

Hebephilia Is Not a Mental Disorder in DSM-IV-TR and Should Not Become One in DSM-5

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The paraphilia section of Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) is being misinterpreted in the forensic evaluations of sexually violent offenders. The resulting misuse of the term paraphilia not otherwise specified, hebephilia, has justified the inappropriate involuntary commitment of individuals who do not in fact qualify for a DSM-IV-TR diagnosis of mental disorder. This article has two purposes: to clarify what the DSM-IV-TR was meant to convey and how it has been twisted in translation within the legal system, and to warn that the DSM-5 proposal to include pedohebephilia threatens to make the current bad situation very much worse in the future.

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Twenty states and the federal government have passed statutes that allow for the involuntary psychiatric commitment of sexually violent predators (SVPs) to begin after their prison sentence has already been served. These statutes were passed as a public safety measure in response to egregious sexual offenses committed shortly after release by former prisoners who had received relatively short sentences. Central to all the statutes is a requirement that the SVP offender be diagnosed with a mental disorder or abnormality. The five to four Supreme Court ruling in *Kansas v. Hendricks*¹ that narrowly supported the constitutionality of SVP statutes rests completely on a presumed ability to distinguish individuals who are mentally disordered from those who are common criminals. Otherwise, the continued involuntary in-

carceration would clearly represent double jeopardy and a denial of due process. There is no constitutional justification for continued preventive retention once a prison sentence has been served, unless dangerousness is specifically caused by mental abnormality.

The Supreme Court ruling does not require that the qualifying mental abnormality be a Diagnostic and Statistical Manual of Mental Disorders (DSM)-defined disorder, but in actual practice, evaluators invariably use one or another of the DSM categories to justify their findings. Although it varies from state to state, the two most commonly used DSM diagnoses to justify involuntary commitment are generally pedophilia and paraphilia NOS (most often NOS, nonconsent, but more recently also NOS, hebephilia).^{2,3} There has been some, but limited, controversy about the suitability of pedophilia,^{4,5} but it is generally accepted within the field as a qualifying DSM-IV-TR mental disorder. The grounds for accepting paraphilia NOS as a qualifying mental disorder are much shakier.

In the first half of this article, we discuss the current misuse of the concept paraphilia NOS, hebephilia, in involuntary SVP commitments. In the second half, we discuss the weaknesses of the DSM-5

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proposal for a new diagnosis of pedohebephilia and its detrimental consequences.

The Misuse of the Diagnosis Paraphilia NOS, Hebephilia

Although it was first mentioned 100 years ago, hebephilia has sprung into sudden prominence only because of its recent use in forensic proceedings.⁶ The term hebephilia has been used to provide a mental disorder diagnosis for those SVP offenders whose targeted victims are pubescent, not the prepubescent targets of pedophilia. The numerous conceptual problems with the diagnosis of hebephilia and the extreme limitations of its research base have already been well described by authorities in the sexual disorders field.⁷⁻¹⁵ This background has not prevented hebephilia (in the official sounding guise of paraphilia not otherwise specified, hebephilia) from being misused as a qualifying diagnosis in legal proceedings, to justify what often becomes a lifelong involuntary psychiatric commitment.

We will attempt to correct the misunderstandings that are shared among many SVP evaluators about the DSM-IV-TR paraphilia section. These misunderstandings result in part from the imprecise DSM-IV-TR wording, which is best understood by reviewing how paraphilia was defined in DSM-III¹⁶ and how and why the wording was changed in DSM-III-R,¹⁷ DSM-IV,¹⁸ and DSM-IV-TR.¹⁹

DSM-III, which first introduced the term paraphilia, noted that “the essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement” (Ref. 16, p 266). The text then went on to offer some examples of what would constitute unusual or bizarre imagery or acts, explaining that they “generally involve either: (1) preference for use of a nonhuman object for sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation or (3) repetitive sexual activity with nonconsenting partners” (Ref. 16, p 266). Because of concerns about the subjectivity and unreliability of the terms unusual and bizarre in the definition, these terms were omitted from DSM-III-R (Robert Spitzer, personal communication, July 8, 2010), leaving only the list of examples that were modified to mention “children” specifically, alongside “other nonconsenting persons.” Notably, the sentences explaining the etymology of the word paraphilia were retained: “In other classifications these disorders are referred to as

Sexual Deviations. The term Paraphilia is preferred because it correctly emphasizes that the deviation (para) lies in that to which the person is attracted (philia)” (Ref. 17, p 279).

