months, which involve non-human objects, the suffering or humiliation of oneself or one’s partner, or children or other non-consenting partners. If these recurrent fantasies, urges, and behaviors involve sexual activities with prepubescent children (generally age 13 or younger), the main diagnostic criterion for pedophilia is met.

Pedophilia encompasses simple voyeurism of nude children, observing children at various stages of undress or assisting them to undress, sexual fondling, exposing oneself, performing oral sex on children and/or requesting them to return oral sex, or mutual masturbation. In most cases (except those involving incest), pedophiles do not require sexual penetration, and do not force their attentions on a child. They instead rely on guile, persuasion, and friendship, often displaying great tenderness and affection toward the child of their desire. Once a person has engaged in sexual activity with a child, he or she is then additionally labeled a “child molester.” Thus, child molestation is subsumed in the overall condition of pedophilia.

A psychological profile of pedophilia escapes development because perpetrators appear to constitute a heterogenous group. However, some common characteristics prevail among both pedophiles and child molesters. The great majority of pedophiles are male, and they may be heterosexual, homosexual, or bisexual in orientation. Preference for children as sex partners may not be exclusive, and more often than not, pedophiles have no gender preference in prepubescent children. However, by a margin greater than two to one, most victims are girls. Moreover, the pedophile is usually a relative, friend, or neighbor of the child’s family. Alcohol is associated with almost 50 percent of molestation cases, but is not necessarily correlated with pedophilia in general. Pedophilia tends to be a chronic condition, and recidivism is high.

The motives for engaging in sexual activity with children are rather divergent among pedophiles, but one theme recurs: the pedophile tends to justify his/her conduct. Pedophiles often indicate to authorities that the child solicited sexual contact or activity, and also claim that the child derives as much sexual pleasure from the activity as the perpetrator. Pedophiles also excuse their behavior as non-harmful, non-violent, non-forced, even “educational” for the child. They often tend not to see themselves as abusers, molesters, or sexually deviant. This quality of being into denial as to the true harm that they may cause belies the fact that clearly, most pedophiles act for their own gratification and not that of the child. In fact, more often than not, they describe their urges as compulsive, non-controllable and overwhelming.

The pedophilic disposition may not manifest until later in life, but more often than not, manifests in adolescence. By definition, it requires a minimum of five years’ age between the perpetrator and the child in order to be classified as pedophilia. The disorder is more common in those who have been sexually abused in their own childhoods. In that subcategory of persons, the perpetrators choose victims in accordance with their own ages at the time of their experiences.

Pedophiles describe themselves as introverted, shy, sensitive, and depressed. Objective personality test results tend to confirm these subjective assessments, with the addition traits of emotional immaturity and a fear of being able to function in mature adult heterosexual relationships. A common characteristic of pedophiles is a moralistic sexual attitude or sexual repression.

Accurate diagnostic studies of prevalence among populations are unreliable for two reasons. First, the tendency may remain latent and undiagnosible unless the person voluntarily seeks counseling or help. Often the condition is masked by feigned responses to diagnostic criteria. Second, there is even among professionals a wide variance in definitional criteria and identification of this disorder.

There are two major professional tools employed to assess and diagnose pedophilia. The first is through phalometric testing (also referred to as penile plethysmographic assessment, or PPG), which measures changes in penile blood volume occurring simultaneously with the presentation of varying erotic stimuli. There has been some criticism of the reliability of this test because physiological changes are easier to measure than interpret. Second, arousal also may be a function of general arousability rather than of specific stimuli. To address this, researchers have developed a second diagnostic tool as a central arousability system intended to work adjunctly with PPG. The contingent negative variation (CNV) system measures brain waves as putative indices of sexual desire under conditions of sexual stimulation relevant to pedophilic arousal.

Treatment

Behavioral treatment of pedophilia does not affect recidivism, nor apparently does incarceration. The condition remains chronic, and for this reason, societal interest in incarceration prevails over what is generally seen as equivocal behavior treatment.

Although most practitioners believe that the etiology of pedophilia is psychologically oriented, a report published in the *Journal of Neuro Psychiatry and Clinical Neuroscience* suggested that bilateral anterior temporal disease, affecting more right than left temporal lobe, could increase sexual interest. The authors’ study was limited to two adult professional patients with late-life homosexual
pedophilia. Therefore, further observation and research is necessary to assess diagnostic and treatment implications for all neurologically based paraphilias.

In late 1999, Israeli researchers published a report on the discovery of the drug triptorelin as an effective treatment for males sex offenders in general. The drug regulates the production of testosterone. Of interest is that it can be injected once a month, compared to other similar anti-androgen drugs, which must be administered more often and have more serious side effects.

Current trends

The effective diagnosis and treatment of pedophilia is threatened by three key developments going into the new century. The 1994 (Fourth) edition of the professional therapists’ bible, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), adds another (controversial) criterion for diagnosing pedophilia. It includes, in its diagnostic definitional criteria, that the fantasies, urges, or behaviors “…cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.” This latest definitional criterion has met with considerable resistance, due to the fact that so many pedophiles deny that their conduct is harmful. The denial serves to assuage any guilt, and therefore may significantly mask or otherwise repress any distress or impairment on the part of the perpetrator.

Secondly, there has been marked pervasiveness and proliferation of child pornographic materials on the Internet and international websites. In a 1998 Interpol raid (the latest data available), a total of 500,000 child pornographic images were found on computers in the United States alone. According to one study, as much as 45 percent of child pornography on the Internet comes from Japan, where child pornography is not an offense. The second largest concentration of child pornographic sites come from Russia. The United Nations Educational, Scientific, and Cultural Organization (UNESCO), in cooperation with the Interpol, continue to police global websites and shut down operations.

Another area of controversy was the late 1998 American Psychological Association’s publication of a study entitled, “A MetaAnalytic Examination of Assumed Properties of Child Sexual Abuse Using College Samples.” The study’s authors advised practitioners not to assume that sexual activity between non-related adults and children was harmful. The study, which was limited to interviews with college students, further posited that if the involved child/victim consented to the sexual activity, little or no harm was done to the child’s adult life or personality. Most of the research in the study had not been subjected to peer review. The study caused an immediate reaction in professional, family, and media entities. On July 12, 1999, the U.S. House of Representatives voted a shut-out 355-0 to condemn the study. As Representative Dave Weldon (R-Fla.) stated to the press, “Children are not capable of giving consent to sexual encounters with adults.”

See also Paraphilias

Lauri R. Harding

Further Reading


Peer acceptance

The degree to which a child or adolescent is socially accepted by peers; the level of peer popularity.

Peer acceptance is measured by the quality rather than the quantity of a child or adolescent’s relationships. While the number of friends varies among children and over time as a child develops, peer acceptance is often established as early as preschool. Factors such as physical attractiveness, cultural traits, and disabilities affect the level of peer acceptance, with a child’s degree of social competence being the best predictor of peer acceptance. Children who are peer-accepted or popular have fewer problems in middle and high school, and teens who are peer-accepted have fewer emotional and social adjustment problems as adults. Peer-accepted children may be shy or assertive, but they often have well-developed communication skills. Peer-accepted children tend to: