Chapter 1

Paedophilia: definitions and aetiology

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Introduction

Seemingly nowhere but in the realms of social science research do sex offenders enjoy such popularity. Yet in spite of the current high level of interest in this area, numerous commentators have noted the lack of cohesiveness and clarity in this field (Van Dam 2001; McCartan 2008). While it might be difficult to orchestrate overall coherence in the face of what is perceived to be a pressing public safety problem, effecting consensus in issues relating to high-risk sex offenders is additionally challenging, in a variety of ways. As this book illustrates, such issues are suffused with debate, ambiguity and argument; yet we are still presented with the harm experienced by individuals at the hand of those labelled as sex offenders, and, crucially, the potential of these individuals to inflict future harm. It is the debate regarding the management and treatment of this future risk that concerns much of this volume. However, in this chapter, we wish to contextualise these issues by reflecting on some of the perceptions and understandings of sex offenders that we have available to us (as a society). Such reflection, we suggest, is requisite of us as academics and practitioners in critically evaluating the theoretical and conceptual foundations upon which issues of treatment and management are grounded.

In this chapter we therefore begin to examine the definitions and aetiology of sex offenders, although, due to limitations of space, we only present some ideas here. In so doing, we focus in particular on sexual offences against children, and paedophilia in particular. This is for a variety of reasons, not least that we must necessarily be selective
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in our coverage and do not attempt here a more comprehensive review of definitional issues. Focusing on this particular group of sex offenders also allows us to illustrate a number of issues that are common (in broad terms) to a range of forms of sexual offending. Moreover, the inclusion of child–adult sexual activity as central to paedophilia allows us to highlight additional factors which problematise existing debate.

Definitions of paedophilia from a multi-disciplinary perspective

Paedophilia has been previously defined as ‘a severe public health problem of staggering proportions’ (McDonald Wilson Bradford 2000: 248). It has thus become a high-profile media issue, increasing exponentially over the last 10 years (Greer 2002; McCartan 2004). Considering the centrality of paedophilia to modern society (McAlinden 2006a), it is easy to assume that there is clarity regarding what paedophilia is, who paedophiles are, what causes a person to demonstrate paedophilic behaviour, and what can be done to manage and treat such behaviour. While most of this book looks at the latter issues, this chapter will begin to discuss the various contemporary understandings of paedophilia, in order to illustrate some of the issues that underlie/necessarily precede management and treatment.

Despite the volume of research into paedophilia, academic and applied clarity and cohesiveness concerning definitions have not resulted (Howitt 1998; Silverman and Wilson 2002), with commentators pointing to the substantial differences (Howitt 1998) in contemporary legal, sociological, and biological definitions of paedophilia. Moreover, the interrelationship between these different arenas presents further challenges, as, for example, in terms of the positioning of paedophilia as a criminal offence as opposed to a pathological condition (Ames and Houston 1990). Such issues are compounded by the additional range of concerns that are attendant on phenomena such as paedophilia (i.e. the nature and definitions of concepts such as child, adult and sexual). While some commentators suggest that our current understandings are better than they have ever been (Van Dam 2001; Ireland and Worthington 2009), it is nonetheless instructive to examine these contemporary perceptions.

Paedophilia from a clinical perspective

One core feature of clinical perspectives (in contrast to legal and other
perspectives, where the term ‘child sexual abuse’ (CSA) is used as a blanket term to cover all forms of CSA and child sexual offenders, Rind et al. 1998) is that within the clinical literature a distinction is made between paedophilia and other forms of CSA. This distinction is reflective of the range of typologies developed from clinical perspectives (for example, extrafamilial child molestation, intrafamilial child molestation, paedophilia, child molestation, hebephilia and paraphilia (for more information, see Bartol and Bartol 2008)). One of the reasons why the clinical definition of paedophilia has become somewhat ambiguous is the focus on the way that offenders are conceptualised by clinicians along a variety of different dimensions, with each individual being categorised through his or her offending behaviour, psychology, personality, personal motivations and degree of risk. For example, an individual clinically classified as a paedophile may not necessarily be classified as a child sexual molester, for he may not offend against a child (Leberg 1997; Howitt 1998), or he may not wish to harm the child, and/or he may believe that he is in love with the child (O’Carroll 1980).