Those preparing DSM-III-R understandably did not anticipate that many years later their truncated definition of paraphilia would be placed under intense scrutiny and have such consequential impact in the context of sexually violent predator commitment hearings. The DSM-III-R listing of eight specific paraphilias, along with the inclusion of seven other patently abnormal examples in the NOS section (e.g., necrophilia (corpses), zoophilia (animals), and coprophilia (feces)), was thought to be sufficient to communicate to clinicians the variety of sexual arousal foci considered to be paraphilic. Subsequent editions have similarly failed to provide a general and abstract definition of what makes a particular sexual arousal pattern paraphilic. Nonetheless, the underlying principle governing inclusion in this category is that a person’s focus of sexual arousal be considered deviant, bizarre, and unusual.

In our roles as Chair of the DSM-IV Task Force and its Editor of Text and Criteria, we must take responsibility for its insufficiently clear wording that has allowed the misuse of the Paraphilia section in SVP hearings. We did not anticipate the later forensic misuse of the section and dropped the ball by retaining the vague DSM-III-R wording that did not include anything approaching a clear and coherent definition of the overall concept of paraphilia. The boundaries of the term paraphilia are admittedly extremely difficult to define precisely, but in retrospect we should have provided more guidance and less room for the loose usage now found in SVP proceedings.

We will annotate the wording of the three introductory sentences in the DSM-IV-TR Paraphilia section, in an attempt to clarify the original intent of DSM-III, DSM-III-R, and DSM-IV and reduce the confusion caused by the unfortunate ambiguity in their wording. We chose these three sentences because they have been the most misinterpreted in forensic settings to justify the inappropriate use of the paraphilia NOS category. We hope that this insider’s parsing of the intended meanings will help to set the record straight and prevent their further misuse in SVP proceedings.

Essential Features of a Paraphilia

Much has been made in legal settings of the wording of the opening sentence of the DSM-IV-TR Paraphilia section: “The essential features of a Paraphilia are recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one’s partner, or 3) children or other nonconsenting persons . . .” (Ref. 19, p 566). This wording is clearly inadequate as a definition, but the sentence was not rewritten during the DSM-IV revision process because never in our wildest dreams did we foresee that it would be misconstrued in legal proceedings to be an operational definition of what types of sexual arousal foci fall within the diagnostic construct of a paraphilia. The opening sentence is meant as no more than a kind of table of contents to the eight specific disorders covered later in the section, sorting them roughly by the type of deviant sexual arousal into seemingly convenient groupings: non-human objects covered two categories (fetishism and transvestic fetishism); suffering and humiliation covered an additional two categories (sadism and masochism); and children and other nonconsenting persons covered the remaining four categories (pedophilia, exhibitionism, voyeurism, and frotteurism).

The sentence was never meant to be taken out of its introductory context and treated as an authoritative and stand-alone legal definition of paraphilia. If we had been more prescient about the risks of its later forensic misuse, we would have returned to the much better worded general definition provided by DSM-III, with its explicit statement that the essence of a paraphilia is that “unusual or bizarre imagery or acts are necessary for sexual excitement” and that “such imagery or acts tend to be insistently and involuntarily repetitive” (Ref. 16, p 266). The changes in wording between DSM-III and DSM-III-R (which were retained by us in DSM-IV) were not in any way meant to change the definition of paraphilia. They reflected instead the concern that words like unusual and bizarre, while conceptually clear, were inherently subjective and thus would be difficult to operationalize reliably.

Much confusion in legal settings could have been avoided had the DSM-III wording been retained to clarify the intended definition of paraphilia, even granting that these terms are inherently imprecise.

The underlying problem is that a satisfyingly precise bright-line definition of paraphilia may not be possible, just as there is no satisfying bright-line definition of the more general concept of mental disorder in either psychiatry or the law. This ambiguity has led to the distressing situation of the defining of paraphilia NOS by the idiosyncratic, unreliable, and untrustworthy standard of “you know it when you see it.” But one thing is clear about the DSM definitions, however imprecise their wording. Paraphilia is meant to apply only to sexual urges, fantasies, and behaviors that are unusual or bizarre. As we shall see in the second section of this article, attraction to pubescent individuals is far too widespread to be considered unusual or bizarre and has not been considered to be evidence of a paraphilia in any of the DSMs from DSM-I all the way through to DSM-IV-TR. Given the rightful illegality of predatory sexual relationships with minors, being intensely sexually aroused by adolescents may predispose the individual with such inclinations to committing a crime, but the attraction in and of itself is not an indicator of mental disorder.

