Expert Consensus

- International Association for the Treatment of Seuxal Offenders, Sept. 2010
  - Europeans voted 100: 1 against Pedohebephilia

Conclusions

- If Pedohebephilia is accepted in DSM-V, Hebephilia will be used for civil commitment, treated and evaluated for SDP
- Allocations of resources which include Hebephilia (v. Pedophilia)
- The scientific field will be challenged to answer questions regarding pathology and treatment

Can the Medicalization of Sexual Deviance Ever Be Therapeutic?

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My argument in this paper relies on two assumptions that should be relatively uncontroversial—if specifically addressed—but they are worth stating. First, it is important for quality mental health care to be available for MAPs—often this will be for the same sorts of issues non-MAPs receive mental health services for, and sometimes it will involve issues specific to MAPs, especially with helping people to live fulfilling and productive lives within the bounds of the law. Second, the primary aims of mental health professionals should be the well-being of patients/clients. While many mental health professionals work in positions closely aligned with the criminal justice system, your therapist is not your probation officer, and the distinction is vitally important.

In America today, pedophilia is the paraphilia of paraphilias, and so I will focus there in considering the question in my title: Can the medicalization of sexual deviance ever be therapeutic? This question is distinct from whether this medicalization is presently therapeutic. Concerning this second question, there are, no doubt, individual clinicians who use the pedophilia diagnosis in compassionate ways to help patients. But on the whole, the answer must be a resounding NO!

First, the pedophilia diagnosis is used to label people as "sexually violent predators," although no commission of violence is actually necessary to be designated as such. This clearly demonizing label is used to "civilly commit" certain sex-offenders *after* completing their sentences—often for life—in the absence of procedural due process. Unlike traditional civil commitment, where proceedings are generally initiated either by a family member or physician of the individual—people who are presumed to have their best interest in mind—"civil commitment" for sex offenders is initiated by prosecutors. For "pedophiles" in the correctional system, this means that an individual can suffer enormous deprivation of basic constitutional rights for being honest about their attractions. The result is that "patients" are discouraged from being honest, which seriously draws into question the therapeutic value of the diagnosis (Hinderliter, 2010).

For MAPs outside of the correctional system, the therapeutic value is also seriously questionable. Because of mandatory reporting laws, even law-abiding MAPs are afraid to admit their attractions to mental health professionals out of fear that they will be reported to the police, which could potentially result in their being outed as a "pedophile," a member of that hated and reviled group. This fear is not unfounded. Some professional organizations, such as the Association for the Treatment of Sex Abusers, actually claim as "fact" that "virtually all pedophiles [defined as 'men with a clear sexual preference for children rather than adults'] are child molesters" (ATSA, n.d.). There is anecdotal evidence that many law-abiding MAPs seeking help from mental health professionals (or coerced into doing so by family members) are not infrequently referred to "experts" of pedo(hebe)philia (meaning people involved in the treatment of sex offenders). Thus, law-abiding people are treated as criminals by the mental health professions, which is unlikely to be good for their mental health.

However, even if the pedophilia diagnosis is not now doing a good job of helping patients, perhaps the way forward is reform rather than throwing it out entirely. The question, then, is whether reform is possible. While some limited degree of reform while working "within the system" is probably possible, I give a two pronged argument for why the diagnosis ultimately needs to be abandoned.

Research

At present, Criterion B for pedophilia[1] indicates that a pedophilic orientation is only a disorder if the person is distressed by it or has "acted on it." While no one is really quite sure what "acted on it" means—and I am told that there are clinicians who consider masturbating to sexual fantasies about prepubescent children as qualifying—it seems that "acted on it" is generally understood to mean "committed a relevant crime." Using this as the basis for research on pedophilia and/or hebephilia systematically excludes well-adjusted, law-abiding individuals. This is consistent with the sampling methods in the vast majority of research on the matter, which has relied almost exclusively on forensic populations. However, people in the correctional system are often not in a position where they feel they can safely be honest (B4U-ACT, 2010). These two problems with relying on forensic populations create a huge obstacle for making quality mental health care available for MAPs because it hinders making available and disseminating accurate information about this population, and it promotes harmful stereotypes of MAPs (i.e. that virtually all of them molest children). The alternatives to relying on forensic samples are (a) recruiting from MAP message boards and (b) broad sampling of community populations with good operational definitions for pedo(hebe)philia.

I personally identify as asexual—someone who experiences little or no sexual attraction—and the niche I have carved out for myself in the asexual community is as someone involved in academic outreach and promoting quality research on the subject. The largest asexual forum—and hub of the asexual community—is asexuality.org, the Asexual Visibility and Education Network (AVEN). Because of its role in the asexual community, people wanting to research asexuality regularly recruit from this site, and sometimes they recruit from other asexual sites and blogs as well. In fall 2010, I joined AVEN's Project Team (PT), and during my tenure as a member of the PT, we have created a standard procedure for people wanting to use the site to recruit people for research. This was intended to create more communication between asexuals and researchers and to decrease the amount of suspicion researchers would sometimes face from some asexuals. We set up these procedures in March 2011, and in the five months since then, we have processed seven requests to recruit participants.

Pedophilia is a far bigger social issue than asexuality—many of you have likely never heard of asexuality before—and pedophilia has vastly more written about it. The oldest existing online MAP message board was created in late 1995, whereas asexual organizing (online or offline) only began around 2000 or 2001. Having searched through Google Scholar and contacted those running the websites BoyChat and GirlChat, two of the largest MAP message boards, I have only been able to identify four times that researchers (excepting a few MAPs themselves) have *ever* attempted to use MAP sites to recruit participants for research. Seen this way, the contrast between online recruitment for studying pedophilia and/or hebephilia vs. asexuality is stark and profoundly troubling. The *Belmont Report*'s exposition of the principle of *justice* says:

> The selection of research subjects needs to be scrutinized in order to determine whether some classes (e.g., welfare patients, particular racial and ethnic minorities, or persons confined to institutions) are being systematically selected simply because of their easy availability, their compromised position, or their manipulability, rather than for reasons directly related to the problem being studied.[2]

Recruiting from MAP message boards will not be an easy matter, and a recent case is illustrative. A doctoral student in psychology intended to do her dissertation on the experiences of boylovers and girlovers (these were the terms she used); she had an anonymous survey hosted on SurveyMonkey, and made recruitment posts on a number of MAP sites.[3] Some posters were supportive, others skeptical but interested, but a large number expressed virulent opposition, some suspecting that she was a law-enforcement officer aiming at entrapment. Some posters were extremely hostile to psychology as a whole, with one person blaming it for the current situation where MAPs no

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[1] For the criteria in both the *DSM-IV-TR* and the proposed *DSM-5*, see Appendix C.

