

## Rejoinder

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Oy, Gott.<sup>4</sup> I am astounded at the number of individuals who responded to my little piece originally prepared for the symposium at the 2001 meeting of the International Academy of Sex Research (IASR) in Montreal. I would have crafted a more extensive document had I known it would be sent by the Editor to every sexologist over the age of 11 (the age of consent in some outer provinces of Canada). At the outset, thank you to those commentators who added to my list of historical and cross-cultural examples of child–adult sex: the child-bride grooms of China; Charles Dodgson (Lewis Carroll), who brought us Alice; James Barrie, who brought us Peter Pan; Muhammad, who brought us Islam; and St. Augustine, who brought us Christianity.

How can *Spitzer*, the father of the modern DSM, with *Wakefield*, say I never define pedophilia or mental disorder? I refer specifically to the operational definitions of DSM-IV and in historical context address sex with prepubertal children (as does DSM). Spitzer and Wakefield characterize mental disorder, inter alia, as a failure “to adequately perform its biologically ‘designed’ (naturally selected) function.” Gays and lesbians, as the children in England scream out from the audience watching Christmas pantos, “LOOK OUT BEHIND YOU!” I don’t disagree with them that sexual attraction to young children needs explanation. My career has been devoted to understanding the processes behind a range of sexualities. I don’t believe that we even understand heterosexual attraction (why do some men eroticize small breasts and

others large ones, some small buttocks, and others large ones, some “svelte” women and some the “full-bodied”?). But our ignorance of the etiology of a behavior doesn’t mean we have to call it a mental disorder for it to be studied. In Spitzer and Wakefield’s tortured avoidance of labeling homosexuality a disorder, my position is misstated: “Green . . . suggests, unlike the case of pedophilia in which harm is *assumed* . . . , homosexuality does not necessarily involve harm to self or others and thus cannot be classified as a disorder” (my emphasis). What I wrote in contrasting these behaviors was “Consensual same-sex adult-adult sexuality does not suggest the element of harm to one participant . . .” Suggesting the element of harm does not equate with the universal certainty of harm.

*Seto* stakes out puberty as the bright line marker in this discourse because it provides information about a person’s reproductive status. He reminds some of us, and informs others of us, “From a Darwinian perspective, a preference for sexually immature, non-reproductive persons is anomalous . . .” Gays and lesbians beware: They’re coming to get you, AGAIN!

*Moser’s* “throw all the rascals out” approach (all the paraphilias from the DSM) is more adventurous than mine. He boldly asserts that the treatment goal with the “paraphilic” patient should be an individual with an atypical sexual interest who is no longer distressed or dysfunctional. This “happy pervert” outcome will surely displease most commentators on my essay.

*Berlin* is forthright when he admits making a value judgement that pedophilia is a disorder. His declaration is not reached by a cramped reading of DSM or an optimistic rationale for federal research funding. He correctly states that pedophilia *can* create both psychological burdens and impairments (as can heterosexuality or homosexuality, I would add ) but (like heterosexuality or homosexuality), *must* it? Why then declare pedophilia a disorder for all? Berlin is reasonable in saying that if labeling pedophiles disordered allows mental health professionals to be better

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<sup>4</sup>“Oh, God,” for the few readers of *Archives* who don’t speak Yiddish.

able to help them, then doing so can serve a useful purpose. This is the same rationale for retaining transsexualism (now gender identity disorder) in the DSM, seen as stigmatizing by transsexuals, but to permit third-party treatment funding. With transsexualism, we are searching for an alternative; perhaps we can do the same here.

*Dixson*, a primatologist, is of the view that human childhood and/or adolescent experiences tilt sexual behaviors in bizarre ways. Perhaps this is because of the dearth of paraphilias among nonhuman primates. Presumably, the richness of postnatal experiences for *Homo sapiens* does them in. But what if *nothing* happens postnatally to create “para” sexual interest?

If I am to agree with *Ericksen* that the DSM is a straw-man, then I stress that it can be a pretty forceful one. Should DSM be acultural, ahistoric? Consider homosexuality. Had psychiatry and the early DSMs been more attentive to history and culture, this could have prevented a lot of needless twentieth century suffering. Gays and lesbians did not become “normal” because of their political struggle; rather, they were deemed not to have a DSM mental disorder. Does this suggest a parallel course for pedophiles? Should NAMBLA (North American Man–Boy Love Association) disrupt psychiatric meetings in the anarchic manner of the 1970 San Francisco meeting of the American Psychiatric Association where I tried to maintain order at a symposium on homosexuality and control pandemonium?

