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Pedophilia: A Diagnosis in Search of a Disorder

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Abstract This article presents a critical review of the recent controversies concerning the diagnosis of pedophilia in the context of the preparation of the fifth edition of the DSM. The analysis focuses basically on the relationship between pedophilia and the current DSM-IV-TR's definition of mental disorder. Scholars appear not to share numerous basic assumptions ranging from their underlying ideas about what constitutes a mental disorder to the role of psychiatry in modern society, including irreconcilable theories about human sexuality, which interfere with reaching any kind of a consensus as to what the psychiatric status of pedophilia should be. It is questioned if the diagnosis of pedophilia contained in the DSM is more forensic than therapeutic, focusing rather on the dangers inherent in the condition of pedophilia (dangerous dysfunction) than on its negative effects for the subject (harmful dysfunction). The apparent necessity of the diagnosis of pedophilia in the DSM is supported, but the basis for this diagnosis is uncertain.

Keywords Pedophilia · Mental disorder · DSM-5 · Paraphilia

Introduction

Some years ago an interesting controversy arose as to whether pedophilia (Green, 2002a), or paraphilias in general (Moser, 2001; Moser & Kleinplatz, 2005), should be included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the catalogue of mental disorders published by the American Psychiatric Association (APA). A fifth edition is now being developed. Given the importance that psychiatric diagnoses can have in the field of individual rights and freedoms (Reich, 1991), a critical reassessment of these issues is important.

Some of the ideas in this analysis could also be applied to other paraphilias, but the focus on pedophilia demonstrates conceptual problems that reveal the lack of a real medical paradigm and the risks of the forensic paradigm. This discussion is limited to what we will call the "conceptual controversy" which does not necessarily exclude other perspectives of analysis and debate.

The purposes are (1) to attempt to clarify the conceptual controversy on the inclusion of pedophilia in the DSM nosology; (2) to identify internal contradictions of this psychiatric status, especially in relation to the absence of homosexuality as a mental disorder; (3) to endeavor to understand the reasons for the confusing and changing status of pedophilic diagnoses in successive DSM editions, including the recent proposal for the future fifth edition of the DSM; and (4) to highlight the different implications of considering pedophilia primarily for forensic and social control functions (dangerous dysfunction) and not for diagnosis and treatment purposes (harmful dysfunction).

In analyzing this conflict between two psychiatric traditions, the Hippocratic and the Lombrosian, it will be concluded that Pedophilia becomes for us a *necessary diagnosis* in search of a still *uncertain disorder*, and suggestions will be made for further research, theories, and debates.

The Inescapable Precedent of Homosexuality and the Criterion of Suffering

The controversial removal of homosexuality from DSM-II in the 1970s has become paradigmatic for academic debates in this field (Sadler, 2009). Many scholars have turned to it either to find arguments with which to attempt to demolish the supposed scientific, rather than moral, basis for psychiatry (Kutchins &

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Kirk, 1997), to examine the medicalization of human existence (Conrad & Schneider, 1980), or simply to illustrate how controversies of this kind originate, develop, and are eventually resolved (Engelhardt & Caplan, 1987).

The past *depathologization* of homosexuality is the strongest argument available to those who take the position that pedophilia and other paraphilias should not be treated as mental disorders (Culver & Gert, 2006; Moser, 2001). Culver and Gert and Moser both claim that the subject's personal suffering is a necessary condition to define a mental disorder and their main argument is that paraphilias, including pedophilia, do not cause any particular distress in the majority of those who experience them. Where such distress is present, they add, it is better explained by the presence of a conflict with society (stigmatization, condemnation, persecution, etc.) than by the condition itself (Vogt, 2006). Indeed, some people are quite capable of integrating it into their lives and personalities with reasonably satisfactory results (Moser, 2001; Suppe, 1987; Wilson & Cox, 1983).

Moser (2001) asserted that homosexuality was not deleted from the DSM for scientific reasons but on political and social grounds, and other paraphilias should also have been eliminated. Bieber, an advocate of treating homosexuality as a pathology, once raised this question regarding the elimination of other paraphilias from the DSM with Spitzer. According to Bieber (1987), Spitzer replied to him that "…these conditions should perhaps also be removed from DSM-II, and that if the group so affected were to organize as did the gay activists, they, too, might find that their conditions would be removed as a diagnostic entity" (p. 433).

This point was also made by others (e.g., Silverstein, 2009; Suppe, 1987), but it did not win much support. Any attempt to question the legitimacy of the psychiatric apparatus, including the DSM as a whole, was rejected as a political strategy by homosexual activists (see Silverstein, 2009, Footnote 3), because it would have jeopardized the goal of excluding homosexuality from the DSM.

It is significant that the elimination of homosexuality and changes in the definition of mental disorder contained in the DSM are linked to the same historical moment and person. In one of his papers, Spitzer (1987) himself connected the two issues:

> When I first was given the job of considering the claims of the gay activists that homosexuality should not be regarded as a mental disorder, I was confronted with the absence of any generally accepted definition of mental disorder. I therefore reviewed the characteristics of the various mental disorders and concluded that, with the exception of homosexuality *and perhaps some of the other 'sexual deviations,'* they all regularly caused subjective distress or were associated with generalized impairment in social effectiveness of functioning. It became clear to me that the consequences of a condition, and not its etiology, determined whether or not the condition should be considered a disorder (p. 404, emphasis added).

In many of his writings, both phenomena are tightly bound up together (Spitzer, 1973, 1981, 1999; Spitzer & Wakefield, 2002). As these remarks show, the issue of sexual deviations was placed on the fine line that separates the "normal" from the "pathological."

According to Paris (2005), the process by which homosexuality was removed from the DSM was part of the progressive decline of psychoanalysis in U.S. psychiatry. Yet psychoanalysis was the only theory that "justified" the pathological nature of these deviations in etiological terms (Mayes & Horwitz, 2005) and it was replaced by references to the consequences in the definition of mental disorder (Bayer, 1981; Bieber, 1987). Thus, DSM-III established that the syndrome or behavior pattern must be "typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability)," adding that "the disturbance is not only in the relationship between the individual and society" (APA, 1980).

One reading of this definition could suggest that distress or disability must be the direct effect of the supposed dysfunction and this may be inferred from the interpretation proposed by Spitzer (1981) in relation to homosexuality. This also explains the criticisms made by those who defended the pathological nature of homosexuality for whom

> …it was the absence of such discomfort that often revealed the depths of pathology. Furthermore, Spitzer's emphasis on the importance of social functioning implied that a number of patently pathological conditions, *especially the sexual perversions*, had been improperly classified as disorders. Instead of providing a sound basis for a psychiatric nosology, the board had made a shambles of the nomenclature (Bayer, 1981, pp. 139–140, emphasis added).

Summarizing, this brief review of the delisting of homosexuality from the DSM highlights three important points. First, the interpretation of the DSM-III definition of mental disorder in the discussion about homosexuality left many people with the impression that subjective distress and impairment are necessary criteria to diagnose a mental disorder. Second, in DSM-III-R (APA, 1987), exactly when homosexuality was unambiguously eliminated, the definition of mental disorder would undergo a change in reformulating the issue of social deviation, making it easier for the mere existence of a conflict with society to be taken as an indication of mental disorder, providing the conflict is caused by a dysfunction in the subject. And, third, since the removal of homosexuality, no one has adequately discussed its status under the new definition of mental disorder and in comparison with other paraphilias.

The Diagnosis of Pedophilia in the DSM

Green (2002a) was certainly on the right track when he noted that the treatment of pedophilia in the successive editions of the DSM "is a trip through Alice's Wonderland" (p. 469). It is interesting to observe this evolution in two distinct phases. The first ends in 1980 with the publication of DSM-III and the apparent modification of the previous paradigm of "sexual deviation." The second phase begins in DSM-III and there are significant changes in every edition thereafter.

From DSM-I and II to DSM-III (1952–1980)

The publication of DSM-III marked a fundamental change in the theoretical grounding of the manual (Mayes & Horwitz, 2005) and, in the area of sexuality, a redefinition of what had formerly been referred to as "sexual deviations," problems epistemologically conceptualized in terms of conflict with prevailing morals and laws. This diagnostic category embraced all atypical manifestations of sexuality, including homosexuality, that were not symptoms of other disorders (APA, 1952, p. 38). According to DSM-II (APA, 1968, p. 44), behavior per se was not sufficient and the disorder was viewed as a morbid condition affecting the individual at the level of his sexuality or at least a genuine motivation rather than the fruit of some other mental disorder or mere circumstance (i.e., lack of acceptable objects of sexual desire).

To judge from a reading of U.S. psychiatric texts published in the 1950s and 1960s (Arieti, 1967; Gregory, 1961; Mayer-Gross, Slater, & Roth, 1954; Noyes, 1968; Sadler, 1953), the paradigmatic example of sexual deviation at the time was homosexuality, while the question of pedophilia was scarcely considered and was sometimes epistemologically associated with the former: "Pedophilia, or a pathological sexual interest in children, is regarded as a variant of homosexuality in which sexual strivings are directed toward children" (Noyes, 1968; see also Sadler, 1953, pp. 699–700).

Two important changes occurred in 1980 with the publication of DSM-III. Pedophilia and the other paraphilias were switched to the general chapter on Psychosexual Disorders, replacing their previous categorization as "Sociopathic Personality Disturbances" (APA, 1952) or "Personality Disorders" (APA, 1968). Furthermore, the term sexual deviation was replaced by paraphilia (supposedly less pejorative) and each of the categories was defined in more specific terms, with the significant difference that homosexuality was included only in its ego-dystonic manifestation.

These amendments were theoretically a response to a major change in the frame of reference. In the first place, these erotic singularities were not disorders related to or caused by a personality disorder, but had their own, separate existence (Schmidt, 1995). And, by shifting the paraphilias away from the notions of deviation and conflict with social norms, it was suggested that the problem was not moral or legal but psychiatric (Mayes & Horwitz, 2005).

From DSM-III to DSM-IV-TR (1980–2000)

Between DSM-III (APA, 1980) and the current DSM-IV-TR (APA, 2000), numerous amendments have been made to the description of paraphilias and further important changes are proposed for the DSM-5. In the case of pedophilia (see Tables 1, 2), changes in every new edition relate mainly to the role played by three variables, namely deviant behavior, distress, and impairment of the subject.

Changes relevant to this analysis, which are discussed later, include that only in the DSM-IV are subject distress or impairment included as a necessary condition, a change made in the context of a general modification in this edition to include the presence of distress/impairment as necessary in almost all diagnoses (First & Frances, 2008). In this case, the impairment could affect different areas—occupational, social, or others—while in DSM-IV-TR it is reduced to "interpersonal difficulty." In DSM-III and III-R, there were no references to impairment. Furthermore, only in DSM-III and DSM-IV-TR is the mere presence of deviant conduct considered sufficient for the diagnosis of pedophilia. Note that in this last edition individual distress becomes a necessary condition for some paraphilias but not for others. This is the case with exhibitionism, frotteurism, pedophilia, sadism, and voyeurism, a selection that suggest the link between the criminal/immoral and the medical (Culver & Gert, 2006).

This current status of pedophilia in the DSM-IV-TR generates two important problems: (1) according to some interpretations, it is possible to be a pedophile (erotic condition) and at the same time not to be a pedophile (diagnostic) (Blanchard, 2010; Green, 2002a) if the person doesn't act and neither distress nor impairment are present; and (2) it is also apparently possible not to have pedophilic feelings but act as such and then be thus diagnosed (First & Frances, 2008). The new proposal for DSM-5 (APA, 2011) tries to "solve" the first problem by differentiating between Pedophilia and Pedophilic Disorder; and the second by modifying the wording in criterion A to consider the behaviors as a manifestation of a "recurrent and intense sexual arousal from prepubescent or early pubescent children" (APA, 2011).

A Conceptual Controversy and the Four "Rules of the Game"

According to Baltas (2000), a scientific controversy "is not a mere disagreement: it is one that cannot be readily settled by resorting to the commonly accepted disciplinary canons for conducting the relevant inquiry, as these have been developed up to that time" (p. 44).

In this case, it seems justified to speak of something more than mere disagreements, as the different positions adopted by

Table 1 Diagnostic criteria for pedophilia, from DSM-III to those proposed for DSM-5

DSM-III (1980)
A. The act or fantasy of engaging in sexual activity with prepubertal children is a repeatedly preferred or exclusive method of achieving sexual excitement
DSM-III-R (1987)
A. Over a period of at least 6 months, recurrent intense sexual urges and sexually arousing fantasies involving sexual activity with a prepubescent child or children (generally age 13 or younger)
B. The person has acted on these urges, or is markedly distressed by them
DSM-IV (1994)
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger)
B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
DSM-IV-TR (2000)
A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger)
B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty
Proposed for DSM-5 (APA, 2011)
A. Over a period of at least 6 months, recurrent and intense sexual arousal from prepubescent or early pubescent children, as manifested by fantasies, urges, behaviors, or extensive use of pornography depicting children of this age
B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or impairment in social, occupational, or other important areas of functioning

Specifications about age differences, sexual orientation, incestuous, exclusive or non exclusive, classic/hebephilic type, in remission or not, etc. have been removed

the parties are based on sharply diverging personal and intellectual positions and these underlying differences interfere with the satisfactory resolution of the controversy.

Participants and Literature

There are basically four main areas of debate that in one way or another are of interest here. The first three are about the appropriateness of including the paraphilias, pedophilia, and (pedo)-hebephilia as mental disorders. The fourth area, perhaps more a simple disagreement than a real controversy, is over the way pedophilia should be described, assuming its presence in the DSM is valid (Blanchard, 2010; First & Frances, 2008; O'Donohue, Regev, & Hagstrom, 2000). Very few authors are known to have actually expressed their opinion in these controversies. This constrains our analysis in terms of ideas, but it also makes it simpler and more manageable.