[2] The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects. Retrieved 8/4/2011 from http://ohsr.od.nih.gov/guidelines/belmont.html

[3] I would strongly recommend anyone wanting to recruit from such sites to read the relevant threads I can provide links via email to anyone interested.

longer have doctor/patient confidentiality, and another asserting that the mental health professions as a whole are sick.

Others refused to participate because of the lack of security cautions that were taken. (The security protocols used were fairly standard in internet research with other populations.) Security is a very serious issue because of anti-pedophile vigilantes—who often go out of their way to make no distinction between law-abiding and law-violating pedophiles. Anti-pedophile vigilantism is largely condoned in modern America, and the result is that many MAPs' fear of being outed comes across as bordering on paranoia.

Gaining the trust of MAPs in order to recruit research participants is made harder by the fact that they have been burned in the past. In 2007, a sociologist named Sarah Goode set up the MAA [minor-attracted adult] Daily Lives project to better understand them. An MAP acting as a gatekeeper posted on MAP message boards and linked people to the "MAA Daily Lives Research Project Website." People were told, "This project seeks to gather reliable data from this population, and to publish the results and conclusions drawn from the data ethically and impartially." However, from the epistemology section in her 2009 book (pp. 48-49), read in light of the rest of the book, her position is, essentially, that because view-from-nowhere objectivity is impossible, she is therefore free to be as biased as all-get-out. At times in her book, she attacks, insults, and berates participants for responses she disagrees with. In her ethics section, she says that she used MAA when talking *to* this community, feeling that "pedophile" would be inappropriate, and yet "pedophile" is the primary word she uses when talking *about* them. While there is much that is of great value in the book, because of these and similar issues, many who helped her felt betrayed, and it will now be harder for people in the future to recruit online out of fear of that incident being repeated.

From what I have seen on MAP message boards, pedophiles and hebephiles do not generally like their sexuality being pathologized—I do not know of any sexual minorities that do—and the issue is very relevant to gaining their trust. I fully expect that if anyone tries to recruit research participants from MAP message boards and tells people, "I want to better understand your disorder," such a person will not be well received.

From whence the pressure against depathologization?

As a branch of medicine, psychiatry should be fundamentally committed to the well-being of patients, and not a branch of the criminal justice system masquerading as medicine. The same applies to the application of mental disorder diagnoses throughout the mental health professions. To be a disorder, something must involve something negatively valued ("harm"). What specific harms are relevant is a controversial matter. I suggest that when the relevant "harm" is primarily toward the individual, the focus of treatment is their well-being; when it is harm to others (real or imagined), the well-being of the individual is too easily sacrificed in the name of "protecting society" (Hinderliter, 2011).

In the *DSM-III-R* (American Psychiatric Association, 1987), pedophilia was considered a disorder if the person was distressed about their pedophilia or if they had "acted on it." The "acted on it" part makes illegal sexual behavior the dividing line between when a pedophilic orientation is a disorder and when it is not, which is inconsistent with the *DSM*'s claim in its introduction that sexual deviance is not a mental disorder (Gert, 1992). Second, it is of questionable therapeutic value. It is generally accepted among psychotherapists that psychotherapy tends to only be effective if the person wants help. If a pedophilic orientation was only a disorder if the person was distressed about their sexuality, then presumably only people wanting help could receive the diagnosis. But what benefit for patients is there from adding the "or acted on it" part? (If pedophilia was only a disorder if the person was distressed about it, the diagnosis could not be used to "civilly commit" people.)

In the *DSM-IV* (American Psychiatric Association, 1994), the paraphilias were made consistent with the *DSM*'s definition of mental disorder (Gert & Culver, 2009) by making them disorders only when they cause distress or impairment, although, at least in the case of pedophilia, this was an accident (First & Halon, 2008), which was changed in the *DSM-IV-TR* (American Psychiatric Association, 2000). This change was quickly picked up on by the National Association for the Research and Treatment of Homosexuality (NARTH), a group committed to seeing homosexuality as a disorder and trying to "cure" it. Although marginal within the mental health professions, NARTH is influential among many politically conservative organizations wanting to work against the ongoing changes in

sexual morality, as the more traditional "within marriage" and "potentially procreative and within marriage"[4] sexual standards are losing adherents, and a "between consenting adults" standard is gaining dominance.

In the first issue of the *NARTH Bulletin*, published in 1995, the front page article is titled, *Pedophilia not always a disorder?* (Nicolosi, 1995) and has the following quote in large letters: "The only conclusion to be drawn is that the A.P.A. is in a state of serious moral and intellectual decline" (pg 1). In the article, NARTH raised alarm: "According to the new *DSM-IV*, a person is no longer a pedophile simply because he molests children or fantasizes about molesting children. He is a pedophile ONLY if he feels bad or anxious about what he's doing, or if his pedophilia impairs him in an important area of functioning." They then provided compelling evidence that their alarm was unfounded:

> NARTH spoke to two representatives of the America Psychiatric Association. Said Dr. Allen Frances, Chairperson of the DSM-IV Task Force: "You're reading too much into this. We're leaving room for clinical judgment."
>
> Said Dr. Chester Schmidt, Chairperson of the DSM's Sexual Disorder Work Group: "It certainly was not our intent to loosen the diagnostic criteria. We wanted to give individual clinicians more latitude. The rationale was to guard against forcing diagnoses on people who did not meet the criteria." Dr. Schmidt denied having been pressured by special-interest groups such as the A.P.A.'s Gay and Lesbian Task Force or NAMBLA. [pg 1]

Ignoring these facts, they then made clear their agenda: "These DSM changes are particularly dangerous because they are a reenactment of the pattern which led to the depathologizing of homosexuality" [pg 1]. While they made this alarmist piece a front page article, it seems to have been largely ignored until they tried again a few years later. About a year after the publication of the now well-known study by Rind, Tromivitch, and Bausserman (1998), NARTH created a "fact sheet" about pedophilia. It opens:

> For many years, Western society has considered adult-child sex to be legally, socially, and morally taboo. Pedophiles have been judged criminal by the courts, sinful by theologians, and psychologically disordered by the mental-health profession. [NARTH, 1998]

The failure to distinguish between "pedophiles" as people attracted to children and "pedophiles" as people who have sex with children misrepresents the *DSM* and obliterates the distinction between the act and the orientation, which has always been of fundamental importance to the concept of paraphilia/perversion, although the terms it has been expressed with have varied. NARTH makes no distinction between pedophiles who have sex with children and those who do not. This fact, along with the rest of the article, makes clear that they are utterly unconcerned with the well-being of MAPs, who, when coming to understand their attractions, often do so where the only images of "people like themselves" are as child molesters, as sexual predators.[5]

The article then creates a story by weaving together a double issue of the *Journal of Homosexuality* in 1990, the Rind *et al.* study, and the changes from the *DSM-III-R* to the *DSM-IV* in the diagnostic criteria for pedophilia. With these, they construct a narrative of how the depathologization of homosexuality inevitably leads to the moral approval of adult-child sex, and that the advocates for "normalizing pedophilia" are gaining a mainstream voice. This rhetorical approach is consistent with how fear concerning children has long played a major role in sex-panics in the US and in anti-gay rhetoric (Jenkins, 1999; Lancaster, 2011; Rubin, 1984, and many others).

