1991) argues, what counts as knowledge in mainstream epistemology rules out the kind of knowing that comes from interpersonal and intersubjective encounters. I apply this insight to psychiatry. In other words, psychiatry uses an epistemological model that entails that knowledge of other persons (including the matrix of desiring-acting-willing) doesn't count as genuine knowledge because it cannot be evaluated with traditional methods. But such a model is "bad science," as I stated earlier. This matrix of abstract concepts as they play themselves out in norms of eroticism, sexuality, and identity are essential genuinely to understand persons attracted to minors. These persons can shed light on what the relationship is of non-normative desire to willing to act and to action itself. Furthermore, it can illuminate and, perhaps, challenge, what counts as normative desire and challenge what the warrant is for designating certain desires as normal or natural. If harmful desire is a determinant, these voices can help us think through why most of our normative desires are considered harmless and if that is truly correct. I am suggesting that another reason (besides distrust) for discounting the voices of service users is that the current model of what counts as scientific knowledge discounts such input as "knowledge." Therefore, I want to turn our attention to the communicative dynamic as a way to correct for these problems and, thereby, improve scientific practices.

II. The virtue of properly attending to others' voices.

The most immediate and basic point of telling is to convey knowledge (Fricker 2007, 60). That fact places a certain responsibility on the listener: that of listening such that we treat the speaker as a potential knower. A knower is someone who contributes to a body of knowledge. The listener plays a role in validating the speaker as a potential knower. Most of us know the experience of feeling like our ideas and viewpoints are not really listened to—as when we report that our contribution to a meeting "fell on deaf ears" or was trivialized or dismissed. Consider the following exchange:

> How did the council meeting go? Were they receptive to your proposal?
>
> No, it was like talking to a wall. I didn't get any uptake at all.

We are familiar with the idea of "**uptake**;" here, we will formalize it. J.L. Austin (1975) introduced the concept of "uptake" to characterize the role that the listener plays in affirming (or disconfirming) the meaning of a speech act. The idea is that some speech acts hold conventional meanings that require listener acknowledgment in order to count that communication *as* a speech act. For example (one of Austin's), we cannot be said to have warned an audience unless that audience hears what we say and takes what we say in a certain sense, say as an alarm, an alert, or a threat (1975, 571). Uptake, then, occurs when the second party, listening to my speech act, reorients herself to me and the relation between us "comes off" with an appropriate response.

It is important for clinicians and others to understand uptake because reliance on the conventions of one's own culture, place, and time may skew a listener's ability to give uptake to the communicator. Thus, a proper response to another's communication, although one need not agree with the communicator, is one that conveys an earnest attempt to understand things from the communicator's point of view. In other words, one cannot rely solely upon language conventions. While most of us are familiar with the experience of not getting uptake, we are not all equally vulnerable in the reception to our speech acts. Evidence suggests that women's anger doesn't get uptake, black people's criticisms of social justice don't get uptake, practitioners of alternative medicine are not given uptake by the public, to name a few domains. Because our listening can be unjust, as well as epistemically wrongheaded, the communicative struggle is integrally bound up with being an ethical clinician.

As I have argued elsewhere (Potter 2002; cf also Potter 2009 for an application of uptake to Borderline Personality Disorder), giving uptake is a virtue, by which I mean that giving uptake as a virtue can miss the mark either by too little or too much. In this paper, I am focusing on the deficiency of giving uptake to minor-attracted persons. In order to give uptake properly, listeners will have to overcome prejudices, biases, and assumptions that impede their being open to speakers' offerings of knowledge-claims. To learn to give uptake properly, listeners may have to develop what is called in the bioethics field "**critical consciousness**" (Pitner and Sakamoto 2005.)

Critical consciousness is a stance we can take toward our own ideas, values, practices, and institutions. It has three aspects: cognitive, affective, and behavioral, and two levels: personal and structural. Critical consciousness is a process by which we continuously expose our own biases, assumptions, and cultural world-views to examination, asking how those beliefs, values, and attitudes shape the way we perceive the world. The idea is that our culturally-inflected perspectives (including our ideas about morality, about sexual desire, and about willing and acting) affect our understanding of power relations and of diversity, and the first step to changing faulty thinking is to subject it to disciplined analysis. Ronald Pitner and Izumi Sakamoto (2005) include discomfort with diversity and ignorance of power imbalances that are found at a structural level—that is, built into the structure of the institution of health care itself—and encourage us to work to change institutions such that they no longer protect us from our biases, distortions, and psychic damage we can do one another.

