Diseased or Demonic: How can we understand paedophilia?

Sexual attraction for children is likely the most condemned trait that appears in society, considered the crime that calls out for punishment, it frequently inspires vigilante action such as that by ‘Groom Resistance Scotland’ in August¹. Convicted paedophiles are usually dealt with judicially, yet psychological programmes such as “Kein Taeter warden” (Don't offend) in Germany have begun the medicalise the issue and ask if these crimes represent manifestations of disease. However, if paedophilia is an illness it raises difficult questions about responsibility. Furthermore, we should be exceptionally confident before considering aberrant sexualities disordered, given the historical use of psychiatry to persecute sexual minorities. This essay will argue that paedophilia, a sexual orientation, is not sufficient to achieve a psychiatric diagnosis. Nevertheless, when this sexuality causes direct harm to an individual concerned, which I believe occurs almost universally, we do have grounds to recognise and treat it. It is a disorder not intrinsically, but because of its damaging effects, and the power of classification rests upon individual circumstances. I shall first draw out tensions in the definition of paedophilia and show how Christopher Boorse’s understanding of disorder will not suffice in this case. I will then suggest a refined version of Jerome Wakefield’s theory where paedophiles may correctly be classified as disordered, using a joint biological and value criterion. Finally, I will suggest some implications for psychiatry.

Tensions in Defining Paedophilia & Separating Sexual Orientation

The ICD-10 describes paedophilia as:

“A sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age.”²

The DSM-V stipulates three conditions:

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

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

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

The simpler ICD version expresses the etymological and commonplace understanding (literally, lover of children). Both do not set a specific age, highlighting the most important consideration: the immaturity of physical and mental sexuality in children. Lack of secondary sexual characteristics, not age, is the crucial factor in recognising paedophilia. This point us towards the biological difference from non-paedophiles and distinguishes it from hebephilia (preference for early adolescent children).

Here, attraction to those who have begun to develop secondary sex characteristics blurs the boundary with non-paedophilic attraction as, though still abhorrent, there may be physical features which devoid of context would cause arousal in non-paedophiles. This conversely explains why we should not consider infantophilia as separate to, but as a subgroup of paedophilia – the biological immaturity remains. At its heart then, paedophilia implies attraction to a group not biologically capable of sexual reproduction.

The ICD is wrong to consider disordered attraction to be sufficient for diagnosis as homosexuality, another example of attraction that is not reproductively efficacious, has shown. The DSM corrects this by requiring ‘distress and interpersonal difficulty’. Consequently, a value judgement

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is considered necessary to defining a paedophile as ill. This is important, though should be compared again to homosexuality, which sadly still causes much distress, yet is never considered an illness. I will return to this tension later. Another feature of the DSM criteria is that having committed paedophilia is sufficient for diagnosis, regardless of distress, thus producing the odd situation where the illegal act is a diagnostic factor, rather than merely an indicator of severity. Paedophilia causes considerable developmental harm to children\textsuperscript{7} and constitutes exploitation in the worst way, but this seems distinct from the medical categorisation – we do not consider it more diagnostic if the person reporting persecutory hallucinations commits assault.

Despite these reservations, the DSM is clearly right to incorporate value into the diagnosis. It is not clear the paedophile who never acts, but accepts his unfortunate predilection requires a medical diagnosis. Michael Seto has argued that paedophilia appears like any other sexual orientation in its age of onset, association with sexual and romantic behaviour, and stability over time\textsuperscript{8}. The ICD therefore dangerously medicalises a sexual orientation by default, and while we may be able to tell compelling stories for why this should be the case, it is a slippery slope. Homosexuality has shown that evolutionary hypotheses, or the mere fact of being a minority sexuality is not good enough for a diagnosis. But neither is an appeal to consequences – an excess of any sexuality can cause criminality, we do not routinely diagnose rapists with hypersexuality. Instead we should be clear that the evil comes from the immorality of acting on the instinct and the illness from the intrapersonal pain desiring an evil act causes. Finally, the ICD implicitly homogenises paedophiles based only on a preference for children when in terms of lifestyle and personality there is great heterogeneity and the “unsensational and often mundane character of most instances of paedophilia” strikes many experts\textsuperscript{9}. I will now show why a biological understanding of disorder alone is not sufficient to label paedophiles as disordered.

