

How to Be a Pervert: A Modest Philosophical Critique of the *Diagnostic and Statistical Manual of Mental Disorders**

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ABSTRACT

This paper is divided into three parts. I begin with a short history of the way American psychiatrists have defined mental disorder in general, and paraphilias (sexual perversions) in particular, from the 1950s to 2013. I look at how the different editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) have articulated (or in the case of the future DSM-5, will articulate) the distinction between health and disease. In the second part I suggest how psychiatrists might want to modify their approach to the definition of mental disorder. In the third part I explain why the paraphilias in particular should be removed from the current psychiatric classification of diseases.

KEYWORDS

Psychiatry, Mental Disorder, Paraphilia (Sexual Perversion), Homosexuality, DSM, Function.

Cómo ser un Pervertido: una modesta crítica filosófica del *Diagnostic and Statistical Manual of Mental Disorders* (Manual diagnóstico y estadístico de trastornos mentales)

RESUMEN

Este documento está dividido en tres partes. Inicio con una breve historia de la forma en que psiquiatras americanos han definido el trastorno mental en general, y las parafilias (perversiones sexuales) en particular, entre 1950 y 2013. Veo cómo las diferentes ediciones del *Diagnostic and Statistical Manual of Mental Disorders* (DSM: Manual diagnóstico y estadístico de trastornos mentales) han articulado (o en el caso del futuro DSM-5, articularán) la distinción entre salud y enfermedad. En la segunda parte sugiero cómo los psiquiatras querrían modificar su aproximación a la definición de trastorno mental. En la tercera parte explico cómo las parafilias en particular deberían ser eliminadas de la actual clasificación de enfermedades.

PALABRAS CLAVE

Psiquiatría, trastorno mental, parafilia (perversión sexual), homosexualidad, DSM, función.

* This paper is based on an independent investigation.

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Como ser um pervertido: uma modesta crítica filosófica do *Diagnostic and Statistical Manual of Mental Disorders* (Manual diagnóstico e estatístico de transtornos mentais)

RESUMO

Este documento está dividido em três partes. Inicia com uma breve história da forma em que psiquiatras americanos vêm definindo o transtorno mental, em geral, e os desvios sexuais (*paraphilia*), em particular, entre 1950 e 2013. Observa-se como as diferentes edições do *Diagnostic and Statistical Manual of Mental Disorders* (DSM) articulam (ou no caso do futuro DSM-5, articularão) a diferença entre saúde e doença. Na segunda parte, sugere-se como os psiquiatras gostariam de modificar sua aproximação à definição de transtorno mental. Na terceira parte, explica-se como os desvios sexuais, em particular, deveriam ser eliminados da atual classificação de doenças.

PALAVRAS CHAVE

Psiquiatria, transtorno mental, desvio sexual (*paraphilia*), homossexualidade, DSM, função.

What is disease? What is health? How do we draw the line between health and disease? Most of us never ask ourselves such abstract questions, perhaps because we trust that doctors know the answers, or perhaps because we simply do not see why we should care. Yet to officially grant the status of disease to a condition can be an act of tremendous social, cultural, political, economic, legal, and ultimately ethical importance. A new disease represents a new market opportunity for pharmaceuticals, it circumscribes a new area of research for scientists, it becomes a new source of fear and hope for patients, it can remove or lessen legal responsibility, it can make individuals lose their jobs or child custody, etc. More profoundly perhaps, new types of subjects are made possible by new diagnoses, for diagnoses carve out, in the fabric of human experience, distinct ways of being.¹ In this paper I will look at how health is being separated from disease mostly by focusing on one specific example of disease: the sexual perversions, or as they are called today by American psychiatrists, the paraphilias.

Why focus on the paraphilias? For a historical reason first: it is in the 1970s, during debates about the medical status of one specific paraphilia (homosexuality), that for the first time doctors, and especially psychiatrists, seriously

tackled the problem of the definition of medical disorder. The paraphilias have thus played a particularly important role in the history of nosological thought. The second reason is philosophical: paraphilia is one of the most controversial medical categories still in use today, and therefore a perfect case study for the philosophical question, what is disease? A few scholars have argued that the paraphilias are not medical disorders, and in the last part of this paper I will also make an argument for the removal of all paraphilias from psychiatric classification of diseases. Finally, a political reason: in May 2013 the line between healthy sexuality and perversion will be officially redrawn in a very significant way – in a way that will result in many more people being labeled as “perverts”. People outside the psychiatric profession need to be aware of this development if they want to be able to resist it better, and I hope that this paper will be a small contribution toward that goal.