Definition of Children

It has been claimed in forensic proceedings that the use of the term children as one of the categories of sexual arousal foci in the introduction of the Paraphilias section was meant also to include attraction to pubescent individuals. For example, in its attempt to annotate the DSM-IV introductory section, an influential manual used by forensic evaluators to guide their evaluations of sex offenders states that “the recommendation is made that evaluators’ interpretation of the word ‘children’ specifically for diagnostic purposes include any of the [following]” (Ref. 20, p 61): “. . . 1) anyone under the legal age of consent (e.g., age 15, 16, 17, or 18 depending on jurisdiction); 2) anyone yet to reach puberty (which the DSM-IV operationalizes as ‘generally age 13 or younger’); or 3) anyone still under the legal guardianship of an adult” (Ref. 20, p 60). This broadening of the concept of children goes far beyond anything that was intended in DSM-IV. As discussed earlier, the use of the word children in the introductory section was intended to be entirely congruent with its use in the diagnostic criteria set for pedophilia, which state “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors with a prepubescent child or chil-

dren (generally age 13 years or younger)” (Ref. 19, p 572).

Furthermore, the parenthetical phrase (generally 13 years or younger) modifying the word children has been used in some SVP commitment cases to argue that a sexual offense against any 13-year-old would qualify under the diagnosis of pedophilia, regardless of whether the child is pubescent. As is often done in diagnostic criteria sets to assist in their clinical utility, the phrase was included simply for the purpose of providing a general upper age limit for the construct prepubescent, one that made more sense in the late 1980s than it does now with the steady decline in the age of attaining puberty.²¹ It is a simple misreading in legal proceedings (and also in the DSM-5 rationale supporting its proposal for pedohebephilia²²) to imply that attraction to all individuals under age 13 would qualify, regardless of whether they are prepubescent. The diagnosis of pedophilia is based on the absence of puberty, not on any arbitrary age cutoff that could be misinterpreted to include pubescent individuals.

Inclusion of Paraphilia NOS

DSM-IV-TR includes sentences that state, “A residual category, Paraphilia Not Otherwise Specified, includes other Paraphilias that are less frequently encountered” (Ref. 19, p 567). “Examples include, but are not limited to telephone scatologia, necrophilia, partialism, zoophilia, coprophilia, klismaphilia, and urophilia” (Ref. 19, p 576). The possibility of including hebephilia as a specific NOS example never arose during the development of DSM-IV or DSM-IV-TR because no one suggested it. This concern did not arise until SVP evaluators started to assert that paraphilia NOS, hebephilia, was a legitimate basis for meeting the mental abnormality requirement in SVP statutes. The promotion of the concept, paraphilia NOS, hebephilia, is a medicalization of criminality mainly undertaken to plug an unfortunate hole in the legal system.

Appropriate Use of NOS Categories in Clinical and Forensic Settings

Our attempt to set the record straight calls for a more general clarification of the purposes of NOS categories in DSM-IV-TR—why they are included, how they are meant to be used in clinical settings, and why they should not be abused in forensic deter-

minations. DSM-IV-TR provides for 46 NOS categories included in the various sections throughout the manual. These are necessary to allow the diagnosis and coding of patients who do not fit well into any of the specific and official categories, but who nonetheless seem, on the basis of clinical judgment alone, to have a mental disorder with clinically significant distress or impairment. As noted in the Use of the Manual section of DSM-IV-TR (Ref. 19, p 4), NOS diagnoses apply for presentations that are subthreshold, atypical, or of uncertain etiology, or when insufficient information is available to enable a more precise diagnosis. The NOS categories are provided for clinical convenience because psychiatric presentations can be so varied and idiosyncratic and it would be impossibly cumbersome to have specific labels for every conceivable presentation.