These two concepts—critical consciousness and uptake—make possible an environment of trust to emerge between speakers and listeners. In our case, speakers are likely to be more forthcoming and more honest if they feel that listeners—like members of the Work Group for the *DSM-5* on paraphilias, or their clinicians—can be trusted to bring to the encounter the self-reflective work of examining carefully their biases and assumptions about minor-attracted persons and a commitment to try to give uptake properly.

III. Speakers' virtues

Recall that one of the criteria for counting testimony as credible is that the speaker does not have an interest in deceiving or misleading the listener. Thus the speaker must have the virtues of accuracy and sincerity (Fricker 2007, ch 5). I emphasize the virtue of being a **trustworthy speaker**.

Trustworthiness is almost always domain-specific; we usually trust people with respect to something we care about but do not trust people globally. (Global trust is reserved for one or two very special people in our lives.) We trust others when we give them the opportunity to take care of something we value—in the case of testimony, it is our beliefs, desires, offerings of knowledge-claims, and self-narrative. We entrust to the listener that he or she will take us seriously and will be respectful and careful in responding to us. (Cf Potter 2002 for a full analysis of trust and trustworthiness.)

But as I stated earlier, listeners often distrust speakers, and perhaps sometimes for good reasons. Therefore, speakers have responsibilities too: in this case, to be worthy of the trust the listener places in him or her.

The point is that listeners need a trusting environment, too. They need to be reasonably confident that the speaker is treating him or her with respect, by not twisting the truth or disguising it, or withholding important information. The speaker must, therefore, be trustworthy so that the listener can properly exercise the virtue of giving uptake appropriately—not being too gullible or too suspicious. Deception on the part of speakers makes it more difficult for listeners to engage in uptake in the future, as well as making it harder for other speakers to be believed. Evaluations of credibility rely on the speaker being seen as a potential knower whose perspective can add to the body of knowledge about minor-attracted persons. The speaker cannot be seen this way if (a) the listener hasn't developed critical consciousness, and (b) the speaker herself is playing games with the truth.

IV. Concluding thoughts

In the 19th century, John Stuart Mill advocated free speech on the grounds that it is necessary for knowledge-production. Mill argues that even the most unpopular lone voice not only has a right to be heard but a duty to be listened to. The idea is that, (1) given that we are fallible knowers, we might be wrong—in which case minority voices will serve as a corrective toward truth, and (2) even if minority voices turn out to be wrong, listeners could strengthen their position by genuinely and openly considering alternative views (Mill). Either way, any liberty-seeking government or organization will make a space for minority voices, in the pursuit of truth and knowledge. This reasoning bolsters the argument that the voices of minor-attracted persons should be listened to and not just "heard." This calls on us to play what Peter Elbow calls the "believing game" rather than the doubting game most of us were trained in: what if what the speaker says is true? In Elbow's words, we must exercise

> the disciplined practice of trying to be as welcoming or accepting as possible to every idea we encounter: not just listening to views different from our own and holding back from arguing with them; not just trying to restate them without bias; but actually *trying* to believe them. We are using believing as a *tool* to scrutinize and test. (Elbow 2009, 1, emphasis in original)

Elbow's concern is with the stance of skepticism that academics are trained to adopt and that hinders the growth of knowledge. I am not sure which ways knowledge will be enhanced through the concepts introduced today—that is an open question until persons attracted to minors are given uptake. But I am confident that giving uptake is a necessary step in the development of a more accurate and less stigmatizing *DSM* category of the phenomenon now known as pedophilia.

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Identifying the Psychological Correlates of Pedophilic Desire and Behavior: How can we Generalize beyond Forensic Samples?

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Pedophilia, characterized by sexual attraction, fantasies, and/or behavior towards prepubescent children, is one of the only psychiatric diagnoses defined by the desire to perform acts which are illegal and recognized as destructive to children. This fact both underscores the importance of and presents significant barriers to empirical research into pedophilic desire and behavior. In fact, despite sophisticated forensic research (Seto, 2008; Prentky *et al*, 2008), surprisingly little is known about the etiology, development, underlying mechanism, and neurobiology of pedophilia. Such research is critical to inform treatment, prevention and public policy. As the present volume exemplifies, there is ongoing controversy about the very definition and diagnostic criteria for pedophilia.