There are basically three main proposals to remove pedophilia (Green, 2002a) or paraphilias in general (Moser, 2001; Moser & Kleinplatz, 2005) from the DSM. All of them are relevant because they have (especially Green's article) generated a significant number of commentaries that will be carefully analyzed here. (e.g., Krueger & Kaplan, 2002; Moser, 2002; Seto, 2002; Spitzer & Wakefield, 2002). Also added is an article by Suppe (1987), which when published was limited only to the DSM-III, and the work of other scholars in the area of philosophy of psychiatry (e.g., Cooper, 2005; Sadler, 2009).

The literature in defense of the diagnosis of pedophilia as a mental disorder is even scantier. We must keep in mind that at least until DSM-IV (APA, 1994), it seems that it was relatively easy to get into DSM, but much more difficult to get out. A qualitative leap in the conception of the Manual was made in the DSM-III (Mayes & Horwitz, 2005) and the policy followed in drafting DSM-IV was to keep the existing classifications and criteria and not to make changes or new additions unless they were sufficiently grounded in empirical observations (Frances, Widiger, & Pincus, 1989; Pincus & McQueen, 2002). However, this made it more difficult to remove the categories already included in the DSM-III-R, even though it may not have been obvious that their presence was justified (Carson, 1991; Kutchins & Kirk, 1997). Homosexuality had been excluded, but the other paraphilias remained, hobbled by tradition, and nobody seriously questioned the reasons for or appropriateness of their presence.

This explains why it is so difficult to find sound arguments for the treatment of pedophilia or other paraphilias as mental disorders. We can only base the discussion on a few scant sources that do not necessarily represent the APA's official position and are, in any case, only sketchily argued. In this sense, the work of Spitzer (1973, 1981, 1999, 2005; Spitzer & Wakefield, 2002) is useful in explaining his suggestions for keeping these other paraphilias in the DSM. Note that Spitzer was one of the leading proponents of the partial elimination of homosexuality from the DSM (Bayer, 1981) and of the current definition of mental disorder (Spitzer & Endicott, 1978).

Finally, the proposal to include hebephilia or pedohebephilia in the DSM (Blanchard et al., 2009) generated a fresh round of debate (Blanchard, 2009; DeClue, 2009; Frances & First, 2011; Franklin, 2009, 2010; Green, 2010a, b; Moser, 2009; Tromovitch, 2009; Wakefield, 2011).

The Four "Rules of the Game"

Broadly speaking, the controversy concerns the appropriateness of the diagnosis of pedophilia depending (1) on its fit with the current concept of mental disorder as contained in the DSM and (2) the usefulness of the diagnosis for the purposes of professional intervention, therapy, research, health, legal, and social policy. The first and more conceptual or theoretical of these frameworks for debate has unquestionably been preeminent

Table 2 Evolution of the diagnosis of pedophilia in the DSM

	Criterion A (symptoms)			Criterion B (consequences)		
	Sexual urges	Fantasies	Behavior	Behavior	Distress	Impairment
DSM-III (1980)	–	Sufficient, but not necessary	Sufficient, but not necessary	–	–	–
DSM-III-R (1987)	Both necessary		–	Sufficient, but not necessary	(Markedly distressed) Sufficient, but not necessary	–
DSM-IV (1994)	Sufficient, but not necessary	Sufficient, but not necessary	Sufficient, but not necessary	–	(Clinically significant distress) Sufficient, but not necessary	(In social, occupational or other important areas) Sufficient, but not necessary
DSM-IV-TR (2000)	Sufficient, but not necessary	Sufficient, but not necessary	Sufficient, but not necessary	Sufficient, but not necessary	(Marked distress) Sufficient, but not necessary	(Interpersonal difficulty) Sufficient, but not necessary
Proposed for DSM-5 (pedophilic disorder) (APA, 2011)	Sufficient, but not necessary	Sufficient, but not necessary	Sufficient, but not necessary (adding extensive use of [child] pornography)	Sufficient, but not necessary	(Marked distress) Sufficient, but not necessary	(In social, occupational or other important areas) Sufficient, but not necessary
	If considered as manifestations of recurrent and intense sexual arousal from prepubescent or early pubescent children					

and will be focused upon; the second, which is of a more practical cast, will only be referred to in passing (see Bullough, 2002; Fink, 2005; Friedman, 2002). Those authors who have addressed the controversy from a conceptual standpoint appear to follow what Zucker (2002), Chair of the DSM-5 Workgroup on Sexual and Gender Identity Disorders, calls the "rules of the game," i.e., "whether or not pedophilia conforms to the DSM definition of a mental disorder" (p. 501).

The first problem, as the DSM itself cautions, is that these rules may be interpreted in different ways and that "no definition adequately specifies precise boundaries for the concept of mental disorder" (APA, 1994, p. xxi). Furthermore, the definition of mental disorder was not initially designed as an objective criterion to decide what is an illness, but rather as a framework for debate and analysis (Spitzer, 1999; Wakefield, 1992b) and perhaps one of the undesired consequences of DSM-III was that "Users took the manual very seriously—much more seriously than the developers intended" (Pincus & McQueen, 2002, p. 13).

This, in fact, suggests firstly that the decision as to whether pedophilia is or is not a mental disorder will be found in some basis other than the concept of mental disorder per se and that any debate over the phenomenon's fit with the definition is basically an idle pursuit. And, secondly, that the adversaries in the controversy, who act as if this definition of mental disorder was a useful and sufficient criterion to reach a solution, are misusing the sense of this definition.

At any rate, some seem to take seriously this conceptual analysis where their arguments appear in general to follow Wakefield's (1992a, b) ideas, who summarized the DSM definition in the well-known phrase "harmful dysfunction" (HD), a proposal that was afterwards defended by Spitzer (1999) but that has never been formally accepted by the APA. According to Wakefield (1992b), disorder implies "the inability of some mental mechanisms to perform their natural function," while this dysfunction in turn "causes some harm or deprivation of benefit to the person" (p. 385). This interpretation could be reformulated in what we may call the three rules of the game: (1) it is known, or supposed, that there is something that does not work inside the individual (dysfunction); (2) this causes the subject distress, and/or (3) it impairs some capacity that is considered socially important.

Significantly, however, none of the parties appears really to address in all of its implications the issue of conflict with society and the harm caused to others, which I will call "dangerous dysfunction" (DD). Yet, the fact remains that the current DSM definition demands the inclusion of a fourth rule in the debate: (4) the supposed dysfunction causes a conflict with society. This present analysis will, then, seek to show that it is the concept of *Dangerous Dysfunction* that actually underlies the presence of pedophilia in the DSM and not that of *Harmful Dysfunction*.

Let us briefly summarize the essence of these disagreements while highlighting the background "assumptions" that are not made explicit. In each case, the level (facts, theories, and principles) at which the controversy is situated in the classification proposed by Engelhardt and Caplan (1987) will be included.