While the NOS categories are essential for clinical practice, they are usually inappropriate and misleading when applied to consequential forensic SVP deliberations. Psychiatric diagnoses from the DSM-IV-TR are generally considered admissible in court because they are accepted by the field at large as recognized, clinically valid categories and are able to be reliably assessed. By virtue of their residual and idiosyncratic nature, cases given the label of NOS are by definition outside of what is generally accepted by the field as a reliable and valid psychiatric disorder. Furthermore, because the NOS categories do not have criteria sets, it is unlikely that they can be diagnosed reliably. There is no reason to assume that different evaluators would agree on an NOS diagnosis and therefore no reason to accept the NOS diagnosis offered by any given evaluator.

The introduction of the DSM-IV-TR includes a section entitled, Use of the DSM-IV in Forensic Settings, which discusses the limitations and the potential advantages of using the DSM in a forensic context, when it is used appropriately. For example, it states “when the presence of a mental disorder is the predicator for a subsequent legal determination (e.g. involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination” (Ref. 19, p xxxiii). It then goes on to say that “by providing a compendium based on a review of the pertinent clinical and research literature, DSM-IV may facilitate the legal decision makers’ understanding of the relevant characteristics of mental disorders” (Ref. 19, p xxxiii). These potential advantages apply only to categories

that represent the distillation of current psychiatric knowledge. Because NOS categories by definition fall outside the realm of the existing established categories, their use in forensic settings is much more likely to lead to inappropriate conclusions about their legal implications.

Thus, the use of an NOS category in a forensic setting should always be seen as extraordinary. If admitted at all as testimony, NOS diagnoses should require the strongest of supportive documentary evidence. They should certainly not be broadly and routinely accepted.

The Misguided DSM-5 Pedohebephilia Proposal

Among several radical proposals made by the DSM-5 Sexual Disorders Workgroup is the backdoor introduction of the hebephilia diagnosis into the DSM-5 by expanding the existing well-accepted pedophilia category to include sexual arousal to pubescent individuals and renaming the broadened construct pedohebephilic disorder. There is no apparent need or compelling rationale to include hebephilia in DSM-5 beyond the research interests of a few scientists and the questionable use of hebephilia in SVP proceedings.

The DSM-5 Workgroup misleadingly minimizes the extent and likely impact of this important change, suggesting that it is simply proposing that the upper age limit of pedophilia be increased one year from age 13 to 14. This claim is based on the fact that the guideline “generally age 13 years or younger” is provided as a parenthetical statement after the phrase “prepubescent children” in the definition of pedophilia in DSM-IV-TR, whereas in the DSM-5 proposal for pedohebephilic disorder, the subtype definition for the optional hebephilic type is given as “sexually attracted to pubescent children (generally age 11 through 14).” In actual fact, the proposed change in the definition is much more significant: from “recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children” in DSM-IV-TR (restricted to children at Tanner Stage 1, i.e., children with no evidence whatsoever of the development of primary or secondary sexual characteristics) to “recurrent and intense sexual arousal from prepubescent or pubescent children,” thus including children at Tanner Stages 2 and 3 as well (i.e., the first two of four stages of primary and secondary

sexual characteristics, such as the development of pubic hair and breasts).

The DSM-5 proposal for folding hebephilia (attraction to pubescent individuals) into pedophilia (attraction to prepubescent children) only makes sense if it can be established that both pedophilia and hebephilia are essentially part of the same underlying condition. Empirical evidence supportive of such a contention would consist of studies demonstrating that across most validators of interest, pedophilia and hebephilia are essentially identical. The recommended guidelines for making changes in the DSM-5²³ stress the importance of demonstrating broad support from several validator classes and particularly from at least one high-priority validator. These high-priority validators include familial aggregation, diagnostic stability, course of illness, and response to treatment. Unfortunately, no studies have been undertaken to compare pedophilia and hebephilia on any of these high-priority validators. Instead, virtually all of the scant empirical data that have compared pedophilia, hebephilia, and so-called teliophilia (i.e., nonparaphilic attraction to adults) have focused on validators of questionable relevance, such as IQ,^{24,25} completed education,²⁴ head injuries before age 13,²⁶ left-handedness,^{24,27} and stature.²⁸ However, even with these weak validators, the empirical data do not support the contention that pedophilia and hebephilia are part of the same overarching diagnostic construct. Instead, the studies consistently demonstrate that the values for hebephilias are intermediate between those for pedophiles and teliophiles, suggesting their lack of equivalence. Similarly, among gynephilic men (i.e., men preferentially attracted to adult women) presenting for evaluation of problematic sexual behavior, sexual arousal to images of and narratives involving pubescent girls is significantly higher than arousal to prepubescent girls.²⁹

