

No. 37822-1-II

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION TWO

IN RE: DETENTION OF LENIER RENE AYERS

STATE OF WASHINGTON,
DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Respondent,

v.

LENIER RENE AYERS,

Appellant.

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STATE OF WASHINGTON
COURT OF APPEALS
DIVISION II
DEPT. OF SOCIAL AND HEALTH SERVICES

ON APPEAL FROM THE SUPERIOR COURT OF THE
STATE OF WASHINGTON FOR CLARK COUNTY

The Honorable John F. Nichols

APPELLANT'S OPENING BRIEF

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A. SUMMARY OF ARGUMENT

Lenier Ayers was civilly committed under Washington's Sexually Violent Predator law on the basis of expert testimony alleging two mental disorders: paraphilia not otherwise specified (hebephilia) and antisocial personality disorder. The first alleged mental disorder has not been accepted by the psychiatric community and is not contained in the Diagnostic and Statistical Manual, IV-Text Revision (4th ed.-text rev. 2000), the definitive reference for mental health professionals, which reflects the consensus of the profession. The second diagnosis describes up to eighty percent of the U.S. prison population and more than seven million Americans, and the APA's position is that it is an over-broad and inappropriate basis for involuntary civil commitment.

Because the first diagnosis is not medically recognized and the second diagnosis is overbroad and imprecise, Mr. Ayers's civil commitment violates due process. Further, trial counsel provided ineffective assistance of counsel for failing to request the first diagnosis be subject to a Frye hearing and for failing to object to the second diagnosis under ER 702. For these reasons, the trial court abused its discretion in denying Mr. Ayers's CR 60(b) motion to vacate the judgment.

B. ASSIGNMENT OF ERROR

The trial court abused its discretion in denying the CR 60(b) motion to vacate judgment.

C. ISSUES PERTAINING TO ASSIGNMENT OF ERROR

1. Whether the significant deprivation of liberty at issue, as well as the interest in avoiding arbitrary civil detention, tips the balance of equities in favor of recognizing Mr. Ayers's claims through a CR 60(b) motion.

2. Whether Ayers's civil commitment violates due process because the State expert's first diagnosis is not medically recognized and the second diagnosis is overbroad and too imprecise.

3. Whether trial counsel was ineffective for failing to raise the due process claim.

4. Whether trial counsel was ineffective for failing to request that the novel hebephilia diagnosis, which is not generally recognized by the psychiatric community, be subject to a Frye hearing.

5. Whether trial counsel was ineffective for failing to object to the antisocial personality diagnosis under ER 702 as unhelpful to the trier of fact because it does not distinguish the dangerous

sexual offender from the dangerous but typical recidivist convicted in the ordinary criminal case.

D. STATEMENT OF THE CASE

In 1991, Lenier Ayers was convicted of sex offenses against three girls who ranged in age from 12 to 14 years old at the time of the offenses. 5/17/05RP 511-13. These convictions were based upon allegations Mr. Ayers sexually assaulted the girls in his home after providing or offering them alcohol. 5/17/05RP 513-14. Mr. Ayers was 32 years old when he was convicted. CP 55 (DOB 5/19/59).

In 2000, after his release from confinement having served his sentences for those offenses, 16 year-old Ebony H. accused Mr. Ayers of buying her cigarettes, touching her leg in a sexual manner, and asking her if she wanted to come to his home to watch a movie and drink beer or smoke marijuana. 5/16/05RP 303, 313-15. Mr. Ayers pleaded guilty to fourth degree assault, without sexual motivation, for this incident. 5/16/05RP 511; 5/26/05RP 1211-12. The State filed a sexually violent predator commitment petition, arguing Mr. Ayers's contact with Ms. Hall was a recent overt act. CP 53-54.

A bench trial followed. The State's expert, Dr. Dennis Doren, testified, without objection, that Mr. Ayers suffered from a mental abnormality, paraphilia not otherwise specified (NOS), and antisocial personality disorder, both of which caused him serious difficulty controlling his sexually violent behavior. 5/17/05RP 519-21, 529, 575-76, 651. According to Dr. Doren, Mr. Ayers's paraphilia took the form of a sexual attraction to adolescents and is also known as "hebephilia." 5/17/05RP 521. Dr. Doren acknowledged the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), which mental health practitioners universally rely upon in forming diagnoses, does not recognize hebephilia as a paraphilia or other mental disorder. 5/17/05RP 527. Dr. Doren also acknowledged Mr. Ayers's sexual urges were directed only at "well-developed" adolescents, as well as adult women. 5/17/05RP 523. Nonetheless, Dr. Doren opined hebephilia should be considered a mental abnormality because it involves an attraction to adolescents who are "children" in a legal sense, that is, too young under the law to be able to consent to sexual activity. 5/17/05RP 522, 527. Dr. Doren also testified that even though Mr. Ayers was not attracted to adolescents exclusively, that did not preclude a diagnosis of

hebephilia. 5/17/05RP 523. Finally, Dr. Doren testified Mr. Ayers's hebephilia caused him "impairment," because it had led to multiple incarcerations and was, by definition, "self defeating," as the objects of Mr. Ayers's sexual interest would necessarily outgrow adolescence and no longer be of interest to him. 5/17/05RP 528.

On the other hand, Dr. Richard Wollert testified hebephilia did not qualify as a mental abnormality, because sexual attraction to adolescents is widespread among men who have never been convicted of a sex offense, and that such attraction can cause distress or other impairment even among normal men. 5/24/05RP 946-47; 5/26/05RP 1188. Further, Dr. Wollert explained, no studies showed any difference in the strength of sexual arousal to adolescents between sex offenders and non-sex offenders; in fact, one study showed *no* difference in arousal patterns between sex offenders and non-sex offenders. 5/26/05RP 1183-85, 1188. Dr. Wollert testified there are no studies showing *any* correlation at all between receiving a diagnosis of hebephilia and being a sexual recidivist. 5/26/05RP 1185-88. Thus, because the diagnosis applies to a broad range of society and does not distinguish between sex offenders and non-sex offenders, it is meaningless. 5/24/05RP 947; 5/26/05RP 1183-86.

The trial court accepted the testimony of Dr. Doren and found that Mr. Ayers suffered from a mental abnormality, paraphilia NOS (hebephilia), and antisocial personality disorder, both of which, independently and in combination, caused him serious difficulty controlling his sexually violent behavior.¹ CP 68-69, 73. The court also found that Mr. Ayers met the other criteria of the statute. CP 75-76. The court therefore ordered that Mr. Ayers be committed indefinitely as a sexually violent predator. CP 77.

Mr. Ayers appealed the order of commitment, arguing that (1) the State violated his constitutional rights to due process and to confront the witnesses when it relied upon a videotaped deposition of a witness that Mr. Ayers had participated in by conference call; (2) the State did not prove his contact with Ebony H. was a recent overt act; and (3) the State did not prove he suffered from antisocial personality disorder, because it presented no evidence the disorder began before Mr. Ayers was 15 years old, a necessary diagnostic criterion. In an unpublished decision, this Court rejected those arguments and affirmed the commitment order. In re Det. of Ayers, 2006 Wash. App. LEXIS 2434 (No. 33604-9-II, Nov. 7, 2006).