The Criterion of Distress

It has been shown, and many of the parties to the controversy would have no difficulty in agreeing, that some people with pedophilia apparently do not suffer as a result and that, in any event, such distress they may experience is rather the predictable result of conflict with society (Bernard, 1985; Howitt, 1995; Vogt, 2006; Wilson & Cox, 1983). This is even clearer if, as the DSM establishes, this distress must be considered as "marked" or "clinically significant."

The presence of distress has been noted by some authors as a required condition in mental disorders (for a defense of this argument using the example of pedophilia, see Cooper, 2005, p. 28; Sadler, 2009). This argument would certainly be shared by those who advocate the exclusion of pedophilia from the DSM in agreement with Culver and Gert (2006), who argue that changes in the area of paraphilias since DSM-III were due to an erroneous interpretation of the definition of mental disorder.

Some of these authors have used an argument based on the hypothetical existence of what Blanchard (2010) calls "the contented pedophile," a subject who has pedophilic preferences but neither realizes his desires nor experiences any distress as a result of his condition or what it implies in terms of sexual frustration. The response of Blanchard (2010) or Spitzer and Wakefield (2002), appealing to the danger to others—supposedly originating in the dysfunction—implies that the pedophile is doomed: he can either be happy and act, in which case he is sick, or he can refrain from acting but at the cost of enduring misery, in which case he is also sick.

The Criterion of Impairment

A less widely debated aspect is impairment. Perhaps the lack of interest in this criterion may be because it can be assimilated into distress, while it is the subject who decides which facets of life are or are not important within the context of an increasingly free and individualistic society. There can be no doubt, however, that it is also because it is not clear what areas are actually affected in the case of the paraphilias, which would explain the change in formulation since its appearance in DSM-IV.

It is worth remembering here that the criterion of impairment was proposed by Spitzer (1981) to argue that only homosexuality should be removed from the DSM, even while accepting that many people affected by paraphilias do not suffer any distress as a result. According to Spitzer (1981) "The necessity of the unusual or bizarre imagery or acts for sexual arousal was regarded as *impairment in the important area of sexual functioning* that justified the inference of a behavioral or psychological dysfunction" (p. 212, emphasis added).

The analysis here could be similar to that of distress: many people with pedophilia experience no occupational, social, or interpersonal difficulty (Vogt, 2006). Another issue is which are the general tendencies of these people, where results are still uncertain and confused by the difficulty of finding a sample that is not biased. Most studies have been done with men from judicial contexts where reliable conclusions are difficult (Seto, 2008). In this case a few social difficulties are the only characteristic apparently relevant in these samples, but it is impossible to generalize results to all pedophiles, and there is the problem of sorting out what is the cause and what is the effect (Howitt, 1995).

In the case of studies based on self-identified pedophiles, three relevant works can be cited where the social difficulties were also a significant characteristic of these men. Wilson and Cox (1983) found that most men were working at professional levels and that some social difficulties were the most relevant characteristic; but it is impossible to conclude if they are cause or effect of the pedophilic condition. Bernard (1985) found that his sample, members of an organization, were in general better educated and that their professions were quite varied, noting that most of them were satisfied with their occupations. A large part of these participants had an academic education, a fact that, according to Bernard, could be explained by a desire to demonstrate their capabilities. In general, he said, they were experiencing difficulties in social life, but these could be attributed to social rejection, in contrast to "the finding that the paedophiles do not wish to isolate themselves" (Bernard, 1985, p. 83).

In a recent study with 82 self-identified pedophiles, Vogt (2006) found that the bulk of participants had above-average levels of education and worked in quite varied occupational areas, but the rate of unemployed was high in relation to the predominance of men with higher educational levels. The differences in self-image of functional social potency with a heterosexual control group were unimportant, meaning that they believe, to a similar extent as the general population, that they are able to influence and control their social conditions. Social isolation and a tendency to be reserved and cautious in establishing and accepting social contacts was higher, a fact that Vogt (2006) attributes as necessary for self-protection. Most pedophiles in these studies were unmarried (Bernard, 1985; Vogt, 2006; Wilson & Cox, 1983), but this is probably a personal choice and not necessarily important to the subject.

The roles played by both distress and impairment caused by the dysfunction itself, rather than conflict with society, are areas of more profound disagreement. These impede progress at this level of the controversy, which is beset by serious differences of opinion, not only at the theoretical level, but also with regard to basic principles and beliefs about human nature and the meaning of mental disorder. Moreover, what has been not adequately discussed is if distress or impairment are a "direct" consequence of the dysfunction and not simply something "associated" with it, a difference recently noted by various authors (First & Wakefield, 2010; Stein et al., 2010), and that could have relevant implications in the case of pedophilia.

The Criterion of Behavior

The evolution of the behavior criterion is the most illustrative of the *raison d'être* for the diagnosis. A dual analysis is required, because this is the only criterion that appears both among symptoms (Criterion A) and consequences (Criterion B). The presence of behavior as a *symptom* dates back to 1980 in all editions except DSM-III-R. The formulation used in DSM-IV-TR implies that behavior alone is sufficient to make the diagnosis, confusing the crime with the disorder (First & Frances, 2008). Turning to Criterion B, the only time behavior does not appear is in the fourth edition, which is the only one to require that the subject suffer distress or impairment. This absence seemed problematic for many people, because it meant that if a patient is neither distressed nor impaired but act on his desires, then the diagnosis of Pedophilia could not be given. This problem was the cause for the change from DSM-IV to IV-TR, where behavior was added again to criterion B (First & Frances, 2008).

The issue of behavior is almost the same thing as conflict with society, and its back-and-forth appearance in the different editions of the DSM is a reflection of the difficulty psychiatry has in accepting its role as an instrument of social control. Returning to the case of the "contented pedophile" (Blanchard, 2010) mentioned above, we may now consider the case of the "contented *criminal* pedophile," who acts on his desires but is not compulsively driven by his instincts and freely opts to break a law maintaining erotic relations with minors that he finds reasonably satisfying. Does such a subject exist? Probably he does (Brongersma, 1986, 1990; Lautmann, 1994; Li, 1990; Suppe, 1987). Does he fit the current diagnosis of pedophilia? Indeed so, because he displays pedophile behavior. But does he fit the DSM's definition of mental disorder?

The definition of mental disorder in the DSM, especially since III-R, would allow this reading where it affirms that conflicts with society are not mental disorders "*unless* the deviance or conflict *is a symptom of a dysfunction* in the individual" (APA, 2000, emphasis added). Hence, if a dysfunction exists and it is the cause of a conflict with society, then it would fit the definition. This view is on one occasion recognized by Moser and Kleinplatz (2005), although they do not share it. As noted below, however, in this case it would once again be more honest and straightforward to talk of a *Dangerous Dysfunction* rather than a *Harmful Dysfunction*, even though the key in both cases lies in the concept of dysfunction.

A prior consensus is needed on the question of whether deviant behavior, though it may be related to a particular situation and its assumed dysfunction, but which is also subject to the conscious free will of the individual and is based on a normal (i.e. non-psychotic) perception of reality, constitutes a sufficient criterion for the diagnosis of mental disorder. This is without doubt

the Gordian knot of the whole controversy and is an example of how "scientific disputes resist closure or resolution when the stakeholders in the debate belong to… [c]ompeting social groups with different views of social control" (Engelhardt & Caplan, 1987, p. 11). At this level of the controversy, principles, theories, and facts need to be untangled.