The historical particularity of this endeavour to provide typologies suitable for carving up the range of behaviours involved in CSA is no better illustrated than in The Diagnostic and Statistical Manual of Mental Disorders (DSM). Generally speaking, from a clinical perspective, paedophilia is seen as a paraphilia (Freund 1994; American Psychiatric Association (APA) 2000). However, there is no consistent clinical definition, as conceptions constantly adapt. The DSM definition, like other typologies, focuses on the assumed homogeneous characteristics of paedophilia (Freund 1994), in spite of its recognised heterogeneous nature (Bickley and Beech 2001; Taylor and Quayle 2003). In the DSM definitions, paedophilia has ranged from being a sexual deviation and a sociopathic condition (APA 1952), to a sexual deviation classified as a non-psychotic medical disorder (APA 1968), to a paraphilia, with offenders being defined as interested only in sexual acts with prepubescent children (APA 1980) and the definition later adapted to include paedophiles who also have an interest in adult–adult sexual relations (APA 1987). More recently, this was further changed so as to define paedophilia as a sexual paraphilia, stating that the offender has to be at least 16 years of age as well as being at least 5 years older than the victim; that the victim is not older than 12 or 13; and that the offender has serious sexual urges/fantasies that are causing him distress or that he has acted upon (APA 2000). These constantly adapting and conflicting
definitions of paedophilia, as well as a lack of specificity in places (Bickley and Beech 2001), have resulted in expert opposition to the DSM classifications (Freund 1994; Feelgood and Hoyer 2008), with O’Donohue et al. (2000) referring to them as vague, poorly defined, and lacking reliability and validity as a tool. Such criticisms have led to calls for the DSM classification of paedophilia to be abandoned (Marshall 1997). These issues raise questions about the possibility of an agreed definition, and the resulting implications for practice. If treatment is predicated on our understanding of the phenomenon, then any such treatment is subject to similar controversy.

**Paedophilia from a legal perspective**

It is notable that proposed clinical typologies of paedophilia often, but not always, depend on the notion of sexual offending for their definition. However, unlike the clinical realm, it is perhaps to be expected that there is no current legal definition of paedophilia (Hansard, 14 October 1997: column WA113), especially considering that paedophilia is not in itself a criminal or illegal act. Any feasible definition tends therefore to focus on the criminal acts and behaviour involved. This consequently suggests that a paedophile is an adult who commits a sexual offence against a child. While this would appear at first glance to be fairly straightforward, albeit circular, problems concerning age and the meaning of ‘child’, ‘adult’ and ‘sexual’ are palpable in this context. For example, from a legal perspective, in England and Wales, a child can be someone under the age of 14 (Children Act 1989), under 16 (Child Benefit Act 2005), or under 18 (United Nations Convention on the Rights of the Child). Moreover, concepts such as child and adult are interdependent, particularly in this context.

The question thus arises regarding at what point on a spectrum of age, sexual offending additionally becomes paedophilia. Weeks (1985) points out that our concern with age in conjunction with sexual activity is ultimately a debate about the appropriate minimum age for engagement in such activity (in England and Wales this currently stands at 16). When assessing this we are really asking when we feel a child has the mental maturity, intellectual capacity and competence to make a free and reasoned decision (Waites 2005). Waites also acknowledges that this is not a straightforward question and can depend on what is held to be important. This also ties in with children’s rights and at what age children should be allowed or even be entitled to participate in decisions regarding their life and
behaviour (for more information on this, see Alderson 1992; Schofield and Thoburn 1996). This would suggest that a child’s competence should be assessed on an individual basis, rather than using a broad-brush approach such as age. While this viewpoint has gained support in other legal areas such as medical law and the availability of assessing a child as Gillick competent, this has not been followed with regard to consent to sexual activity.

The age of consent law in England and Wales would thus suggest that paedophilia, from a legal perspective, is sexual activity with a child under 16. This, however, does not align with the DSM definition discussed above. In clinical understandings, paedophilia is sexual activity with a child not older than 12 or 13. Despite this clinical interpretation, the law in this area is designed to protect vulnerable children from harm, and to a lesser extent serves to protect the child from him/herself. However, common understandings of paedophilia might, we suggest, include a 40-year-old man participating in acts of a sexual nature with a 15-year-old boy or girl – even though it is accepted that in clinical terms this might be viewed as ephebophilia. Such fine distinctions are not apparent outside psychological circles, and thus we see common understandings perhaps originating from socio-legal rather than clinical perspectives.

The most relevant legislation in this area is the Sexual Offences Act (SOA) 2003, which, although it does not use terms such as ‘paedophile’, ‘paedophilic’ or ‘paedophilia’, can still be useful in examining legal concerns around the phenomena of child, adult and sexual. The Act, as it name suggests, sets out a number of sexual offences, including rape, sexual assault and sexual activity with a child. For almost all offences, there needs to be a physical act coupled with an intention to commit that physical act. Some offences also require that the act be sexual. This is defined in section 78 of the Act as either sexual because of its nature, regardless of the circumstances, or, although in nature it may not be regarded as sexual, because of the circumstances or characteristics of the individual offender it is regarded as such (this has the ability to turn ‘normal’ behaviour into that which has a sexual undertone). Defining a person as a paedophile because he has a sexual preference for children does not, therefore, fit in with legal conceptualisations, and again highlights differences between clinical and legal approaches.