This Court issued a mandate on October 31, 2007. CP 78.

¹ A copy of the trial court's findings of fact and conclusions of law is attached as Appendix A.

On February 11, 2008, Mr. Ayers, *pro se*, filed a CR 60 motion in the trial court, requesting a new commitment trial. CP 92-180. He argued the trial court erred in relying upon Dr. Doren's diagnoses of paraphilia, NOS (hebephilia) and antisocial personality disorder, as neither diagnosis qualified as a "mental abnormality or personality disorder" under the statute.² CP 92-180; RCW 71.09.020(16). On June 11, 2008, the trial court entered an order denying, without explanation, the motion for new trial. CP 227. This appeal follows.

E. ARGUMENT

1. CR 60 PROVIDES A VIABLE AVENUE FOR MR. AYERS TO CHALLENGE THE COMMITMENT ORDER

As discussed more fully in the sections below, Mr. Ayers is entitled to a new commitment trial, because the State's and the trial court's reliance on Dr. Doren's diagnoses of paraphilia NOS (hebephilia) and antisocial personality disorder violated his constitutional right to due process. That is because the first diagnosis is not medically recognized and the second diagnosis is overbroad and too imprecise. Further, Mr. Ayers received

² Mr. Ayers separately filed a *pro se* personal restraint petition in this Court, raising similar arguments. On September 18, 2008, on its own initiative, this Court entered an order consolidating the personal restraint petition, COA No. 37747-1-II, to the direct appeal, COA No. 37822-1-II.

ineffective assistance of counsel when his trial attorney failed to challenge Dr. Doren's diagnoses or request they be subject to a Frye³ hearing. Mr. Ayers is entitled to relief via CR 60 for these constitutional claims.

Civil Rule 60 allows persons committed pursuant to Washington's sexually violent predator law to move to vacate judgment. In re Det. of Ward, 125 Wn. App. 374, 379, 104 P.3d 751 (2005). CR 60(b) authorizes the court to relieve a party from a final judgment "upon such terms as are just."

Proceedings to vacate judgments are equitable in nature and the court should exercise its authority liberally to preserve substantial rights and do justice between the parties. Haller v. Wallis, 89 Wn.2d 539, 543, 573 P.2d 1302 (1978).

"[C]ircumstances arise where finality must give way to the even more important value that justice be done between the parties." Suburban Janitorial Servs. v. Clarke American, 72 Wn. App. 302, 313, 863 P.2d 1377 (1993). "CR 60 is the mechanism to guide the balancing between finality and fairness." Id. In balancing the equities within the SVP context, where a person faces extreme deprivation of liberty, this Court recognizes "[t]he interest in finality

³ Frye v. United States, 293 F. 1013, 34 A.L.R. 145 (D.C. Cir. 1923).

of judgments is easily outweighed by the interest in ensuring that an individual is not arbitrarily deprived of his liberty." Ward, 125 Wn. App. at 380.

Subsection (11) of CR 60 authorizes a trial court to grant relief from judgment for "[a]ny other reason justifying relief from the operation of the judgment." A person committed as a sexually violent predator may move to vacate judgment under CR 60(b)(11) when his circumstances do not permit moving under another subsection of CR 60(b). Ward, 125 Wn. App. at 379. For the detainee to be entitled to relief under CR 60(b)(11), the case must involve "extraordinary circumstances" that constitute irregularities extraneous to the proceedings. Id. But again, because the infringement on a person's liberty in the sexually violent predator context is immense, the interest in finality of judgments must give way to the interest in ensuring the deprivation of liberty is not arbitrary. Id. at 380.

A trial court's decision whether to vacate judgment pursuant to CR 60 is reviewed for abuse of discretion. In re Marriage of Tang, 57 Wn. App. 648, 653, 789 P.2d 118 (1990). A trial court abuses its discretion when its decision is manifestly unreasonable or based on untenable grounds. State ex rel. Carroll v. Junker, 79

Wn.2d 12, 26, 482 P.2d 775 (1971). A court's decision is manifestly unreasonable if it is outside the range of acceptable choices, given the facts and the applicable legal standard. In re Marriage of Littlefield, 133 Wn.2d 39, 47, 940 P. 2d 1362 (1997). "The range of discretionary choices is a question of law and the judge abuses his or her discretion if the discretionary decision is contrary to law." State v. Neal, 144 Wn.2d 600, 609, 30 P.3d 1255 (2001).

a. Mr. Ayers's CR 60(b)(11) motion is timely. CR 60(b)(11) motions must be made within a "reasonable time." A determination of what constitutes a "reasonable time" depends on the facts and circumstances of each case. State ex rel. Campbell v. Cook, 86 Wn. App. 761, 766, 938 P.2d 345 (1997). In Ward, this Court concluded the CR 60(b) motion was not brought within a reasonable time, where a decade had passed since the Washington Supreme Court issued its decision that Ward claimed constituted a significant change in the law, and Ward did not provide a good reason for failing to take action sooner. 125 Wn. App. at 380-81.

Here, this Court must conclude Mr. Ayers filed his *pro se* motion in the trial court within a reasonable time. The trial court

entered the order of commitment on September 12, 2005. CP 55. Mr. Ayers filed a direct appeal, which was mandated on October 31, 2007. CP 78. Mr. Ayers then filed the CR 60(b) motion in the trial court on February 11, 2008, less than four months after the mandate was issued. Because Mr. Ayers acted promptly after the judgment became final, his motion must be considered timely.

b. Mr. Ayers is entitled to relief under CR 60(b)(11) for the due process violation. In Ward, the detainee argued he was entitled to relief from judgment under CR 60(b)(11), because the State had not met its burden of proving he was an SVP. 125 Wn. App. 374. At the time of his initial commitment, Ward had stipulated to being a sexually violent predator but did not admit to committing a recent overt act. The Washington Supreme Court subsequently decided that, in order to prove the necessary element of present dangerousness, the State was required to prove a person released into the community had committed a recent overt act. See In re Pers. Restraint of Young, 122 Wn.2d 1, 41, 857 P.2d 989 (1993). The Ward Court noted such a change in the law regarding the State's burden of proof, which "goes to the very basis of Ward's commitment," may constitute extraordinary circumstances justifying relief under CR 60(b)(11) and that "the

equities balance in Ward's favor." 125 Wn. App. at 380. But as noted, this Court did not grant relief, finding instead that Ward had failed to file his motion within a "reasonable time." Id.

