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COMMENTARY ON DSM-5

Why Can't Pedophilic Disorder Remit?

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The DSM-5 (American Psychiatric Association, 2013) was released in May 2013. Although there had been discussions about the pedophilia category during the development of DSM-5 (Blanchard, 2010, 2013; Blanchard et al., 2009; Fedoroff, Di Gioacchino, & Murphy, 2013; First, 2010; Green, 2010; O'Donohue, 2010), in the end, when compared to DSM-IV-TR (American Psychiatric Association, 2000), only small changes were made.

One was that "Pedophilia" was changed to "Pedophilia" or "Pedophilic Disorder" to make it consistent with the distinction between Paraphilias and Paraphilic Disorders throughout the chapter on Paraphilias in the DSM-5. The DSM-5 now defines Pedophilic Disorder as follows:

> Criterion A: a paraphilia with "recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger)" and Criterion B: "the individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty."

The criterion for "Pedophilia" is the same as for "Pedophilic Disorder" but without the B criterion. The proposed and finally accepted DSM-5 diagnostic criteria for Pedophilic Disorder have been soundly criticized both for what they include and exclude (e.g., Blanchard, 2013; Fedoroff et al., 2013; First, 2010; Green, 2010; O'Donohue, 2010). For example, debates have occurred over the potential inclusion of a diagnostic category for people with a sexual preference for early pubertal adolescents (so called Hebephilia), about the importance of victim counting, about mixing up pedophilic interest with sexual orientation, about disregarding attention to motivation or disinhibition, and the lack of field trials to test reliability and validity of criteria. This commentary is intended to draw attention to another important part of the DSM-5 criteria for Pedophilic Disorder that is problematic due to its absence, namely, the absence of the specifier "in remission."

Pedophilic Disorder is the only Paraphilic Disorder in the DSM-5 without an "in remission" specifier. Why? The DSM-5 offers no explanation aside from commenting that "pedophilia per se appears to be a lifelong condition" although its symptoms can "fluctuate." How is this possible since the criteria for Pedophilic Disorder include elements that predictably change over time with or without treatment: subjective distress (e.g., guilt, shame, degree of sexual frustration, feelings of isolation); psychosocial impairment; the simple effect of ageing; and the propensity to intentionally harm children. The Board of Trustees (BOT) of the American Psychiatric Association rejected the proposed diagnostic criteria for Pedophilic Disorder and preserved the diagnostic criteria as they appeared in the DSM-IV-TR. This rejection included the various specifiers, including "in remission," that were proposed for this diagnosis. Because the diagnostic criteria for all of the other Paraphilias were accepted by the BOT, Pedophilic Disorder is now the only Paraphilia that does not include an "in remission" specifier. Given that it is accepted that all other Paraphilic Disorders can go into remission, what is the evidence that Pedophilic Disorder is the only paraphilia that does not?

How often do recurrent, intense sexually arousing behaviors (recalling that sexually intense fantasies, sexual urges, or behaviors are part of Criterion A) with a pre-pubescent child

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persist? Every trait can vary according to state and can lead to different behaviors—or not. But why is the comment that pedophilia is a life-long condition allowed to stand given the scarcity and diversity of data on this topic (Müller et al., 2014; Seto, 2012)? Simply stating without evidence that Pedophilia is a lifelong condition draws unfortunate comparisons to the statement that sexual orientation is life-long and, by doing so, adds to the confusion between paraphilic interest and sexual orientation (Cantor, 2012; Seto, 2012). This is a mix up of definitions with significant implications. There is no categorical difference between Pedophilia and the other paraphilias in terms of natural history and the development of the paraphilias in general. However, there is a significant difference between problematic sexual interests (the Paraphilias) and sexual orientation, which is not a disorder.

If experts define (and thereby construct) something as unchangeable, then it becomes unchangeable and therefore by definition incurable. For clinicians treating men and women with Pedophilic Disorder (not restricted to those with unchangeable sexual interests), the reported diversity of sexual interest in children varies so widely that the current diagnostic criteria become useless unless the diagnosis is restricted to people whose sexual interest in children turns out to be lifelong. People who respond to treatment and whose sexual interest in children changes during therapy will need to be reclassified as people who were mistakenly diagnosed with Pedophilic Disorder. This is not a scientific approach. Since no one can predict if a specific person will not go into remission, it is wrong to make immutability part of the diagnosis. Clinicians will be reluctant to verify the person is improving since that would imply the diagnosis of Pedophilic Disorder was wrong. Even if the clinician is certain about the diagnosis: Is there a scientific basis to support the view that the prognosis is hopeless in all cases? In our respectful opinion, the answer clearly is "No."

Anyone who works with patients with Pedophilic Disorder knows there are individuals with an exclusive, extremely fixated sexual interest in children that developed during puberty and has never changed since then. And "Yes" this type of Pedophilia shares a similarity to sexual orientation, namely persistence. However, unlike sexual orientation, which is a human characteristic that is independent of sexual motivation, Pedophilic Disorder is a paraphilia that, by definition, is sexually motivated and involves non-consensual sex if acted on. Validated risk assessment instruments like the Stable 2007 (Hanson, Harris, Scott, & Helmus, 2007) include the designation of "in remission" in the sexual deviance category.

Individuals do not voluntarily decide to have a sexual interest in children. Sex researchers hold this view almost universally and only about 30 % of the general population thinks that individuals choose to become pedophiles (Jahnke, Imhoff, & Hoyer, 2014). However, we expect that a self-attribution of having an unchangeable Pedophilic Disorder could negatively influence specific self-efficacy and thereby the possibility to actually change behaviors and interests. In other words, people who accept the DSM-5 criteria for Pedophilic Disorder by fiat also accept the claim that they can never get better, regardless of treatment of any kind.

We should also not confound chronicity and unchangeability with biological cause and determinism. Sexual interest in children and pedophilia are highly politicized phenomena and it is questionable if it helps to argue that pedophilia is like homosexuality, which—by definition—is not a paraphilia (Cantor, 2012) and not because it is biologically, psychologically or socially determined. It is wrong to attempt to modify sexual orientation (Spitzer, 2012), which is not a disorder. Pedophilic Disorder clearly is not a sexual orientation but a multidimensional disorder. It does not help patients with Pedophilic Disorder if their disorder is conceptualized solely as biologically determined, fixed at birth, and unchangeable. Especially in the absence of data.

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