Because of the illegal status of pedophilic behavior there are inherent risks in honest self-disclosure for pedophilic subjects. Accurate self-report of sexual activity with children raises the risk of significant legal consequences. Even when researchers trouble to protect confidentiality, subjects may still feel the need to censor their answers. Consequently, most research on pedophilia is conducted on individuals already in the criminal justice system, either currently incarcerated, in forensic inpatient settings, or in outpatient sex offender clinics coordinated with the criminal justice system (Cohen *et al*, 2002a,b, 2007; Gebhard, 1967; Prentky *et al*, 2008). This creates significant selection biases, as individuals with pedophilia within the criminal justice system may be significantly different from those outside of it, specifically those who have acted on their pedophilic urges but never been caught or who have never acted on such urges (Seto, 2008, Haywood *et al*, 1996). Likewise, as there are significant selection biases within the criminal justice system (Pettit & Western, 2004), there are demographic biases resulting from this limitation in subject recruitment. Many subjects in pedophile research are low socio-economic status, have low levels of education, and may be over-representative of minorities (cf. Cohen *et al*, 2002a,b,c; 2007). This suggests that highly educated, upper-income individuals with pedophilia are not sufficiently represented in pedophile research. For example, there is evidence that priests with pedophilia, an educated cohort, differ from non-clerical pedophiles in specific psychological traits (Haywood *et al*, 1996).

To illustrate this heterogeneity, we now present material on two individuals with pedophilic inclinations. The following passage is from an email sent to the first author from a member of B4U-ACT, the organizers of this conference, as part of an email campaign to persuade the *DSM-5* task force for the paraphilias to incorporate their concerns into the development of *DSM-5* diagnostic criteria for pedophilia.

> When I was thirteen I started to realize that I was physically and emotionally attracted to younger girls, mostly ones that had not reached puberty. I have never felt too unsettled by this. I have never hurt or done anything sexual to any of the girls I thought were beautiful, nor have I have ever been tempted to do so.
>
> Despite that, I did feel kind of alone. Even though I knew I wasn't what was portrayed in the

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> media or TV, I felt that perhaps I was the only one of my kind without any cruel tendencies. I have since learned that there are many more people such as myself who were born this way and are perfectly functioning, caring human beings.
>
> I feel that the task force revising the DSM needs to hear from more people similar to myself. Right now they are getting most of their information from people who have been incarcerated for sexual offences against young people, which I feel is hardly an accurate source of information.

In contrast, we describe a subject from our own research sample, recruited from a sex offender clinic affiliated with the criminal justice system. This 41-year-old male entered our study after having been recently released from prison. He had completed a 15 year sentence for sexually abusing his 12-year-old daughter in addition to an unrelated attempted murder charge. He had served two prior sentences, one year for unlawful entry and federal larceny and six years for manslaughter. He had a history of polysubstance dependence, was HIV+ and had continued problems with aggressive outbursts. Of note, he reported no prior pedophilic behavior/urges before the abuse of his daughter. While this contrast is clearly extreme, it can illustrate the profound heterogeneity of pedophilic individuals.

We will now briefly consider the current diagnostic systems, specifically the *DSM* system which is the official mental health diagnostic system in the United States. The *DSM-IV-TR* (APA, 2000) characterizes pedophilia by six months of sexual attraction, fantasies or behavior towards a prepubescent child, generally age 13 or younger. There is no distinction between sexual desire and behavior and no inclusion of sexual desire for pubescent children. Subgroups include heterosexual, homosexual, and bisexual types, incest type and exclusive/non exclusive types. Non-exclusive types also have significant sexual attraction to age appropriate partners. While there is some evidence that these distinctions are meaningful and predict to different clinical and forensic profiles, there is also evidence of substantial overlap among subgroups (Cohen & Galynker, 2002). The proposed revisions to the *DSM-5* add hebephilia to the diagnosis (pedohebephilia disorder). Hebephilia pertains to sexual attraction to pubescent children (APA, 2010). A behavioral criterion is also added, sexual activity with 2 or more prepubescent children or 3 or more pubescent children, although it is not clear if this behavioral criterion is sufficient for the disorder in the absence of six months of sexual attraction. Subtypes include attraction to males, females, or both and pedophilic, hebephilic, or pedohebephilic types.