Much like Ward, who claimed the State had not met its due process burden of proving all of the elements of the SVP designation, Mr. Ayers is ineligible for involuntary commitment because the State did not prove the required element of "mental abnormality" or "personality disorder." As discussed in the sections below, Dr. Doren's diagnoses are not valid bases for commitment under the Due Process Clause and the State may not rely upon them to sustain its burden of proof.

Moreover, much of the criticism of Dr. Doren's diagnoses was not published until after Mr. Ayers's mid-2005 trial and therefore, as in Ward, extraordinary circumstances justify this collateral attack on the judgment. Of particular note is an article by Thomas Zander, published in December 2005, which discusses the relevant academic and professional literature and specifically criticizes Dr. Doren's use of the diagnoses of paraphilia NOS (hebephilia) and antisocial personality disorder in civil commitment trials. See Thomas K. Zander, Civil Commitment Without Psychosis: The Law's Reliance on the Weakest Links in

Psychodiagnosis, 1 Journal of Sexual Offender Civil Commitment: Science and the Law 17 (2005) (available at <http://www.soccjournal.org>).

Also of note are several recent letters to the editor of the journal "Archives of Sexual Behavior," published only within the last year, by commentators who forcefully critique the validity of Dr. Doren's idiosyncratic diagnosis of paraphilia NOS (hebephilia). See Gregory DeClue, Should Hebephilia be a Mental Disorder? A Reply to Blanchard et al., Archives of Sexual Behavior (Oct. 16, 2008); Karen Franklin, The Public Policy Implications of "Hebephilia": A Response to Blanchard et al., Archives of Sexual Behavior (Oct. 16, 2008); Joseph J. Plaud, Are There "Hebephiles" Among Us? A Response to Blanchard et al., Archives of Sexual Behavior (Oct. 16, 2008); P. Tromovitch, Manufacturing Mental Disorder by Pathologizing Erotic Age Orientation: A comment on Blanchard et al., Archives of Sexual Behavior (Oct. 16, 2008); Thomas K. Zander, Adult Sexual Attraction to Early-Stage Adolescents: Phallometry Doesn't Equal Pathology, Archives of Sexual Behavior (Oct. 16, 2008). These publications make plain what may not have been plain at the time of Mr. Ayers's trial -- that

Dr. Doren's use of this novel diagnosis is far from achieving general acceptance in the relevant scientific community.

Finally, it is only within the last year that courts have issued published decisions specifically addressing the validity of the diagnosis of paraphilia NOS (hebephilia) in sexually violent predator proceedings. In those cases, the courts concluded the State had not met its burden of proof by relying on that diagnosis. See United States v. Abregana, 574 F.Supp.2d 1145 (D. Haw. 2008) (holding government did not prove hebephilia was a serious mental disorder); United State v. Shields, 2008 U.S. Dist. LEXIS 13837, at *4-6 (D. Mass. 2008) (holding State did not prove sexually violent offender status where State did not show hebephilia was generally accepted as a mental disorder by professionals who assess sexually violent offenders). Mr. Ayers is aware of no published case prior to his trial that invalidated the diagnosis of hebephilia in a civil commitment proceeding, or that even considered the validity of the diagnosis or its acceptance within the psychiatric community.

In sum, only since Mr. Ayers's trial has it become clear that experts in the field generally disagree with Dr. Doren's reliance on the diagnoses of hebephilia and antisocial personality disorder in

civil commitment proceedings. Further, only since Mr. Ayers's trial have other courts had occasion to consider whether the State sustains its burden of proof in an involuntary commitment trial by relying solely on those diagnoses. Given the enormity of the liberty interest at stake, "the equities [therefore] balance in [Ayers's] favor." 125 Wn. App. at 380. Because the due process violation "goes to the very basis of [Ayers's] commitment," it is an extraordinary circumstance that justifies relief under CR 60(b)(11). Id.

c. Mr. Ayers is entitled to relief under CR 60(b)(11) because he received ineffective assistance of counsel. As discussed more fully below, Mr. Ayers received ineffective assistance of counsel based on his attorney's failure to challenge Dr. Doren's diagnoses at trial. This provides an independent basis for relief under CR 60(b)(11).

This Court recognizes that a person may challenge a judgment under CR 60(b)(11) based on his attorney's unauthorized surrender of substantial rights, and that such a violation creates the kind of extraordinary circumstances that warrant vacation of the judgment pursuant to CR 60(b)(11). Graves v. P.J. Taggares Co., 25 Wn. App. 118, 126, 605 P.2d 348 (1980); Lane v. Brown & Haley, 81 Wn. App. 102, 107, 912 P.2d 1040 (1996).

Here, Mr. Ayers's attorney failed to challenge the diagnoses on due process grounds. He also failed to note the lack of consensus among experts in the field or request the diagnoses be subjected to a Frye hearing. As argued below, it is plain there is a lack of consensus regarding the diagnosis of paraphilia NOS (hebephilia) and thus the diagnosis could not meet the requirements of Frye. Finally, counsel failed to object to the expert testimony regarding antisocial personality disorder under ER 702 on the basis it was unhelpful to the trier of fact. Because counsel therefore surrendered, without authorization, Mr. Ayers's substantial right to challenge the diagnoses, Mr. Ayers is entitled to relief under CR 60(b)(11).

2. AYERS'S INVOLUNTARY COMMITMENT VIOLATES DUE PROCESS BECAUSE IT IS PREMISED ON DIAGNOSES THAT ARE NOT ACCEPTED BY THE PROFESSION AND ARE OVERBROAD AND TOO IMPRECISE

a. Due process requires the State prove an involuntary civil committee has a valid, medically recognized, mental disorder. The state and federal constitutions guarantee the right to due process of law. U.S. Const. amend 14; Wash. Const. art. 1, § 3. A person's right to be free from physical restraint "has always been at the core of the liberty protected by the Due Process

Clause from arbitrary government action." Foucha v. Louisiana, 504 U.S. 71, 80, 112 S. Ct. 1780, 118 L. Ed.2d 437 (1992). The indefinite commitment of sexually violent predators is a restriction on the fundamental right of liberty, and consequently, the State may only commit persons who are *both* currently dangerous *and* have a mental abnormality. Id. at 77; Kansas v. Hendricks, 521 U.S. 346, 357-58, 117 S. Ct. 2072, 138 L. Ed.2d 501 (1997); In re Detention of Thorell, 149 Wn.2d 724, 731-32, 72 P.3d 708 (2003). Current mental illness is a constitutional requirement of continued detention. O'Connor v. Donaldson, 422 U.S. 563, 574-75, 95 S. Ct. 2486, 45 L. Ed.2d 396 (1975).

Three Supreme Court precedents are directly applicable to this case: Foucha, 504 U.S. 71; Hendricks, 521 U.S. 346; and Kansas v. Crane, 534 U.S. 407, 122 S.Ct. 867, 151 L.Ed.2d 856 (2002). Taken together, these cases establish that involuntary civil commitment may not be based on a diagnosis that is either medically unrecognized or too imprecise to distinguish the truly mentally ill from typical recidivists who must be dealt with by criminal prosecution alone.