This political reason to focus on the paraphilias determined the type of approach I have decided to adopt for this paper. In several previous essays I have used the work of Michel Foucault as a springboard to study a variety of historical objects, such as masturbation (Singy 2003), sadism (Singy 2006a), or scientific observation (Singy 2006b). When it comes to the topics of sexuality and psychiatry, I have in general found Foucault’s radical historical critique extremely inspiring, despite certain ambiguities (Lamb and Singy 2011). By showing the historical contingency of sexuality and psychiatry, Foucault invites us to question, and ultimately to get rid of, some of the most constraining categories that structure our modern experience. But such a strategic kind of resistance, which aims at overthrowing entire systems of thought, is not always feasible, nor necessarily desirable. A more targeted attack might be more appropriate when

¹ For a detailed historico-philosophical example of this process of “making up people” through a diagnostic category, see Hacking (1995).

one is dealing with a circumscribed source of oppression. Although it remains important to try to provide a radical critique of psychiatry, it seemed to me that the urgency of the problem discussed in this paper called for something more modest, and hopefully also more efficient—a tactical resistance. Consequently, the point of this paper is not to try to escape psychiatric power/knowledge altogether, but by using the tools of analytic philosophy, to lay bare some of its internal conceptual weaknesses and to offer a reflection on how to make it less pernicious.

Defining Mental Disorder

The history of the definition of mental disorder in the USA is tied to the history of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM, of which the next edition is due out in May 2013, is the official American classification of psychiatric diseases. In this manual each psychiatric disease is described in the form of a list of symptoms. People qualify for a diagnosis if they have a minimum number of these symptoms. For instance, someone is a pathological gambler if he/she suffers from five out of ten symptoms, which among others include “needs to gamble with increasing amounts of money in order to achieve the desired excitement,” “lies to family members, therapist, or others to conceal the extent of involvement with gambling,” and “has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling” (American Psychiatric Association 2000, 674). To give a diagnosis with the DSM is a fairly simple procedure—and that is precisely the point. Armed with the DSM, psychiatrists should be able to agree with one another, since the DSM shuns theoretical disputes and focuses only on symptoms that are easily ascertainable.² Transparent throughout the DSM is an ideal of

mechanical objectivity, born in reaction against the complex and subjective hermeneutic method of psychoanalysis, and in part inspired by computer science (Demazeux 2011).³

The scientific and cultural importance of the DSM cannot be overstated. Psychiatrists have to rely on it for insurance purposes, for instance. It is also crucial for research: since all American psychiatrists rely on this same book to diagnose diseases, they can compare how different cures work on one disease, how rare or common a disease is, how it evolves, etc.⁴ The DSM is often referred to as the “Bible of psychiatry”—and that says it all: it is *the* reference book for American psychiatrists.

The publication of the DSM-III in 1980 marked a revolution in the history of the DSM. One of the most visible changes was the increase in the number of mental disorders: from 182 disorders in the DSM-II of 1968, to 265 disorders in the DSM-III (the current DSM-IV-TR lists 297 disorders). This nosological proliferation is of course not due to some sudden and mysterious degeneration of the human species, but to a combination of more mundane factors. To begin with, the psychiatrists in charge of the DSM-III followed what they called the “fundamental principle [of] inclusiveness”: “in order to maximize its clinical utility, DSM-III should include—with only a few exceptions—all widely used diagnostic categories that clinicians find essential to their work, even if satisfactory reliability and validity data are lacking” (Spitzer and Williams 1994, 459). In the name of clinical utility, there has been a tendency to bring many out-of-the-ordinary conditions into the purview of the DSM. In addition (but this is mostly true for the DSMs after the DSM-III, starting with the DSM-III-R of 1987), psychiatrists have often been pressured by outside groups, such as pharmaceutical companies, to increase the number of disorders or to expand the territory that they cover (Demazeux 2011). Finally, and this is crucial for my argument, the

2 See these pages: 155-7, 225-8, 248-9, 253. Needless to say, the atheoretical stance of the DSM leads to an epistemological impasse. As Dominic Murphy (2006) rightly argues, there are “obvious drawbacks to a causally neutral taxonomy of malfunctions that does not take into account information about normal functioning. ... Imagine how the state of health care would be if somatic medicine limited itself to symptoms in this way: we would classify together everyone who coughs as sufferers from ‘cough disorder’ and thereby miss the fact that someone who coughs may be doing so for a number of very different reasons. She may just have something lodged in her throat, or be irritated by the smoky atmosphere in Rudy’s Bar and Grill. Or she may be suffering from a variety of pathological conditions, including TB, bronchitis, or pulmonary edema. It is, to say the least, undesirable to fail to distinguish all these different causes of coughing, yet that is the result of relying exclusively on clinical phenomenology. Notice that ‘cough disorder’ could be a very reliable diagnosis in the technical sense of conducive to agreement among observers” (Murphy 2006, 311-12).