The Criterion of Dysfunction

According to Spitzer and Wakefield (2002) (see also Seto, 2002, 2008; Spitzer, 1999), pedophilia is a dysfunction of a sexual function purportedly designed in evolutionary terms for reproduction. This assertion is not shared by other authors, however. Green (2002b) denies it without further explanation, ironically remarking that it seems to be nothing but another pathologization of homosexuality. Moser and Kleinplatz (2005) do not mention the concept of dysfunction, although they do refer to a supposed criterion of sexual health/disorder that has yet to be defined. Moser (2001) thinks that these are only subjects who suffer due to their sexual condition, whatever it may be, although Spitzer (2005) reproaches him for this because then the clinician has nothing to go on to form an independent judgment.

While Spitzer (1981) initially argued that the choice of heterosexuality as the norm was "a value judgment and not a factual matter" (p. 212), in his later writings the absence of heterosexual desires becomes an unquestionable factor. In discussing Wakefield's Harmful Dysfunction proposal, Spitzer (1999) used precisely the example of pedophilia to affirm that "The HD analysis would suggest that despite limitations in our understanding of sexual development, a reasonable assumption is that evolution has evolved built-in mechanisms to ensure that sexual arousal in adults is directed toward other adults—not children" (p. 431). In reality, Spitzer adds, this reasoning simply "illuminates why so many observers agree that this kind of difference is not merely a difference but constitutes a disorder" (p. 431).

What about the case of homosexuality? Spitzer (1999) has argued that on the HD definition "certain forms of homosexuality are disorders" (p. 431; see also Spitzer & Wakefield, 2002). Therefore, for these authors, the homosexuality that Spitzer (1981) already defined as "a persistent pattern of absent or weak heterosexual arousal" (p. 212), is a *dysfunction* like pedophilia. If it is not a mental disorder, this is because, in contrast to pedophilia, "homosexuality does not necessarily involve harm to self or others" (Spitzer & Wakefield, 2002, p. 500).

As has already been shown, this assertion is debatable, as homosexuality can generate a great deal of suffering in some societies, including our own. On the issue of harm to others, a subject which will be addressed more fully in the next section, it cannot be ignored that many people continue to regard homosexuals as dangerous, among other reasons, because they may seduce and corrupt youth and children—the higher age of consent for homosexual relations in some countries is a revelatory example.

The argument advanced by Spitzer and Wakefield (2002), Seto (2002, 2008), and Blanchard (2010) that any departure from the heterosexual-reproductive instinct is a dysfunction is a very contested theory (Cahill, 1987; Lilienfeld & Marino, 1995; Sadler, 2009; Sadler & Agich, 1996; Suppe, 1987). In any event, its acceptance would imply a radical change in the epistemology of paraphilias, in which the fundamental shift in focus would be from what attracts to *what does not attract*. The term paraphilia would be rendered meaningless. And, of course, the diagnosis of hebephilic type in pedophilic disorder (APA, 2011) would be more difficult to sustain in its heterosexual form with minors with secondary sexual traits (Quinsey, 2011).

Pedophilia as a Dangerous Dysfunction

One way to overcome the contradictions inherent in the conceptual analysis of pedophilia in relation to the concept of mental disorder established in the DSM is to appeal to the concept of danger. As Spitzer (1999) explained, "Because pedophilic behavior results in the victimization of children, the dysfunction also represents a harmful condition by social standards. Thus, pedophilia (at least when severe) is correctly classified as a disorder, not a normal variant" (p. 431). It is not clear what the words in parentheses mean, but the implication is that pedophilia should be in the DSM and, indeed, in the corpus of contemporary psychiatry, not because it is a *Harmful Dysfunction*, but because it is considered a *Dangerous Dysfunction*. Silverstein (2009), who played a key role in the negotiations that culminated in the elimination of homosexuality from the DSM, recently forecast that the paraphilias would probably also be removed eventually, although this would only happen in cases of "consensual adult–adult sex" (p. 162). In his review of the events leading up to the removal of homosexuality from the DSM, Silverstein remarked, "The professional members of the committee…argued that all the sexual disorders should be removed from DSM, except for the section on child molesting, obviously the hottest button on the list" (2009, Footnote 3).

If the criterion of legal or moral transgression is sufficient to Silverstein, then he should have also added other paraphilias as the authors of DSM-IV-TR did, including the behavior criterion only for those paraphilias that might potentially involve breaches of the law (First & Frances, 2008). This reveals that these conditions are perceived in essence not as harmful to those who experience them, but rather as dangerous to others, thus further accentuating the more than evident moral charge inherent in this diagnosis. As Sadler (2009) explains, "The revised criterion [in DSM-IV-TR] serves even further to saturate Pedophilia with moral-badness as the mark of disorder" (p. 219).

The Forensic Background

Money (1984) pointed out that the eight paraphilias contained in DSM-III were included "because of their forensic history, rather than their pathology and therapeutic need" (p. 164), suggesting that the sense and place of the paraphilias is a result rather of the Lombrosian (forensic) tradition in psychiatry than the Hippocratic (curative) tradition. Details in support of these ideas include:

1. Various editions of DSM (APA, 1987, p. 280; 1994, p. 524) recognize that some of the paraphilias are more common in clinical contexts than others. These include exhibitionism, voyeurism, and pedophilia, all manifestations that are in breach of the law. As Malin and Saleh (2007) noted, "With the exception of those who are in legal trouble, most, but not all, persons with paraphilia probably do not seek treatment." It is not a condition, then, that is usually examined for reasons of personal distress or suffering.

2. It is equally significant that the last editions of the DSM defined pedophilia as a paraphilia involving sexual interest in "children or other non-consenting persons" (APA, 1994, p. 523), placing it on the same level as the other paraphilias that imply a lack of consent on the part of the other person concerned. The intention behind this formulation seems to be an intent to avoid the use of concepts such as "unusual and bizarre" (Frances & First, 2011), but apart from other problematic implications (Frances & First, 2011; Wakefield, 2011), it is evident that it can easily be interpreted as asserting that the lack of the child's consent is an element in the attraction felt by a pedophile individual, as is the case in exhibitionism and voyeurism, where the elements of surprise and concealment are in themselves objects of attraction. Note that the DSM-5 Paraphilias subworkgroup proposal doesn't clarify this point (APA, 2011).

