Diagnosing and Litigating Hebephilia in Sexually Violent Predator Civil Commitment Proceedings

John Matthew Fabian, PsyD, JD, ABPP

In recent years, state and federal legislative initiatives have heavily emphasized punitive laws to combat sexual crime. These statutes include indefinite civil commitment, which is the ultimate infringement on sexual offenders' civil liberties. Many of these committed offenders have repeatedly offended against prepubescent children (pedophiles), and many have committed nonconsensual sexual offenses against adults (rapists). A substantial number of sex offenders have offended against postpubescent adolescents and teenagers outside the age range of pedophilia (commonly referred to by some clinicians and researchers as hebephilia). The use of the term hebephilia has recently received heightened scrutiny in sexually violent predator civil commitment proceedings. Specifically, experts debate whether hebephilia is recognized within the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) and whether it is a generally accepted diagnosis within the field of sexual offender assessment. Scholars and practitioners question how hebephilia pertains to sexual deviance and one's risk of reoffending and whether it ultimately meets the legal mental abnormality threshold of civil commitment through DSM diagnostic criteria. This article addresses these questions and provides recent federal case law that attends to hebephilia in sexually violent predator proceedings.

J Am Acad Psychiatry Law 39:496–505, 2011

The United States Supreme Court legalized the civil commitment of sexually violent predators in two landmark cases: *Kansas v. Hendricks*[1] and *Kansas v. Crane*.[2] In the nearly 15 years since *Hendricks*, 20 states and the federal government have initiated civil commitment legislation for dangerous sex offenders. These statutes have weathered heavy debate as to their legal constitutional parameters, the art and science of sexual violence risk assessment, and the assessment and diagnosis of paraphilias and personality disorders.

The substance of this article addresses the latter topic with a specific lens: the diagnosis of paraphilias, and in particular, the assessment of sexual attraction to postpubescent adolescent females, referred to by some as hebephilia. I will highlight current literature and debate among scholars and practitioners, as well as recent federal case law pertaining to hebephilia within sexually violent predator civil commitment proceedings.

Dr. Fabian is a Forensic Psychologist and a Clinical Neuropsychologist in practice in Cleveland, OH. Address correspondence to: John Matthew Fabian, PsyD, JD, ABPP, 815 Superior Avenue, No. 2017, Cleveland, OH 44114. Email: john@johnmatthewfabian.com.

Disclosures of financial or other potential conflicts of interest: None.

Sexually Violent Predator Civil Commitment Law

In response to high-profile cases that attracted media attention and national legislative initiatives to get tough on sex offenders, civil commitment laws experienced a rebirth in the early to mid-1990s and received constitutional support from the U.S. Supreme Court.

In *Kansas v. Hendricks*, the U.S. Supreme Court in a five-to-four decision, upheld the constitutionality of the civil commitment of sex offenders. The Court sustained a Kansas civil commitment law for those sex offenders who have engaged in harmful predatory sexual offending in the past; currently have a mental abnormality including a mental illness and/or personality disorder; and pose a threat of committing

predatory acts of sexual reoffending because of this mental abnormality or personality disorder.[3]

Five years after the *Hendricks* decision, the Court heard *Kansas v. Crane*, in which it was asked to review the Kansas commitment act by alternatively focusing on mental abnormality and the volitional element in sex offending. The Court acknowledged that in *Hendricks* it was not asked to set a formal volitional requirement associated with the amount of control a person might lack over his sexual behavior to qualify for commitment. The Court in *Crane* ruled that the "nature" and "severity" of the mental disorder "must be sufficient to distinguish the nondangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist considered in an ordinary criminal case."[2]

Interestingly, and in regard to the substance of this article, both Hendricks and Crane had various paraphilic psychiatric disorders. Leroy Hendricks had a noteworthy history of child molestation offenses toward boys and girls that prompted a diagnosis of paraphilic disorders, including pedophilia and exhibitionism.

Conversely, Michael Crane primarily had an antisocial personality disorder (APD) as well as exhibitionism, rather than a primary paraphilic disorder (pedophilia) like that of Hendricks. Crane argued that for the state to commit a personality-disordered individual, the individual should display volitional impairment sufficient to make him unable to control his sexually violent offending patterns.

The Court in *Crane* held that for a sex offender to be civilly committed, the person's mental abnormality or personality disorder must cause the individual to have "serious difficulty in controlling his sexual behavior," rather than "total or complete lack of control."[2]

Concerning the term "mental abnormality," the Court in *Hendricks* supported its use, because it is a broader term than that of "mental illness." The court stated that "mental illness" is devoid of any talismanic significance. Not only do "psychiatrists disagree widely and frequently on what constitutes mental illness," but the Court itself has used a variety of expressions to describe the mental condition of those properly subject to civil confinement.

As of this writing, the U.S. Supreme Court has not opined on whether controversial paraphilias (i.e., paraphilia NOS, nonconsent, or hebephilia) qualify as legal mental abnormalities in SVP civil commitment cases. In fact, as of June 2010, the U.S. Supreme Court denied *certiorari* in hearing *McGee*, *Michael L. v. Bartow*, *Dir., WI Resource Center*, which presented the issue as to whether due process permits the indefinite civil commitment of a convicted sex offender based on a rape paraphilia diagnosis.[4]

Fittingly, before addressing symptoms and behaviors constituting the alleged mental illness of hebephilia, I will briefly address the statutory requirements of the mental abnormality required for commitment and the prevalence of various psychiatric disorders in those civilly committed as sexually violent predators.