3 Interestingly, since the DSM-IV the American Psychiatric Association has stressed on the contrary the importance of clinical judgment: “It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion” (American Psychiatric Association 1994, xxiii). See Demazeux (2011).

4 However, at the same time that it facilitates comparisons, the DSM’s exclusive focus on symptoms undermines scientific research by separating diseases that might be symptomatically different but nomologically similar, or vice-versa. See Poland, Von Eckardt and Spaulding (1994).

DSM does not have a solid definition of mental disorder that could have curtailed the expansion of what it calls disorders. If one does not really know how to distinguish a mental disorder from a perhaps unfortunate character trait (for instance, social phobia from shyness), then the boundary between them can very quickly become fuzzy.

The DSM's strength is in the clarity and simplicity of its descriptions. But it is much weaker when it comes to justifying why in the first place social phobia, pathological gambling, the paraphilias, or any other diagnostic category, must be considered disorders.⁵ In fact, in the first two DSMs the concept of "mental disorder" was not even defined. The assumption probably was that you know a mental disorder when you see one. The same assumption was also clearly at work with specific disorders. The "sexual deviations," for instance, were listed but not defined in the DSM-I (American Psychiatric Association 1952), and they were very unscientifically and intuitively identified as any kind of non-heterosexual or "bizarre" sexual interest in the DSM-II (American Psychiatric Association 1968).⁶

In the 1960s and 1970s, this cavalier approach became irritating to homosexuals, who no longer accepted being described as sick individuals. The concept of homosexuality was invented in the nineteenth century, and while from the middle of the nineteenth century on a small minority of people thought that being homosexual was a natural way of being—just as natural as being heterosexual—most people, and especially psychiatrists, thought that homosexuality was a disease. In the mid-twentieth century, with the sexual revolution, the opinion started to shift, and gays began to organize and fight for their rights. They went to conventions of the American Psychiatric Association to let psychiatrists know that they wanted homosexuality to be removed from the DSM. Some psychiatrists also became critical of their own profession's attitude toward homosexuals. In the end, the question of whether homosexuality is a mental disorder or not was put to a vote. After many debates, in 1973 58% of psychiatrists decided that it should be removed from the DSM (Bayer 1987).

The psychiatrist who has been mostly responsible for the removal of homosexuality from the DSM is Robert

L. Spitzer. What Spitzer did in the 1970s with the DSM-III was to offer a definition of mental disorder that enabled him on the one hand to include many conditions that were uncontroversially thought to be diseases, and on the other hand to exclude homosexuality, which a majority of psychiatrists no longer wanted to consider pathological. Although it would be interesting to parse in detail Spitzer's original definition of mental disorder, and although several small changes have been made to the definition between the DSM-III and today's DSM-IV-TR, it is clear that there has been an unchanging core of the definition, which I would state as follows: from the DSM-III until the DSM-IV-TR, a mental disorder has been defined as a *harmful dysfunction*. Something is a disorder if and only if it is at the same time a dysfunction and a cause of harm. This definition is meant to cover not just mental disorders but any medical disorder.

Let us see how the definition is supposed to work, with three examples. Is a heart attack a disorder? According to the definition, the answer is clearly "yes": it is a dysfunction (it disturbs the function of the heart, which is to pump blood), and it causes harm. Is homosexuality a disorder? No, because while it might be dysfunctional (if we assume that the function of sex is reproduction—more on this point below), it is not harmful. Homosexuals are often well-adjusted individuals who do not suffer from their condition *per se*. Since only one of the two necessary conditions of the definition is met (the *dysfunction* prong of the definition), homosexuality does not qualify as a disorder. Finally, is teething a disorder? It can be very harmful, but it is a natural process, so it is not dysfunctional. Once again, since only one of the two necessary conditions is met (this time, the *harmful* prong of the definition), teething is not a disorder.