Another potential problem with expanding pedophilia to include attraction to pubescent individuals is its likely impact on diagnostic reliability. As part of a study of the reliability of sexually violent predator civil commitment criteria in Florida (which was found to be poor, $\kappa = 0.56$), Levenson³⁰ examined the reliability of the application of psychiatric diagnoses. She reported that the diagnostic reliability of pedophilia was only fair ($\kappa = 0.65$) and suggested that the most likely sources of unreliability came from the determination of constructs in the criteria such as the 6-month required time period, the use of

terms such as recurrent and intense, and the determination of whether there was impairment or distress. Moving the diagnostic cutoff from prepubescent children (which is likely to be a relatively reliable construct due to its being defined by the complete absence of signs of puberty) to the inherently blurry dividing line between pubescent children and post-pubescent children is likely to compromise diagnostic reliability further. For example, in terms of pubic hair, the difference between Tanner Stages 1 and 2 (the current boundary between pedophilia and no paraphilia) is the lack of pubic hair at all versus sparse growth of long, downy hair with slight pigmentation. In contrast, the dividing line between Tanner Stages 3 and 4 (which would be the new boundary between pedohebephilia and no paraphilia) is pubic hair that is coarser, curled, and pigmented and spreads across the pubes versus adult-type pubic hair but with no spread to the medial thigh.^{31,32} As Zander¹² so aptly put it, this is “splitting pubic hairs” in a way that will almost certainly compromise its already problematic diagnostic reliability.

The DSM-5 Workgroup has also decided to impose a requirement for a minimum number of victims: two or more offenses if the victims are prepubescent; three or more if one or more of the victims are pubescent. Notably, the only citation provided on the DSM-5 web site for these pseudoprecise cutoffs is a single study of 365 men³³ that in actuality does not offer any support for using a cutoff of three or more victims to balance false positives versus false negatives in the diagnosis of pedophilia. What this study in fact demonstrated was that the sensitivity of penile plethysmography (a fallible laboratory measure of a man’s preferred sexual arousal foci) grew as the number of victims increased.³⁴ As noted by the authors in their discussion of these results, “Our analyses for offenders against unrelated children confirmed the expected result that men with greater numbers of victims had a greater likelihood of being diagnosed as pedophilic” (Ref. 33, p 124). In response to a recent critique of the lack of an empirical footing for the three-victim cutoff, Blanchard³⁵ performed a reanalysis of phallometric data on men referred for a clinical evaluation, most of whom had one or more sexual offenses against children, adults, or both. According to this analysis, the diagnostic specificity for a three-victim cutoff was 91 percent. The problem, of course, with these kinds of analyses is that the results are dependent on the particular

sample studied (i.e., they are valid only for this particular population of men who had been referred to the Centre for Addiction and Mental Health in Toronto from 1995 to 2009). While it is certainly possible, given the large number of subjects and relatively diverse range of referral sources, that these results can be generalized to groups of men referred for paraphilia evaluations in countries other than Canada, the question is an empirical one that would have to be demonstrated. Furthermore, the use of a minimum requirement of three victims may also lead to significant false negatives. An offender could sexually molest one victim daily for years (e.g., a family member or neighbor) and would not qualify for the diagnosis.

Overall, the research evidence supporting the inclusion of a new diagnosis of hebephilia is remarkably sparse and almost completely irrelevant. Most of the few available studies have been performed by a single research group on a sample of convenience (consisting mostly of offenders without a proper control group of nonoffenders) and typically compare individuals with a putative diagnosis of hebephilia with other groups of offenders (e.g., those with attraction to prepubescent or sexually mature victims) on variables that are not at all relevant to the validity, reliability, or clinical utility of the diagnosis of hebephilia (e.g., IQ, height, and handedness). Furthermore, we have no idea how the suggested DSM-5 criteria set would work in practice. Would it be reliable? Could it distinguish offenses arising from a paraphilic arousal pattern from those that are criminal or opportunistic or arise from impulse dyscontrol caused by a more established mental disorder (e.g., substance abuse, mania, mental retardation, or schizophrenia) or from brain injury? How should the evaluator define the fuzzy boundaries between prepubescent, pubescent, and sexually mature victims, all of which are imprecise?