Unlike their 1995 front page article on pedophilia, NARTH's "fact sheet" sparked a political firestorm that eventually resulted in the unprecedented act of a scientific study being condemned by Congress. I will not go into the details of this, as they have been well documented elsewhere (Kramer, n.d.; Lilenfeld, 2002; Rind, Tromovitch, & Bauserman, 1999) and, for present purposes, the important point is that changes in the *DSM*'s diagnostic criteria were used to help excite panic and that these were repeated a number of times by opponents of the Rind *et al.*

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[4] And, of course, "marriage" here is understood as "heterosexual marriage." The meaning of "marriage" is a much contested issue in America today.

[5] Goode (2009) gives a powerful example of the potential consequences of this in the first chapter.

study—even though NARTH's 1995 article provided compelling evidence that their interpretation of the change was entirely wrong.[6]

Another brief (and much smaller) political eruption occurred following a May 2003 symposium at the American Psychiatric Association's annual meeting about the *DSM*'s sexual and gender identity disorders. There Charles Moser presented a paper by himself and Peggy Kleinplatz in which they argue for the removal of the paraphilias from the *DSM*. They explicitly stated that they were not arguing that adult-child sex should be morally approved or legalized, but this was ignored as parts of their presentation were selectively leaked to some conservative organizations, who distorted what they said in ways similar to the above incident. (For a first-hand account, see Kleinplatz and Moser, 2006.) In addition to this, I want to draw attention to a very candid and telling remark by Robert Spitzer in his response to Moser and Kleinplatz's paper:

> What are the consequences if we go the route that Drs. Moser and Kleinplatz suggest and remove the paraphilias from the DSM? First of all, it is not going to happen because it would be a public relations disaster for psychiatry. There was already a little disaster when the initial DSM-IV put in the "clinical significance" criterion that had the effect of requiring distress or impairment before pedophilia could be diagnosed. The APA wisely corrected that in DSM-IV-TR. Let us now consider gender identity disorder. [Spitzer, 2006 p. 115]

Conspicuously, there is no second reason. There is only one negative consequence mentioned, a predicted PR disaster that would be created by some organizations using fear about child sexual abuse as a weapon in ongoing social struggles concerning sexual ideologies, especially concerning homosexuality. This has nothing whatsoever to do with the well-being of patients and potential patients.

Reading through NARTH's journal and other publications shows that they seem to be perfectly capable of addressing pedophilia with some degree of nuance—if the discussion is not in a front page article or a fact sheet. In the prominently displayed pieces, such nuance is abandoned. The sense I get from the publications more generally is that the members of the organization are angry at how professional opinion in the mental health professions has changed over the past few decades: NARTH's views on homosexuality have moved from dominance to the margins. Their "therapy" to "cure" homosexuality has been condemned as unethical, and they are not happy about it. By pressing the pedophilia issue—the panic button—they exact revenge on the APAs. The primary opposition to removing pedophilia from the *DSM* comes from people for whom—knowingly or unknowingly—MAPs are collateral damage in a larger struggle against the increasing acceptance of homosexuality.

To be sure, if enough momentum mounted to make the declassification of the paraphilias in general and pedophilia in particular a realistic possibility, there would certainly be opposition from those who have built their careers around a pathological understanding of pedophilia, just as the primary opposition to the declassification of homosexuality *per se* came from "experts" such as Irving Bieber and Charles Socriades. (It should be noted that Socriades was one of the founding members of NARTH.)

Conclusion

Three things are vitally important for making compassionate mental health care available for MAPs. Each one is a prerequisite for the following. First, creating collaborative relationships with MAPs. Second, collecting and disseminating accurate information. Third, combating false information as well as harmful and inaccurate stereotypes. None of these will be easy tasks.

Because of its reliance on forensic samples and its inherently criminological focus, the pedophilia diagnosis cannot achieve these. Furthermore, when virtually all information about MAPs that is given to the public by mental health professionals is based on forensic samples, this helps to reinforce—rather than combat—false and misleading information. The primary political pressure that works to keep pedophilia in the *DSM* comes from people who spread false and misleading information about "pedophiles" with the aim of combating changing sexual ideologies,

[6] Lilenfeld (2002) notes that they often mistakenly held the Rind *et al*. study was published in a journal of the same APA that published the *DSM-IV* in which the revised diagnostic criteria for pedophilia appeared.

especially regarding homosexuality. For them, MAPs are simply collateral damage. To date, rather than standing up to these organizations (as is regularly done regarding homosexuality), the well-being of patients is sacrificed at the altar of moral panic.

Labeling a sexual interest as a disorder because it creates feelings of horror and disgust in others and because it evokes responses of "Oh my God, you're a pervert!" is completely and totally inconsistent with the role of physicians as healers of the sick and with the role of members of the helping professions to help those they work with. It promotes a situation instead where they are agents of controlling undesirables, a role which is more properly the domain of the criminal justice system, where procedural due process and the rights of the accused apply.

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Sexual Alignment: Critiquing Sexual Orientation, the Pedophile, and the *DSM-5*

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By request of the author, the paper *Sexual Alignment: Critiquing Sexual Orientation, the Pedophile, and the DSM 5* by Jacob Breslow is not included in these proceedings. The author plans to publish it at a later time as part of a larger project underway at the London School of Economics that uses queer theory, phenomenology, and feminist materialisms to critically challenge assumptions of normative sexuality. Contrary to the way is has been mischaracterized by certain media outlets, the author's presentation at the symposium argued for "challenging sexual pathologization while simultaneously being more critically responsible and ethical towards all living and non-living things and beings." The author wishes to thank those who attended the symposium and provided feedback, comments, and questions.