In Foucha, the Court held that a criminal defendant found not guilty by reason of insanity could not be held involuntarily in a state

mental hospital solely "on the basis of his antisocial personality which, as evidenced by his conduct at the facility, . . . rendered him a danger to himself or others." 504 U.S. at 78; see also id. at 82 (rejecting the argument that "because [an individual] once committed a criminal act and now has an antisocial personality that sometimes leads to aggressive conduct, . . . he may be held indefinitely"); id. at 83 n.6 (rejecting the contention that a state may detain an individual based on a "finding of dangerousness . . . based solely on the detainee's antisocial personality that apparently has caused him to engage in altercations from time to time").

The Court explained that the State's "rationale [for commitment] would permit [it] to hold indefinitely any other insanity acquittee not mentally ill who could be shown to have a personality disorder that may lead to criminal conduct. The same would be true of any convicted criminal, even though he has completed his prison term." Id. at 82-83. The Court reasoned that if a supposedly dangerous person with a personality disorder "commit[s] criminal acts," then "the State [should] vindicate[] [its interests through] the ordinary criminal processes . . . , the use of enhanced sentences for recidivists, and other permissible ways of dealing with patterns of criminal conduct" -- i.e., "the normal means of dealing with

persistent criminal conduct." Id. at 82. In her concurring opinion, Justice O'Connor added that it was "clear that acquittees could not be confined as mental patients absent some medical justification for doing so." Id. at 88 (O'Connor, J., concurring in part and concurring in the judgment).

In Hendricks, the Court reaffirmed that "dangerousness, standing alone, is ordinarily not a sufficient ground upon which to justify indefinite involuntary commitment"; rather, "proof of dangerousness [must be coupled] with the proof of some additional factor, such as a 'mental illness' or 'mental abnormality.'" 521 U.S. at 358. The Court then upheld Hendricks's commitment under the Kansas Sexually Violent Predator Act (KSVPA), noting that "[t]he mental health professionals who evaluated Hendricks diagnosed him as suffering from pedophilia, a condition the psychiatric profession itself classifies as a serious mental disorder." Id. at 260 (citing DSM-IV). Thus, "Hendricks' diagnosis as a pedophile . . . suffice[d] for due process purposes" and, further, his admitted inability to control his pedophilic urges "adequately distinguish[ed] [him] from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings." Id.

In his concurrence, Justice Kennedy, who provided the fifth vote in support of the majority opinion, also emphasized that Hendricks' "mental abnormality--pedophilia--is at least described in the DSM-IV." *Id.* at 372 (Kennedy, J., concurring). He therefore concluded that, "[o]n the record before [the Court], [Hendricks' commitment] conform[ed] to [the Court's] precedents." *Id.* at 373. He was quick to add, "however, . . . [that] if it were shown that mental abnormality," as defined by state law, "is too imprecise a category to offer a solid basis for concluding that civil detention is justified, our precedents would not suffice to validate it." *Id.*

Justice Breyer, joined by Justices Stevens, Souter, and Ginsburg, agreed that Hendricks' commitment comported with due process but did not agree with all of the majority's analysis. *Id.* at 374 (Breyer, J., dissenting). Justice Breyer's opinion thus "set forth three sets of circumstances that, taken together, convince[d]" him that Hendricks' commitment did not violate due process:

First, the psychiatric profession itself classifies the kind of problem from Hendricks suffers as a serious mental disorder. [Citing the DSM-IV]. . . . The Constitution permits a State to follow one reasonable professional view, while rejecting another. The psychiatric debate, therefore, helps to inform the law by setting the boundaries of what is reasonable. .

Second, Hendricks' abnormality does not consist simply of a long course of antisocial behavior,

but rather it includes a specific, serious, and highly unusual inability to control his actions. . . .

Third, Hendricks' mental abnormality also makes him dangerous. . . .

Id. at 374-76 (emphasis added; citations omitted).

Most recently, the Court revisited the KSVPA and held that due process requires that "there must be proof of serious difficulty in controlling behavior" in order to support involuntary civil commitment. Crane, 534 U.S. at 413. The Court reemphasized that its decision in "Hendricks underscored the constitutional importance of distinguishing a dangerous sexual offender subject to civil commitment 'from other dangerous persons who are perhaps more properly dealt with exclusively through criminal proceedings.'" Crane, 534 U.S. at 412 (quoting Hendricks, 521 U.S. at 360).

Thus, an individual cannot be involuntarily committed unless he suffers from a mental abnormality 'sufficient to distinguish . . . him . . . from the dangerous but typical recidivist convicted in an ordinary criminal case.'" Id. at 413. In reaffirming the significance of this distinction, the Court specifically cited to a study finding that forty to sixty percent of the male prison population is diagnosable with APD. Id. at 412 (citing Paul Moran, The Epidemiology of Antisocial Personality Disorder, 34 Social Psychiatry & Psychiatric Epidemiology 231, 234 (1999)).

In light of these United States Supreme Court cases, the Washington Supreme Court similarly recognizes that in sexually violent predator proceedings, due process requires the State to prove the detainee has a serious, diagnosed, mental disorder that causes him difficulty controlling his sexually violent behavior. In re Det. of Thorell, 149 Wn.2d 724, 736, 740-41, 72 P.3d 708 (2003). "Lack of control" requires proof "sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him [or her] to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case." Id. at 723 (quoting Crane, 534 U.S. at 413). Expert testimony is essential to tie a lack of control to a diagnosed mental abnormality or personality disorder. Id. at 740-41. This proof must rise to the level of proof beyond a reasonable doubt. Id. at 744.

Although states have considerable leeway to define when a mental abnormality or personality disorder makes an individual eligible for commitment as a sexually violent person, see Crane, 534 U.S. at 413, the diagnosis must nonetheless be medically justified. See Hendricks, 521 U.S. at 358 (explaining that states must prove not only dangerousness but also mental illness in order to "limit involuntary civil confinement to those who suffer from a

volitional impairment rendering them dangerous beyond their control"); Thorell, 149 Wn.2d at 732, 740-41 (explaining State must present expert testimony and prove beyond a reasonable doubt that offender has serious, diagnosed, mental illness that causes him difficulty controlling his behavior).

i. The State's expert's diagnosis of paraphilia NOS (hebephilia) violates due process because it is an invalid diagnosis that is not accepted by the profession, including the APA and the DSM-IV-TR. The expert's diagnosis of "paraphilia NOS (hebephilia)" is invalid and its use as predicate for Ayers's involuntary civil commitment therefore violates due process. The Supreme Court has upheld involuntary civil commitment only in cases in which the diagnosed disorder was one that "the psychiatric profession itself classifies as a serious mental disorder." Hendricks, 521 U.S. at 360; id. at 375 (Breyer, J., dissenting); Crane, 534 U.S. at 410, 412; Hendricks, 521 U.S. at 372 (Kennedy, J., concurring); see also Foucha, 504 U.S. at 88 (O'Connor, J., concurring in part and concurring in the judgment) (involuntary civil commitment requires "some medical justification"). During oral argument in Hendricks, Justice Souter drove home precisely why

the Due Process Clause requires consensus "medical recognition" before it can justify involuntary civil commitment:

SOUTER: You don't take the position . . . that [a] State could say, we recognize a category of mental abnormality or mental illness. It hasn't been recognized in any medical or psychiatric literature, but we're recognizing it now, and that satisfies [due process?] . . .

