A Dissenting Opinion on DSM-5 Pedophilic Disorder [Letter to the Editor]

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On December 1, 2012, the American Psychiatric Association (APA) announced that its Board of Trustees (BOT) had voted to reject the changes to the diagnostic criteria for pedophilic disorder proposed by the Paraphilias Subworkgroup for DSM-5 and to retain the diagnostic criteria published in DSM-IV-TR.[1] I was the Chair of the Paraphilias Subworkgroup (one of three Subworkgroups of the Sexual and Gender Identity Disorders Workgroup). I am writing this letter to document my continued personal opposition to this decision, to review the content of the Subworkgroup's proposed changes and explain the reasons for them, and to speculate on the possible interpretations and implications of the BOT's decision. By necessity, this letter will not include an "insider's view" of specific people, events, or APA politics connected with that decision. All members of DSM-5 Work Groups were required to sign an agreement with the APA that prohibits them from divulging any "confidential information," which was defined so as to include group discussions, internal correspondence, or any other information about the DSM-5 development process. Thus, this letter will not include any unpublished information except for the personal reactions, questions, and speculations I have developed since the BOT's vote and the effective dissolution of the Paraphilias Subworkgroup.

It is easy to explain the diagnostic problem that the proposed changes were designed to correct. The DSM-IV-TR diagnostic criteria for pedophilic disorder (then called pedophilia) define this paraphilia as the sexual preference for prepubertal children. There is only one generally accepted medical or scientific definition of prepuberty, that is, Tanner Stage 1 of

[1] DSM-IV-TR lists three diagnostic criteria for pedophilia. The one relevant to this Letter is Criterion A, which describes the nature of the paraphilia: "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)" (American Psychiatric Association, 2000, p. 572).

pubertal development.[2] The average age of pubertal onset (i.e., Tanner Stage 2) has been falling for many years.[3] Therefore, the DSM-IV-TR criteria, literally interpreted, would diagnose as pedophilic only those persons who sexually prefer the youngest children.

There are, however, many persons (overwhelmingly men) who sexually prefer early pubertal rather than prepubertal children. Early pubertal children are children in Tanner Stages 2 and 3, which correspond generally to ages 11 through 14 years. According to a literal reading of the DSM-IV-TR diagnostic criteria, these men are—by default—sexually normal, at least in regard to partner preference. Such an assessment would not square with the average layperson's concept of sexual normalcy and probably does not square with the average clinician's either.

The ICD-10 got around this disconnect in a straightforward way; the DSM-IV-TR got around it with a dodge. The ICD-10 definition of pedophilia is "A sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age" (World Health Organization, 1992, p. 171). This definition departs from Krafft-Ebing's classical definition, but it agrees with

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[2] There are five Tanner stages of physical development, with Tanner Stage 1 indicating prepuberty and Tanner Stage 5 indicating full maturation (Marshall & Tanner, 1969, 1970; Tanner, 1978). Tanner stages pertain to breast development and pubic hair growth in females, and to genital development and pubic hair growth in males. The stages of present relevance may be briefly described as follows. *Tanner Stage 1:* girls, no palpable breast tissue; boys, genitals similar to early childhood; both sexes, no pubic hair at all. *Tanner Stage 2:* girls, breast bud stage; boys, enlargement of scrotum and testes, with change in the color and texture of scrotal skin; both sexes, sparse growth of long, slightly pigmented downy hair, appearing mainly along the labia or base of the penis. *Tanner Stage 3:* girls, further enlargement of breast and areola with no separation of their contours; boys, growth of the penis and testes to half adult size or less; both sexes, pubic hair is darker and coarser, but lesser in quantity and different in quality from adult type.

[3] The average age at which the onset of puberty occurs has been dropping for at least 150 years, and research indicates that it has continued to drop over the last few decades (e.g., Biro et al., 2010). In a multi-site study, for example, Biro et al. found that 18.3 % of white girls, 42.9 % of Black non-Hispanic girls, and 30.9 % of Hispanic girls had started puberty by the age of 8 years. A study on boys (Herman-Giddens et al., 2012) found comparable results for boys at age 9. By this age, 26.1 % of white boys, 43.4 % of African-American boys, and 44.4 % of Hispanic boys had started puberty, as indicated by Tanner Stage 2 (or higher) of genital development.

real-life clinical practice. The DSM-IV-TR definition is “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger)” (American Psychiatric Association, 2000, p. 572). The statement that prepubertal children are “generally age 13 years or younger” is, of course, true, but it would be equally true if it read “generally age 15 years or younger.” In my opinion, the reference to age 13 years is nowadays not so much a realistic guideline to probable age of pubertal onset as it is a backdoor method for permitting the diagnosis of pedophilia in men who actually prefer early pubertal children.