The *DSM* and the Stigmatization of People who Are Attracted to Minors

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> Fear of stigma discourages individuals from getting the help they need. More tragically, it deprives people of their dignity and interferes with their full participation in society.
>
> — Center to Address Discrimination and Stigma, U.S. Department of Health and Human Services

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) provides the mental health professions' official description of people who are sexually and emotionally attracted to children or young adolescents. Although many "minor-attracted people" (MAPs) may not meet *DSM* diagnostic criteria for pedophilia, the only description of the attraction to minors found in the dominant professional literature is that devoted to pedophilia. This literature frequently repeats the description found in the *DSM* (e.g., Hall & Hall, 2007; *Pessimism about Pedophilia*, 2010) and influences professional beliefs and practices. Therefore, the *DSM* has a profound influence on the accuracy of the professional literature and on the extent to which MAPs are stigmatized by it, which in turn affect their willingness to seek mental health services.

In this paper, I analyze the *DSM-IV-TR* (American Psychiatric Association, 2000) and proposed *DSM-5* (American Psychiatric Association, 2011) entries for pedophilia for accuracy and potential sources of stigma. First, I will briefly describe characteristics of people who are attracted to minors based on non-forensic research and present survey results regarding their feelings of stigma and reluctance to seek mental health services. Then I will analyze *DSM* documents for their accuracy and potential to stigmatize. After this, I will use survey results to demonstrate the extent to which MAPs actually feel stigmatized by the *DSM* and related literature, and how this contributes to their reluctance to seek mental health services. Finally, I will propose guidelines for revising the *DSM* so that it will serve its professed purpose of helping practitioners identify the needs of their clients.

Characteristics of people who are attracted to children or adolescents

To understand the stigmatizing potential of the *DSM*, it is helpful to examine relevant findings about the characteristics and behavior of MAPs from non-forensic literature. Forensic research suffers from two shortcomings: it is based on extremely unrepresentative samples—people who have been charged or convicted of crimes—and it starts from criminological assumptions, which bias its results. Thus, by non-forensic research, I mean research that not only uses samples of MAPs in the general population, but also does not start from inaccurate assumptions of pathology or criminality. Although such research is essential for understanding MAPs, it is rare and difficult to conduct today (e.g., see Goode, 2010, pp. 43-56). However, a few helpful studies were conducted 20 to 30 years ago.

Possibly the most important finding from non-forensic literature is that sizable numbers of MAPs may refrain from sexual interaction with children (Hall, Hirschman, & Oliver, 1995; Okami & Goldberg, 1992). They often do so due to the child's desires and/or the adult's knowledge of the risk sexual activity poses (Okami & Goldberg, 1992; Sandfort, 1987; Wilson & Cox, 1983).

Another important finding from non-forensic literature (and even some forensic literature) is that the attraction to minors is similar to the attraction to adults in some important ways. It typically involves feelings of affection and being in love (Blanchard, 2009; Howells, 1981; Ingram, 1981; Li, 1990; Sandfort, 1987; Wilson & Cox, 1983). For example, in his study of 27 minor-attracted men in the general population, Li (1990) noted that the majority stressed the importance of affection and emotional closeness in their feelings toward children. Li wrote that that their interaction with children is "comparable to that which obtains in the socially acceptable forms of heterosexual

courtship …" (p. 139). Wilson & Cox (1983) found in their study of 77 MAPs that the qualities they found attractive in children were the same as those that form the basis for attraction between adults, and that their sexual fantasies had much in common with those of men attracted to adults. They concluded that "the sexual preferences of the paedophile are not so far removed from those of the normal man as they might at first appear (pp. 100-101).

In addition, the psychological functioning of MAPs in the general population may be similar to those of people attracted to adults, except possibly for those aspects affected by society's negative reactions to them. Wilson & Cox (1983) found in their sample that the "majority showed no sign of clinically significant psychopathy or thought disorder. The majority of paedophiles … seem to be gentle and rational" (p. 122). Similarly, in their review of non-forensic research on pedophiles, Okami & Goldberg (1992) concluded that "little clinically significant pathology was found" (p. 297).

Feelings of stigma and reluctance to seek services

An online survey conducted by B4U-ACT in the spring of 2011 (B4U-ACT, 2011) showed that MAPs experience intense feelings of stigma at an early age, making them reluctant to seek mental health services when they are aware they need them. A total of 193 respondents ranging in age from under 18 to over 70 participated in this survey. About half (48%) were in the United States, and most of the rest were in Germany (10%), Canada (8%), the Netherlands (8%), and the U.K. (7%).

Feelings of attraction to younger children and the need to hide these feelings occurred early in the lives of respondents. The median reported age at which they were first preferentially attracted to children younger than themselves was 13 (n = 192), and the reported median age at which they first became aware of their feelings was 16. Two-thirds (66%) were under age 18 at first awareness. Respondents made comments such as:

- "At the age of 13, I didn't really feel there was anyone I could talk to about my attraction to minors or the difficulty I experienced living with the attraction."
- "Parents will disown you, teachers will report you, friends will abandon you … people in my situation can't discuss this without serious risk of persecution and/or harassment."

A significant number of respondents had considered suicide, often while still teenagers, but most felt unable to talk to anyone about their suicidal thoughts or reasons for them. Out of the 171 respondents who answered the questions about suicide, 46% had seriously considered it, 32% had planned a method for carrying it out, and 13% had attempted it. The median age at which they first considered suicide was 19, and 41% were under 18 when they did so. Two-thirds (67%) of respondents with suicidal thoughts felt unable to talk to another person about them. One respondent wrote, "You can't talk to anybody … The shame of committing suicide, or even of having attempted it, is far less than the shame of having attractions society deems inappropriate." Some teens post at online mental health forums about this. One recently posted:

> I'm a 15 year old male … I'm not attracted to anyone my age or older anymore. I'm only attracted to pre pubescent girls … i feel like there is no hope for me to live and sometimes I feel like killing myself … I know the idea of a psychologist and everything but I can't talk to anyone at this time because my parents would find out and get the wrong idea and people will judge me and think i really want to hurt little kids …

Most people in the survey affirmed that MAPs could benefit from mental health services, but they did not seek services due to fear that professionals would misunderstand, mistreat, and/or report them. Over 80% agreed with the statement, "Sometimes minor-attracted people could benefit from mental health services for reasons related to their attraction other than changing these attractions" but only 30% agreed that "I would seek help from a mental health professional if needed for an issue related to my attraction to minors" (n = 175). Forty percent said that they had actually wanted mental health care for reason related to their attraction to minors, but did not receive it (n = 159). Reasons for their reluctance to seek services included perceptions that their feelings would be misunderstood (85%), that they would be treated disrespectfully (54%; 28% were uncertain), judgmentally (63%; 26% were uncertain), or unethically (46%; 33% were uncertain), or that professionals would not maintain confidentiality about their feelings (51%; 25% were uncertain).