A *Krueger* and *Kaplan* comment reminds me of the historic APA homosexuality debate and the clinical sample fallacy: “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. [But] [i]n our combined 40 years of experience in treating such populations, we have, however, yet to encounter such an individual.” I’m not surprised! Over three decades ago, Judd Marmor pointed to the clinician’s fallacy of generalizing from those who come for help and enter patient files to the nonclinical population. Applying the same patient source and logic, Marmor suggested, would lead to the conclusion that heterosexuality is a mental disorder.

*Langevin* argues “Even if we assume that there is an exact parallel between adult-child sexual contacts in other cultures and our own [not assumed by me], does that make it acceptable?” Although this can be an argument for imposing criminal sanctions, it should not be one for labeling it a mental disorder.

*Friedman*, in an intracerebral “Q & A,” asks “Should mental health professionals turn away people requesting

treatment for [paraphilia] and instead refer them to the legal system?” and replies that a “response in the *negative* would mean that mental health services should not be provided such individuals” (my emphasis). I presume he means “positive.” At any rate, people don’t get referred to the legal system unless they breach a law. Many pedophiles don’t. They could be treated for “ego-dystonic pedophilia,” similar to the short-lived DSM-III diagnostic compromise for homosexuality.

*Gaither* considers making pedophilia a “sexual orientation” rather than a paraphilia, but wants to retain it as a disorder as otherwise it carries with it a new ethical dilemma. Analogizing to “reparative therapy” for “converting” homosexuals, he cites the position statement of the American Psychiatric Association:

... APA opposes any psychiatric treatment, such as “reparative” or “conversion” therapy, that is based on the assumption that homosexuality per se is a mental disorder or is based on the a priori assumption that the patient should change his or her homosexual orientation. (p. 486)

Whose assumption is this—therapist or patient? A person may want to modify sexual orientation because an alternative one could provide perceived advantages, such as spouse and children. Is such treatment less ethical than treating what is uniformly mistakenly identified as mental illness?

*Miner* makes an interesting comparison with the DSM’s Impulse Control Disorders. But were the behaviors sanctioned there ever condoned? Was kleptomania accepted? Isn’t that a legal problem? Was pyromania? During the centuries in England when the age of consent was 10, did the English people endorse fire setting? I don’t find the substance use disorder analogy persuasive:

... it is not the use of substances or even the heavy use of substances that results in the diagnosis. Rather, it is the use of substances, coupled with problems associated with their use. The same can be said for pedophilia . . . contact with the criminal justice system generally results in . . . [clinically significant] consequences as loss of jobs, disruption in marriages and relationships . . . (p. 490)

This need not be true for the fantasy-only pedophiles (who, as I pointed out, may not be diagnosed pedophiles unless distressed over the fantasies). Further, the negative reactions are societal with pedophilia, in contrast to a “druggy” reduced to incoherence or who believes he can fly when jumping from a high rise.

Although I like *Bullough’s* sexual harassment analogy where a previously “acceptable” behavior is now condemned, this is not completely on point. Sexual harassment has become illegal, not a mental disorder.

As I responded live when *Zucker* made this point at the IASR meeting, I agree that whether all other symptom systems are “A-OK” is not relevant to a primary diagnosis (anymore than in delusional disorder). But, the structure of my essay was to track so far as possible the 1970s debate on homosexuality.

For the commentaries of *Berner*, *Fazekas*, *Ng*, *Prentky*, and *Rind*: No harm, no foul.

A general critique of my paper was that cultural variations are not the equivalent of frank pedophilia. I never said they were. But a lot of these adults would have probably made it into DSM. DSM does not require pedophilic arousal to be exclusive—just present for 6 months. These big folks were having sex with little folks. As these cultures did not apparently condemn adult-child sexuality, we do not know the strength of the sexual motivation of the participants (both adult and child).

If a society does not condemn a behavior, more will participate. I do not agree that those who continue to participate when society does condemn are necessarily mentally ill. Antisocial behavior may be criminal (it often is), but it need not be a mental illness (it often is not). Many influences may determine whether or not a person with a pedophilic fantasy life acts on it with a child. My doctoral student, Claire Morris, at the University of Cambridge is trying to learn something about what distinguishes contact from noncontact pedophiles. What is the factor that moves the pedophile to pedophilic perpetrator?

I end with *Okami*'s full commentary: “Green’s paper seems to me so level-headed that any controversy surrounding it should be worthy of close sociological scrutiny.” Perhaps a future issue of the *Archives* will take up the challenge. Olivay.<sup>5</sup>

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<sup>5</sup>“It should only happen,” for the same readers.