An alternative classification includes the distinction between “true” vs. “opportunistic” pedophilia. This subgroup classification is not included in either *DSM* system but is mentioned throughout the research and clinical literature on pedophilia (McConaghy, 1998; Barnard *et al*, 1989; Lanning, 2001; Prentky *et al*, 2008). Related terms include fixated vs. regressed and preferential vs. situational subgroups (Lanning, 2001; Prentky *et al*, 2008; McConaghy, 1998). Likewise, the distinction between pedophilic and non-pedophilic child molesters (according to *DSM-IV* criteria), provides an operationalization of this general concept. True pedophiles have a *persistent sexual attraction to prepubescent children, which is not dependent on context.* In opportunistic pedophiles *the attraction to children is more a function of the situation.* Such individuals may be socially isolated from adults, alcoholism or other forms of substance abuse may impair behavioral control, poor social skills may make children seem more attractive, or children may provide a convenient sexual outlet while sociopathy reduces moral inhibitions.

Although this notion is still derived from research with forensic populations, it’s great advantage is that it implicitly distinguishes between desire and behavior. True pedophiles’ behavior is driven by a specific sexual desire; opportunistic pedophiles are characterized less by a specific desire than by a failure to inhibit destructive behavior. This is not to say that desire and disinhibition are mutually exclusive, only that they are dissociable. Likewise, there is some discussion over whether this distinction reflects a categorical difference or whether people with pedophilia fall along a continuum (Maletzky, 1992).

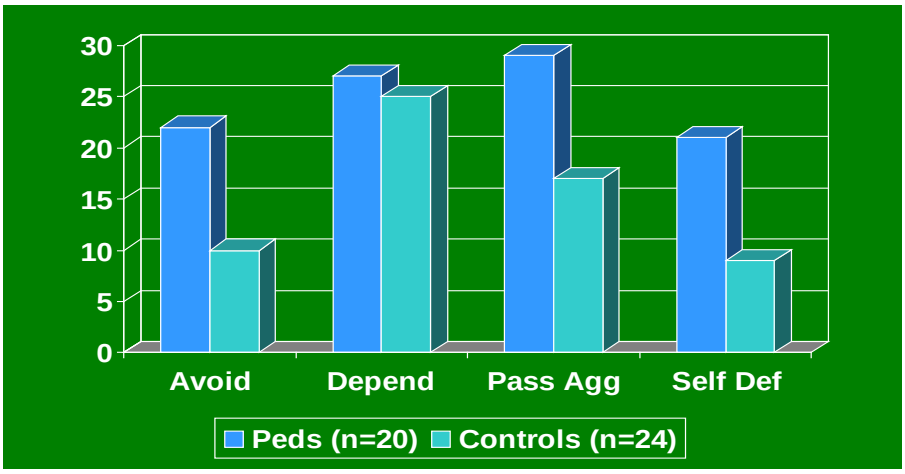
In light of this discussion, we will now present data from our research program into the psychological correlates of pedophilia. This research was conducted as part of a larger inquiry into (1) behavioral and chemical addictions and (2) the relationship between trauma and personality. Specifics of the studies are published elsewhere (Cohen *et al*, 2002 a,b,c, 2008, 2007, 2010); here we will briefly review some of our key findings in light of the questions regarding heterogeneity among individuals with pedophilia.

Our total sample included 51 males with pedophilic behavior, recruited via a clinic specializing in sex offenders. Thus this is an outpatient forensic sample. All subjects were either charged or convicted of a sexual crime related to a child aged 13 or under. The pedophilic group was compared to a sample of healthy controls (total 84, 77% males) and subjects with opiate addiction (53, 69% males). Demographic differences were accounted for statistically. Not all subjects participated in all studies.

Our primary assumption is that pedophilic inclinations and behavior derive from aberrant motivation and/or impaired behavioral inhibition. Two proposed motivational factors included personality traits related to social anxiety and the "abused abuser theory" (Araji & Finkelhor, 1985), such that childhood experiences of sexual abuse may predispose individuals to develop pedophilic inclinations. Three proposed inhibitory factors include impulsivity, propensity towards cognitive distortions and psychopathy. The large and growing literature on neurobiological factors and on cognition (e.g., Schiltz *et al*, 2007; Cantor *et al*, 2005) falls outside the scope of the current paper.