In light of this data and the potential of the *DSM* to influence professional perceptions of MAPs, I now examine the ways in which the *DSM* may contribute to stigma and MAPs' reluctance to seek professional assistance.

Stigmatic aspects of the *DSM*

Documents related to the *DSM-IV-TR* and the proposed *DSM-5* entry for pedophilia contain implicit assumptions and interpretations that contradict the findings of the non-forensic literature, and that have the potential to significantly stigmatize MAPs.[1]

First, the *DSM-IV-TR* assumes and implies that all or most people attracted to children or young adolescents engage in sexual behavior with them. Although the *DSM-IV-TR* accompanying text cursorily allows the existence of those who do not, it goes on to provide a long list of illegal or manipulative acts without ever describing those who do not engage in them. The implication that such behavior is typical is seen in the use of the term "pedophilia" to refer not to the attraction to children, but to sex offenses, as the text drifts into criminological language rather than psychological description. For example, the authors write of "Pedophilia involving male victims" and "the recidivism rate for individuals with Pedophilia." Such statements are meaningless if pedophilia refers to attractions rather than behavior. Similarly, the literature review supporting the proposed *DSM-5* diagnostic criteria (Blanchard, 2010) cites only three non-forensic studies of MAPs, but more than 30 forensic articles.

The *DSM-IV-TR* accompanying text also perpetuates the belief that people who are attracted to children or adolescents are violent or aggressive, a stereotype that has been thoroughly debunked (Bradford *et al.*, 1988; Constantine, 1981; Crawford, 1981; Feierman, 1990a; Hall, 1996; Howells, 1981; Ingram, 1981; Okami & Goldberg, 1992; Virkkunen, 1981; West, 1998; West & Woodhouse, 1990; Wilson & Cox, 1982). The text misleadingly claims that people with pedophilia "use varying degrees of force" and that in some cases "the disorder is associated with Sexual Sadism." Such statements could of course be said about people who are attracted to adults; there is simply no research suggesting that aggression is more common among MAPs in the general population than among those who are attracted to adults.

Another problematic implication of the *DSM* is that the attraction to children or adolescents is qualitatively different from the attraction to adults. The *DSM-IV-TR* accompanying text makes no mention of the non-sexual feelings that accompany sexual attraction, providing instead only a lengthy list of alleged sexual behaviors. Similarly, the proposed *DSM-5* diagnostic criteria refer only to sexual feelings and behaviors. The reader may be left with the misleading impression that sexual attraction to children is devoid of any feelings of love or concern and therefore something alien and incomprehensible.

The accompanying text also presents the reader with questionable interpretations of the motives of MAPs who interact with children. It suggests that any behavior that seems caring should instead be interpreted as malicious in intent. No studies have established that this is typically the intent of MAPs in the general population, and there is no consideration of the alternative possibility that MAPs may be attentive to children's needs because they care about them in a way similar to that of people attracted to adults (Ingram, 1981; Li, 1990; Sandfort, 1987; Wilson & Cox, 1983). In this way, the text characterizes MAPs as incapable of caring about children and therefore fundamentally different and incomprehensible.

Even if unintentionally, the *DSM* documents may give clinicians and MAPs the impression that the appropriate mental health response is adversarial and focused on social-control rather than therapeutic. This is because the predominant focus on offenders defines MAPs solely as criminals of the kind most feared and reviled by society. The literature review supporting the proposed *DSM-5* diagnostic criteria (Blanchard, 2010) contains no mention of the important findings of the non-forensic literature described earlier. Instead, it identifies illegal behaviors as virtually the only symptoms used for diagnosis. There is no discussion of the diagnostic use or reliability of the single non-criminological criterion (clinically significant distress) as there is for the criminological criteria (sex offenses). In fact, a new criminological criterion has been added to the current proposal—use of child pornography—and another

[1] For the diagnostic criteria and accompanying text in the *DSM-IV-TR* and the proposed criteria in the *DSM-5*, see Appendix C.

has been suggested for future *DSM* revisions—online sexual chatting with a police officer posing as a child. No non-criminological criteria, such as feelings of emotional or romantic attraction, have ever been proposed.[2]

There are additional features of the literature review that may encourage an adversarial, social control stance by the clinician. The review seems to take for granted that the patient will lie about his sexuality and that the clinician's role is to diagnose him against his will. The article can be interpreted to say that the author has used phallometry (placement of a sensor around the penis to measure erection during the presentation of sexual stimuli) for this very purpose. Additionally, the rationales for adding hebephilia to the *DSM-5* include the fact that many men are arrested for sex with adolescents and that the basis for civil commitment should be strengthened.

Effects of the *DSM* on the professional literature

Professional literature about the attraction to children may follow the *DSM*'s lead and propagate similar inaccurate and potentially stigmatizing assumptions. For example, a recent article published for clinicians in the Harvard Mental Health Letter (*Pessimism about Pedophilia*, 2010) repeats a list of behaviors similar to those in the *DSM-IV-TR*, suggesting that they are typical of MAPs. Similarly, the Association for the Treatment of Sexual Abuser's fact sheet on adult sex offenders (Association for the Treatment of Sexual Abusers, 2001) provides a similar list of behaviors and claims that "virtually all pedophiles are child molesters" and that "[t]heir offenses are usually predatory."

Such literature provides little to no guidance for addressing the psychological needs of MAPs. In a survey conducted in the summer of 2011 by B4U-ACT[3], MAPs who wanted mental health services but did not seek them identified the reasons for wanting them, as shown in Table 1.

Table 1. Reasons identified by MAPs for wanting mental health services (n = 62).

Reason identified by respondents	Percent of respondents
1. Figure out how to live in society with this attraction	79%
2. Deal with society's negative response to my attraction	69%
3. Improve my self-concept	60%
4. Deal with sexual frustration	55%
5. Understand the cause of the attraction	45%
6. Learn to control the sexual feelings	29%
7. Develop or increase an attraction to adults	24%
8. Extinguish or reduce the attraction to boys or girls	23%
9. Other	21%

The professional literature appears to ignore the most pressing needs identified by MAPs, generally addressing only goals 6 and 8. It is virtually impossible for MAPs to find literature suggesting that professionals recognize the difficulties they face in developing positive outlooks, relationships, and self-concepts within a society that reviles their feelings of emotional and sexual attraction or that professionals acknowledge the feelings of hopelessness and

[2] It may be asserted that this is an effort to depathologize the attraction itself as long as it is not acted upon illegally. However, such an approach would imply that the disorder lies in the lack of self-control rather than the object of attraction, so that the term "pedophilic disorder" would inaccurately identify the nature of the disorder. Furthermore, research has not established that the level of self-control among those diagnosed according to the proposed *DSM-5* criteria is lower than that among the general population—nor is there evidence that any such research is proposed.