This is a research enterprise that is just beginning and certainly is not ready to deliver a new diagnosis, especially one carrying so much forensic baggage. Finally, because of the limited funding available for the DSM-5 field trials, none of the sexual disorders (including pedohebephilia) will be included among the diagnoses that will be field tested. Including it in the manual without any field testing would be essentially flying blind, with potentially disastrous results.

The problems go far beyond the primitive research base. Suppose all the practical research were com-

pleted and the data were to prove that hebephilia exists as a discrete diagnostic entity and that it could indeed be reliably diagnosed. It still would not qualify as a Paraphilia. The essence of a paraphilia is that the sexual interest is deviant. Several studies have demonstrated the completely obvious, that attraction to pubescent individuals is common and within the range of normality. In a penile plethysmography (PPG) study, Barbaree and Marshall³⁶ found that a third of their small sample of 22 nonoffending men showed sexual arousal to adolescents as well as adults. In a PPG study of 48 heterosexual men in compulsory military service, Freund and Costell³⁷ found that the subjects' reactions to nude images of both adolescent (ages 12–16) and adult (ages 17–36) females were similarly high; those to images of female children (ages 4–10) were intermediate; and those to male children, adolescent or adult, were negative. In another study, Quinsey and colleagues³⁸ compared 20 child molesters against 21 controls (a mixture of non-sex offenders and males from the community), in penile circumference, skin conductance, and rankings of sexual attractiveness in response to photographs of persons of various sexes and ages. Similar to the 1970 Freund study, the normal group's arousal to pubescent females was elevated compared with a neutral stimulus, as well as to female children, and did not differ from the child molester group.

The advertising industry needed no studies to know that attraction to adolescents is common in the general population. The use of provocatively attired adolescent girls to promote products is certainly not uncommon. For instance, the famous (or maybe infamous) Calvin Klein advertisement using a youthful appearing Brooke Shields reflects the conventional wisdom that the general consumer population contains enough adult males attracted to a sexualized adolescent to justify making such a portrayal the center of an advertising campaign. It is fallacious to assert that having sexual urges involving pubescent youngsters is sufficient for a diagnosis of a mental disorder. Having such urges is normal; acting on them is a serious crime, not a mental disorder. The risks of the DSM-5 proposals are magnified because they emerge against the background of a push toward the increased diagnosis of hebephilia in SVP cases.

The DSM-5 Workgroup is suggesting a far-reaching change that can have an impact on individual civil liberties and the misuse of psychiatry in forensic settings. Such a radical and consequential change

should require a clearcut need, a compelling rationale, a conceptual justification, extensive empirical validation, and a careful risk-benefit analysis. None of these has been offered for hebephilia, for the simple reason that there is no clear need or rationale for this category, the empirical data are remarkably sparse, and the conceptual foundation that it is a paraphilia is at best questionable. The Workgroup does offer the naïve claim that including hebephilia as an official category might actually reduce the use of the diagnosis in SVP commitments, because it would be made more specifically. The opposite is much more likely to be true. Conferring official status on this unproven diagnosis would legitimize it, contribute to its credibility, and result in greatly expanded use. It is a great and puzzling paradox that the American Psychiatric Association has taken an extremely strong position opposing SVP statutes as a misuse of psychiatry³⁹ while its DSM-5 Workgroup is suggesting a diagnosis that would provide great impetus to increased SVP involuntary commitment.

Conclusions

Hebephilia is not a legitimate DSM-IV-TR mental disorder, and it should not be included as a DSM-5 mental disorder, for both conceptual and practical reasons. Hebephilia is not a paraphilia, because the sexual arousal pattern that would define it is not inherently deviant. Normal men have fantasies and urges in response to pubescent targets; acting on such attractions is a serious crime, not a mental disorder. Beyond this seemingly conclusive conceptual obstacle, the research support for hebephilia is remarkably undeveloped, weak, and unconvincing. The sudden attention focused on hebephilia as a forensic diagnosis has unfortunately been influenced by its inappropriate and premature use in qualifying SVP defendants for indefinite psychiatric commitment. 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. That a large number of forensic mental health workers have been mistrained to regard paraphilia NOS as a valid diagnostic category in SVP proceedings should not be construed as proper representation of the views of the entire mental health field. Similarly, the very preliminary studies conducted by a few research groups should not be construed to indicate that hebephilia

has any solid scientific support. Hebephilia is not an accepted mental disorder that can be reliably diagnosed and should not be treated as such in SVP proceedings.

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