Traits related to social anxiety may contribute to the motivation for pedophilic acts because elevated levels of social anxiety and poor self confidence may inhibit appropriate sexual relations with adults. There is some evidence of elevated personality traits related to social anxiety in the research literature (Raymond *et al*, 1999; Black *et al*, 1997). Our own research shows elevated levels of Cluster C personality disorder traits, poor self esteem and impaired assertiveness in our pedophilic samples vs. healthy controls (Cohen *et al*, 2002a,c). Figure 1 shows data comparing 20 male pedophilic subjects and 24 demographically matched controls on Avoidant, Passive-Aggressive, Self-Defeating and Dependent Personality Disorder scales from the Millon Clinical Multiaxial Inventory -2 (MCMI-2) (Millon, 1987). Avoidant and Dependent Personality disorders are grouped in the *DSM-IV* Cluster C Personality Disorders, the anxious and fearful personality disorders. We propose that passive aggressive, categorized in the *DSM-IV* as provisional and in need of further study, and self-defeating, which was listed in the *DSM-III-R*, also reflect social inhibition. As can be seen in Figure 1, pedophiles score significantly higher on the Passive-Aggressive, Avoidant and Self-Defeating scales than healthy controls although there is no difference between the groups on the Dependent scale.

Figure 1: Traits Related to Social Anxiety

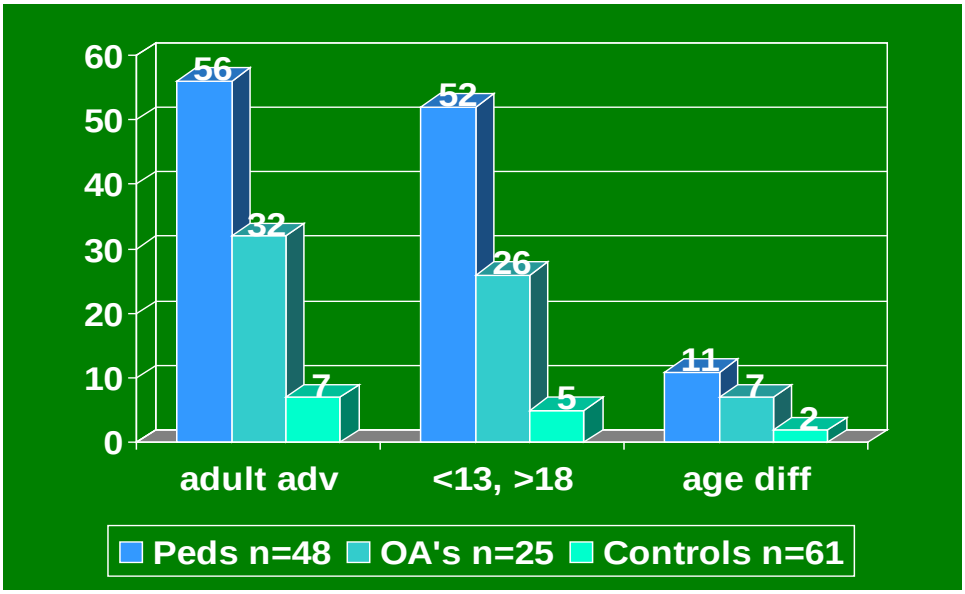


Comparison of personality traits related to social anxiety (MCMI-2 Personality Disorder scales) in 20 males with pedophilic behavior and 24 demographically matched controls. All differences are statistically significant except on the Dependent Personality Disorder scale.

Thus there is some evidence that pedophilic individuals may as a group have elevated rates of personality traits related to social anxiety. However, it is unlikely that such traits are either necessary or sufficient for the development of pedophilia. A further question pertains to the direction of causality. In our narrative data, we found that some subjects reported turning to children out of social discomfort with same-age peers. However, other subjects reported social anxiety and lowered self esteem as *a result of* their pedophilic inclinations and/or behavior.