[3] Findings reported in this paper are preliminary, based on data collected during the first six weeks of an ongoing survey. Results of the full survey will be posted at www.b4uact.org/science/survey/02.htm.

suicidal thoughts experienced by MAPs, including young adolescents. The *Pessimism about Pedophilia* article mentioned only law enforcement approaches and methods to control sexual thoughts and behavior. While small numbers of MAPs may have difficulty with self-control, the majority have different and much broader mental health needs. Professional writing may suggest to the MAP a dismissal of these needs, decreasing significantly the willingness of MAPs to seek mental health services when needed.

Reactions of MAPs to the *DSM* and professional literature

Are MAPs actually stigmatized by the *DSM* and professional writing about pedophilia? More findings from the summer 2011 survey address these questions. The survey asked respondents to read and react to excerpts from three documents: the *DSM-IV-TR* accompanying text,[4] the literature review supporting the *DSM-5* (Blanchard, 2010), and *Pessimism about Pedophilia* (2010). For comparison purposes, respondents were also asked to react to an excerpt from the non-forensic study conducted by Wilson & Cox (1983).

The vast majority (72-89%) of MAPs responding to the survey questions (79 or 80 people, depending on the question) felt that the *DSM-IV-TR* accompanying text was inaccurate but reflected the understanding of the typical professional, and that it contributed to a professional view that discouraged them from seeking mental health services (see Table 2). They said it did not encourage professionals to focus on their psychological well-being but instead contributed to adversarial therapist-client relationships and unethical practices by professionals. Responses to the excerpt from *Pessimism about Pedophilia* were very similar, with 69-72 people responding. Comments showed that several felt the articles were dehumanizing and promoted social control rather than therapeutic goals.

Reactions to the *DSM-5* literature review (Blanchard, 2010) were in the same direction (with 69-71 respondents), although not quite as strong. A majority (66%) disagreed with the statement that the author's recommendations would encourage professionals to focus on the patients' psychological well-being, and 60% agreed that the recommendations would contribute to adversarial professional-client relationships. Almost half (49%) thought they would encourage unethical treatment (34% were uncertain or neutral), and 60% thought the author accepted the use of phallometry against the patient's will. A large majority (80%) disagreed with the statement, "The recommendations of this article encourage me to seek help from a mental health professional." Again, respondents' comments expressed suspicion of a social control agenda:

- "Isn't the goal of therapy for the person to feel comfortable enough to open up to the therapist about his/her attractions rather than using what amounts to a sexual lie detector?"
- "[The article] dehumanizes the pedophile. The phallometric test in this instance is unethical and morally reprehensible. The study is meant to prove something, not to help anyone …"
- "The article is … buying into the idea that MAPs should be punished as harshly as possible."

It is instructive to compare these findings with responses to the non-forensic Wilson & Cox excerpt. Survey respondents reacted to this passage in a way that was almost exactly opposite to their reactions to the other three excerpts. Out of 75-78 respondents, the majority (65-74%) felt that the passage was accurate and expressed a desire to understand MAPs, that it encouraged professionals to focus on their psychological well-being, that it did not contribute to adversarial relationships or unethical practices, and that they "would seek help from a professional who believed information like this." Some respondents said that they could recognize themselves in the description given in the excerpt. One respondent wrote, "A positive feature of the text is the way it seeks to remove the 'them verses us' world view" and another said, "[T]he attitude represented here would be a non-negotiable factor if I ever felt a need for professional help."

[4] See Appendix C.

Table 2. Respondents' Agreement with Statements About
Two Pieces of Professional Writing About Pedophilia

Statement	***DSM-IV-TR* Accompanying Text for Pedophilia**			***Pessimism about Pedophilia***		
	Agree	**Uncertain/ Neutral**	**Disagree**	**Agree**	**Uncertain/ Neutral**	**Disagree**
Information like this reflects the understanding held by the typical mental health professional.	74%	19%	8%	67%	29%	4%
Information like this is accurate.	11%	17%	72%	12%	12%	77%
The writers seem to want to understand people who are attracted to boys or girls.	9%	11%	80%	10%	13%	77%
Information like this encourages mental health professionals to focus on the psychological well-being of people who are attracted to boys or girls.	6%	5%	89%	7%	6%	87%
Information like this contributes to an adversarial relationship between the mental health professional and the minor-attracted person.	85%	10%	5%	84%	7%	9%
Information like this encourages mental health professionals to treat minor-attracted people unethically.	81%	13%	6%	76%	16%	8%
I would seek help from a mental health professional who believed information like this.	8%	10%	82%	7%	6%	87%
Some respondents' comments about the *DSM-IV-TR* accompanying text: • "This only serves to strengthen the misunderstanding and hate society at large has for us …" • "What would be the point in seeking out a professional likely to traumatize me with these prejudices?" • "This passage has nothing to do with mental health … It does not assist a mental health provider in providing treatment for a minor attracted person, only in identifying the minor attracted person's illegal activities with the presumption that they exist." • "It has little to no focus on pedophiles as human beings."						
Some respondents' comments about *Pessimism about Pedophilia*: • "It refers to 'pedophiles' as if they were some kind of dangerous animal, or a threat by default. It is quite offensive." • "[I]n short, the focus should be on treating individuals, not punishing criminals." • "[T]he author clearly sees pedophiles as the enemy." • "Information like this is intended to dehumanize us."						

Revising the *DSM*

One respondent wrote that the *DSM-IV-TR* accompanying text expresses a "view that is unable to allow both the therapist and the client to work towards a positive outcome." If MAPs perceive the *DSM* as portraying them as so fundamentally different from other people, so incomprehensible, and so dangerous that containment and control are the only possible responses, then it is unlikely they would ever believe that professionals would address their needs and help them develop fulfilling lives that contribute positively to their communities and society.