This definition of pedophilia in terms of "non-consent" is problematic to the perceptions and understanding of both professionals and society at large. Logic dictates that a man with pedophilia should wish for his partner's consent and affection (Lautmann, 1994; Li, 1990), even though society may consider that a child is not in a position to give such consent. It may be that consent is often an "illusion" entertained by the adult, who misinterprets the child's behavior, but this doesn't imply that such men generally find it desirable that their partners should not participate in, or should even resist, the relationship. It is quite possible that many men with pedophilia consider the child's consent and pleasure to be basic criteria for a satisfactory erotic relationship and, if the child doesn't consent willingly, many of these men will not continue or will not fully enjoy the relationship, just like the majority of people in relationships between adults. This assertion is not, of course, meant to justify anything; it is simply the recognition of a fact. Consequently, the stress laid by the DSM on "non-consent" in this category is at best a conceptual error, which is explained by the implicit role played by the Manual as a tool for the control of social deviations.

3. A further matter for debate, in addition to the controversy over whether pedophilia should or should not be included in the DSM, is the need to change the way in which DSM-IV-TR defines the diagnosis. Here the authors involved mostly come from the clinical-forensic field. The only proposal to reformulate the diagnosis from the standpoint of providing assistance is that of Moser and Kleinplatz (2005). The usual argument is that the diagnosis of pedophilia "is virtually ignored by both practitioners and researchers" (O'Donohue et al., 2000, p. 96; see also Marshall, 1997; Prentky & Burgess, 2000).

In this light, one solution to all of the practical and conceptual problems discussed would be to make the pathology and the crime overlap. Thus, "A single instance of sexual behavior with a child should be sufficient to label someone as having a disorder" (O'Donohue et al., 2000, p. 103). Interest in the diagnosis is not, then, primarily concerned with the search for therapeutic help, which is confirmed by statements such as "The longer we wait before diagnosing, the longer it may take for the person to obtain treatment and the longer the person can potentially abuse children" (O'Donohue et al., 2000, p. 101). What is at stake is, to these authors, a useful diagnosis for the purposes of prevention and control of an actual or potential crime, which they see as caused by the disorder (Kingston, Firestone, Moulden, & Bradford, 2007). The initial—but now abandoned—DSM-5 Paraphilias subworkgroup's proposal to count the number of victims to establish the diagnosis, appeared to be a compromise between these requests and the abusive use of this diagnosis in sexual predator laws (Wakefield, 2011).

4. In a similar vein, the recent review by Blanchard (2010) of the diagnosis of pedophilia in the DSM and his proposal with regard to hebephilia (Blanchard et al., 2009) are based on forensic and social control criteria, while the possible distress suffered by the individual is treated as irrelevant. The main diagnostic interest is, therefore, confined to detecting pedophilia and concentrates on the measurement of penile reaction, a technique drawn not from the medical tradition of Hippocrates but from the criminological tradition of Lombroso, who developed the forensic uses of such measurements (Horn, 2003). Moreover, the presence of behavior considered as a sufficient symptom for the diagnosis of pedophilia (Criterion A) is, in reality, a forensic requirement, as the repetition of certain patterns of sexual behavior is the only possible basis for diagnosis, given that people accused of crimes of this kind habitually deny the fact (Blanchard, 2010).

5. If the diagnosis of pedophilia were in the Hippocratic tradition, it would be formulated exclusively in terms of what we understand of the condition. This would be something simple, like the definition in International Classification of Diseases (ICD-10 F65.4): "a sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal age," recurring in the self-described experiences of the patient in order to evaluate its presence and intensity. Meanwhile, a definition of this

erotic preference that includes behavior as a symptom or as a consequence can only be intended to meet a forensic need.

6. There seems to be some justification for the critiques voiced by Franklin (2009) and Zander (2005) with regard to the connection between the increasing imposition of civil constraints on sex offenders and the need to ground the application of such measures on a psychopathological diagnosis. "Because many sex offenders do not suffer from traditional mental disorders, forensic evaluators have developed a highly contested—some would say pretextual—diagnostic nosology centering around the triad of Antisocial Personality Disorder, Pedophilia, and Paraphilia Not Otherwise Specified" (Franklin, 2009, p. 319). Proposals for a diagnosis of "Paraphilic Coercive Disorder" run in the same vein (Knight, 2010).

Harmful Dysfunction vs. Dangerous Dysfunction

In one of his articles on homosexuality, Spitzer (1981) argued that the concept of illness is a human construct applied to certain conditions that entail negative consequences with a clear purpose: "The advantage of identifying certain conditions as mental or physical is that it makes it easier for individuals with those conditions to receive care that may be helpful to them" (p. 211). This is Klein's (1978) "sick role," a label that supposedly allows us to help that person in his suffering. It is an argument for service, in the form of care for the suffering, which we all recognize as useful and necessary in many situations. The problem arises when this model, which falls within the Hippocratic tradition and gives priority to the patient, breaks down to become a false discourse, as is apparently the case with pedophilia.

There is, of course, no lack of authors (e.g. Berlin, 2002; Krueger & Kaplan, 2002) who defend the humanitarian and therapeutic reasons for treating pedophilia as a mental disorder with all the compassion and assistance that currently seems to be lacking (Schmidt, 2002). This spirit is in some way reflected in some of the confused amendments made to the diagnosis in the different editions of the DSM, which in turn reveal the enduring ambiguity of psychiatry between the Hippocratic and Lombrosian traditions of cure and control, as Culver and Gert (2006) point out.

However, it seems that the perspective of care and humanitarian compassion is far from being the priority in the current treatment of pedophilia. Actually, contrary to what has happened with other mental disorders: schizophrenia, depression, etc., where their medicalization has contributed to the development of a more humane understanding and treatment of the people affected, in the case of pedophilia, the existence of a diagnosis is not apparently changing our ideas in this direction (Vogt, 2006). On the contrary, this diagnosis and especially its management by professionals or lay persons could be having in general the effect of reinforcing the image of these men as dangerous slaves of their own libido, without the capacity for love, lacking any empathic feeling for children, and incapable of managing their condition in a socially acceptable way.

For the rhetoric of medical care and the alleviation of distress to be convincing here, psychiatry and the other related professions would need to undertake a labor of research and social education that they are currently most unwilling to tackle (Vogt, 2006). This work would require addressing pedophilia from a more humanistic angle, explaining to society the personal drama of the pedophile as a matter deserving of our compassion (Berlin, 2002; Friedman, 2002; Goode, 2010; Krueger & Kaplan, 2002; Schmidt, 2002; Seto, 2008). It cannot be denied, however, that this would be very difficult for clinicians, as their subjects do not, in general terms, see themselves as ill and do not wish to be cured.

In Vogt's (2006) research, the overwhelming majority of participants accepted their sexual orientation and saw it as healthy, rarely as pathological. They saw helpful sources of assistance in general personal conversations with friends, pedophiles or not, or non-therapeutic professionals, self-help groups and literature on the subject. Comments about what they would hope to attain from psychotherapy include ideas about improving general capabilities, finding meaning and satisfaction, overcoming and dealing with affective disorders and dealing with one's own sexuality, i.e., to live in an almost inevitable sexual abstinence. In general, experiences in psychotherapy were considered positive and helpful. A small minority described therapeutic experience as very negative, all of them in compulsory therapy.

