Commentary on Pedophilia Diagnostic Criteria in DSM-5

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Human beings differ in sexual makeup. Most adults are not sexually attracted to prepubescent children, but some are. Societal values can be of relevance in determining whether such a difference is considered to be a psychiatric condition. Were a society to believe that adult-child sexual interactions should not be prohibited, such a difference might not be viewed as a disorder. According to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), a difference in sexual makeup can be considered a disorder when it causes interpersonal difficulty or marked distress. In contemporary society, pedophilia can do both. According to DSM-IV-TR, for a diagnosis of pedophilia, there must be both a qualitative difference in sexual makeup (i.e., sexualized urges directed toward children) and a quantitative difference (i.e., the sexualized urges must be intense). However, just as a heterosexual man with low (i.e., nonintense) sexual urges is still heterosexual, DSM-5 should similarly allow that individuals with low sexual urges in response to children qualify for a diagnosis of pedophilia.

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When considering psychiatric categorization, it is important to keep in mind the intended purpose of making a diagnosis. In simple terms, any medical or psychiatric diagnosis merely constitutes a shorthand means of conveying relevant information. For example, a diagnosis of diabetes mellitus or schizophrenia conveys a great deal of useful information to a properly trained physician. Ordinarily, a psychiatric or medical diagnosis is not made merely because of some observable difference (e.g., blue eyes versus brown). Instead, in most instances, a diagnosis is made only when the condition in question has either the potential to impair function severely, as in the case of congestive heart failure or schizophrenia, or when it causes distress or suffering, as in the case of severe depression.

Arriving at a diagnosis often requires making a clinical judgment (e.g., distinguishing between pathological grief and the more customary grieving process). In addition, although frequently unacknowledged, inherent to most diagnoses is the presence of an implicit value judgment. Respiration is a good thing, a biological process that does not require a diagnosis. Rapid cellular proliferation (cancer) is a bad thing, a biological process that should be diagnosed.

The adult heterosexual makeup is different from the adult homosexual makeup. However, neither impairs an individual's capacity to perform sexually with a willing partner whose sexual orientation is compatible. In addition, neither orientation (heterosexual or homosexual), in and of itself, causes intrinsic suffering. Beyond that, in contemporary society, a consensus has emerged (albeit with some dissenters) to the effect that neither orientation is a bad thing.

In defining heterosexuality or homosexuality (or for that matter, bisexuality), rarely does a description contain language (such as that used in the DSM when categorizing pedophilia) that refers to the presence of "recurrent, intense sexually arousing fantasies" and "sexual urges" (Ref. 1, p 572). Instead, as suggested by Blanchard,[2] an individual would ordinarily be considered to have an adult sexual orientation when the act, or fantasy, of engaging in sexually explicit activities with another adult is a repeated or an exclusively enduring method of achieving sexual excitement. Although ordinarily not acknowledged, one reason that an adult sexual orientation does not, in and of itself, lead to a psychiatric diagnosis is because of the implicit assumption that such an orientation is not a bad thing.

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In contemporary society, having a pedophilic sexual orientation (whether of the exclusive or nonexclusive form) is considered to be a bad thing. In a society that felt otherwise, such a condition might not be construed as psychiatric pathology. To suggest that the inclusion of pedophilia in the DSM is not at least partially dependent on making such a value judgment would be disingenuous.

In today's world, for good reasons, having a pedophilic sexual makeup can be a bad thing, which is not to say that persons with such a makeup are bad people. Society has the responsibility of protecting children. Persons, who through no fault of their own are sexually attracted to children, may be in need of psychiatric assistance to be able to resist the temptation of acting on those attractions.[3] They (and others as well) can also suffer a great deal of discomfort if they are unable to maintain full control of themselves through willpower alone. The fact that such persons may be in need of mental health assistance constitutes an important basis for considering pedophilia to be a psychiatric disorder, even if that consideration is based, at least in part, on an implicit set of values.

In keeping with Blanchard's definition of an adult sexual orientation, an individual could be considered to have a pedophilic sexual makeup when the act, or fantasy, of engaging in sexually explicit activities with prepubescent children is a repeated, or an exclusively enduring, method of achieving sexual excitement.[2] In essence, that is how pedophilia was defined in DSM-III. Arguably, a more detailed operational definition may be required in further developing diagnostic parameters for DSM-5. However, the phrase "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors" that is currently a part of the DSM-IV-TR definition (Ref. 1, p 572) may be unnecessarily esoteric and potentially confusing.

At present, the DSM confuses the extent to which pedophilia represents a qualitative, as opposed to a quantitative, variation in sexual makeup. Heterosexual men share in common the fact that they experience eroticized desires, or urges, for women that are sustained over time, at least intermittently. That shared qualitative aspect of their sexual makeup is independent of the intensity of their desire for women, an intensity that can vary at any given moment from high to low. A heterosexual makeup is still just that, even if and when the intensity of desire is low. Pedophilic men share in common that they experience eroticized urges for prepubescent children that are sustained over time, at least intermittently. Yet Criterion A of the current DSM definition of a pedophilic disorder specifies the presence not only of such urges, but of "intense" urges (a quantitative concept). A man who experiences eroticized urges for prepubescent children that are sustained over time should still be seen as having a pedophilic sexual makeup (of either the exclusive or nonexclusive form), irrespective of the intensity of his urges.

Criterion B of the current DSM requires either that an individual has acted on his eroticized urges or that those urges or fantasies have caused "interpersonal difficulty" or "marked distress," before the diagnosis of a pedophilic disorder can be made (Ref. 1, p 572). That is so, at least in part, because differences in sexual makeup that are not acted on and that are not associated with personal distress or interpersonal difficulty may not be of clinical concern. Thus, a person can differ from the norm in experiencing recurrent sexual attractions to prepubescent children. However, if he is in full control of himself, does not act on, and is not distressed by those attractions, under such circumstances, such a difference in sexual makeup would not have to be classified as a disorder.[4]

It is in addressing DSM Criterion B that the intensity of the pedophilic urges may become most relevant. Persons with intense pedophilic urges may experience heightened difficulty in resisting temptation (i.e., they may be more volitionally impaired) than are persons whose pedophilic urges are less intense.[5] In that sense, all else being equal, persons with more intense urges would most likely be at greater risk of acting on them, potentially causing both interpersonal difficulties and distress (Criterion B). Parenthetically, it might be noted that it is just such an impairment in volitional capacity (an impairment that may be proportional in its degree to the intensity of sexual cravings) that has been used to justify the involuntary civil commitment of some individuals with pedophilia.[6]

Finally, Blanchard has recently proposed that an option for DSM-5 may be to return to the earlier language of DSM-III, which had conceptualized pedophilia as an "erotic preference."[2] The term "preference" can suggest many meanings that create further difficulty. A person does not have pedophilia in

the first place because it is his preference to have it, and his preference may be that he not succumb to his pedophilic urges. Including the word preference in the diagnostic criteria for a pedophilic disorder would be likely to do more to confuse than to elucidate.

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