For the purposes of the SOA 2003, a child is generally regarded as an individual who is under the age of 16, mirroring the age of consent. In covering sexual activities with children, the Act includes a number of offences where the child is under 13 and some where
the child is under 16 (this distinction is largely because the offence is deemed more serious where the child is under 13, and thus such crimes attract higher sentencing powers). This might suggest that paedophilia from a legal perspective involves committing offences against those younger than 16, although, clearly, sexual acts directed towards children aged between 13 and 15 years of age are considered to constitute a lesser degree of harm than those directed towards children under the age of 13 – an age closer to that suggested in the DSM definition and the definition found in the Children Act 1989.

However, perhaps unsurprisingly, the Act has anomalies. For example, it extends the list of persons who can be guilty of a sexual offence committed against a child in a family (incest) and, for these offences, considers a child to be someone under 18 (sections 25–26). Similar examples can be found in relation to the offence of child pornography/indecent photographs, where the raising of consent to imagery of sexual acts until the age of 18 gives rise to the suggestion that it is more harmful for a 16-year-old to have a sexual photograph taken than to have sexual intercourse (Stevenson et al. 2004). Such distinctions point to a range of contemporary moral concerns around the hierarchical arrangements of harm in relation to children and sexuality, and indicate how twenty-first-century reforms focus on separating sex and sexuality from the world of children (Phoenix and Oerton 2005).

The age of the offender is also important under the Act. To commit an offence under sections 9–12 and 14–15 the offender must be aged 18 or over. However, section 13 of the SOA 2003 makes the offences covered in sections 9–12 additionally criminal where the offender is aged under 16. Again, we see that there is incongruence with clinical understandings, where the victim must be under 13 and the perpetrator older than 16. From a criminality viewpoint, the decision of whether or not to prosecute a child will turn on the existence of factual consent and understanding, not legal consent (Stevenson et al. 2004). The question remains, however, as to whether consensual sexual activity that is not prosecuted can be considered paedophilic if the victim is under 13 (the DSM age). Is it the nature of the sexual activity that we are concerned about, the age of the perceived victim, the age of the offender, or, as the DSM now focuses on, the age gap between the perceived offender and victim? Until such questions are answered, it is difficult to provide a clear and specific definition of what is and is not classed as paedophilic activity, and thus when the term is used, we need to be aware that it can mean a variety of things.
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Paedophilia from a medical perspective

While it can be argued that the law does not need to define paedophilia, it is important that it facilitates the use of such terms in other social and clinical arenas where, arguably, their use is more important. While so far we have found little consensus between clinical and legal understandings, these fields become further intertwined and arguably more powerful in the regulation of individuals under mental health law. Mental health law in England and Wales is largely governed by the Mental Health Act 2007. The major change of the new Act with regard to the meaning of paedophilia is the amendment to the meaning of the term ‘mental disorder’. Under the preceding 1983 Act, a person did not suffer from a mental disorder by reason of immoral conduct, promiscuity, dependence on alcohol or drugs, or sexual deviancy (Bowen 2007). The 2007 Act largely reverses the exception of sexual deviancy, giving the term ‘mental disorder’ a much wider meaning. Indeed, it was argued in the House of Commons that ‘the amendment makes it clear that paedophilia is not within the scope of the exclusion’ (Hansard, 19 June 2007: column 1326).

Commentators, including Bowen (2007), have argued that in practice the amendment will make little difference, as it was always possible under the 1983 Act to justify an individual’s detention and treatment by arguing that their behaviour either caused or was caused by a mental disorder. However, it may make a huge difference to how the condition, preference or sexuality is more generally understood. While it remains the case that a person cannot be held in a mental institution solely due to his or her sexually deviant behaviour, as other tests involving appropriateness and necessity also need to be met, it does offer a means by which sexual deviants, including paedophiles, can be forcibly detained and treated under the Act. Consequently, the change in the definition of mental disorder means that definitions published by the APA can now permissibly work under English and Welsh law. Given the issues in the DSM definition as set out above, there is clearly a need for further clarification in the application of this legislation. Moreover, as some point to the far from straightforward relationship between sexual offending and mental illness (for more information on this, see Chapter 11 of this volume), the debate over criminality versus pathology is clearly as pertinent now as it has been in the past.
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Aetiology of paedophilic offenders

The debate regarding criminality and pathology is inevitably tied to the question of cause, to which we now turn, albeit with some brevity. In terms of general characteristics, paedophiles (classified by DSM definitions) are a heterogeneous population, including both men and women (Howitt 1998; McCartan 2008), although it is accepted that the majority of paedophiles are men (Dobash et al. 1996). Other noted characteristics from research include, for example, that paedophiles tend to come from a working-class background, although this is not always the case (La Fontaine 1990), and that some, albeit not all, experienced a disorganised family system in childhood (Howitt 1998).

