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Peer Commentaries on Green (2002) and Schmidt (2002)

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

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

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

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

40 years of experience in treating such populations, we have, however, yet to encounter such an individual. Something has to bring an individual in for evaluation and treatment; otherwise, they are not seen.

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

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

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