In this context, patients would be difficult to find, in the first place because the "symptoms" of the disorder are easily concealed and, in the second, because very few pedophiles would be likely to come forward and seek help in the current climate, especially where reporting is mandatory (Malin & Saleh, 2007). Furthermore, they would be faced with a disorder that has no cure at present. The existence of an effective treatment is not essential, of course, and indeed many other conditions are incurable but are still considered to be disorders. However, it would have to be shown that any hypothetical intervention to help these persons would necessarily involve the elimination/modification of the dysfunction or its symptoms (i.e., erotic desire, attraction, and attachment to children).

The thrust of the current treatment philosophy seems to be usually antagonistic toward the subject, though the commendable purpose may be to protect others. As Howitt (1995) argued, this is the most common stance: "The ideological basis of therapy for pedophilia, by and large, remained hostile and based on its elimination. A very small number of therapists have adopted a rather different stance much more supportive of the pedophile" (p. 191). Gieles (2001), in his critical analysis of the usual methods of treatment for pedophiles, suggest that the hoped-for elimination of pedophilic attraction may thus be an iatrogenic outcome that would be experienced by the individual as an invasion of privacy accompanied by a sense of menace to his sexual orientation, with the consequent negative impact on his personal identity, view of the world, and value system. For the rhetoric of

assistance to be believable, then, the Hippocratic principle of *primum non nocere* should be reestablished.

Moreover, it has not been shown that other types of intervention are of no use and that it would not be better, if we wish to succor such people, or at least some of them, to help them learn to accept and live with their condition. In some proposals along these lines, "Goals are defined in terms of enlarging the autonomy of the men and not, as in regular treatment programs…in terms of regulating socially unacceptable or illegal behavior" (Zessen, 1991). Some authors have also suggested that a counseling process in this area should help the person to develop a positive sexual identity, live with it and have constructive relations with minors without harming them or breaking the law (van Naerssen, 1991).

In Vogt's (2006) study, most participants found helpful self-help groups of pedophiles. This author and others (Gieles, 2001; Zessen, 1991) conclude that this kind of approach seems promising for non-violent and primary pedophiles. In fact, the paradox may even arise that treatments of this kind actually succeed in reducing the abuses committed by pedophiles and making it less likely that they will cause harm. Even if the abuse takes place, perhaps its most violent and extreme forms could also be reduced.

This perspective is in relation to the idea that abuse of children is a deviant behavior that cannot be explained only from pedophilic feelings, but for other personal traits and a social environment that stimulates this antisocial behavior directly or indirectly (Fog, 1992; Seto, 2008; Vogt, 2006). Self-help methods and support therapy could help to reduce personal and environmental elements such as fear, depression or social conflict and isolation that could be conducive to sexual abuse (Silverman & Wilson, 2002). This is an approach not adequately developed nor studied, and which, of course, does not seems appropriate in all cases.

The welfare of the subject may sometimes coincide with the welfare of society, and we should certainly not wish to deny that helping pedophiles to regulate their behavior may benefit both the men themselves and society in general. What needs to be brought to light through these ideas is that the approach taken to the problem may be one or the other and each one has its own paradigms and frameworks for intervention. If the definition of a disorder as a *harmful dysfunction* is appropriate, psychiatry must differentiate it from *dangerous dysfunctions* and seek to clarify when the problem consists of the former, the latter or both.

Certain manifestations of schizophrenia can be dangerous to others, but schizophrenia is in the DSM not because it is a danger but because it causes patients and their families intense distress. To conflate these two aspects without any discussion, as has been the case with pedophilia, is a mistake that demands correction. For its own good, not to mention that of society and the scientific community, psychiatry should put a stop to this ambiguity, because it hinders honest debate, scientific progress, and the clarification of certain controversies.

The Perilous Concept of Danger in Psychiatry

In the mid-twentieth century, psychiatry suffered a serious problem of authority and meaningfulness, to which the supposedly scientific nature of DSM-III provided a partial solution (Mayes & Horwitz, 2005). In its efforts to gain recognition as a profession by society, the discipline looked to its elder sister, medicine, as a possible model to follow (Paris, 2008). However, such imitation only works in cases that are basically free of controversy about whether the condition constitutes a (mental) disorder, such as schizophrenia, major depression, etc. (Spitzer, 1999, p. 430), where the whole edifice is constructed around the patient's distress or an evident and abnormal alteration of self-perception.

However, psychiatry has also come in for justified criticism when it has overstepped the bounds of such phenomena and sought to expand, as it did over the whole of the last century, by medicalizing behaviors with a more debatable clinical status (Conrad & Schneider, 1980) in which the patient's distress is less obvious. One such criticism is that voiced by the more seriously ill patients and their families, who fail to understand how their problems can be lumped together in the same catalogue with phenomena like the paraphilias with no differentiation between what they call "actual disorders" and mere "distress, behavioral differences, and deviance" (Hall, 2002).

From this perspective, the criterion of genuine patient distress would to some extent serve to ward off certain temptations that have shown themselves to be treacherous ground in the past. As Culver and Gert (2006) note: "Rigorous adherence to this definition of mental disorder frees psychiatry from any temptation to enforce social conformity and contributes to psychiatry's simply being one more medical specialty" (p. 742).

My impression is that the scientific and professional community from which most of the parties to the controversy, on both sides, are drawn is understandably wary of the use of psychiatric diagnosis to regulate potentially dangerous behavior. Large parts of the past excesses of psychiatry were due to the inappropriate use of psychiatric diagnoses to exclude and control socially undesirable subjects (Reich, 1991). This is the perilous side of psychiatry's power. Perhaps the answer is not to deny the utility of dangerousness as a concept in psychology but to handle it with great care and prudence, applying it only in extreme cases (Walker, 1994).

Is Pedophilia Dangerous?

Would such a concept be applicable to pedophilia in such case? Are men with pedophilia dangerous? If they are, in what way? Under what circumstances? Does their dangerousness depend on their erotic peculiarity or on their character? The key is surely to break down the multitude of different phenomena embraced by this confused concept. In any event, associated characteristics are certainly relevant to the issue, contrary to what Zucker

(2002) has argued. Indeed, they are as relevant as they were in the case of homosexuality. And we must also recognize that the concept of "harm" can have multiple dimensions—physical, moral, psychological, religious, etc.—that would deserve a more careful analysis. Even ideas can be considered harmful by some people, i.e., the "apology of pedophilia" has been suggested as a crime in Spain (Boletín Oficial del Estado, 2008).

Any assertion in this sense may be premature and incomplete, given the limited state of our current knowledge which rests largely on the evidence gleaned from very biased samples of subjects who have been imprisoned for criminal offences (Seto, 2008). And it has been suggested that "it is likely that the criminal offending requires additional individual risk factors separate from the paraphilic interest per se" (Langström, 2009, p. 2). Any potential answer to the question if pedophilia is dangerous per se would need a more in-depth analysis than academia has done so far.

