

fantasies or sexual arousal to prepubescent children. Again, this situation is not inconsistent with other mental disorders defined in the *DSM*. Pathological Gambling is a behavior that is engaged in by many individuals without negative consequences. It is when the behavior becomes preoccupying, escalates, and results in negative consequences that it is considered a mental illness. The same can be said for substance use disorders. Many individuals use a variety of substances, both legal and illegal. The use of drugs and/or alcohol becomes problematic, and thus meets criteria for a mental disorder, when its recurrent use results in (1) "... a failure to fulfill major role obligations at work, school, or home"; (2) the substances are used "in situations in which it is physically hazardous"; (3) the individual experiences "recurrent... legal problems" due to their substance use; and/or (4) there is "continued substance use despite having persistent or recurrent social or interpersonal problems" (American Psychiatric Association, 2000, p. 199).

In the case of Substance Use Disorders, 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. The *DSM* not only requires that an individual have recurrent sexual fantasies, urges, and behavior, but that these fantasies, urges, and/or behaviors result in clinically significant problems. Certainly, legal problems are not necessary and sufficient to be considered "clinically significant"; however, contact with the criminal justice system generally results in such "clinically significant" consequences as loss of jobs, disruption in marriages and relationships, and financial hardships. Additionally, the negative sequelae of pedophilia does not require contact with the criminal justice system. Many men with a recurrent pattern of sexual interest and behavior with children experience social isolation resulting from their failure to develop primary interpersonal relationships, their estrangement from peers, and a deep sense of shame related to their pedophilic interests. These factors may result in significantly debilitating affective and/or mood states (Raymond, Coleman, Ohlerking, Christenson, & Miner, 1999), as well as an inability to engage in appropriate major role obligations such as remaining gainfully employed and/or successfully attending school or other training programs.

Thus, while Green raises some interesting issues, many of his concerns are consistent across the *DSM*, not inconsistent, as is his contention. Pedophilia, like the impulse-control disorders, appears to be characterized by acting on urges in spite of the threat of social sanctions and other significantly negative consequences. Like the substance use disorders, pedophilia is the persistence of

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

urges, fantasies, and behaviors despite experiencing numerous, significant negative consequences. The fact that men in Polynesia in the eighteenth century engaged in sexual behavior with children does not mean that pedophilia should not be defined as a mental disorder. Pedophilia may be thought of as the extreme manifestation of a behavior that many "normal" people experience, which is, for the most part, the defining characteristic of many, if not all, mental disorders.

### Are Any of the Paraphilias in *DSM* Mental Disorders?<sup>1</sup>

Charles Moser, Ph.D., M.D., Institute for Advanced Study of Human Sexuality, 45 Castro St., No. 125, San Francisco, California 94114 (e-mail: docx2@ix.netcom.com)

Three decades ago, Green (1972) argued that homosexuality did not meet the definition of a mental disorder and, by implication, should not be listed in the *DSM*. Now, he continues this line of reasoning by suggesting that pedophilia also does not meet the criteria for a mental disorder. My comments are meant to expand upon his point.

The assumption that certain strong, sexual interests are mental disorders has pervaded the *DSM* since its inception and has been promulgated from edition to edition without serious review. I ask the obvious questions: Are any of the paraphilias mental disorders? Do the paraphilias meet the *DSM* definition of a mental disorder? Are there data to support the inclusion of any paraphilia diagnosis in the *DSM*? Do we need to argue separately about the removal of each paraphilia from the *DSM*? I believe the answers to all these questions is "No!"

The *DSM-IV-TR* (American Psychiatric Association, 2000) purports to be both culturally sensitive and supported by an extensive empirical foundation. However, in the case of the paraphilias, both of these are in doubt. The assumption that the paraphilias constitute psychopathology is erroneous and is not supported by objective research. On the contrary, any sexual interest can be healthy and life-enhancing. Historically and cross-culturally, there are numerous examples of sexual interests that were proscribed and are now accepted and interests that were accepted and are now proscribed. This supports the view that sexual interests occur in cultural context and are judged relative to the prevailing social norms. We could view the individual who cannot accept the nontraditional lifestyle choices of others as having a mental disorder, rather than

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blaming the "cause" of their discomfort. The sociopolitical context in which the diagnostic process occurs should not be ignored, nor its consequences.