The Failure of Boorse’s Account

Christopher Boorse famously argued that a disorder is present when there is a dysfunction such that some internal part does not perform its “typical functions with typical efficiency”. Typicality is the performance level of a normal reference group and disease reduces this “normal functional ability”\(^\text{10}\). Clearly this biological criterion is necessary in any concept of disorder. For many medical conditions, like diabetes, it is sufficient for defining illness. Psychiatric conditions can be understood as brain dysfunction – we do not need to understand the aetiology of depression to say the brain is not performing the function of holding a relatively stable mood. If we accept the main function of sexuality is driving reproduction, paedophiles do not perform this with typical efficacy because reproduction is impossible. But as previously alluded to, using only biological criteria would mean homosexuality is considered diseased – there is no room for whether dysfunctions matter to people’s identity or way of living. Boorse could respond the function of sexuality is not reproduction, but this seems unlikely based on natural selection. Alternatively, he could take population level approach and say that the small proportion of homosexual people means the function of reproduction is maintained at this level. Clearly though we do not normally say that diseases with a limited affect within the population as a total, are not diseases at all.

Using biological dysfunction is particularly problematic within psychiatry. Describing normal function beyond the Glasgow Coma Scale, and except for the relatively well-defined symptoms of psychosis and mood disorder, we have little understanding about what a dysfunctional mind is. Personality disorders are perhaps the best attempt at saying particular characteristics are dysfunctional, but this is measured in terms of the failure of such individuals to cope in normal society. The person with borderline personality disorder is considered so because the nature of her actions leads to a difficulty adjusting to normal life. But these seem to be merely exaggerations of normal personality traits and it is clearly not appropriate to consider hospitalisation or pharmacological...

\(^{10}\) Christopher Boorse, ‘Health as a Theoretical Concept’, *Philosophy of Science* 44 (1997), pp. 558-567.
treatment for such individuals. To put it more broadly, there is no perfect biological output when it comes to higher brain function, and while we might suggest extremes of temperament are a real dysfunction, it is difficult to escape the charge of social influence. A middling level of outgoingness in one culture might be considered outrageous in another, and there is little way of saying which is closer to ‘normal’. Thus, the apparent strength of Boorse, its objective pretence, is illusory when applied to the mind. Several examples of this are given by Ron Amundsun, who similarly argues that Boorse’s “functional determinism” – the idea we can identify a meaningful dichotomy between normality and abnormality – is false. It ignores developmental plasticity, failing to acknowledge that an organ can function outside normal parameters but still live successfully. It is also antithetical to Darwinism, because all useful adaptations start as statistical aberrations and therefore everything under the bracket of normal must have been abnormal at some point.\textsuperscript{11}

Boorse’s account fails in two other ways, in that the reference classes from which normality would be judged are irreconcilably arbitrary. Is the 95\textsuperscript{th} percentile abnormal, or the 99\textsuperscript{th}? Clearly nothing special happens at the transition point and moreover shifts in the average will affect who falls behind the chosen cut-off. In addition, if we were to take ideal function as that of young athletic people, then surely aging would then become a disorder (this may be correct but is certainly not he common understanding). At this point it may be objected that while these points argue against the overall theory, they are a straw man, as paedophilia is not just an extreme point on the continuum of sexuality, as we might consider hyper/hyposexuality. Firstly there is some empirical evidence against this understanding, which will be discussed later, but also can still agree that paedophilia or homosexuality are not diseases under Boorse, but that is a failure of the simplicity of his account – though biological dysfunction is a necessary starting point for understanding disorder, in practice it

labels someone as disordered without paying any attention to the individual subject or the social impact of the label ‘disease’.

Wakefield’s dual approach

Jerome Wakefield adds another element to the classification of disease: value judgements. He argues that disorder occupies the space between the natural world of Boorse’s objective dysfunction and the value laden social world. It requires both biological dysfunction based on a failure to fulfil its evolutionary adaption and a cultural agreement that the dysfunction causes harm in non-biological terms. Moreover, biological dysfunction is judged “on the basis of standards set by the design of internal mechanisms, rather than by statistical norms”\(^\text{12}\). The appeal to standards of natural selection helps avoid problems of arbitrary categorisation as it is a single objective standard for comparison, although interpreting the “design of internal mechanisms” is likely to be controversial. The addition of a value element allows us to exclude evolutionarily mal-adaptive states which are irrelevant in the modern world. Homosexuality may be maladaptive in reducing fertility, but it is clearly not an illness. Only biological functions “people care about and need within the current social environment, not those that are interesting merely on evolutionary theoretical grounds” can be candidates for disorder\(^\text{13}\). That a biological dysfunction may exist but not cause disorder is counterintuitive, but not without prescient. Everyone with a subclinical viral infection surely has a biological dysfunction, the failure to clear a virus, however if they have no symptoms and no future repercussions, we cannot consider them diseased.