It has been shown that paedophiles can be employed in a diverse variety of careers (Wilson and Cox 1983); that there are no concrete findings regarding their IQ, although those who abuse children are thought to have lower IQs than other offenders (Cantor et al. 2005); and that paedophiles can be, but are not always, of a specific age group (Whiskin 1997; Howitt 1998). Research also suggests that paedophiles tend to have higher levels of social introversion, sensitivity, loneliness and depression (Wilson and Cox 1983), with poor interrelationships and social skills (Blanchette and Coleman 2002), often leading them to feel socially isolated (Taylor 1981). Despite this, it has also been found that paedophiles can be, or often have been, married or in age-appropriate relationships (Groth and Birnbaum 1978) and are capable of complex grooming behaviours (McAlinden 2006b).

Moreover, there is no single aetiology, with paedophilia being described by different sources as a mental illness (Bagley et al. 1994), a mental deficiency (Blanchard et al. 1999), a brain deficiency (Cantor et al. 2008), a developmental abnormality (Lee et al. 2002), or the result of a cycle of abuse (Bagley et al. 1994; Howitt 1998). While the origin of paedophilic behaviour is difficult to isolate, why such offending commences and continues has been explained by the cycle of sexual offending behaviour (Wolf 1984, cited in Silverman and Wilson 2002) and the existence of cognitive distortions (Burn and Brown 2006). The cycle of sexual offending behaviour commences with an offender’s poor self-worth, which leads to self-rejection, withdrawal, the development of fantasies, escapism, and grooming, in turn leading to sexual offending, guilt and finally acceptance of guilt. Each time the cycle restarts, the offending increases and the offender arguably becomes more dangerous. This explanation has been developed to incorporate the central use of CSA imagery (Bentovim 1993; Taylor and Quayle 2003) by paedophiles, although this has
been challenged by some paedophiles themselves (O’Carroll 1980; Howitt 1998). Similarly, the suggestion that paedophiles experience cognitive distortions (for example, that the child enjoys it, that they are helping the child to develop, etc. (O’Carroll 1980; Brongersma 1984)) is also used to explain the commencement and continuation of CSA, particularly when they are reinforced through contact with other paedophiles (Taylor and Quayle 2003).

Given the discussion so far, it is probably not surprising that typical offending behaviour of paedophiles has not been identified. Predictably, they do not all offend in the same fashion, nor with the same frequency or level of intensity (Howitt 1998; La Fontaine 1990). Moreover, paedophiles do not always sexually and/or physically abuse children (Taylor and Quayle 2003; Howitt 1998), for some can achieve sexual arousal from chatting with children online, looking at child abuse imagery, or having non-contact time with children (Silverman and Wilson 2002; Taylor and Quayle 2003). Research with victims of CSA indicates that sexual intercourse is the least prevalent form of abuse, non-physical sexual abuse being more common, followed by physical sexual abuse (Dobash et al. 1996).

The lack of a single aetiology of paedophilia (Bradford 2000) makes the treatment of paedophiles a complex and difficult issue to resolve. A range of different approaches exist, including cognitive-behavioural programmes (see Chapter 5 of this volume), community care programmes such as Circles of Support and Accountability (see chapter eight of this volume) and drug treatments (see Chapter 7 of this volume). As one might expect, different treatments work better or worse for different offenders, and this will be discussed in the aforementioned chapters. The heterogeneity of this group thus presents problems not simply for definition, but also, ultimately, for treatment.

Addressing variation in understandings of paedophilia

Thus far, we have been faced with a variety of definitions and explanations of paedophilia. This variety stems in part from the acknowledgement that the group of people who are (at least from clinical perspectives) labelled paedophiles differ greatly from one another in a variety of ways. However, as we know, while definitions are important, as they specify the problem in need of attention, they are inherently ideological (Gough 1996). Thus, legal and clinical definitions vary according to the orientation of the
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disciplines themselves, although, they are also subject to their socio-historical context. We can see, for example, how clinical definitions of paedophilia have shifted over time, and how the legal notion of mental disorder under mental health legislation continues to be revised.