Any sexual interest, even a "normophilic" interest (i.e., the supposedly healthy ideal), can be an appropriate focus for a mental health intervention. The clinician should first assess whether there is a problem. If so, is the sexual interest actually the cause of the problem? The "paraphilia" could be unrelated to the problem or it may be the reaction of others that is problematic. A diagnostic paradigm that classifies specific, sexual interests as pathological implies the interests per se are the cause of problems and that eliminating these interests will resolve the problems. Such a paradigm equates the sexual interest with the disorder, even when the sexuality is experienced as life-enhancing and does not cause distress or disability.

The presence of paraphilias as a category of mental disorders in the *DSM* has unintended political and social implications. Individuals lose jobs, security clearances, child custody, and other rights on the basis of being branded with a psychiatric diagnosis. One's career, self-esteem, and relationships can be affected negatively by a stigmatizing diagnosis. Trying to live a "normophilic" lifestyle is difficult and problematic for both those with unusual sexual interests and their partners. Attempts at transforming their unusual sexual interests to conventional ones are hindered by a dearth of effective treatments. Despite the beliefs of some therapists, there is a paucity of data to suggest that psychotherapy or just plain will power can alter the character of any sexual interest. Medical interventions (e.g., SSRI's and anti-androgens) can decrease unusual sexual desires, but often result in hypoactive sexual desire or sexual arousal disorders. To paraphrase from Schmidt's article, those who have unusual sexual interests and must deny themselves the experience of love and sexuality deserve our respect, rather than our contempt.

Even when distress or disability is related to the interest itself, eradicating the interest may not be the appropriate therapeutic goal. The death of a parent may trigger an episode of clinical depression, but not everyone who loses a parent will become clinically depressed. Although some depressive symptoms may be common, they are not present in all individuals who lose a parent. In short, depression is the diagnosis, rather than the loss of the parent. Treatment may focus on the loss of the parent, but will necessarily target other issues. The intended outcome will be an individual without depression who has suffered a parent's death. Trying to eradicate the patient's feelings for the deceased parent is obviously inappropriate. The intended treatment outcome with a "paraphilic" patient will be an individual with an atypical sexual interest, who is no longer distressed or dysfunctional.

Therapists and physicians commonly attempt to help normophilic individuals enrich their sexual lives. Medical, surgical, and psychotherapeutic treatments of sexual dysfunctions are common, targeting the distress and difficulties these individuals experience. The same consideration should be given to unusual sexual interests; their repression also can affect one's quality of life adversely. I am not advocating the change of any law or acceptance of inappropriate sexual behavior; society clearly has the right and obligation to protect its citizens from unwanted or predatory sexual advances. People who break laws are criminals, not necessarily mentally disordered.

Sexuality can be a source of tremendous satisfaction in our lives. We should help our patients reach their sexual potential, not limit it by pathologizing individuals a priori, based only on the nature of their desires. A rational and compassionate approach requires that we stop viewing unconventional sexual expression as pathological. The paraphilia section of the *DSM* should be removed and replaced with a generic diagnosis that does not identify the specific behavior (for one such proposal, see Moser, 2001).

#### Pedophilia from the Chinese Perspective

Emil M. L. Ng, M.D., Department of Psychiatry, University of Hong Kong, Queen Mary Hospital, Pokfulam Road, Hong Kong, People's Republic of China (e-mail: Ng.Man.Lun@hku.hk)

In traditional Chinese medicine, there has never been a mental disease akin to, or called, pedophilia or homosexuality or most of the so-called sexual variations for that matter. Depiction of "child romance" in ancient or modern Chinese literature is not difficult to find. It includes passages on joyous heterosexual or homosexual activities by children as young as 12–13-years-old with one another or with adults. Children are usually described as natural sexual beings and erotic stimulation and sex play is viewed as beneficial to their healthy development (Chen, 2000).

In China, the current minimum legal age for sexual intercourse is 18 for both sexes. For marriage, it is 22 for males and 20 for females (Ruan & Lau, 1997). But in ancient China, when population control was not a concern, the age was much lower. In a large part of Chinese history, the minimum marriage age suggested by the government ranged between 12 and 16, and it was not legally binding, especially in the wealthy class or some minority ethnic groups. Until the first half of the last century, there was still the practice of child bridegrooms in, but not restricted to, the Hubei region of China (Lou, 1970). A male child of any age, even before birth, could by parental arrangement