Would a paedophile be disordered on this account? On the biological side a clear biochemical or other aetiology is elusive (in common with mental disorders generally). One potential story is that paedophiles are the consequence of a personality disorder that makes them inadequate to compete


\(^{13}\) Ibid. p. 384.
with other men for heterosexual sex\textsuperscript{14}. The reply to that would be that many people struggle to compete without becoming paedophiles, and many paedophiles also form conventional relationships. If we cannot work out a convincing mechanism, we can at least say that paedophiles have a sexuality that is too broad, that is ‘activated’ despite a lack of secondary sexual characteristics. Reproduction is impossible, so the obvious function of attraction, to pass on genes, is not applicable. That some emotional reciprocation is sometimes reported\textsuperscript{15} and only a minority use force or violence in their sexual assaults might suggest other biological motives such as malfunctioning desire for closeness\textsuperscript{16}. But such benefits as companionship and mutual intimacy, cannot be seriously reciprocated, and do not seem strong enough to cause profound biological change. When you consider that community disgust would likely lead to social exclusion and reduce chances of survival, the likelihood that there is some adaptive reason for paedophilia becomes remote. Both directly, in reducing fertility and indirectly by upsetting social structure, there are selective pressures against it and can therefore be understood as a biological dysfunction, even if we cannot yet locate the abnormal physiology.

If paedophilia is a maladaptation, why has it not been eliminated? It seems to have a genetic element to it so random mutations without heritability could account for many cases\textsuperscript{17}. Such genes could be passed on through reproductive relationships, both by paedophiles, and potentially by those who are not. This is possible because paedophilia may not be a simple binary as we have assumed thus far. In an unorthodox experiment, explicit slides of people between 5 and 26 were shown to adult non-paedophiles. Several of the participants had erections in response to images of children down to 8 years old\textsuperscript{18}. Richard Green uses this study in arguing against the existence of pedophilia as a distinctive entity, backing his argument up with arbitrariness of childhood and the historical variance

\textsuperscript{15} Tony Parker, \textit{The Twisting Lane: Some Sex Offenders} (Panther, 1970), pp. 71-72.
of acceptable sexuality to suggest the disorder is more or a spectrum. But showing that subconscious arousal is more widespread than would be thought does not necessarily refute that it is a dysfunction. The maladaptation may simply be widespread but to varying degrees, or we could point out that sexuality has a considerable social context, and physical arousal is but one component.

One explanation is to consider it an evolutionary by-product resulting from “unstructured variation” below the level of ordinary mental adaptation: a change in a highly complex mental superstructure that can be maladaptive and yet continue to appear in the phenotype because it is like “genetic noise” within a bigger psychological system. This idea takes inspiration from an argument by Gould and Lewontin, that body plans (especially for the brain) are so interconnected and constrained by developmental, natural selection cannot alter them easily. On this view paedophilia is a dysfunction, but is too imbedded into the much deeper structure of sexuality to be expunged. Finally, that negative environmental triggers correlate with paedophilia further suggests more complex a more complex picture than pure genetics. Paedophiles are heterogeneous but tend have suffered exposure to violence, either from or, between parents and they describe difficulty integrating in their community. In one fascinating case, a heterosexual male who suddenly developed paedophilic urges was found to have a brain tumour which, when removed, reverted his sexuality. Although causation is difficult to ascertain, this suggests that the genetic propensity to become a paedophile may be present in many people, and only come to light under certain developmental conditions, or indeed certain pathological conditions.