Legal Mental Abnormality: Prevalent Paraphilias Commonly Disputed in SVP Proceedings

Criteria necessary for civil commitment of sex offenders typically include a history of charge(s) or conviction(s) of sexual crimes or both; an identified mental abnormality, personality disorder, or both; and an opinion that, as a result of the abnormality or disorder, the offender is likely to engage in future sexual offending if not confined in a secure facility.[5]

Given the statutory language in SVP laws that include an investigation of mental abnormalities and personality disorders as well as future dangerousness, forensic psychologists and psychiatrists practicing within SVP proceedings are relied on to assess and evaluate mental disorders derived and outlined through the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).[6]

Recent assessments of the psychiatric profiles of those offenders civilly committed as sexually violent predators are outlined below.

The most common diagnoses in state civil commitment SVP proceedings include pedophilia; antisocial personality disorder; paraphilia not otherwise specified (NOS), in particular nonconsent rape and hebephilia types; personality disorder NOS; and substance abuse disorders.[7] Unfortunately, the majority of studies addressing psychiatric diagnoses commonly found in SVP proceedings do not formally break down paraphilia NOS into specific hebephilia diagnoses. Table 1 represents common psychiatric diagnoses found in state SVP proceedings.[8–12]

Obviously, the trier of fact in SVP proceedings relies heavily on the forensic mental health experts to

Table 1 Percentage of Patients Carrying Common Psychiatric Diagnoses Found in State SVP Proceedings

State	Most Prevalent Diagnosis	Second Most Prevalent Diagnosis	Third Most Prevalent Diagnosis	Fourth Most Prevalent Diagnosis
Florida[8]	Any substance use disorder, 54%	Total paraphilia NOS, 51%	Antisocial personality disorder, 48%	Pedophilia, 39%
Wisconsin[9]	Any substance use disorder, 55.6%	Pedophilia, 47.1%	Personality disorder, 41.4%	Paraphilia NOS, 37.5%
Minnesota[10]	Substance abuse or dependency, 52%	Pedophilia, 35%	Antisocial personality disorder, 26%	Personality disorder NOS, 8%
Washington[11]	Personality disorder, 83.2%	Pedophilia, 56.3%	Alcohol abuse/dependence, 43.2%	Paraphilia nonconsent, 42.6%
Arizona[12]	Personality disorder, 77%	Pedophilia, 63%	Paraphilia NOS, 56%	Drug abuse or dependence, 30%

assist in providing diagnostic education regarding the consideration of whether a particular offender suffers from a legally recognized mental abnormality. The experts utilize the DSM-IV-TR to assist in guiding them in identifying and ruling out clinical psychiatric disorders, yet there are some unanticipated dilemmas that stem from its use.

Quandary With the DSM-IV-TR

It should be noted that the DSM nosology for paraphilias has not always been consistent. The first DSM published in 1952 did not include paraphilias; rather, sexually deviant behavior was conceptualized as a type of sociopathic personality disorder. The term paraphilia first appeared in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III).[13] The DSM-III included a category for atypical paraphilias and the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R)[14] replaced this category with paraphilias not otherwise specified (NOS). In general, the DSM-III-R paraphilia categories are the same with minor changes.[15] However, none of the DSM manuals has ever formally included a paraphilia NOS category for hebephilia.

In theory, the DSM-IV-TR has its derivations in aiding in diagnosis of mental disorders with the objective of assessment and treatment rather than the application of behaviorally driven symptomatology to answer legal questions.

While some argue that the classification of a mental disorder in the DSM-IV-TR must be regarded as the primary standard for medical validity,[16] others argue that there is no published evidence that verifies the connection and that there is nothing that states that DSM-IV-TR support of a finding of mental abnormality is a legal requirement.[17] Consequently, there is an imperfect fit between psychiatry and the law.

Some experts question the strict incorporation of the DSM-IV-TR because of problems with reliability, validity, insufficient categories, and symptom thresholds. Conversely, other experts abide by the DSM, as it is universally relied on in the United States in clinical contexts and legal arenas as the authoritative source on mental disorder and personality disorder.[18]

Criteria for various forms of sexual deviance based on the DSM-IV-TR have caused considerable controversy, and their reliability and validity are largely unknown.[7,16,19–21]

For example, researchers have identified problems with the diagnosis of pedophilia as they question the utility, reliability, validity, and essential psychometric qualities of the diagnosis.[22–23] Particular attention has been paid to the problems with interrater reliability and test-retest reliability of the diagnosis.[21] Experts also disagree about how to measure ambiguous terms in the DSM-IV-TR, including recurrent and intense, and whether behaviors, urges, and fantasies cause a particular offender distress or impairment. Other scholars have considered empirically supported factors extraneous from the DSM, identifying pedophilic urges in child molesters that may assist in diagnosis, such as targeting males and having more than one victim, prepubescent victims, or extrafamilial victims.[25]