The abused abuser theory, such that a history of sexual abuse predisposes to pedophilic tendencies, has robust support in the literature (Freund, Kuban, 1998; Cohen *et al*, 2002b, 2010; Dhawan, Marshall, 1996). Studies report a range of 40 to 100% of subjects with pedophilic behavior report a childhood history of sexual abuse (CSA). There is a higher incidence of such histories in perpetrators of sexual abuse against children than in sexual offenders against older age groups and than in non-sexual offenders (Freund & Kuban, 1994; Haywood *et al*, 1996). One study is particularly convincing, given that it was conducted with a large community sample and thus escapes the self-report biases of forensic samples. Bagley *et al* (1994) found that men who reported multiple incidents of sexual abuse in childhood were almost 40 times more likely to report a history of pedophilic acts than those without childhood sexual abuse histories (0.2% vs. 7.7%). Figure 2 presents our own data on childhood sexual abuse in pedophilic subjects compared to healthy controls and subjects with opiate addiction. In this comparison there were demographic differences between groups, which were corrected statistically. The presence of childhood sexual abuse was determined through a variety of questions on the Sexual History Questionnaire (Cohen *et al*, 2002b, 2010). Figure 2 presents the percentage of subjects (1) who report any adult having made sexual advances at them as a child, (2) whose first sexual contact occurred at 13 or younger with a partner aged 18 or older, and (3) the mean age difference between self and first sexual partner. In all three measures, pedophilic subjects were elevated relative to control groups.

Figure 2: Comparison of 48 males with pedophilic behavior (peds), 25 subjects with opiate addiction (OA), 61 healthy controls (HC) on childhood sexual abuse history via the Sexual History Questionnaire.



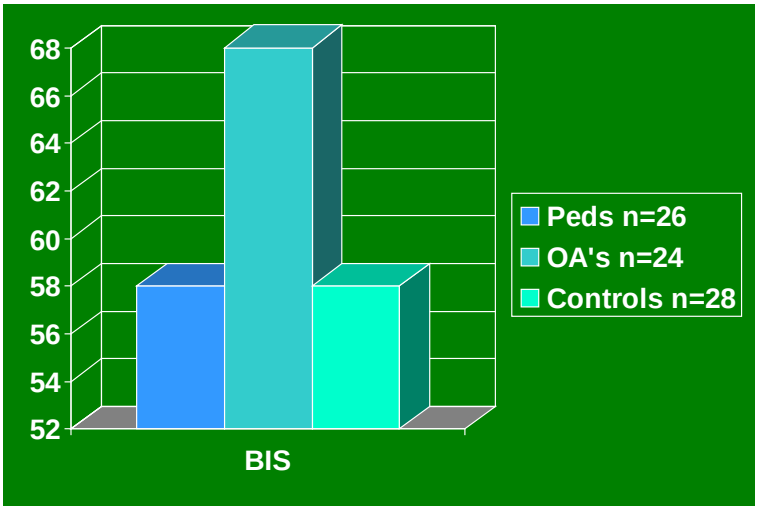
Fifty-six percent of pedophilic subjects report experiencing adult sexual advances as children compared to 32% of OAs and 7% of HCs. Fifty-two percent of Peds reported first sexual contact age 13 or under with a partner aged 18 or over compared to 26% of OAs and 5% of HCs. The age difference between self and first partner was 11 years for Peds, 7 for OAs and 2 for HCs. Peds scored statistically significantly higher than other groups.

Thus it is likely that childhood experience of sexual abuse plays some role in the development of pedophilia. The mechanism behind this is unclear. One possibility is the concept of "identification with the abuser", in which victims of abuse identify with the powerful abuser in order to avoid crushing feelings of helplessness (Araji, Finkelhor, 1985). Normalization of adult-child sex is another proposed mechanism (Araji & Finkelhor, 1985; Freund & Kuban, 1994). Finally, it is possible that premature exposure to sexual stimulation may alter sexual neurodevelopment. Indirect support for this includes a growing body of literature supporting the neurodevelopmental sequellae of trauma (cf. Rick & Douglas, 2007). Further, alterations in sexual brain-behavior relationship have been demonstrated in rats depending on their exposure to sexual experience (Stark, 2005). The biggest problem with the "abused abuser theory," however, is that a substantial proportion of pedophile samples do not report CSA. It is possible that

heterogeneity plays a role here. Perhaps abused pedophiles are more likely to be "true" pedophiles than "opportunistic" pedophiles. Support for this idea comes from a 1990 study by Freund *et al*. Incidence of CSA was higher in pedophilic child molesters than in non-pedophilic child molesters.