[KANSAS]: That would not be the argument the State would make

SOUTER: What is the function of this medical recognition . . . under Foucha? . . . Why do we . . . say that in order to satisfy the mental illness element under Foucha there has got to be a medically recognized category within which the particular individual falls?

[KANSAS]: . . . [S]o that the Court doesn't worry that we confine merely for dangerousness or merely for a class of people that we don't want to be around [T]o be able to civilly commit . . . them it has to be a medically recognized condition

SOUTER: It's less likely to be abused if there's a categorical approach rather than a purely individual approach.

Transcript of Oral Argument, Hendricks, 521 U.S. 346 (Nos. 95-1649, 95-9075), at http://www.oyez.org/cases/1990-1999/1996/1996_95_1649/argument/.

"Paraphilia NOS (hebephilia)" fails the Court's "medical recognition" or "medical justification" test because it is not recognized by either the psychiatric profession in general or the

American Psychiatric Association (APA) or DSM-IV-TR in particular. Put simply, it is a wholly unreliable and invalid diagnosis that fails to distinguish Ayers from any "dangerous but typical recidivist" who cannot be civilly committed under the Due Process Clause. Crane, 534 U.S. at 413.

The DSM-IV-TR does recognize a general diagnosis of "Paraphilia Not Otherwise Specified." American Psychiatric Association, The Diagnostic and Statistical Manual of Mental Disorders, IV-Text Revision 576 (4th ed.-text rev. 2000) ("DSM-IV-TR"). "This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories," id., the "specific categories," including, for example, pedophilia, exhibitionism, and sexual sadism. See id. at 566-75. The DSM-IV-TR explains that examples of paraphilia NOS "include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine)." Id. at 576.

While, by its terms, this diagnosis "is not limited to" the variants specifically listed, it would be hard to imagine that the DSM-IV-TR would list such "relatively rare" and "inherently

nonviolent" disorders while omitting a valid diagnosis of paraphilia NOS (hebephilia), which would be "more common and certainly more socially problematic" than the disorders specifically identified. Zander, Civil Commitment Without Psychosis, supra, at 43; see also, e.g., Marilyn Price, et al., Redefining Telephone Scatologia: Comorbidity and Theories of Etiology, 31 Psychiatric Annals 226, 226 (2001) (describing the paraphilia-NOS category as "reserved for sexual disorders that are either so uncommon or have been so inadequately described in the literature that a separate category is not warranted"). Rather, the logical inference is that the modifier "hebephilia" was deliberately omitted.

This inference is supported by the treatment of nonconsensual sexual conduct in other sections of the DSM-IV-TR. For example, sexual abuse of a child is mentioned in the section of the DSM that covers "other conditions or problems" that may merit "clinical attention" but are not independently diagnosable mental disorders. See DSM-IV-TR at 731, 738-39; Zander, Civil Commitment Without Psychosis, supra, at 43-44.

In addition to the failure of the APA to recognize the disorder, numerous professionals and commentators conclude that it is invalid and diagnostically unreliable. To understand these

criticisms, it is necessary to review the diagnostic criteria for paraphilias established by the APA in the DSM. Criterion A of the general diagnostic category of paraphilias in DSM-IV-TR requires that the person demonstrate "recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving (1) nonhuman objects; (2) the suffering or humiliation of oneself or one's partner, or (3) children or other nonconsenting persons that occur over a period of at least six months." DSM-IV-TR at 566. Criterion B requires that the person be distressed or have impaired functioning, except for the diagnoses of pedophilia, voyeurism, and sexual sadism, which can be made based solely on the person having acted on his or her paraphilic urges. Id.

Consistent with these criteria, in this case Dr. Doren testified that he diagnosed Mr. Ayers with paraphilia NOS (hebephilia) based on his assessment that: (1) Mr. Ayers was attracted to adolescents, who are "children" in a legal sense and therefore incapable of consent; and (2) the attraction caused Mr. Ayers "impairment" because it had led to multiple incarcerations and was, by definition, "self defeating," as the adolescents to whom Mr. Ayers was attracted would necessarily grow up. 5/17/05RP 522, 527-28. Dr. Doren acknowledged Mr. Ayers was not attracted to

adolescents exclusively, as he was also attracted to adult women, but Dr. Doren testified that did not preclude a diagnosis of hebephilia. 5/17/05RP 523.

Dr. Doren is the most widely-recognized proponent of using the diagnosis of paraphilia NOS for sex offenders. Zander, Civil Commitment Without Psychosis, *supra*, at 41. In his 2002 book written specifically for forensic evaluators in sexually violent predator proceedings, Dr. Doren advocated the use of the diagnosis of paraphilia NOS (hebephilia) for offenders who have had sexual contact with, and are sexually attracted to, adolescents. Dennis M. Doren, Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond 80 (2002). Dr. Doren acknowledged studies showing that up to one-third of adult men are sexually attracted to adolescents as well as adults, but argued whether this represents a pathological condition depends on the degree to which the person is impaired by that attraction. *Id.* at 80-81. Consistent with his testimony in this case, Doren argued men who repeatedly have sexual contact with adolescents "despite the ongoing risk of legal consequences and inability to maintain such relationships on a long-term basis due to the adolescents' growing beyond the age of interest," can receive the diagnosis of hebephilia. *Id.* at 81.

Commentators have identified several logical flaws in Dr. Doren's theories. For instance, Zander recognized that if the diagnosis of hebephilia is justified primarily by the "impairment" or "consequences" of an adult's sexual attraction to adolescents, and not by the attraction itself, this raises the question, is it conceptually valid to label a behavior a mental disorder when it is primarily defined by the societal intolerance of it? If so, then it would be arguably justified to redesignate homosexuality as a mental disorder, as there continues to be widespread intolerance of it. Zander, Civil Commitment Without Psychosis, *supra*, at 48.

Further, there is no professional consensus, and indeed much doubt, that the diagnosis is justified merely because the adolescent with whom the adult had sexual contact was under the legal age of consent. Given that the sexual attraction is common, those offenders should be considered diagnostically in the same way as adults who sexually assault other adults, and they should not be diagnosable if the sexual contact is mutual. *Id.* at 48-49. The fact that the legal age of consent for sexual activity varies from jurisdiction to jurisdiction also has implications for the conceptual validity of the diagnosis, as "diagnosis of psychopathology is wholly dependent upon the social response to the behavior that

constitutes the diagnosis." Id. at 49. Further, the contextual variability of Doren's diagnosis would appear to contradict the admonition in DSM that "[n]either deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual." Id. (quoting DSM-IV-TR at xxxi).