Although the diagnostic criteria for pedophilia appears straightforward, problems with the reliability of the diagnosis include the subjective manner in which information about sexual interests is considered by examiners and the dilemma experts experience when assessing sex offenders against children, as

these perpetrators are often unwilling to admit to deviant sexual thoughts and practices.[18]

Another highly contested diagnosis in SVP proceedings is paraphilia NOS, nonconsent (rape) subtype. The paraphilia NOS, nonconsent, diagnosis and the term rape are not formally mentioned in the DSM-IV-TR, and it is recommended by some that use of the paraphilia NOS category to accommodate rapists is inappropriate and does not fit with the intentions of the authors of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)[26] or DSM-IV-TR.[27]

Paraphilia NOS, nonconsent, lacks a defined set of diagnostic criteria,[28] it is used as a catch-all category for adult sex offenders who have multiple rape type offenses, it lacks reliability, its prevalence and epidemiology among rapists is unknown, and there are problems in differentiating the diagnosis from that of antisocial personality disorder.[29]

Coincidentally, the APA is currently writing the DSM, Fifth Edition (DSM-5), and is proposing draft revisions to various psychiatric disorders, including paraphilias.[30] For example, the Paraphilias Subworkgroup has proposed a paraphilic coercive disorder diagnosis to describe a person who experiences distress or impairment from sexually arousing fantasies or urges of sexual coercion. It is my understanding that at the time of this writing, the Subworkgroup has rejected paraphilic coercive disorder for inclusion in the DSM-5 as a formal diagnosis, but may add it to the appendix section.

When considering the substance of this article, the Paraphilias Subworkgroup is proposing changes to the diagnosis of pedophilia to be called pedohebephilic disorder, in which the diagnosis includes the hebephilic type (sexually attracted to pubescent children, generally ages 11 through 14).[30]

One then may question whether sex offenders whose victims are adolescents (outside the age range for pedophilia and younger than adult victims) qualify for a sexual deviancy disorder.

Accordingly, I will address this matter as it pertains to the utility of the clinical construct or diagnosis of hebephilia.

Hebephilia: Clinical Construct or Psychiatric Diagnosis?

Before I describe the construct and diagnosis of hebephilia, the reader should note that there are many sex offenders who are crossover offenders with histories of sexually assaulting children, adolescents, and adults.[31] In a study of incarcerated and paroled sex offenders,[31] the authors found relatively few offenders who offended against only one type of victim. Thirteen percent of inmates disclosed molesting only child victims and 18 percent disclosed assaulting only adult victims with the remaining offenders (70%) assaulting both adult and child victims. They found that 52 percent of inmate sex offenders who were known to assault adults also admitted to assaulting only children. In fact Bradford and colleagues[32] found that among pedophiles, 9 percent had assaulted an adult, and 13 percent had attempted to assault an adult. Among hebephiles, they had a higher crossover range of 10 and 24 percent. Abel and colleagues[33] found that 40 percent of child molesters admitted to assaulting an adult and 50 percent of rapists admitted to molesting a child. This research suggests that many sex offenders are crossover offenders who victimize a variety of victims of different ages, and brings into question whether offenders who repeatedly commit sexual assaults are typically exclusively interested in a particular type of victim.

The sexual attraction and preference for pubescent females,[34] defined as 13 to 16 years old in one study,[35] and as 11 or 12 to 14 years old in another,[36] has been defined as hebephilia. The term was first introduced in a sex offender prison psychiatric experiment in the 1950s which categorized the acts of sex offenders as rape, pedophilia, incest, and hebephilia.[34] Researchers rejected the hebephilia term, as it was not equated with sexual deviance like pedophilia was.[37] Later on, Freund[38] operationalized ephebophiliacs as men charged with homosexual offenses against 13- to 17-year-old boys, and he invoked the term hebephilia, defined by Glueck[34] as the heterosexual counterpart applied to men who prefer adolescent girls in the 13- to 15-year age range.

Notably, hebephilia is not formally listed in the DSM-IV-TR, and as a result, some experts challenge its existence,[39] contending that it is not abnormal for men in various cultures to be attracted to this age group.[40] Since it is not listed in the DSM-IV-TR, some claim that its reliability remains unchecked compared with pedophilia.[41]

The DSM-IV-TR section on paraphilias allows for a paraphilia not otherwise specified category in which a clinician may diagnose a paraphilia not specifically limited to and outlined in the manual (Ref.

6, p 576). Consequently, many clinicians diagnose hebephilia as a paraphilia NOS.

Researchers supporting the diagnosis of hebephilia have found that hebephiles have a discernable erotic age preference distinct from pedophilia.[36] Blanchard and his colleagues[36] found that men who verbally reported maximum sexual attraction to pubescent children had greater penile responses to depictions of pubescent children than to depictions of younger or older persons. Therefore, there was a remarkable consistency between the offenders' self-reported age preferences and their phallometric results. Penile responses distinguished these men from those who reported maximum attraction to prepubescent children and those who reported sexual attraction to adults. Some offenders had repeatedly sexually assaulted pubescent victims and had responded most strongly to laboratory stimuli depicting pubescents, more so than to those depicting prepubescents and adults. Consequently, Blanchard et al.[36] described the DSM-IV-TR's shortcomings in diagnosing paraphilias and offered recommendations such as replacing the diagnosis of pedophilia with pedohebephilia and allowing clinicians to specify subtypes (i.e., sexually attracted to children younger than 11 (pedophilic type), sexually attracted to children ages 11–14 (hebepihlic type), or sexually attracted to both (pedohebephilic type)).