The Value Criterion

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Wakefield’s value criterion is fulfilled if a dysfunction is understood in a given culture to constitute some sort of harm to the afflicted. While dealing with the problems of only using biological dysfunction, it seems to make disorder relative to culture, changing over time and between groups of people, thus losing objectivity. Moreover, it is not clear what the cultural understanding of harm is and how we could identify whether it existed for paedophilia. Further, multiculturalism demands that several cultural expressions be held in parallel, all equally valid, meaning that disorder could be dependent on a meaningless category. This relativity allows attacks from critics of mental illness. Thomas Szasz’s famously critiqued that mental illnesses are all “problems in living” that prevent real discussions between conflicting values and encourage mental homogenisation, by shrouding deviance in medical terms. To say that a diagnosis depends on culture is to move away from an objective definition and to encourage such scepticism. Patterns of sexuality change have changed before: consider pederasty, an erotic relationship between an older man and a “youth who had obtained full height”, probably a teenager, was of course a Greek cultural norm. This was hebephilia, but though occurring between two males makes it a biologically dysfunctional it was accepted as a non-harmful social practice. If such a practice was discovered in today’s culture it would likely be considered harmful and so become a disorder. Conversely adult heterosexual relationships such as gerontophilia, are considered odd and are often biologically inexpedient, but are not something which culture finds harmful if two consenting adults are involved. The fact children are involved is justly considered to make it immoral, be it pedophilia or hebephilia, and we can appeal to objective grounds for making these actions illegal. However, it seems uncertain whether harm occurs to the adult in every case, and therefore to appeal to the values of society is too broad a stroke.

Harm is difficult concept to make sense of. There is no scientific measurement for relevant psychological factors like the degree of difficulty someone has and the suffering they receive in trying

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to control their impulses\textsuperscript{26}. This is particularly problematic in a legal context when trying to assess responsibility but is also a problem for the value criterion. Actual harm could vary substantially between people with the same disorder. Using cultural norms might lead to people being told they are disordered when they are not harmed by their dysfunction at all. The individual involved is alone in being able to make this judgement, and though it will be influenced by culture and community values, it is a personal thing. The solution would be move the level of the harm criterion from culture to the individual. This is the idea I will try to support in the rest of my essay. First, we must deal with the fact that simply asking people if they are harmed makes diagnosis contingent on individual sentiment alone, which might be affected by irrelevant factors or even delusions.

How paedophiles are harmed.

Can we combine individual judgment and objective values? The harm criterion should be considered fulfilled when there is a loss of wellbeing, based on an objective account of wellbeing which draws on various theories, considering whether there is a sustained impact on a person’s life causing direct mental suffering and reducing opportunities for human flourishing. This must result directly from being a paedophile and, while acknowledging the role social factors play, be separate from them. This should provide a universally applicable judgement of whether the biological dysfunction is really harming that person. The task of psychiatry, through interview, would be to ascertain whether a given person had been harmed in this way in cases where it was not obvious, as psychiatrists are well practiced in inferring how people are affected by mental illness. This seems a better way to meet Wakefield’s compromise between the social word and objective biological categorisation. It is clearly impossible to introduce a concept of value that is entirely objective, but this new value criterion is amenable to more solid principles than culture.

The idea that two people could have the same dysfunction, to be paedophiles, but only one have a disorder, is peculiar but more accurately reflects the reality that abnormal mental traits do not

\textsuperscript{26} Anthony Kenny, \textit{Free Will and Responsibility} (Routledge, 1978), p. 41.
always cause harm, the closest analogy in medicine is perhaps harmless variations in anatomy which are biologically deviant but not considered a specific disease. How one feels about being a paedophile will depend on the strength of their urges, as well as their interest in what society thinks of them. If a paedophile does not consider themselves harmed, that is their prerogative, we should be careful before telling them that they are mistaken. This is difficult because the consequences of paedophilia can be so bad, we naturally want to pathologize it, and therefore make a strong expressivist statement that this is not normal, even though we know that using hypothetical social consequences of a particular trait to make a diagnosis is a slippery slope to repression.