With his definition of disorder as harmful dysfunction, Spitzer managed to remove homosexuality from the DSM without entirely challenging the validity of the rest of the disorders. The definition could in principle also serve as a conceptual test that conditions have to pass in order to be included in the DSM. This was especially important given the cultural context of the 1970s. At the time, the anti-psychiatry movement was accusing psychiatry of bringing support to the regimes around the world that were trying to oppress sexual, racial, and political minorities. To Spitzer's credit, he took this accusation seriously. He understood that psychiatry needed to rely on a definition of mental disorder that would block, or at least make

5 As many critiques have noted, the DSM favors reliability over validity. See Horwitz (2002).

6 The DSM-III still referred to the paraphilias as "bizarre"; the term was finally omitted in the DSM-III-R. See Frances and First (2011).

difficult, the direct translation of social deviance into mental disorder.⁷

And yet, the DSM definition of mental disorder has remained toothless, mostly because it does not specify what *dysfunction* means. Here is a well-known example that illustrates how the lack of a specification of dysfunction can have very troublesome consequences. In 1851, Dr. Samuel A. Cartwright described a condition that he called “drapetomania,” a disease that made slaves try to flee captivity (Cartwright 1851). Is drapetomania a real disease? If we apply the DSM’s current definition of mental disorder, the answer might very well be “yes,” depending on how we interpret dysfunction. Indeed, slaves who try to escape from their masters do not “function” in a racist society: they are socially dysfunctional. And they harm their masters by depriving them of their property.

The idea that a slave who tries to escape from his master does not function in a racist society is obviously very different from the idea that the heart does not function when it is having a heart attack. In the example of drapetomania, dysfunction is no longer a biological or psychological concept, but a socio-cultural one. The DSM does not clearly distinguish between these two types of dysfunction, and without this distinction nothing stops psychiatry from becoming exactly what anti-psychiatrists have for decades accused it of being: a mere instrument of social control. Spitzer’s response to the anti-psychiatry critique only plays hide and seek with the thorny problem of values. The criterion of dysfunction gives an air of objective rigor to Spitzer’s definition of mental disorder, seemingly making it less dependant upon socio-cultural values. But because dysfunction can in fact be interpreted in a socio-cultural manner, its objectivity is more illusory than real. Prejudices can thus hide behind a veil of objectivity.

Because of this dangerous ambiguity in the current definition of mental disorder, some of the psychiatrists who in the past have been in charge of the DSM, such as, quite recently, Spitzer himself, have begun to push for a stricter understanding of dysfunction (Spitzer 1999; Wakefield and First 2003).⁸ They have usually relied on the influential work of Jerome Wakefield, who also speaks in terms of

harmful dysfunction but with a crucial precision regarding dysfunction (Wakefield 1992a; Wakefield 1992b). According to Wakefield, a function should be understood as a *mechanism selected by evolution*. For instance, the heart makes a beating noise and it pumps blood. But making noise is not the function of the heart, whereas pumping blood is. Why? Because, as Wakefield explains, “it is the pumping, and not the sound, that explains why we have hearts and why hearts are structured as they are” (Wakefield 1992a, 236). The same holds true for psychological or behavioral characteristics. For instance, fear might have the evolutionary function of making you better prepared to face possible dangers. When you are afraid, your senses are heightened, you no longer feel pain, hunger or thirst, all your attention is concentrated on the danger and on how to avoid it. Seen from this evolutionary perspective, someone who is afraid when there is absolutely no danger has a dysfunctional type of fear and might suffer from a form of pathological phobia.

The theory of evolution is thus meant to ground the concept of mental disorder in biological and psychological science, and to make it less directly dependent on socio-cultural values. Now we can say, for instance, that Cartwright’s drapetomania is not only revolting by modern cultural standards (we hope), but also scientifically wrong. From an evolutionary point of view, trying to run away from an oppressor is certainly not dysfunctional.

Today the DSM still relies on Spitzer’s original definition of disorder (with a few minor changes), but several influential psychiatrists have lately endorsed Wakefield’s more precise proposal and suggested it should be used for the future DSM-5. Will the DSM-5 follow this suggestion?

Apparently not. In 2010 the psychiatrists working on the DSM-5 made available online their proposals for the future DSM (see www.dsm5.org). What very clearly transpires from these proposals is that instead of trying to strengthen the definition of mental disorder in order to make psychiatry less dependent upon socio-cultural values, the DSM-5 is about to undermine both the criterion of harm and the criterion of dysfunction. That is, the DSM-5 is ready to open the gates to conditions that are neither harmful nor dysfunctional.

This trend is especially clear with the paraphilias.⁹ Let us look at the problem of dysfunction first. Instead of

7 The 1970s philosophical debate about the nature of health and disease was in great part motivated by a fear of what Christopher Boorse called the “psychiatric turn,” i.e., the “strong tendency ... to debate social issues in psychiatric terms” (Boorse 1975, 49).