Blanchard's study has come under scrutiny by scholars for various reasons.[24,39,41–44] First is the contention that the term hebephilia, as categorized under paraphilia NOS, is not widely accepted, and there is no professional consensus among practicing clinicians of such a diagnosis. Second is the lack of consistent research supporting the diagnosis. Third and specific to the study, scholars have noted methodological limitations, including the absence of model subjects aged 15 to 18 (mid to late adolescence) among the phallometric stimuli.[36] Therefore, the authors of the study could not determine whether the adult offenders who were aroused in response to early-stage adolescents might be equally or more aroused by those in mid to late adolescence. Accordingly, the decision to judge behavior to be pathological should not be based on phallometric data alone; rather, it should also consider the extent to which the behavior is abnormal in one's particular culture.[36]

Other empirical data have refuted the perception that hebephiles are sexually deviant. In particular, research has revealed heterosexual men to be sexually aroused by adolescents,[45] and both pedophiles and a control group were distinguishable in their sexual arousal to prepubescent stimuli, but both groups showed similar arousal patterns to stimuli in the hebephilic age range.[46] Further, research has revealed no evidence of deviant sexual arousal patterns among either rapists or heterosexual hebephiles.[47]

The question remains as to whether Blanchard's outcome data pathologizes men attracted to early-stage adolescents as part of an overall arousal pattern in response to adolescents of all ages. Can the sexual attraction to adolescents be differentiated into pathological and nonpathological groups on the basis of age and stage of sexual development?

Some doubt the diagnosis of hebephilia, as it may not be abnormal for men to be attracted to the adolescent age group in various cultures.[24,39,41,45,46] Surveys of social organizations of persons acknowledging erotic interest in children, samples of sex offenders, and surveys from the general population have revealed that attraction to children of pubescent age is more often reported than is the attraction to those of prepubescent age.[36]

In addition to the cultural association, others query whether attraction to postpubescent adolescents is in actuality a sexual deviation at all, especially given that from biological and evolutionary perspectives, such attraction patterns may be considered adaptive and normal.[41] Along these lines, Blanchard[48] suggests that when considering evolutionary adaptedness, men with erotic preference for pubescent females have greater reproductive success, either because they acquire female mating partners who are near their onset of fertility which prevents them from being impregnated by other men, or because they have more years in which to impregnate their female mates.

Sexual attraction to females is in part dependent on female reproductive physiology and development. Some men are sexually attracted to females before their first menstruation while other men prefer females who have experienced their first menses. This separation is recognized within diverse cultural and religious attitudes toward menarche.

The ability to distinguish pedophiles from hebephiles is related to the variability and definitions of pubertal onset in children and the decreasing age of pubertal onset.[39] This same question is noted to affect the diagnosis of pedophilia, as clinicians are sometimes challenged with the differentiation be-

tween prepubescence and pubescence in setting diagnostic criteria for pedophilia.

Hall and Hall[35] propose that when compared with pedophiles, hebephiles are more interested in having reciprocal sexual affairs and relationships with children, they are more opportunistic when engaging in sexual acts, they have better social functioning, and they have a better prognosis after treatment. It has also been recommended that the term hebephilia be applied to those who have more sexual attraction to pubescent individuals than to mature adults.[44]

Hebephilia, Experts, Politics, and the Courts

To this date, there appears to be no clear professional consensus as to the clinical application of hebephilia. I contend that adult sexual arousal in response to pubescent and postpubescent females is not likely to be pathologically deviant. As others have asserted,[39] the DSM-IV-TR draws the distinction between pathological age-related sexual preferences, as adult sexual arousal to prepubescents is considered to be pathological and adult arousal to pubescents and postpubescents is considered to be nonpathological. Put simply, hebephilia is not in the DSM-IV-TR currently as a listed paraphilia, and the paraphilia NOS category in the DSM-IV-TR does not include evidence suggesting that it is intended to include hebephilia as a paraphilia. Since hebephilia is absent from the DSM-IV-TR, its reliability and validity as a diagnosis is negated. Along these lines, sexual attraction to adolescent females or males, for that matter, is not a rare form of behavior. Scientific research, as outlined above, is imprecise in its attempt to pathologize sexual attraction to adolescents. Non-sex offender heterosexual males have been found to be sexually attracted to adolescents. Furthermore, while hebephiles and pedophiles may be sexually attracted to adolescents, the former group as a whole is not consistently sexually attracted to children. When assessing sex offenders with adolescent victim(s), clinicians should consider the tendency of pathological and sexually deviant offenders to have victim(s) in the prepubescent pedophilic age range. Similar to those who repeatedly target adult victims, sex offenders who commit multiple sex offenses targeting the hebephilic age group may be considered hypersexual which has been cited in the literature and is in part separate from a sexually deviant paraphilic disorder.[49,50] Notably, as of yet hypersexual disorders have not been included in the DSM.