In an article that I wrote before I joined the DSM-5 Work Group on Sexual and Gender Identity Disorders (Blanchard et al., 2009), I suggested a solution that would combine the pragmatism of the ICD-10 approach with more precise definitions that were already available. Specifically, I suggested replacing the diagnosis of *pedophilic disorder* with *pedohebephilic disorder*—defined as greater or equal sexual attraction to children age 14 and younger than to physically mature adults (Blanchard, 2010a) —and allowing the clinician to specify one of three subtypes: Sexually Attracted to Children Younger than 11 (Pedophilic Type), Sexually Attracted to Children Age 11 to 14 (Hebephilic Type), or Sexually Attracted to Both (Pedohebephilic Type). The term *hebephilia* had been coined by Glueck (1955) to denote the sexual preference for pubertal children, and the term *pedohebephilia* had been coined by Freund, Seeley, Marshall, and Glinfort (1972) to denote a roughly equal sexual preference for prepubertal and early pubertal children (as opposed to later adolescents or physically mature adults).

In a later iteration, published on the APA’s DSM-5 Website in May 2012, I dispensed with the age guidelines altogether (in order to avoid confusion with legal ages of consent for sexual intercourse in different jurisdictions) and worded the type-specifiers as follows: Classic

Type—Sexually Attracted to Prepubescent Children (Tanner Stage 1), Hebephilic Type—Sexually Attracted to Pubescent Children (Tanner Stages 2–3), and Pedohebephilic Type—Sexually Attracted to Both.

In summary, the goal of the proposed change in diagnostic criteria and diagnostic labels was to increase the accuracy of diagnosis, not to increase the number of individuals diagnosed, and I am convinced that that is exactly the effect it would have had. Resistance came from various quarters, including people who wanted all paraphilias removed from the DSM, hebephiles who opposed the explicit listing of hebephilia as a mental disorder, and forensic psychologists and psychiatrists who viewed all proposed changes in clinical diagnosis in terms of their anticipated (or fantasized) consequences in the courtroom.

Several commentators (DeClue, 2009; Janssen, 2009; Moser, 2009; Tromovitch, 2009; see also Rind & Yuill, 2012) immediately recognized after the on-line publication of Blanchard et al. (2009) that there were two separate matters at issue: (1) Does hebephilia (a sexual preference for early pubertal children) exist, and (2) is hebephilia a paraphilia? I agree with that distinction, and I believe that one could have an honest argument about the second point but not about the first. Few critics, however, chose to acknowledge the overwhelming evidence that hebephilia exists and go on to address the much more difficult question of where to draw the line between a paraphilia and a predilection. More commonly, they fused the two points. This is exemplified by the following blog post from Frances (2011):

> The basic issue is that sexual attraction to pubescent youngsters is not the slightest bit abnormal or unusual. Until recently, the age of consent was age 13 years in most parts of the world (including the United States) and it remains 14 in many places. Evolution has programmed humans to lust for pubescent youngsters—our ancestors did not get to live long enough to have the luxury of delaying reproduction.…It is natural and no sign of mental illness to feel sexual attraction to pubescent youngsters.

In other words, there is no such thing as hebephilia, and it's normal anyway.

This rhetorical sleight-of-hand ignores the distinction between sexual attraction and sexual preference. It is true that men who sexually prefer adults respond with some degree of penile tumescence, at least in the laboratory, to depictions of nude pubertal children of their preferred sex. In fact, they even respond to nude prepubertal children of their preferred sex. This finding was made in the Kurt Freund Laboratory (Freund, McKnight, Langevin, & Cibiri, 1972), and it was confirmed 38 years later in the same laboratory (Lykins et al., 2010). The issue is not whether normal men respond sexually to early pubescents. The issue is whether it is normal for an adult to respond as much or *more* to early pubescents than to physically mature individuals. In other words, would it be normal for an adult, given a free and unencumbered choice of sexual intercourse with a 12-year-old or an equally attractive 20-year-old, to take the 12-year-old every time?

Besides all-men-are-hebephiles, the other major argument against modifying the diagnostic criteria to acknowledge the related phenomenon of hebephilia was an appeal to Darwinism—in effect, an appeal to reproductive success as a touchstone of mental disorder. Franklin (2009) objected to the proposal to roll hebephilia into the diagnosis of pedophilic disorder in DSM-5 on the grounds that "such attractions are evolutionarily adaptive" (p. 319). Franklin did not explain this argument any further. Presumably, Franklin meant something along the following lines: In the environment of evolutionary adaptedness, men with a sexual preference for early pubescent females had greater reproductive success, either because they acquired female mates near the onset of their fecundity and thus prevented them from being impregnated by other men, or because they had more years in which to impregnate their mates themselves, or both. Since hebephilia is of evolutionary design, it cannot be a mental disorder.