8 Michael B. First was the Editor of the DSM-IV-TR.

9 This paragraph and the three following ones are adapted from Singy (2010).

appealing to a Wakefieldian concept of dysfunction grounded in evolutionary theory, or even of continuing to use Spitzer's well-intentioned but deficient definition, the people working on the DSM-5 shamelessly embrace the criteria of cultural abnormality and social deviance. For them, a pervert, to put it simply, is someone who is weird: "Paraphilias are characterized by persistent, socially anomalous or deviant sexual arousal" (American Psychiatric Association 2011).

It is as if the people who are responsible for the paraphilia section of the future DSM-5 had not learned anything from what happened with homosexuality in the 1970s. Gay activists in the 1970s forced psychiatrists to realize that being different is not the same as being sick. They forced psychiatrists to articulate a definition of mental disorder that would block the all-too-common association between being outside the cultural norm and having a psychiatric disease. What the DSM-5 is about to do is to give up completely on that effort, and to reduce paraphilias to whatever culture says is an abnormal sexual interest.

But it gets worse. As if reducing the dysfunction criterion to cultural disapproval were not problematic enough (both scientifically and ethically), the people working on the DSM-5 are also trying to undermine the critical importance of the harm criterion. If they succeed, a "harmless paraphilia" would no longer be an oxymoron: people who enjoy sex in a way that harms no one, yet happens to be outside the cultural norm, would now have a paraphilia and would find their place in the DSM-5. By contrast, remember that since the DSM-III, for a condition to be considered a paraphilia it was necessarily harmful. The DSM-5's removal of the harm criterion signifies that homosexuality could in principle be reinserted in a future edition of the DSM.

We are heading toward an epidemic of perverts. Starting in May 2013, when the DSM-5 is due out, Americans will be considered sexual perverts if what they enjoy sexually is outside the norm. It will not matter if it is functional or dysfunctional, and it will not matter whether it causes harm or not. What the DSM-5 is about to do is nothing less than to pathologize difference.

Redefining Mental Disorder

How can we try to resist this obvious encroachment of psychiatric power on our freedoms? The most radical

move would probably be to dismiss psychiatric knowledge altogether. Given how ingrained psychiatry has become in our society, this dismissal is obviously not very realistic. Short of such a radical approach, what more limited but also more effective tactic could we use to resist the conclusions of the future DSM-5?

The first step is perhaps to recognize that when it comes to psychiatry, the only thing more dangerous than a bad definition of mental disorder is no definition at all. Unfortunately, after Spitzer's effort to try to define mental disorder there has been a lack of concern for this issue among most psychiatrists. Allen Frances, who was Spitzer's successor in charge of developing the DSM-IV, recently claimed that "there is no definition of a mental disorder. It's bullshit. I mean, you just can't define it" (quoted in Greenberg 2010).

Yet few people should feel more concerned than Frances about trying to give a definition of mental disorder. Frances has become one of the fiercest and most influential critiques of the future DSM-5.¹⁰ He warns that the DSM-5 will lead to false positive diagnoses, for instance by indicating that some people are paraphiliacs when really they are not. But how can he say that some people are not paraphiliacs, if he does not know what paraphilia in particular, or mental disorder in general, is? The very idea of false positive requires that you have a point of reference against which you can compare a case and conclude that an apparent positive is in fact a false positive. If you do not know what a mental disorder is, and if you think that matters of definition are "bullshit," then it is frankly disingenuous to accuse the DSM-5 of leading to false positive diagnoses. With his nonchalant, atheoretical, and dismissive attitude toward the question of the definition of mental disorder, Frances undermines his own criticism of the DSM-5. His debate with the DSM-5 is similar to a debate between two people who disagree about which ice cream flavor is best. More problematically, by framing the debate in these subjective terms, he indirectly supports the DSM-5's general approach to nosology at the same time that he attacks its specific conclusions.¹¹

¹⁰ See his blog at <http://www.psychologytoday.com/blog/dsm5-in-distress>.

¹¹ For instance, Ray Blanchard (2010) defines a paraphilia simply as something "abnormal" and argues for the insertion of "hebephilia" in the DSM-5. Frances (Frances and First 2011, 80) argues on the contrary that "hebephilia" should not be inserted in the DSM-5, on the ground that it is *not* "bizarre." Both Blanchard and Frances thus use

What definition of mental disorder should we adopt? There are three main camps regarding this issue: the naturalists, who believe that disease and health can be defined objectively, on empirical grounds; the normativists, who argue that what we call disease and health are nothing more than the reflections of value judgments; and finally, the position that is probably most common, and to which Wakefield and many others belong: the hybrids, i.e., those who think that disease and health are concepts that refer to facts of nature *and* to human values..