As mentioned above, the question of deviance and pathology may be answered with the advent of the DSM-5, which currently advocates for a pedohebephilic disorder to be diagnosed in the future.[30] However, this current uncertainty and discord among clinicians is heightened when they testify as experts in forensic sex offender proceedings, especially when the consequence is indefinite civil commitment. Specifically, within the forensic mental health arena, defense-oriented experts often treat hebephilia as a nonentity. Others view it as a clinical construct, a theoretical entity, or a working hypothesis and concept for adult male attraction toward pubescent females. In contrast, many prosecutorial experts clearly recognize the diagnosis of hebephilia through the DSM-IV-TR as a paraphilia NOS and utilize it as satisfying the legal criteria for mental abnormality in SVP proceedings.

If the Paraphilias Subworkgroup upholds a pedohebephilic diagnosis for repetitive sexual behavior toward 11- to 14-year-olds, it can be assumed that the diagnosis will be considered and used in many sex offender risk assessment evaluations, with the ultimate effect being more commitments.

Before the advent of new-age sexually violent predator civil commitment laws, the term hebephilia was not given much consideration by experts or the courts. In fact it has been suggested that the term is proposed as a quintessential example of pretextuality, in which special interests promote a pseudoscientific construct that advances an implicit instrumental goal (that of civil commitment by states).[51] In a LexisNexis-based review searching for case law containing the term hebephilia, Franklin[51] found that of the 36 cases in which the term was used, all were within the past decade, and 75 percent were sex offender civil commitment proceedings. When reviewing the 27 civil commitment cases involving hebephilia, its definition is for the most part idiosyncratic based on the testimony of the expert.[51] For example, in *People v. Robledo,*[52] one expert described hebephilia as a sexual attraction to young adolescent males whose sexuality is just emerging. In *United States v. Shields,*[53] an expert described hebephilia as a deviant pattern of sexual arousal in response to adolescent individuals under the age of consent. In addition, the review of civilly committed sex offenders in Washington and Wisconsin found that 23.7 percent and 16.3 percent

of the offenders respectively carried diagnoses of paraphilia NOS other than rape or nonconsent (suggesting diagnoses of hebephilia).[9,11]

In this final section, I take a glance at how federal courts have interpreted hebephilia as satisfying the legal mental abnormality requirement in SVP civil commitment proceedings.

The U.S. Congress passed a civil commitment statute for federal sex offenders as part of the Adam Walsh Act of 2006.[51] Consequently, there have been federal sex offender cases that have been litigated pertaining to indefinite civil commitment.

In *United States v. Abregana*,[55] the defendant Jay Abregana exposed his genitals to a 12-year-old boy in a movie theater. Mr. Abregana then sent 16 diskettes containing child pornography to an undercover U.S. Postal Inspector. The disks included 221 images of prepubescent, adolescent, and teenaged boys engaged in sexually explicit conduct. On executing a search warrant at his residence, agents found five disks that contained child pornography, including pictures of the accused engaged in oral sex with a 15-year-old boy. The defendant was sentenced to prison and was subsequently released, violated supervision, and admitted to having sexual contact with a 17-year-old minor during his supervision. The defendant acknowledged that the boy touched the defendant's penis through his clothing and that on another occasion the defendant had masturbated the minor's penis. The accused was placed in custody and began a second term of supervised release. He again violated supervision by viewing pornography and contacting three minors through e-mail. He accessed photos of nude males, some sexually explicit, and created a profile on an online chat room claiming to be 14 years of age. He sent e-mails to male youths who were 10, 12, and 14 years of age. Before he completed his federal sentence, the Bureau of Prisons certification review panel certified him as a sexually dangerous person.

The federal court heard testimony from three psychologist experts on sex offenders. The government's expert diagnosis of Mr. Abregana was hebephilia under the paraphilia NOS diagnostic category, because of his sexual arousal in response to postpubescent adolescents (i.e., teenagers or minors with secondary sex characteristics). The defense expert testified that Mr. Abregana had an attraction to adolescents but noted that hebephilia is not listed as sexually deviant in the DSM-IV-TR. The other defense expert agreed with the government's diagnosis of hebephilia. This expert recognized the controversy over whether hebephilia is a valid diagnosis. While acknowledging that hebephilia is not included in the DSM-IV-TR, he stated that there are authorities in the field who regard it as a mental disorder and that it has been part of the literature on sex offenses for several decades. However, the expert testified that the degree to which hebephilia is pathological is much less than that of other paraphilias, such as pedophilia or sexual sadism.

In its opinion, the federal trial court ruled that the government had not shown that Mr. Abregana had "a serious mental illness, abnormality, or disorder as a result of which he would have serious difficulty in refraining from sexually violent conduct or child molestation if released."[56] The court found that the defendant had the mental disorder paraphilia NOS, hebephilia, but that the expert evidence had shown that hebephilia does not constitute a serious mental disorder.