The next three personality traits relate to impairment in behavioral inhibition. Impulsivity impairs inhibition due to *inadequate consideration of consequences.* High levels of impulse control disorders have been found within pedophilic samples (Galli *et al*, 1999; Raymond *et al*, 1999). However, such findings are not consistent across studies. In an old but thorough study, Gebhard (1967) found that the vast majority of pedophilic crimes (70-85%) were premeditated vs. impulsive. Figure 3 presents our comparisons of the Barratt Impulsivity Scale scores (Barratt & Stanford, 1995) across pedophilic, opiate addicted and control groups. There was no difference between the pedophilic group and controls whereas the opiate addicted group scored significantly higher than either of the other two groups. These contradictory findings might be explained by heterogeneity among individuals with pedophilia. It is possible that true pedophiles are not notably impulsive while opportunistic pedophiles are much more so.

Figure 3. Comparison of Impulsivity across Peds, OAs and Controls

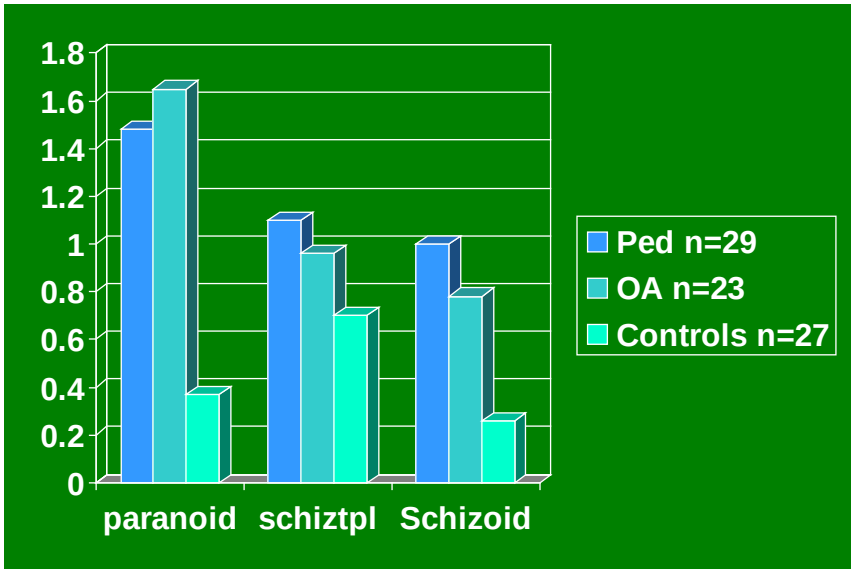


OAs scored significantly higher on the Barratt Impulsivity Total Score than either Peds or Controls. Peds did not differ from Controls. Covariation for demographic differences did not change this finding.

Cognitive distortions impede behavioral inhibition by creating a distorted understanding of the implications of sex with children. There is robust evidence of the tendency towards distorted thinking among pedophilic samples, such that subjects routinely rationalize, minimize and normalize pedophilic behavior (Haywood & Grossman, 1994; Blumenthal *et al*, 1999). There is also evidence that the tendency towards cognitive distortions may generalize into a broader personality trait and Henderson & Kalichman (1990) found elevated schizotypal traits among a pedophilic sample. In Figure 4, we show the comparison across groups of Cluster A personality disorder traits on the *Structured Clinical Interview for DSM-IV* (SCID) (First *et al*, 1995). Cluster A disorders are as known as the "odd cluster," characterized by distortions in cognition.