The naturalist position seems to me to be clearly untenable. A value component exists in all concepts of disorder. We say that cancer is a disease because we value life, for instance. The normativist position seems much more plausible theoretically, but it can have dangerous consequences. From a normativist perspective one can claim that being interested in Michel Foucault, not believing in God, or fleeing from a master are all pathological conditions, for instance. There would be no ground upon which to rest in order to challenge these opinions. *De gustibus non est disputandum*. When Foucault was diagnosed with AIDS, at a time when AIDS was not well known, his friend Paul Veyne asked him whether “AIDS exists really or whether it is only a moralizing myth.” Foucault replied: “I’ve studied this question, I’ve read quite a few things about it, and yes, it exists, it is not a myth. American physicians have studied this closely” (Veyne 2008, 211). This kind of basic distinction between real and mythical disease is something that I think we should try to preserve, not only because it intuitively makes sense (without it the very concept of disease becomes nonsensical) (see Murphy 2006, 23-29), but also because it can serve as a barrier against the expansion of psychiatric power in our modern societies.

So I subscribe to a hybrid position –disease and health are concepts that have both an empirical basis and a value component. But which empirical basis and which value component? This is where problems arise, of course. Regarding the empirical basis, I find Wakefield’s evolutionary approach attractive, but for a very perverse reason. Instead of helping doctors draw the line between disease and health, evolutionary theory would often make this task more arduous, and might therefore force them to take seriously the provisory nature of most of their diagnostic categories. In prac-

subjective criteria (abnormality, bizarreness), but what is bizarre/abnormal for one is not so for the other.

tice, it is indeed often very difficult to know the natural function of something.

Take something as basic as sex. Here is what Spitzer wrote, in an article co-authored with Wakefield: “One does not need knowledge of evolutionary theory to recognize that the function of sexual attraction is to facilitate selection of fertile mates and behavior that leads to reproduction” (Spitzer and Wakefield 2002, 499). And here is what Spitzer wrote in another article: “Why do we have sexual arousal? It is obvious. Sexual arousal brings people together to have that interpersonal sex. Sexual arousal has the function of facilitating pair bonding which is facilitated by reciprocal affectionate relationships” (Spitzer 2005, 114). Those are of course two completely different statements about the function of sex, and this striking discrepancy illustrates how it is often quite difficult to identify a natural function with certainty.

Some practitioners have rejected Wakefield’s definition of mental disorder on the ground that it is often unworkable (Bolton 2008). But that is precisely the reason why I like it. If implemented, it would force psychiatrists to be much more skeptical about their diagnoses. Making the concept of disorder dependent on evolutionary theory would mean that it would be *harder*, not easier, to know what a disorder is, and this might inject a healthy and much needed dose of skepticism into the practice of psychiatry.

I should add, however, that I myself might be suffering from “naïvism,” if such a disease existed. Instead of fostering intellectual debates and skepticism, as I would hope, the fact that the evolutionary function of a behavior remains often indeterminate could very well encourage psychiatrists to use the theory of evolution to reinforce pre-existing prejudices.¹² Wakefield himself has had a pattern of running to the rescue of the DSM by claiming that such and such DSM category refers to an evolutionary dysfunction, even when no solid evidence could back up this claim.¹³ There is obviously

12 For a general critique of evolutionary psychology and of its uses, see Kitcher (1985) and Dupré (2001).

13 See for instance Wakefield: “We do not have to know the details of evolution or of internal mechanisms to know ... that typical cases of thought disorder, drug dependence, mood disorders, sexual dysfunction, insomnia, anxiety disorders, learning disorders, and so on, are failures of some mechanisms to perform their designed functions; it is obvious from surface features” (Wakefield 1997, 256). For a criticism of Wakefield on this point, see Demazeux (2010); Murphy (2006 and 2011). See also Demazeux’s similar criticism of Boorse in Demazeux

a very difficult balancing act to do between advocating the use of a biological theory for the sake of limiting the number of possible disorders, and warding off the pernicious effects that this same theory might have because of its inconclusive results. I am not quite ready to give up on the idea that the difference between health and disease can be partly determined empirically, but I must admit that I am not sure how to go about resolving this problem.

Regarding the value aspect of disease, I think the most urgent task for psychiatrists is to make their values explicit (Fulford 2002). For instance, if psychiatrists want to continue making fetishism into a disorder, they need to lay out the notion of sexuality that they value to justify the validity of this diagnosis. I am quite certain that once the values behind psychiatric diagnoses are out in the open, some of the DSM diagnoses will lose much of the aura of scientificity that they still have today in the lay public. It would become clearly visible, for instance, that the psychiatrists who are dealing with the paraphilias rely on traditional values that are out-of-sync with those of modern liberal societies.