Other commentators have leveled similar criticisms at Doren's self-created diagnosis of hebephilia and its use in the sexually violent predator context. See Gregory DeClue, Should Hebephilia be a Mental Disorder? A Reply to Blanchard et al., Archives of Sexual Behavior (Oct. 16, 2008); Karen Franklin, Invasion of the Hebeophile Hunters: Or, the Story of How an Archaic Word Got a New Lease on Life, In the News: Forensic Psychology, Criminology, and Psychology-Law (Oct. 31, 2007); Karen Franklin, The Public Policy Implications of "Hebephilia": A Response to Blanchard et al., Archives of Sexual Behavior (Oct. 16, 2008); Joseph J. Plaud, Are There "Hebeophiles" Among Us? A Response to Blanchard et al., Archives of Sexual Behavior (Oct. 16, 2008).⁴

⁴ Copies of these articles are attached to this brief as Appendix B for this Court's convenience. Also attached in the appendix is a copy of Ray Blanchard, et al., Pedophilia, Hebephilia, and the DSM-V, Archives of Sexual Behavior (Aug. 7, 2008), to which Franklin, DeClue, and Plaud respond. The Blanchard, et al.,

The paucity of support for the diagnosis in the DSM-IV-TR and in the professional literature, as well as its contextual variability, suggests that it lacks conceptual validity. Zander, Civil Commitment Without Psychosis, *supra*, at 49. The diagnosis has not been recognized outside of the SVP commitment context. *Id.* Further, there are no published studies reporting interrater reliability of the diagnosis in clinical practice, research settings, or in any context other than SVP cases. *Id.* In sum, the psychiatric community is far from recognizing the validity or reliability of the diagnosis of hebephilia.

Courts have recently acknowledged these problems with relying on the diagnosis of hebephilia in the sexually violent predator context. For instance, in United States v. Shields, Dr. Doren testified for the State that Shields had a mental disorder called "hebephilia." 2008 U.S. Dist. LEXIS 13837, at *4 (D. Mass., No. 07-12056-PBS, Feb. 26, 2008). The District Court found that although the State presented expert evidence showing hebephilia is generally accepted in the field as a group identifier or label, that literature "does not establish that hebephilia is generally accepted

article presents the results of a research study demonstrating 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. *Id.* at 1.

as a mental disorder by professionals who assess sexually violent offenders. In fact, both sides agree that the attraction of an adult male to a pubescent adolescent is not, without more, indicative of a mental disorder." Id. Dr. Doren's book, which was not peer-reviewed, was the lone source cited by the government for the proposition that some kinds of hebephilia fall under the diagnosis of paraphilia NOS. The court found that evidence "does not suffice." Id. at *6. Therefore, the court concluded the State did not prove Shields was a sexually dangerous offender. Id.

Similarly, in United States v. Abregana, Dr. Doren diagnosed Abregana with paraphilia NOS (hebephilia). 574 F.Supp.2d 1145, 1150-51 (D. Haw. 2008). On the other hand, the defense experts testified hebephilia is not listed as a sexual deviance in DSM-IV-TR or other important literature in the field, and that even if it is a valid diagnosis, the degree of pathology of hebephilia is much less than that of other paraphilias such as pedophilia or sexual sadism. Id. at 1153. Given this conflicting evidence, the court concluded the government did not prove by clear and convincing evidence the disorder was a serious mental disorder. Id. at 1154, 1159.

In sum, absent a diagnosis that "the psychiatric profession itself classifies as a serious mental disorder," Hendricks, 521 U.S.

at 360, involuntary civil commitment violates the Due Process Clause. As Justice Souter put it, "medical recognition" is necessary to prevent "abuse[]" of civil commitment procedures. Transcript of Oral Argument, Hendricks, 521 U.S. 346 (Nos. 95-1649, 95-9075). Doren's self-created diagnosis of paraphilia NOS (hebephilia) lacks such medical recognition. It is not in the DSM or recognized by the APA. There is no consensus within the psychiatric community of its validity as a diagnosis or its appropriateness in SVP proceedings. Accordingly, due process prohibits its use as a predicate for involuntary civil commitment.

ii. The State's reliance on APD as a basis for civil commitment violates due process, as APD is too imprecise a diagnosis to satisfy due process. Ayers's involuntary commitment also violates due process insofar as it is based on a diagnosis of APD. To begin with, the Supreme Court's decision in Foucha strongly implies that due process prohibits involuntary commitment on the basis of such a diagnosis. See 504 U.S. at 78, 82-83.

APD is simply "too imprecise a category to offer a solid basis for concluding that civil detention is justified." Hendricks, 521 U.S. at 373 (Kennedy, J., concurring). For this reason, the diagnosis is fatally "[in]sufficient to distinguish the dangerous sexual offender

whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case." Crane, 534 U.S. at 413. For example, in Crane, the Court cited a study that found that forty to sixty percent of the male prison population is diagnosable with APD. Id. at 412. In reality, this number is probably seventy-five to eighty percent. See, e.g., Eric S. Janus, Foreshadowing the Future of Kansas v. Hendricks: Lessons from Minnesota's Sex Offender Commitment Litigation, 92 N.W. U. L. Rev. 1279, 1291 & n.59 (1998) (collecting studies indicating that seventy-five to eighty percent of all prisoners are diagnosable with APD). Indeed, an estimated seven million Americans -- including more than six million men -- are diagnosable with APD. Harriet Barovick, Bad to the Bone, Time, Dec. 27, 1999. Thus, APD certainly is not the sort of "highly unusual" disorder that at least four Justices in Hendricks agreed was a constitutional prerequisite to involuntary civil commitment. See 521 U.S. at 375 (Breyer, J., dissenting).

That millions of Americans and a substantial majority of the male prison population are diagnosable with APD is not surprising. The core of an APD diagnosis is the existence of any three of the following seven behaviors:

- (1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- (3) impulsivity or failure to plan ahead
- (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
- (5) reckless disregard for the safety of self or others
- (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

DSM-IV-TR at 706.⁵

Far from "distinguish[ing] . . . the dangerous but typical recidivist convicted in an ordinary criminal case," Crane, 534 U.S. at 413, these criteria essentially describe a typical recidivist (as well as millions of non-criminals). During oral argument in Crane, Justice Ginsburg recognized precisely this problem and expressed

⁵ The remaining "diagnostic criteria" of APD are that the individual must be at least 18 years of age, there must be some "evidence" of a "Conduct Disorder" before age 15, and the antisocial conduct underlying the diagnosis must not relate exclusively to schizophrenia or a manic episode. DSM-IV-TR at 706. A "Conduct Disorder" is, more or less, a juvenile version of APD. See id. at 98-99, 702; Zander, Civil Commitment Without Psychosis, supra, at 55. APD does not require an actual diagnosis of conduct disorder; rather, "a history of

significant concerns over the use of APD as a predicate for involuntary civil commitment:

[I]f you look at the definition of [APD] and they say pick three out of a list of seven, you could pick out habitually doesn't work, doesn't pay debts, is reckless, irritable. That's . . . considerably less than what is defined as an abnormality like pedophilia. There are a lot of ordinary people who would fit that description.