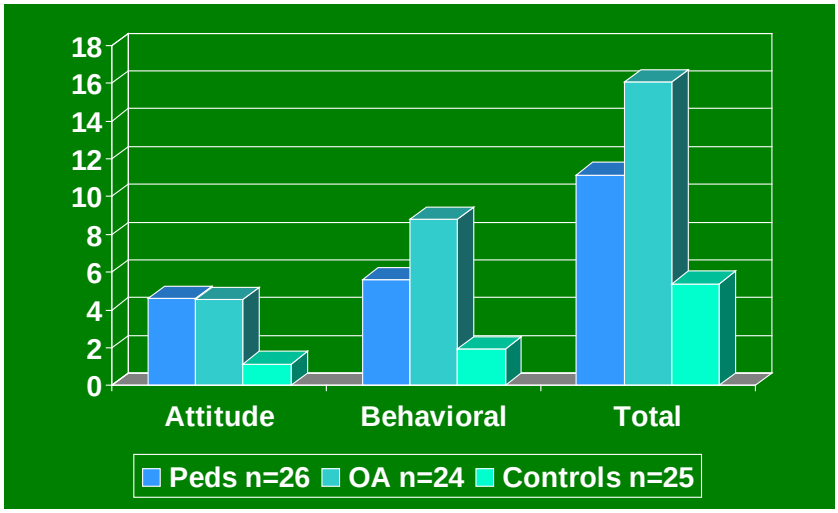
Psychopathic traits can impede behavioral inhibition via inadequate concern about harm done to others, particularly young victims. Many studies support this finding (Cohen *et al*, 2002a, 2008; Raymond *et al*, 1999; Black *et al*, 1997); in fact, it is one of the most robust findings. Figure 5 shows our results comparing groups on the Hare Psychopathy Checklist-Revised (Hare, 1991). While both the pedophilic and opiate-addicted groups scored higher than controls on all scales, the opiate-addicted group scored higher than controls on the behavioral scale, consistent with their greater impulsivity scores. Heterogeneity may apply here as well, however. For example, pedophilic priests have been found to be less psychopathic than non-clerical pedophiles (Haywood *et al*, 1996). Likewise, psychopathic traits may well be higher in those who act on their urges than in those who do not.

Figure 4. Comparison of Traits Related to Propensity towards Cognitive Distortions



SCID II scales of Cluster A Personality Disorder traits were compared across groups as measure of general propensity towards cognitive distortions. Both Peds and OAs scored statistically significantly higher than Controls on Paranoid Personality Disorder traits and Peds scored higher than controls on Schizoid Personality Disorder traits.

Figure 5. Hare Psychopathy Checklist-Revised in Peds, OAs and Controls



Groups were compared on attitudinal, behavioral and total psychopathy scores. Both Peds and OAs scored significantly higher than controls on all scales. OAs also scored significantly higher than Peds on behavioral and marginally higher ($p<.1$) on total psychopathy scores.

In sum, the strongest evidence seems to be for the motivational factor of a childhood history of sexual abuse and the disinhibitory factors of propensity towards cognitive distortions and psychopathy. Evidence is more mixed for impulsivity and traits related to social anxiety. We can now consider how the true vs. opportunistic distinction might influence these purported motivational and disinhibitory factors. We propose that "true pedophiles" or those most characterized by specific and persistent sexual desire for prepubescent children, would be most likely to have a history of childhood sexual abuse, and to be prone to towards cognitive distortions. They may have psychopathic and

socially avoidant traits but would be less likely to be significantly impulsive. In contrast, "opportunistic pedophiles" would more likely be impulsive and have psychopathic traits. They would be less likely to have childhood sexual abuse histories or be prone to cognitive distortions but they may have socially avoidant traits. These hypotheses have yet to be tested and are intended to provide direction for future research. There is some initial supporting data, however. For example, Freund *et al* (1990) found non-pedophilic child molesters to have less incidence of childhood sexual abuse than pedophilic child molesters. Further, Eher *et al* (2003) found "non-sexualized" rapists of adults to have greater lifestyle impulsivity than "sexualized" sex offenders against either minors or adults.

Of course, such hypotheses still pertain mainly to forensic populations, or specifically to those individuals who have acted on their pedophilic urges. To address this limitation, we can further divide the category of "true pedophiles" into those who do and do not inhibit their urges. We would then hypothesize that individuals with pedophilic desires who succeed in inhibiting their urges would demonstrate lower levels of psychopathy, impulsivity and propensity towards cognitive distortions, than those who do not.

In this discussion we did not address the psychobiological phenomenon of sexual arousal, attraction and desire. While that is clearly a central aspect of pedophilic desire and behavior, it is beyond the scope of this paper. Nonetheless the psychological (or historical in the case of CSA) correlates of pedophilia are important areas of research and offer potentially valuable targets for treatment and prevention.

To conclude, there is tremendous variability among individuals with sexual attraction to prepubescent children. Comprehensive research is necessary to understand the range of psychological traits associated with pedophilic desire and behavior and to provide the basis for maximally effective diagnostic systems.

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