The distinction between health and disease is a philosophically complex and abstract problem, and my preceding tentative and very brief remarks are not meant to solve it, only to stir the conversation in a certain direction. I am convinced of only one thing: because receiving a diagnosis can have important social and existential consequences, psychiatrists should be very careful about not blurring too much the line between disease and health. Unfortunately, instead of continuing and pushing further the debate about the nature of mental disorder, the DSM-5 seems eager to go back to the callous, paternalistic and theoretically immature approach of the DSM-I and DSM-II—an approach which, phenomenologically, is probably rooted in a visceral reaction of disgust against those who are different, and which, historically, has too often made psychiatry the servant of oppressive powers.

Erasing Perversion

As I explained above, it would be illusory to try to throw the entirety of psychiatry overboard. But when

(2011). John Z. Sadler rightly remarks that Wakefield's early work was more prescriptive than it is today: "It appears [Wakefield] has gone from evaluating categories for assignment of disorder status to explaining, post hoc, why the status quo is the status quo" (Sadler 1999, 434).

it comes to sexual perversions, we can show that, even when judged from within the epistemological field of modern psychiatry, the diagnosis of paraphilia is questionable, to say the least. In this final section of my paper I would like to explain why all the paraphilias should be removed from the DSM, without challenging the usefulness or validity of psychiatry itself, or even of the DSM. In order to make my argument I need first to make a detour through the history of the concept of perversion.

All the terms that refer to sexual perversions, including the expression "sexual perversion" itself, have been invented in the second half of the nineteenth century, usually by German psychiatrists. The emergence of this new lexical field is the symptom of an entirely new way of thinking about sex, which we call "sexuality" (also a nineteenth-century word). It is crucial to stress that psychiatrists began to talk about sadism, homosexuality, exhibitionism, fetishism, etc., not in a clinical context, but in a forensic one. What these first psychiatrists were concerned with was not helping patients in distress, but determining whether defendants were responsible for crimes.

For instance, the first important case of perversion dates from 1849 and was about a French soldier who had sex with corpses and tore them to pieces: the sergeant François Bertrand. The question that was asked during his trial was: did this man voluntarily desecrate corpses, or was he driven by an irresistible instinct? (Anonymous 1849). Psychiatrists thought that since he was young, good-looking and intelligent, if he had wanted he could have had sex with living women (Brierre de Boismont 1849; Baillarger 1858). The only possible explanation for his behavior was therefore, according to these psychiatrists, that he suffered from a perversion of the sexual instinct.

A few years later the same type of question was raised about people who had sex with people of the same sex. This time it took place in Germany rather than in France, because sodomy was illegal in Germany but not in France. German psychiatrists determined that some people simply cannot help desiring people of the same sex. It is not a choice: it is part of their nature; they are a different kind of people than normal people. And so they were called "homosexuals." Because homosexuality was thought to be a disease rather than a choice, psychiatrists argued that homosexuals should not be deemed legally responsible for the crime of sodomy.

All the paraphilias that have ended up in the DSM have a similar forensic origin.¹⁴ It is always the same pattern: a crime is committed –rape, sodomy, exhibitionism, etc. –and then the issue of responsibility is raised: did the defendant commit this crime voluntarily, or could he not have helped himself because it was part of his nature? Today it is still within a forensic context that new paraphilias are created. For instance, lately there has been a fierce debate about “hebephilia,” a paraphilia characterized by sexual attraction to pubescent children. “Hebephilia” is not in the current DSM-IV-TR, but there is pressure for it to be included in the future DSM-5, since it is in fact already used by some forensic psychiatrists in the courtroom (Blanchard *et al.* 2009).¹⁵ Today, just like in the nineteenth century, the paraphilias are born in the courtroom, not on the couch.

The fact that the paraphilias have a forensic origin indicates that what is fundamentally at stake in a diagnosis of paraphilia is the issue of self-control. Think of the two situations in which the diagnosis of paraphilia plays an important forensic role: the insanity defense and the civil commitment under the Sexually Violent Predator (SVP) laws.¹⁶ In the case of an insanity defense the forensic psychiatrist who claims that a person suffers from a paraphilia implies that this person is not legally responsible because he lacks self-control. In the case of a paraphiliac who is civilly committed under the Sexually Violent Predator laws, the assumption is that this person will not be able to control himself if released into society, just like a wild beast cannot help but kill. For this reason, after these paraphiliacs have completed their sentence in prison they must be kept in an institution that will try to cure them of their paraphilia, and that will above all protect society. In the case of the insanity defense, the question of self-control is directed toward the past, while in the case of civil commitment it is directed toward the future –but in both cases what is at stake is self-control. When forensic experts are being asked, “Does this person suffer from a paraphilia?”

what they are really being asked is, “Does this person lack, did s/he lack, or will s/he lack self-control?” In the courtroom, the assumption is that if you have a paraphilia, you lack self-control.