In another recent federal civil commitment case, *United States v. Shields*,[53] the federal district court ruled that the government had not provided persuasive expert evidence that the offender had a mental illness, abnormality, or disorder called hebephilia. The court reasoned that while the peer-reviewed literature may establish that hebephilia is generally accepted in the field as a group identifier or label, it does not establish that it is widely accepted as a mental disorder by professionals who assess sexually violent offenders. The court recognized that both sides agreed that the attraction of an adult male to a pubescent adolescent is not, without more persuasive evidence, indicative of a mental disorder. The court acknowledged the state experts' opinions that hebephilia includes abnormal behavior; however, it found that the government did not point to any peer-reviewed literature recognizing either experts' diagnostic definition of a mental disorder called hebephilia. The court ruled, "Significantly, the American Psychiatric Association considered and rejected hebephilia as a diagnostic category for a mental disorder. Moreover, there is no expert testimony in this record that psychiatric experts generally accept this definition of hebephilia as a mental disorder."[53]

Another federal district court case ruling on hebephilia in a civil commitment context is *United States v. Carta.*[57] In *Carta,* the federal government sought to commit Todd Carta. After pleading guilty to child

pornography charges in October 2002, he was sentenced to five years in federal prison and three years of supervised release. He began sex offender treatment in the Bureau of Prisons, and withdrew, in part due to his inability to curb his sexual interest in the program's younger participants. During treatment, he described his sexual interest in children aged 12 to 17 and secondary interest in children aged 7 to 11. He admitted to storing up to 20,000 images on his computer while spending up to 14 hours per day looking at child pornography before his arrest. He admitted to sexually abusing minors on many occasions, with his youngest victim being a child in diapers. His primary victim age group by self-report was between the ages of 13 and 17. Before his release date, the Bureau of Prisons certified that he was a sexually dangerous person and began civil commitment proceedings. The government experts' diagnosis of Carta was paraphilia NOS, characterized by hebephilia. The defense's expert concluded that hebephilia was not a generally accepted diagnosis in the mental health community and did not fit within the DSM's definition of paraphilia, lacked diagnostic criteria, and could not be consistently defined, adding that normal adults may find adolescents arousing and that articles offered by the government to support a hebephilia diagnosis were not legitimate peer-reviewed research.

The district court found that the government had not proved by clear and convincing evidence that Carta was a sexually dangerous person and that hebephilia was not a "serious mental illness, abnormality, or disorder" under the statute. The court acknowledged that hebephilia is not listed within the DSM category of paraphilia NOS and is not otherwise found within the DSM. The court considered whether classifying hebephilia as a mental disorder was supported by research in the field of psychology and whether it was generally accepted in the psychiatric and psychological community, finding that there was some dispute in the field and that it was not generally recognized as serious mental illness.

The court cited *United States v. Shields* and *United States v. Abregana* as the only cases in which federal courts had addressed the diagnosis of hebephilia in sexually dangerous person cases and that both courts had rejected it as a basis for commitment. The court questioned why the DSM editors would limit examples of paraphilia NOS to rare sexual fixations if the category was intended to include a sexual interest as common as attraction to postpubescent adolescents. The court recognized that research has indicated that normal adult males experience sexual arousal in response to sexually developed adolescents and that, as a consequence, the definition of hebephilia could pathologize normal men. The court considered the difficulty in determining what age range qualifies as adolescence, given that the age of consent varies across jurisdictions as well as the extent to which the difference in age between the adolescent and the adult affects the diagnosis.

The U.S. Court of Appeals for the First District reviewed the district court's decision in *Carta.*[58] To date, this is the only federal court of appeals case dealing with hebephilia. The court criticized the district court's approach in considering hebephilia as qualifying for the legal civil commitment criterion of a "serious mental illness, abnormality, or disorder."

The court held that Carta fell into the paraphilia diagnostic category in the DSM. Specifically, it cited the paraphilia NOS category as a catch-all category that lists various paraphilias. Carta's history of sexually abusing minors; his decades-long sexual fixation on minors, which had caused him significant distress or impairment in his life; and his in-prison behavior and expressed attitudes seemingly justify the court's classification of his disorder as a paraphilia. The court opined that it would be clear error to state that the DSM definition of paraphilia excludes an intense sexual fixation on young teenagers similar to Carta's offending behaviors. While the district court did not want to stretch hebephilia into the paraphilia NOS category because it could pathologize normal men, the First Circuit accepted hebephilia as a diagnosis by simply pointing out that adolescents were the target of Carta's fixation.

The court ruled that not everyone sexually attracted to adolescents is mentally disordered; rather, those offenders whose urges are so strong as to produce the symptoms and consequences identified in the DSM (similar to Carta) could be classified as having a paraphilia NOS that is characterized by hebephilia. Finally, the court suggested that the government's position depended only on showing whether Carta's sexual attraction to teenagers fell within the DSM's definition of paraphilia NOS, not on showing that hebephilia is a mental disorder. The court remanded the case to the district court to consider whether Carta was a sexually dangerous person.