However, non-forensic research demonstrates that the *DSM* portrayal of MAPs is not the result of objective research, and that the alienation of MAPs from the mental health system is not inevitable. If the *DSM*'s purpose is to help clinicians identify and understand the mental health needs of MAPs, it seems prudent for those responsible for the *DSM-5* entry on pedophilia to heed the American Psychiatric Association's exhortations regarding the *DSM* revision process:

- "[A]ll recommendations should be guided by research evidence" from "diverse perspectives, disciplines, and areas of expertise" (American Psychiatric Association, 2010a and 2011). Non-forensic research free from assumptions and interpretations that are unwarranted or based primarily on forensic data is needed. A narrow focus on sex offenders is inadequate.
- The *DSM* should clearly "reflect the needs of our patients" (American Psychiatric Association, 2010b) rather than appear to focus on social control. It must take into account the impact of stigma and the life problems MAPs face.
- Patient and family groups should be involved in the revision process (American Psychiatric Association, 2010a). MAPs in the general population and their families have invaluable first-hand knowledge regarding the nature of attraction to children and adolescents, their own feelings and motives, the effects of stigma, their own mental health needs, and the problems they must negotiate living in society.

Revising the *DSM* in a productive way will require a change in the authors' perception of MAPs from seeing them solely as offenders or potential offenders to seeing them as humans with needs and motives that are similar to those of other humans. It is B4U-ACT's experience that this change requires face-to-face meetings.

Unless this happens, many MAPs will likely doubt the *DSM*'s credibility and perhaps that of the mental health profession and will likely avoid mental health services from clinicians who take the *DSM* seriously. MAPs will remain in hiding, with no support for living law-abiding lives. Both adolescents and adults will continue to experience depression, engage in self-harming behavior, and seriously contemplate or attempt suicide. This outcome is unsatisfactory for children, for minor-attracted people, and for society.

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Appendix: Symposium Handouts

A. Symposium Program

B. Information about B4U-ACT

C. Definition of MAP and Current and Proposed *DSM* Entries on Pedophilia

B4U-ACT

Living in Truth and Dignity

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

August 17, 2011

9:00 Welcome and Introductory Remarks
Russell A. Dick, LCSW-C, Co-founder & Board Chair, B4U-ACT

9:15 Keynote Talk:
Understanding Pedophilia and Other Paraphilias from a Psychiatric Perspective
Fred S. Berlin, M.D., Ph.D., Johns Hopkins University School of Medicine

10:15 Decriminalizing Mental Disorder Concepts: Pedophilia as an Example
John Z. Sadler, M.D., University of Texas Southwestern Medical Center

10:45 Break

11:00 "Is Anybody Out There?": Testimony of Minor-Attracted Persons and Hearing versus Listening to their Voices
Nancy Nyquist Potter, Ph.D., Department of Philosophy, University of Louisville

11:30 Identifying the Psychobiological Correlates of Pedophilic Desire and Behavior: How Can We Generalize Our Knowledge Beyond Forensic Samples?
Lisa J. Cohen, Ph.D. and Igor I. Galynker, M.D., Ph.D.
Beth Israel Medical Center, Albert Einstein College of Medicine

12:00 Discussion

12:30 Lunch

1:30 The Forensic Implications of the DSM-V's Pedohebephilia
Renee Sorrentino, M.D., Harvard Medical School

2:00 Can the Medicalization of Sexual Deviance ever be Therapeutic?
Andrew C. Hinderliter, M.A.
Department of Linguistics, University of Illinois at Urbana-Champaign

2:30 *Sexual* Alignment: Critiquing Sexual Orientation, The Pedophile, and the DSM V
Jacob Breslow, M.Sc.
Gender Institute, London School of Economics and Political Science

3:00 Break

3:15 The DSM and the Stigmatization of People who Are Attracted to Minors
Richard Kramer, B4U-ACT

3:45 Discussion

4:45 Adjournment

This symposium will be audio-recorded by the organizers for transcription and archival purposes. Audio-recordings and transcriptions will not be disseminated without the express permission of the speakers.

Any other recording (audio or video) and photography are strictly prohibited. This policy will be enforced under all applicable local, state, and federal laws.

B4U-ACT

Living in Truth and Dignity

How should we approach

PEOPLE WHO ARE SEXUALLY ATTRACTED TO CHILDREN?

Experts estimate that 1% to 5% of all males develop a preferential emotional and sexual attraction to children or adolescents.[1] However, there are no inviting mental health services for this population. Accurate information about such clients and how to work with them is hard to find.

B4U-ACT is a unique collaborative effort between mental health professionals and people attracted to minors to address this problem. Established as a 501(c)(3) organization in 2003, our goal is unprecedented: to make effective and compassionate mental health care and accurate information available to individuals who self-identify as minor-attracted and who are seeking assistance in dealing with issues in their lives that are challenging to them. We want to give them hope for productive and fulfilling lives, rather than waiting for a crisis to occur.

To reach this goal, we promote communication and understanding between the two groups. We help mental health professionals learn more about attraction to minors and to consider the effects of stereotyping, stigma, and fear. That way they can be informed before they work with clients who are attracted to minors, and before they talk about or make public statements about minor-attracted people.

WHO ARE MINOR-ATTRACTED PEOPLE?

We use this term to refer to adults who experience feelings of preferential sexual attraction to children or adolescents under the age of consent, as well as adolescents who have such feelings for younger children. It is important to realize that these sexual feelings are usually accompanied by feelings of emotional attraction, similar to the romantic feelings most adults have for other adults.

No one chooses to be emotionally and sexually attracted to children or adolescents. The cause is unknown; in fact, the development of attraction to adults is not understood. A large number of theories involving hormonal influences, genetics, evolutionary processes, negative socialization, poor parental relationships, and childhood sexual experiences have been proposed, but most have not been tested scientifically, and none are supported by reliable evidence.[2]

Studies of personality characteristics on average find low levels of aggression among minor-attracted people. Other than the attraction to minors itself, studies fail to find any abnormal or pathological characteristics.[3] Enduring feelings of attraction to prepubescent children first become apparent at puberty.[4]

THE NEED FOR SERVICES

Like all people, those who are attracted to minors sometimes desire mental health services to deal with issues unrelated to their sexuality, but they feel the need to be honest about their sexuality and still accepted. Some are dealing with depression, anxiety, or other issues that are found throughout society. Some minor-attracted people seek services to help them deal with issues that result from society's negative reactions to their sexual feelings. Others seek assistance and support in developing fulfilling lives and relationships while living within the law.

Some minor-attracted people have had very negative experiences with therapists who did not understand them, or who saw them only as criminals and did not value their mental health needs. Those who have not interacted with mental health professionals suspect that professionals, like most Americans, are strongly influenced by the negative messages in the media and from politicians. They especially notice stigmatizing and stereotype-perpetuating statements made by some professionals and professional organizations. As a result, minor-attracted people often fear that therapists will not understand them, will ignore their mental health needs, or will not treat them with respect and compassion.