Transcript of Oral Argument, Crane, 534 U.S. 407 (No. 00-957), at http://www.oyez.org/cases/2000-2009/2001/2001_00_957/argument/. Justice Ginsburg also noted that anyone who was "a liar" and "a malingerer" and did "not pay [his] debts" would satisfy the criteria. Id. And when Kansas's counsel took the position that a person exhibiting such unexceptional criminal and non-criminal behaviors "could be committed," Justice Souter's only response was, "Wow." Id.; see also, e.g., Zander, Civil Commitment Without Psychosis, supra, at 54-56 (explaining how an unexceptional "parking ticket scofflaw" could be diagnosed with APD). Such concerns likely explain why, in remanding the case for further proceedings, the Crane Court specifically noted that Crane suffered from "both exhibitionism⁶ and

some symptoms of Conduct Disorder before age 15" will suffice. DSM-IV-TR at 702; Zander, Civil Commitment Without Psychosis, supra, at 55.

⁶ Exhibitionism is a paraphilia that is specifically recognized by the DSM-IV-TR (at 569). It involves a serious difficulty controlling urges to "expos[e] one's genitals to an unsuspecting stranger." Id.

[APD]," 534 U.S. at 411, and then suggested, albeit obliquely, that a diagnosis of APD alone might be too imprecise and overbroad to survive constitutional scrutiny. *Id.* at 412.

The APA also has taken the position that APD is an over-inclusive and inappropriate basis for civil commitment. For instance, in 2006, the APA approved an Action Paper supporting the elimination of APD as a basis for the civil commitment of sex offenders. APA Final Action Paper, Eliminating the Use of Antisocial Personality Disorder as a Basis for Civil Commitment (APA Assembly, May 19-21, 2006), available at <http://tinyurl.com/6ykpxu>. The Action Paper explained that APD should not serve as a predicate for involuntary civil commitment because, *inter alia*, it "is a disorder largely defined on the basis of the behavior exhibited by the individual; *it is not premised on any underlying disturbance of thought, mood, cognition or aberrant sexual urge.*" APA Final Action Paper, *supra*, at 1-2 (emphasis added).⁷

⁷ The APA opposes the use of an APD diagnosis as a basis for civil commitment despite the disorder's inclusion in the APA-published DSM-IV-TR. As the DSM explains (at xxxvii): "It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category . . . does not imply that the condition meets legal . . . criteria for what constitutes a mental disease, mental disorder, or mental disability." Thus, while consensus professional recognition, as reflected by the DSM, should be seen as a *necessary* condition for civil commitment under the Due Process Clause, it should not be viewed as a *sufficient* condition.

In addition to APA's opposition to the use of APD as a predicate for involuntary commitment, numerous individual mental health professionals and commentators have leveled similar criticisms. See, e.g., Daniel F. Montaldi, *The Logic of Sexually Violent Predator Status in the United States of America*, 2(1) *Sexual Offender Treatment* (2007), available at <http://www.sexual-offender-treatment.org/57.0.html>; Bruce Winick et al., *Should Psychopathy Qualify for Preventive Outpatient Commitment?*, at 8, available at <http://papers.ssrn.com/abstract=984938> (APD does not justify involuntary civil commitment because it "does not impair cognitive processes or otherwise interfere with rational decision making" and "does not make it difficult for [the individual] to control [his] conduct."; Zander, *Civil Commitment Without Psychosis*, *supra*, at 52-62 (summarizing studies and scholarly opinion).

Even a prominent article espousing the minority view in the profession that involuntary commitment based on APD may be appropriate in some cases concedes that "[t]he use of [APD] to justify civil commitment is unlikely to find general acceptance among mental health professional groups." Shoba Sreenivasan et al., *Expert Testimony in Sexually Violent Predator Commitments:*

Conceptualizing Legal Standards of "Mental Disorder" and "Likely to Reoffend", 31 J. Am. Acad. Psychiatry & L. 471, 477 (2003).

In sum, the Supreme Court has twice suggested (and perhaps once concluded), and consistent with the APA's official position, APD is simply too imprecise and overbroad a diagnosis to survive constitutional scrutiny. See Foucha, 504 U.S. at 82-83; Crane, 534 U.S. at 412-13. The diagnosis does absolutely nothing to satisfy the State's constitutional obligation to differentiate "the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case." Crane, 534 U.S. at 413. To the contrary, as numerous studies now indicate, it comes perilously close to justifying the civil commitment of "any convicted criminal." Foucha, 504 U.S. at 82-83. Under Foucha and progeny, APD is not a valid basis for civil commitment, and Ayers's continued detention on that ground violates due process.

iii. Mr. Ayers's commitment violates due process because it is based on unreliable evidence. The Due Process Clause imposes limits on the use of unreliable evidence. State v. Dahl, 139 Wn.2d 678, 686, 990 P.2d 396 (1999); State v.

Ford, 137 Wn.2d 472, 481, 973 P.2d 452 (1999); accord White v. Illinois, 502 U.S. 346, 363-64, 112 S.Ct. 736, 116 L.Ed.2d 848 (1992) (Thomas, J., concurring in part and concurring in judgment).

Washington courts apply the Frye standard in determining the reliability and admissibility of scientific evidence. State v. Greene, 139 Wn.2d 64, 70, 984 P.2d 1024 (1999). In the context of involuntary civil commitment proceedings, where the State seeks to impose a significant deprivation of liberty solely on the basis of psychiatric testimony, the Frye standard is a practical and appropriate proxy for the reliability that due process requires.

Frye directs courts to apply particular criteria in assessing the reliability and admissibility of expert testimony. Under the Frye standard, novel scientific evidence is admissible only if (1) the scientific theory or principle upon which the evidence is based has gained general acceptance in the relevant scientific community of which it is a part; and (2) there are generally accepted methods of applying the theory or principle in a manner capable of producing reliable results. Greene, 139 Wn.2d at 70. The Frye standard recognizes that because judges do not have the expertise to assess the reliability of scientific evidence, the courts must turn to experts in the particular field to help them determine the

admissibility of the proffered testimony. Id. The inquiry turns on the level of recognition accorded to the scientific principle involved; the court "look[s] for *general acceptance* in the appropriate scientific community." Id. (quoting State v. Janes, 121 Wn.2d 220, 232-33, 850 P.2d 495 (1993)). "If there is a significant dispute between qualified experts as to the validity of scientific evidence, it may not be admitted." Id. (quoting State v. Cauthron, 120 Wn.2d 879, 887, 846 P.2d 502 (1993)).