I believe almost all paedophiles will fulfil the value criterion even if they were only mildly attracted to children. Paedophilia firstly involves a loss of autonomy. Unlike the rest of the population, they is unable to fulfil themselves sexually without an extreme violation of morality, as well as social and legal consequences. Having strong desires but being unable to act upon them may be distressing. It is true that non-paedophiles can also suffer because they find it difficult to locate a partner. But every paedophilic attraction is off limits, regardless of their other, perhaps positive character traits, and that situation is permanent. Secondly a paedophile will probably attempt to hide their urges from non-paedophiles, including members of family and doctors, preventing them from seeking help. This may create a positive feedback loop isolation and alienation, which is likely to be paralysing over time. Even more generally, because the social stigma against paedophilia is so strong, it is implausible that any individual would choose to be this way. Awareness of one’s situation and the unfairness of it might cause shame, confusion and frustration, causing further harm. Finally, if a paedophile is discovered they will suffer a huge upheaval in their life: if arrested they will be shamed publically, before suffering further because of imprisonment and laws requiring paedophiles to notify a community they move into. Ordinary criminals are not seen as disordered when they experience similar harms because they are not grounded in a specific biological dysfunction. In sum we would be right to suspect most paedophiles are disordered but must accept that this is something that must be demonstrated, is not a priori true, and that healthy paedophiles are a logical possibility. This could occur in paedophile who
is aware of their sexuality but just accepts it as part of who they are, without guilt, and is not troubled by a desire to act on it. Conversely in a hypothetical society where paedophilia was not ethically and socially abhorrent, but a paedophile still felt an agonising sense of guilt about their sexuality, they would be disordered. Fred Berlin argues on a similar vein that while some paedophiles may require interventions to help resist unacceptable cravings “in a society permissive of adult–child sexual interactions, such persons might not be in need of help.” Even in our world a paedophilia resulting only in non-distressing fantasies might be benign27.

Implications for classifying mental disease

I have suggested that classifying mental illness is intimately bound up with each individual and how they respond to their propensities. Consequently, paraphilias like voyeurism may only very rarely be disorders, and personality disorders must also be questioned. It also follows that we should reject the understanding that paedophiles are automatically disordered if they commit sexual offences, which the DSM explicitly endorses28. The writers admit this is done because “in clinical practice, the patient’s history of sexual offenses against children is often the only basis for making a diagnosis of paedophilia” self-reporting is not effective29. This is an unfortunate practical problem, but we should not be tempted, as this implies, to use medicine as a tool to demarcate criminals. Michael Miner argues that paedophiles who seek commit a crime suffer from an impulse control disorder: they fail to refrain from acting on socially unacceptable or intrusive behaviours like kleptomania or pathological gambling.30 This would make paedophilia sufficient evidence for harm, but I find this argument questionable as it surely pathologizes things like rape, which may just be straightforwardly evil. On my account it is possible a paedophile who committed a sexual offence could be healthy if they did so

feeling totally in control of their actions, and without contrition, though they would then be entirely
culpable legally. Those who are more harmed by being a paedophile are more disordered and so less
culpable, as far as mental disorder can be considered an excuse, although there may be other reasons
for strong penal sentences.

Paedophiles who are disordered will be medicalised and offered treatment. But this should
aim to alleviate the harm their dysfunction causes. This could be achieved by attempts to alter
sexuality so that they are no longer a paedophile. There are anecdotal reports of success, with one ex-
paedophile describing it as “like a dream”\(^31\) though the effectiveness of behavioural therapies is not
scientifically demonstrated, and their ability to change underlying sexuality looks doubtful\(^32\).
Consequently, efforts to help people come to terms with their sexuality and control themselves so
that the value criterion was no longer fulfilled would be equally expedient, though they would still be
a paedophile and would probably be taken up with gusto, if there was less of a stigma around
admitting a problem.

Conclusion

I used the DSM-5 and the ICD-10 as a starting point from which to ask what it meant for
someone to be a paedophile and argued that sexual orientation should not be considered disordered.
I then showed how Boorse’s theory of disease would do just that and so we should reject it for its
overly expansive nature and for not being as value free as it appears. I used Wakefield’s conception of
dysfunction, based on both an evolutionary disfunction and a value criterion, as a better starting place.
I showed how this principle could be made less vague and deal with the criticism that it is too relative
by defining harm using more objective standards and making it variable between individuals. Finally,
I suggested some implications for diagnosis in psychiatry.

\(^{31}\) Parker, *The Twisting lane* p. 42.
Gunter Schmidt shrewdly noted that paedophiles embody a dilemma between reducing discrimination of a minority who, after all, did not choose their sexuality, while protecting potential victims. “Faced with this dilemma, we presumably have nothing but wrong answers. But perhaps some answers are less wrong than others.” 33 What I have laid out here may be counterintuitive but allows us to move towards a more consistent understanding of when we give someone the label of mentally ill, and to be as defensive as possible when doing so.

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