Conclusions

As can be seen, the federal courts are somewhat mixed in their handling of hebephilia. The U.S. Court of Appeals for the First Circuit in *Carta* focused its opinion on the behavioral symptoms of a paraphilia, including intense sexual fixations and urges that are so strong as to produce the symptoms and consequences identified in the DSM. Specifically as to Carta's behaviors, the court cited the amount of child pornography he stored (up to 20,000 images); the excessive hours he spent viewing the child pornography (up to 12 to 14 hours a day); his history of abusing minors, including the number of victims (approximately 12 victims), the chronicity (nearly 28 years), and the frequency of his sex-offending behaviors; and his behavior while incarcerated and attitudes, all substantiating that he had significant distress or impairment relevant to a paraphilic condition.

The court's opinion tends to have some connection with the forensic mental health literature relevant to the risk factors associated with sexual violence.[59,60] The court's opinion also has a relationship with the language in the DSM. The DSM-IV-TR attempts to define mental disorder, admits to inadequacies in doing so; focuses on the necessity of distress, disability, and dysfunction; and states, "Neither deviant behavior (e.g., sexual) [is a mental disorder] unless the deviance is a symptom of a dysfunction in the individual" (Ref. 6, p xxxi).

The court in *Carta* focused on the offender's behavior as causing him distress, impairment, and dysfunction in his life. However, the question of whether hebephilia is a type of paraphilia NOS, depends on whether it is considered deviant and abnormal to have a sexual attraction and to engage in subsequent sexual behaviors toward pubescent adolescents and postpubescent minors. To this date, neither the case law nor clinical research on sex offenders has clearly supported classifying hebephilia as an abnormal pathology.

As we can see through this psycholegal analysis, both clinicians and the courts disagree as to whether hebephilia is a pathological sexual deviance disorder. Given the fact that the U.S. Supreme Court recently denied *certiorari* in hearing *McGee*, *Michael L. v. Bartow*, *Dir.*, *WI Resource Center*, addressing whether a rape paraphilia NOS, nonconsent, meets the constitutional threshold for legal mental abnormality for civil commitment, it is unlikely that the Court will hear such a case addressing hebephilia. More likely, the DSM-5 will provide guidance for clinicians, attorneys, and judges who evaluate and litigate this issue in civil commitment proceedings.

References

1. Kansas v. Hendricks, 521 U.S. 346 (1997)
2. Kansas v. Crane, 534 U.S. 407 (2002)
3. Kan. Stat. Ann. § 59-29a02(b) (2009)
4. Frances A: Rape, psychiatry, and constitutional rights: hard cases make for very bad law. Psychiatr Times. September 1, 2010, available at www.psychiatrictimes.com. Accessed November 23, 2011
5. Washington State, R.C.W. Title 71, Chapter 71.09 (2001)
6. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000
7. Levenson J: Sexual predator civil commitment: a comparison of selected and released offenders. Int J Offend Ther Comp Criminol 48:638–48, 2004.
8. Levenson, J, Morin J: Factors predicting selection of sexually violent predators. Int J Offend Ther Comp Criminol 50:609–29, 2006
9. Elwood R, Doren D, Thornton D: Diagnostic and risk profiles of men detained under Wisconsin's Sexually Violent Person's Law. Int J Offend Ther Comp Criminol 54:187–96, 2010
10. Janus E, Walbek N: Sex offender commitments in Minnesota: a descriptive study of second generation commitments. Behav Sci Law 18:343–73, 2000
11. Jackson R, Richards H: Diagnostic and risk profiles among civilly committed offenders in Washington State. Int J Offend Ther Comp Criminol 51:313–23, 2007
12. Becker J, Stinson J, Tromp S, *et al*: Characteristics of individuals petitioned for civil commitment. Int J Offend Ther Comp Criminol 47:185–95, 2003
13. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, DC: American Psychiatric Association, 1980
14. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised. Washington, DC: American Psychiatric Association, 1987
15. Malin H, Saleh F: Paraphilias: clinical and forensic considerations. Psychiatr Times. April 15, 2007, available at www.psychiatrictimes.com. Accessed November 23, 2011
16. Prentky A, Janus E, Barbaree H, *et al*: Sexually violent predators in the courtroom: science on trial. Psychol Public Policy Law 12: 357–93, 2006
17. Wollert R: Poor diagnostic reliability, the Null-Bayes Logic Model, and their implications for sexually violent predator evaluations. Psychol Public Policy Law 13:167–203, 2007
18. Fabian J: Paraphilias, personalities and predators: the ethical application of psychiatric diagnoses in partisan sexually violent predator commitment proceedings. J Forensic Psychol Pract 11:82–98, 2011
19. Marshall W, Kennedy P, Yates P, *et al*: Diagnosing sexual sadism in sexual offenders: reliability across diagnosticians. Int J Offend Ther Comp Criminol 46:668–77, 2002
20. Miller H, Amenta A, Conroy M: Sexually violent predator evaluations: empirical evidence, strategies for professionals, and research directions. Law Hum Behav 29:29–54, 2005
21. O'Donahue W, Regev L, Hagstrom A: Problems with the DSM-IV diagnosis of pedophilia. Sex Abuse 12:95–105, 2000.