But over the course of the twentieth century, the concept of paraphilia has been extracted from its original forensic context and used in clinical settings. Clinical psychiatrists were no longer interested in the forensic issue of self-control. In the paraphilia section of today’s DSM, lack of self-control is indeed not a necessary condition for something to count as a paraphilia. For instance, someone who has always been able to resist his urge to molest children, but is distressed by the fact that he has this urge, qualifies for a diagnosis of pedophilia. In its Introduction, the DSM warns very explicitly that “the fact that an individual’s presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual’s degree of control over the behaviors that may be associated with the disorder” (American Psychiatric Association 2000, xxxiii).¹⁷ What matters in a clinical setting is to alleviate the suffering of patients, not to determine whether they have self-control or not.

There is obviously room here for some very dangerous confusion. Lawyers use the paraphilia diagnoses of the DSM to imply that a person lacks self-control, while the DSM claims that you can have a paraphilia without lacking self-control. The same diagnosis of paraphilia turns out to mean something different in a medical context than it does in a legal one.¹⁸ From a forensic perspective, it would certainly be much more appropriate to ask directly whether a defendant lacks self-control than to ask whether he has a paraphilia, because the latter question is only an indirect and misleading way to get at the former question, which is the only one that matters forensically. Since the DSM claims that having a paraphilia is neither a sufficient nor a necessary condition for lacking self-control, there is no forensic reason for the paraphilias to remain in the DSM.

14 Frances and First seem unaware of this historical background. For this reason they do not realize that their criticism against the inclusion of hebephilia in the DSM-5 should logically apply to all the other paraphilias as well: “The alleged diagnosis ‘paraphilia not otherwise specified, hebephilia’, arose, not out of psychiatry, but rather to meet a perceived need in the correctional system. This solution represents a misuse of the diagnostic system and of psychiatry” (Frances and First 2011).

15 For a criticism of the hebephilia diagnosis, see for instance Franklin (2010) and Wakefield (2011).

16 On the SVP laws, see Janus (2009).

17 Winick rightly notes that “the language in DSM-IV describing even the impulse control disorders and sexual disorders –conditions involving repetitive criminal and sometimes violent behavior– suggests a failure on the part of the individual to resist strong impulses or urges, rather than an inability to do so” (Winick 1995, 579).

18 This problem is not restricted to the diagnosis of paraphilia but affects the category of mental disorder as a whole. As Michael S. Moore has shown, “writers in the area of legal insanity have often been confused between two quite distinct concepts: legal insanity and mental illness” (Moore 1980, 30). See also Murphy (2006); Neu (1980); Winick (1995).

Would there be at least a clinical reason for keeping the paraphilias in the DSM? If a fetishist is miserable, for instance, shouldn't psychiatrists try to cure him of his fetishism? Can't a diagnosis of paraphilia make clinical sense in some cases? But here we need to ask ourselves: what exactly does this fetishist suffer from? Compare with an anorexic: the anorexic clearly suffers from her condition; in fact she might die from it. But if paraphiliacs suffer, it is not because of their sexual preference *per se*. It is because of how people react to their sexual preference. For instance, it is of course very possible that a homosexual would suffer from depression, and that it would not be the case if he were heterosexual. But depression is not caused by homosexuality itself; it is caused by the discrimination that a homosexual might feel in a homophobic society. Homosexuality is not the problem: the problem is society's reaction to homosexuality. The situation is analogous to African-Americans who are depressed as a result of living in a racist environment, or to women who are depressed as a result of living in a misogynistic environment (Moser and Kleinplatz 2005). Psychiatrists might want to help African-Americans and women with their depression, but they will not try to cure them of their race or womanhood. The same should hold true for paraphiliacs, and this is why the inclusion of the paraphilias in the DSM makes no more sense clinically than it does forensically.

For centuries the adjudication of sex has been keeping moralists, theologians and politicians very busy. It is perhaps understandable that since the second half of the nineteenth century psychiatrists have wanted their share of what has turned out to be, after all, excellent business. But inasmuch as they conceive of their discipline as a modern science, psychiatrists need to subject themselves to much higher standards of theoretical coherence. The current psychiatric thinking on perversion is so deeply flawed –so deeply perverted, one might say– that I fail to see how it could be salvaged. Nor can I think of any reason why it should be. ☞

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