Franklin's hypothesis was probably intended to explain hebephilia only in heterosexual men, since pubescent boys cannot become pregnant any more readily than prepubescent boys. In any event, Franklin did not address why homosexual pedophilia might be considered a disorder but homosexual hebephilia should not. Another basic flaw in this argument is equally obvious: If reproductive success is a criterion in deciding whether a sexual orientation is a paraphilia, then homosexuality should be reinstated in the DSM, because gay men and lesbian women reproduce at much lower rates than their heterosexual counterparts. At any rate, the available clinical (Blanchard, 2010b) and anthropological (Hames & Blanchard, 2012) evidence indicate that "not only is hebephilia not an adaptation but more reasonably a mal-adaptation in both ancient and modern environments" (Hames & Blanchard, 2012, p. 747). Despite the problems with the Darwinian argument, it was uncritically repeated by other opponents of the proposal (see Blanchard, 2012).

Behavioral, physiological, and self-report data converge on the conclusion that sexual orientations towards people of different ages, like most psychological traits, fall on a continuum. Virtually all of the possible age-orientations have been identified by clinicians and given their own names: pedophilia (the preference for prepubertal children in Tanner Stage 1, generally age 10 or younger), hebephilia (early pubertal children in Tanner Stages 2 and 3, generally ages 11 through 14), ephebophilia (late pubertal adolescents in Tanner Stage 4, generally ages 15 and 16), teleiophilia (adults in Tanner Stage 5, between the ages of physical maturity and physical decline), and gerontophilia (the elderly). Another way to look at the controversy at hand is whether, at the younger end of the continuum, the dividing line between paraphilia and normalcy should be drawn between sexual objects in Tanner Stage 1 and Tanner Stage 2, or between sexual objects in Tanner Stage 3 and Tanner Stage 4.

In my view, the dividing line should be drawn between Tanner Stages 3 and 4, for the following reasons. First, pedohebephilia is common enough to convince me that pedophilia and hebephilia are related phenomena, and second, children in Tanner Stages 2 and 3 look very different from fully mature or even nearly mature humans. The interested reader can readily form his or her own opinion on the latter point by searching for "Tanner stages" on the internet. Such a search will produce a plethora of medical photographs and medical drawings, often accompanied by verbal descriptions of the defining physical features of each stage. Medical photographs give a better sense of the appearance of real children in early puberty than do descriptions of secondary sexual characteristics alone.

As I wrote at the beginning of this letter, the APA's BOT, for reasons presently known only to themselves, decided that the DSM-5 diagnostic entity representing the sexual preference for the immature physique should not include the preference for children in Tanner Stages 2 and 3. This decision raises various questions that I cannot answer, because I had nothing further to do with the DSM-5 section on pedophilic disorder after the BOT's vote. These questions need to be considered, however, because the answers have practical significance for researchers and, more importantly, for clinicians.

The first question concerns the BOT's decision (assuming there was a vote on this) not to include the proposed diagnostic criteria in Section 3 of DSM-5, the section intended for conditions that require further research. It can hardly be the case that the existing literature on hebephilia is too small to justify the formal encouragement of more research. Hebephilia is mentioned in at least 100 texts (http://individual.utoronto.ca/james_cantor/page21.html) and over 30 peer-reviewed articles (http://individual.utoronto.ca/james_cantor/page19.html). A new research article on the topic was published less than a month before the present writing (Beier et

al., 2013). Thus, the BOT's action gives the impression, whether accurate or not, that the BOT, or some faction within it, actively wishes to discourage research on hebephilia.

The second question is whether the BOT's decision should be interpreted as a position statement from the APA that the sexual preference for children in the early stages of puberty is normal. It is difficult to rule out this interpretation, given that the BOT was presented with a clear opportunity to assert that the sexual preference for children in early puberty is paraphilic.

The third question, which is related to the second one, is whether hebephilia may be diagnosed under DSM-5 as an "other specified paraphilic disorder (hebephilia)." This would be a continuation of the common practice, under DSM-IV-TR, of giving the diagnosis Paraphilia Not Otherwise Specified (Hebephilia).

It remains to be seen how the BOT will respond to these questions when they start to arise in real-life settings, which they will. It seems to me that there are only two possibilities. If the BOT denies that it meant to assert that the sexual preference for children in early puberty is normal, then it has to allow the diagnosis of "other specified paraphilic disorder (hebephilia)." If the BOT, or someone officially speaking on behalf of the BOT or the whole APA, states or testifies that the BOT intended to prohibit the diagnosis of "other specified paraphilic disorder (hebephilia)," then that is tantamount to stating that the APA's official position is that the sexual preference for early pubertal children is normal.

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