While we began this chapter with the claim that paedophilia is a ‘public health problem of staggering proportions’, it has not always and everywhere been so. As various commentators (e.g. Gough 1996; Thomas 2005) have pointed out, understandings of sexual behaviour change over time. Thus, a number of researchers in the area of paedophilia have pointed to the historical and cultural variation in our understandings of adult–child sex. For example, Green (2002) points to the work of various authors who have documented the acceptance of sexual contact between adults and children in other times and cultures, quoting Bauserman (1997), who states that ‘almost every sort of sexual activity … has been considered normal and acceptable in some society at some time’ (120). In addition, a number of authors have pointed to the problems surrounding the necessary boundary between adulthood and childhood that underlies the problem of adult/child sex, particularly as childhood is a relatively new, and to a certain degree a Westernised idea (Jenkins 1996; Cunningham 1995). Recourse to the seemingly fundamental biological marker of puberty is similarly problematic (Weeks 1985; Green 2002), with an array of exotic examples regularly mobilised to illustrate the particularity of our current understandings. These include, for example, various rites of passage involving childhood sexuality (e.g. Bauserman 1997), along with other reports of sexual activity between or involving prepubescent children. In some cases, these are perceived as beneficial for the child, rather than gratifying the adult (Green 2002). This inevitable variation can also be used to important effect in questioning the positioning of paedophilia as a mental disorder (Green 2002).

Social constructionist perspectives (see Burr 1995) may be particularly useful here, in that they allow us to approach phenomena such as paedophilia with an expectation of such variation. As noted by Stainton Rogers and Stainton Rogers (1999), areas of social policy and professional practice, such as law, medicine and social work, are in the process of being influenced by constructionist ideas. They explain how the uncertainty and incoherence that are markers of scholarship can be seen as problematic in practical contexts. However, as they further elucidate, constructionist perspectives have the potential to focus our attention on the more intractable problems that are
often ignored when focusing on deviant individuals that and can contribute to a climate of change. It is by engagement at this critical level that, they suggest, we might begin to examine whose interests are being served by the creation of such moral panics – and what is being obscured. As noted by Best (1990, cited in Stainton Rogers and Stainton Rogers 1999), focusing on deviant individuals pays little attention to flaws in the social system, and controlling individuals serves to make fears of these particular threats more manageable.

The complexity highlighted in this chapter, which is inevitable from a social constructionist perspective, further problematises the issue of whether it is possible to have a one size fits all definition of paedophilia and, if it were possible, what this would mean for practice. If treatment is predicated on our understanding of the phenomenon itself, then any such treatment is subject to the same level of disagreement.

**Conclusion**

This chapter has provided an overview of current theoretical and evidence-based underpinnings around sex offenders, sexual offending in general, and paedophilia in particular. Although this chapter is a brief introduction to what is a complex and continually growing area (Farrington 2009), our aim has been to provide the reader with a grounding in definitions and understandings of paedophilia, some of which will be built on and developed in the reminder of the book. Given the way in which theories, research and attitudes towards sexual offending are continually adapting and vary across different contexts, we have also pointed to the potential contribution of social constructionist ideas in this area, as a means through which we might examine contemporary changes and adaptations in understandings of sexual offending – in terms of not only public opinion, but also government policy, academic research and professional practice. However, we are also mindful of responding appropriately to current constructions of paedophilia. As such, this chapter points to the need for ideas around sexual offending, in its widest conception (i.e. stalking, rape, child sexual abuse, paedophilia, etc.) and through all related aspects (i.e., aetiology, offender behaviour and personality, treatment, etc.), to be evidence based (Farrington 2009), and subject to critical reflection, rather than based upon or influenced by knee jerk reactions.
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Notes

1 The phrase ‘Gillick competent’ derives from the case of Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, which involved the provision of contraceptive advice to girls under the age of 16. Victoria Gillick was a mother of five girls who sought a ruling that none of her daughters would be prescribed or advised about birth control, while under 16, without her knowledge or consent. The case progressed to the House of Lords, where Lord Fraser laid down a number of criteria, which have since become known as the Fraser Guidelines. The guidelines centre on the child’s ‘maturity and intelligence to understand the nature and implications of the proposed treatment’ (113) with the premise being that once this stage has been reached, the parent’s right to determine matters relating to medical treatment ends.

2 Offences where the child is under 16, including sexual activity (9), causing or inciting a child to engage in sexual activity (10), engaging in sexual activity in the presence of a child (11), causing a child to watch a sexual act (12), arranging or facilitating commission of a child sex offence (14) and meeting a child following sexual grooming (15).

References

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