"I guess I always had feelings for younger boys. The guilt has led me to self-mutilation, but I haven't cut in five months which is something I'm proud of. I'm just trying to accept myself. I hate myself so much at times and I feel ashamed and dirty. But I've tried all I can to change. I don't know how much longer I can put up with this. One time I posted that I was attracted to younger boys in a musical forum. So many people said I should do the world a favor and commit suicide." —Danny, age 15

"At one rock-bottom period of my life, I completely isolated myself from people because I felt like no one wanted to hear what I had to say, and I wasn't sure I could deal with not saying it. It was most likely at this moment in my life that I was the most depressed and devoid of joy that I have ever been. At one point I called the police and told them that I had slit my wrist. Although I had and have no intentions to end my life, I cut many slashes in my wrist and blood started to drip." —Alfonso, age 19

"What do I do? How I do I find any form of happiness or a kind of relationship I want? How do I understand my weird orientation? Would counseling be helpful? I think of killing myself." —Tristan, age 17

OUR WORKSHOPS

B4U-ACT holds workshops in Maryland for, and led by, mental health professionals, researchers, and minor-attracted persons. The goals of the workshops are to promote communication and mutual understanding, and to raise awareness of various issues related to the attraction to minors. These issues have included barriers to communication between the two groups, consequences of those barriers, professional and popular language that is used to discuss minor-attracted people, how that language can be a barrier to access to mental health services, goals and approaches to therapy with minor-attracted people, and consequences of stigma and fear for minor-attracted people and for all of society. Social workers and psychologists who attend B4U-ACT workshops receive continuing education units.

"There's no way that anyone can understand what minor-attracted people are all about unless you attend one of these workshops."
—Joseph B. Hicks, LPCMH, CCMHC

"Frank and courageous discussion about a reality that challenges clinical counter transference." —Anthony Swetz, PhD

MINOR-ATTRACTED PEOPLE AND THE DSM

Minor-attracted people are particularly affected by the Diagnostic and Statistical Manual of Mental Disorders (DSM). This document influences the beliefs and practices of mental health professionals, the criminal justice system, the media, and the public. For that reason, the American Psychiatric Association states that DSM revisions must be based on accurate and complete scientific information, that revision workgroups should include representation from "patient and family groups," that the revision process must seek "input from stakeholders," and that DSM should be "sensitive to the needs of clinicians and their patients."

B4U-ACT is in strong agreement with this position of the APA, particularly in regard to DSM revisions regarding sexual attraction to minors. The DSM has an especially profound effect on people, including teenagers, who are emotionally and sexually attracted to children or adolescents.

Yet the DSM is currently being revised in the absence of information from the vast majority of these people. Instead, revisions are being based on limited data from unrepresentative forensic populations who cannot be honest with researchers. The lack of accurate information feeds intense fears surrounding people who are attracted to children or adolescents—fears which lead to severe stigma and adversarial policies that force minor-attracted people into hiding, making the gathering of accurate information even more difficult. Perpetuating this vicious cycle neither protects children nor leads to effective policies. It renders the APA powerless to gather and disseminate accurate information.

B4U-ACT is proposing a solution to this otherwise intractable problem by proposing that at least one member of the paraphilias subworkgroup meet in person with a small group of minor-attracted people who are not under the supervision of the criminal justice system.

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Minor-Attracted Person – person who is primarily emotionally and sexually attracted to children or adolescents younger that him or herself. Note that this includes adolescents primarily attracted to prepubescent children or to adolescents younger than themselves. B4U-ACT uses this term because other terms call to mind inaccurate preconceptions.

DSM-5 Proposal

Diagnostic Criteria for 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.

DSM-IV-TR

Diagnostic Criteria for Pedophilia

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

Accompanying Text

The paraphilic focus of Pedophilia involves sexual activity with a prepubescent child (generally age 13 years or younger). The individual with Pedophilia must be age 16 years or older and at least 5 years older than the child. For individuals in late adolescence with Pedophilia, no precise age difference is specified, and clinical judgment must be used; both the sexual maturity of the child and the age difference must be taken into account. Individuals with Pedophilia generally report an attraction to children of a particular age range. Some individuals prefer males, others females, and some are aroused by both males and females. Those attracted to females usually prefer 8- to 10-year-olds, whereas those attracted to males usually prefer slightly older children. Pedophilia involving female victims is reported more often than Pedophilia involving male victims. Some individuals with Pedophilia are sexually attracted only to children (Exclusive Type), whereas others are sometimes attracted to adults (Nonexclusive Type). Individuals with Pedophilia who act on their urges with children may limit their activity to undressing the child and looking, exposing themselves, masturbating in the presence of the child, or gentle touching and fondling of the child. Others, however, perform fellatio or cunnilingus on the child or penetrate the child's vagina, mouth, or anus with their fingers, foreign objects, or penis and use varying degrees of force to do so. These activities are commonly explained with excuses or rationalizations that they have "educational value" for the child, that the child derives "sexual pleasure" from them, or that the child was "sexually provocative"—themes that are also common in pedophilic pornography. Because of the ego-syntonic nature of Pedophilia, many individuals with pedophilic fantasies, urges, or behaviors do not experience significant distress. It is important to understand that experiencing distress about having the fantasies, urges, or behaviors is not necessary for a diagnosis of Pedophilia. Individuals who have a pedophilic arousal pattern and act on these fantasies or urges with a child qualify for the diagnosis of Pedophilia.

Individuals may limit their activities to their own children, stepchildren, or relatives or may victimize children outside their families. Some individuals with Pedophilia threaten the child to prevent disclosure. Others, particularly those who frequently victimize children, develop complicated techniques for obtaining access to children, which may include winning the trust of a child's mother, marrying a woman with an attractive child, trading children with other individuals with Pedophilia, or, in rare instances, taking in foster children from nonindustrialized countries or abducting children from strangers. Except in cases in which the disorder is associated with Sexual Sadism, the person may be attentive to the child's needs in order to gain the child's affection, interest, and loyalty and to prevent the child from reporting the sexual activity. The disorder usually begins in adolescence, although some individuals with Pedophilia report that they did not become aroused by children until middle age. The frequency of pedophilic behavior often fluctuates with psychosocial stress. The course is usually chronic, especially in those attracted to males. The recidivism rate for individuals with Pedophilia involving a preference for males is roughly twice that for those who prefer females.