22. Kingston D, Kingston D, Firestone P, *et al*: The utility of the diagnosis of pedophilia: a comparison of various classification procedures. Arch Sex Behav 36:423–36, 2007
23. McConaghy N: Unresolved issues in scientific sexology. Arch Sex Behav 28:285–318, 1999
24. Moser C: When is an unusual sexual interest a mental disorder? Arch Sex Behav 38:323–5, 2009
25. Seto M: A brief screening scale to identify pedophilic interests among child molesters. Sex Abuse 13:15–25, 2001
26. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC: American Psychiatric Association, 1994
27. Marshall W: Diagnostic issues, multiple paraphilias, and comorbid disorders in sexual offenders: their incidence and treatment. Aggress Violent Behav 12:16–35, 2007
28. Prentky R, Coward A, Gabriel A: Commentary: muddy diagnostic waters in the SVP courtroom. J Am Acad Psychiatry Law 36:455–8, 2008
29. Spitzer R: Memo to Advisory Committee on Paraphilias. Washington, DC: American Psychiatric Association Library, 1986
30. DSM-5, Proposed Revisions. Available at http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=416. Accessed November 23, 2011
31. Heil P, Ahlmeyer S, Simons D: Crossover sexual offenses. Sex Abuse 15:221–36, 2003
32. Bradford J, Boulet J, Pawlak A: The paraphilias: a multiplicity of deviant behaviours. Can J Psychol 37:104–8, 1992
33. Abel G, Osborn C: The paraphilias: the extent and nature of sexually deviant and criminal behavior. Psychiatr Clin North Am 15:675–87, 1992
34. Glueck B: Final report: research project of the study and treatment of persons convicted of crimes involving sexual aberrations, June 1952 to June 1955. New York: New York State Department of Mental Hygiene, 1955
35. Hall R, Hall R: A profile of pedophilia: definition, characteristics of offenders, recidivism, treatment outcomes, and forensic issues. Mayo Clin Proc 82:457–71, 2007
36. Blanchard R, Lykins A, Wherrett D, *et al*: Pedophilia, hebephilia, and the DSM-V. Arch Sex Behav 38:335–50, 2009
37. Mohr J, Turner R, Jerry M: Pedophilia and Exhibitionism. Toronto: University of Toronto Press, 1964
38. Freund K: Diagnosing homo- or heterosexuality and erotic age-preference by means of a psychophysiological test. Behav Res Ther 5:209–28, 1967
39. Zander T: Adult sexual attraction to early-stage adolescents: phallometry doesn't equal pathology. Arch Sex Behav 38:329–30, 2009
40. Moser C: Are any of the paraphilias in the DSM mental disorders? Arch Sex Behav 31:490–1, 2002
41. Franklin K: The public policy implication of "hebephilia": a response to Blanchard et al (2008). Arch Sex Behav 38:319–20, 2009; author reply 331–4
42. Green R: Sexual preference for 14-year-olds as a mental disorder: you can't be serious!! Arch Sex Behav 39:585–6, 2010
43. Tromovitch P: Manufacturing mental disorder by pathologizing erotic age orientation: a comment on Blanchard et al (2008). Arch Sex Behav 38:328, 2009; author reply 331–4
44. DeClue G: Should hebephilia be a mental disorder?—reply to Blanchard et al (2008). Arch Sex Behav 38:317–18, 2008; author reply 331–4
45. Freund K Costell R: The structure of erotic preference in the nondeviant male. Behav Res Ther 8:15–20, 1970
46. Quinsey V, Steinman C, Bergerson S, *et al*: Penile circumference, skin conductance, and ranking responses of child molesters and "normals" to sexual and nonsexual visual stimuli. Behav Ther 6:213–19, 1975
47. Baxter D: Deviant sexual behavior: differentiating sex offenders by criminal and personal history, psychometric measures, and sexual response. Crim Just Behav 11:477–501, 1984
48. Blanchard R: The fertility of hebephiles and the adaptationist argument against including hebephilia in DSM-V. Arch Sex Behav 39:817–18, 2010
49. Kafka M: Hypersexual disorder: a proposed diagnosis for DSM-V. Arch Sex Behav 39:377–400, 2010
50. Kafka M, Hennen J: Hypersexual desire in males: are males with paraphilias different from males with paraphilia-related disorders? Sexual Abuse 15:307–21, 2003
51. Franklin K: Hebephilia: quintessence of diagnostic pretextuality. Behav Sci Law 28:751–68, 2010
52. People v. Robledo, No. H030287 (Cal. Ct. App. November 14, 2007)
53. United States v. Shields, 2008 U.S. District LEXIS 13837 (D. Mass. February 26, 2008)
54. Adam Walsh Child Protection and Safety Act of 2006, Pub L. No. 109-248, 120 Stat. 587 (2006)
55. United States v. Abregana, 574 F. Supp. 2d 1145 (D. Haw. 2008)
56. 18 U.S.C. § 4247(a)(6) (2006)
57. United States v. Carta, 620 F. Supp. 2d 210 (D. Mass. 2009)
58. United States v. Carta, 592 F.3d 34 (1st Cir. 2010)
59. Hanson K, Bussière M: Predicting relapse: a meta-analysis of sexual offender recidivism studies. J Consult Clin Psychol 66:348–62, 1998
60. Hanson K, Morton-Bourgon K: The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. J Consult Clin Psychol 73:1154–63, 2005