A Diagnosis in Search of a Disorder

The title of this article was inspired by an article entitled "A historical appraisal of America's experience with 'Pyromania'—A diagnosis in search of a disorder" (Geller, Erlen, & Pinkus, 1986). Considering the controversial history of this diagnosis in U.S. psychiatry, concluded that "Pyromania became a barometer of psychiatry's struggle with the individual's responsibility for his actions. From the historical perspective, pyromania is less a diagnosis in search of a disorder than a measure of each generation's struggle with the definition of personal accountability" (p. 223). While the diagnosis of pedophilia, like that of pyromania, is bound up with the question of moral accountability, the idea suggested by the title may fit the case of the former even better, because the confused history of the diagnosis and its treatment in the DSM indicates that it is a (necessary) diagnosis in search of an (uncertain) disorder to justify its existence.

The necessary diagnosis of pedophilia in terms of a *Dangerous Dysfunction* is difficult to change. The definition of the DSM as the "psychiatric Bible" (Kutchins & Kirk, 1997) is not a mere play on words, given the normative status which this psychiatric instrument has acquired in a society like ours that is based on the principle of "expert" knowledge, so that political and moral decisions need the support of supposedly scientific arguments.

In a society in which risk management and the control of potentially dangerous subjects by the State has gained increasing importance (Pratt, 2000), psychiatry and other related professions that perform a public function will continue to be enlisted to deal with the danger of pedophilia, and they will therefore need a diagnosis, even if it is a debatable one (Zander, 2005). In reality, such a diagnosis will not provide any kind of solution but only a partial remedy, the utility of which will always require further evaluation. And its current use in the involuntary psychiatric commitment of sexually violent predators has been seriously criticized (Frances & First, 2011; Zonana et al., 1999), although this is a issue of intense controversy (Stern, 2010, 2011; Tucker & Brakel, 2012).

However, forensic applications do not exhaust the utility of this diagnosis, as the treatment of pedophilia as a disorder is necessary in another more profound sense. It is by diagnosis, which is to say the differentiation of the morbid from the healthy, that psychiatry plays a key symbolic role in our society, which is to give a name to the irrational (Reich, 1991). The recent analysis of Wakefield (2011) about paraphilias in DSM-5 shows that, contrary to what Wakefield defends (Fulford & Thornton, 2007), our idea of a paraphilia rests upon certain intuition about the existence of something that doesn't work, i.e., is "dysfunctional." It is not an objective scientific determination, it is a subjective value judgment arising from our ideas and feelings about what is normal or natural and what is not.

The mere mention of pedophilia places us in the realm of the irrational, as homosexuality did only a half century ago. To lower the profile of pedophilia in the DSM to a mere problem of morality, illegality, and social deviation would be to leave the job half done. It is necessary rather to attend to the concept of perversion, of which pedophilia is the most feared embodiment today. It is more than a mere deviation, because, in the words of Simon (1994), "it constitutes a violation of the common understanding that renders current sexual practice plausible" (p. 5).

Psychiatry is an institution originally created out of the efforts of modern society to establish the boundaries between the rational and the irrational, the natural and the unnatural. This is, then, a matter that goes far beyond mere morality, reaching the roots of our collective imagination, and our ideas about the world and human nature. It is, as Sadler (2009) says, an ontological question full of thorny moral issues. This is why Spitzer (2005) falls back in the last resort on his personal feelings to underline the absurdity of dropping the classification of pedophilia as a pathology. Most people experience the same horror of the condition. Thus, it is the invocation of the pathological that allows us to control these fears and deal with uncertainty.

This apparently has not yet happened with homosexuality for those participants in this controversy. If this atypical condition succeeded in escaping from the imaginary orbit of mental disorders and the DSM, it was because it became possible in some way, under a given set of social and economic circumstances, to view it as within the realm of the *natural.* Various groups and persons, including scholars and professionals, helped change the scene so that society began to be less obsessed with the dangers of homosexuality and started to judge these people more on their character and behaviors, rather than solely on their sexual orientation. Is such an approach to the problem of pedophilia possible? To be honest, I do not know, but the social sciences, and especially sexology, bear much of the responsibility for investigating the question.

Nevertheless, many of the authors in this controversy seem to agree that paraphilic feelings or even conditions, including pedophilic feelings, are not always disorders. This is evident, of course, in those who defend the removal of pedophilia from the DSM, but also for those few that have argued for its retention. Comments of authors like Spitzer or Wakefield to the effect that pedophilia or homosexuality are disorders *at least sometimes* (Spitzer, 1999; Spitzer & Wakefield, 2002) suggest that the status of these erotic conditions as mental disorders is not clear even for these authors.

Likewise, the recent proposal to differentiate between *pedophilia* as a condition and *pedophilic disorder* (APA, 2011) reveal this ambiguity. In an ambivalent affirmation, this group actually defends that a "paraphilia by itself would not automatically justify or require psychiatric intervention." What exactly this means and implies is so extremely complex and potentially problematic that it far exceeds the scope of this article.

Conclusion

Few would deny that the current diagnosis of pedophilia is a slough of problems. The controversies herein discussed suggest that the diagnosis would not pass "the harsh test of substantive content, logical consistency and practical relevance" (Klein, 1978, p. 41). Participants in these discussions seem to have two main disagreements. First, the different interpretations about the meaning of a dysfunction in human sexuality and, consequently, the real reasons for removing homosexuality from the DSM. Second, the tension between the Hippocratic and Lombrosian traditions, with the problematic consideration of any mental disorder primarily as a *Dangerous Dysfunction*. This makes reaching a consensus almost impossible because there are serious differences in fundamental assumptions. Three suggestions are offered in conclusion about further analysis and debates about the status of pedophilia and other atypical sexualities.

First, this controversy is limited to a conceptual analysis based in a probably erroneous interpretation of the meaning of a "definition" of mental disorder as well as the nature of diagnostic categories in the DSM (Paris, 2008). Moreover this conceptual discussion is mostly based on Wakefield's model of *harmful dysfunction*, a proposal that is very limited and full of problems (e.g., Murphy & Woolfolk, 2001a, b). Opening the controversy to other theoretical perspectives could be helpful and enriching.

Second, perhaps we should recognize our rather simplistic conceptualization of human eroticism in these discussions. A simplicity which is in part reflected in the Manichaean approach to this controversy in which the discussion is about all or nothing. It is not that there are not disorders in human eroticism, but the omnipresent forensic paradigm is an important source of oversimplification (e.g., limited to data from laboratory use of penile plethysmographs). Human eroticism is much more complex than that and we should have in mind what is the meaning of a disorder in this area in order to understand these issues (Suppe, 1987).

In this sense, finally, we should consider the possibility of conceptualizing pedophilia as a very complex phenomenon that, contrary to other paraphilias, it is oriented towards another person and not to objects or animals, parts of the body or any kind of act. Its essence does not reside in exploitation, assault or harm to others, and some pedophiles look also for the child's friendship and love (Lautmann, 1994; Li, 1990; Schmidt, 2002; Seto, 2012). Regardless of the intense feelings of rejection that some of its manifestations generate in most of us, to conceptualize and discuss this condition in the same category with the compulsive necessity to show one's genitals to an unsuspecting stranger is contributing to an inadequate, ineffective, and confusing theory of human eroticism and its problems.

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