The Frye standard applies in determining the reliability and admissibility of expert testimony regarding whether an individual suffers from a particular novel psychiatric diagnosis. Greene, 139 Wn.2d at 70. Under such circumstances, the question is whether the diagnosis is generally accepted within the psychiatric community as a recognized mental condition that is regularly diagnosed and treated. Id. at 71. In Greene, the court concluded dissociative identity disorder was generally accepted in the psychiatric community, because it was included in the DSM-IV. Id. The court explained, "The DSM-IV's diagnostic criteria and classification of mental disorders reflect a *consensus* of current formulations of evolving knowledge in the mental health field." Id. (quoting DSM-IV at xxvii). Further, the disorder was regularly

diagnosed and treated by mental health professionals in this state. Id. at 72. For these reasons, the expert testimony regarding the disorder met the Frye standard in Greene.

In contrast to dissociative identity disorder, however, paraphilia NOS (hebephilia) has not been generally accepted in the psychiatric community. As discussed above, "there is a significant dispute between qualified experts" as to the validity of the diagnosis. Id. at 70. Therefore, expert testimony diagnosing an individual with paraphilia NOS (hebephilia) does not meet the Frye standard for admissibility.

Further, expert testimony is admissible under ER 702⁸ only if it is helpful to the trier of fact under the particular facts of the case. Greene, 139 Wn.2d at 73. Under ER 702, expert testimony will be deemed helpful to the trier of fact only if its relevance can be established. Id. at 73. Scientific evidence that does not help the trier of fact resolve any issue of fact is irrelevant and does not meet the requirements of ER 702. Id. Unlike the Frye standard, this

⁸ ER 702 provides:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.

inquiry turns on the forensic application of the particular scientific principle or theory. Id.

Here, the relevant question to be resolved by the trier of fact was whether Mr. Ayers had a serious mental disorder that caused him difficulty controlling his sexually violent behavior. Thorell, 149 Wn.2d at 736, 740-41; Crane, 534 U.S. at 413. As discussed in the previous section, the expert testimony regarding the diagnosis of APD did absolutely nothing to satisfy the State's constitutional obligation to differentiate "the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case." Crane, 534 U.S. at 413. To the contrary, the disorder merely describes a majority of convicted criminals and therefore is not a valid basis for civil commitment.

Also as discussed, the use of the diagnosis of APD in civil commitment proceedings has not found general acceptance among the relevant community. While APD is recognized by mental health professionals, as well as the DSM-IV-TR, as a potentially useful diagnosis for clinical or research purposes, it is not considered a valid basis for civil commitment.

Thus, even though the diagnosis of APD may have gained general acceptance in the psychiatric community as a potentially useful diagnosis for clinical or research purposes, it is not helpful to the trier of fact in sexually violent predator proceedings and was therefore inadmissible under ER 702.

b. Mr. Ayers is entitled to relief if either diagnosis is held invalid. Where a verdict in a criminal case rests upon a statutory alternative means that is later held to be unconstitutional, the judgment must be reversed if it is impossible to say under which means the conviction was obtained. Stromberg v. California, 283 U.S. 359, 51 S.Ct. 532, 75 L.Ed 1117 (1931); Street v. New York, 394 U.S. 576, 585-86, 89 S.Ct. 1354, 22 L.Ed.2d 572 (1969). Where the verdict is the result of a bench trial, the question is whether the ground of the judge's decision can be ascertained from the record. Street, 394 U.S. at 586. Moreover, even if the record precludes the inference that the conviction was based *solely* on the improper means, the reviewing court must still reverse if the conviction could have been based upon *both* the proper and the improper means. Id. at 587-88; cf. State v. Bourgeois, 72 Wn. App. 650, 664, 866 P.2d 43 (1994) (exceptional sentence must be

reversed where record shows trial court placed "significant weight" on inappropriate aggravating factor in imposing sentence).

Here, the record shows the trial judge relied upon *both* of Dr. Doren's diagnoses in finding Mr. Ayers met the sexually violent predator criteria. In its written findings, the court stated: "The Court finds that *both* the Respondent's Paraphilia NOS, involving sexual attraction to adolescents (Hebephilia), *and* his Antisocial Personality Disorder are congenital or acquired conditions, that they affect the Respondent's emotional or volitional capacity, and that they predispose him to the commission of criminal sexual acts to the degree constituting him a menace to the health and safety of others." CP 68-69 (emphasis added). The court further stated, "*both* the Respondent's Paraphilia NOS, involving sexual attraction to adolescents (Hebephilia), *and* Antisocial Personality Disorder, *independently and in combination with each other*, cause him serious difficulty controlling his sexually violent behavior." CP 69 (emphasis added). Finally, the court stated, "[t]he Respondent's mental abnormality and personality disorder, *both independently and in combination*, make(s) him likely to engage in predatory acts of sexual violence if not confined in a secure facility." CP 75 (emphasis added).

Thus, the record is plain that the court relied upon *both* diagnoses in finding Mr. Ayers met the sexually violent predator criteria, and that it placed significant weight on each one. Thus, even if only one of the means is held to be unconstitutional, this Court must reverse and remand for a new trial.

3. MR. AYERS RECEIVED INEFFECTIVE ASSISTANCE OF COUNSEL

Detainees in sexually violent predator proceedings have both a due process and statutory right to the assistance of counsel. As noted, civil commitment for any purpose is a significant deprivation of liberty that requires due process protections. Addington v. Texas, 441 U.S. 418, 425, 99 S.Ct. 1804, 60 L.Ed.2d 323 (1979). The constitutional right to procedural due process includes the right to counsel. Specht v. Patterson, 386 U.S. 605, 609-10, 87 S.Ct. 1209, 18 L.Ed.2d 326 (1967).

Moreover, the SVP statute provides a right to the assistance of counsel at the commitment trial. RCW 71.09.050(1).

To show ineffective assistance of counsel in a sexually violent predator context, the claimant must show counsel's performance fell below an objective standard of reasonableness and the deficient performance prejudiced the detainee, "i.e., that there is a reasonable possibility that, but for the deficient conduct,

the outcome of the proceeding would have differed.” In re Det. of Stout, 159 Wn.2d 357, 377, 150 P.3d 86 (2007); see also Strickland v. Washington, 466 U.S. 668, 688-89 (1984). In applying this test, courts presume counsel was effective. Id.

a. Counsel was ineffective for failing to raise the due process challenge. Ayers's substantive due process claim was a significant and obvious issue and should have been raised in trial court. As discussed above, at the time of Ayers's civil commitment trial, Hendricks had already stressed the importance of a disorder's recognition by the DSM and that some disorders might be too imprecise to satisfy due process. Hendricks, 521 U.S. at 360; id. at 372-73 (Kennedy, J., concurring); Id. at 375 (Breyer, J., dissenting). The Court again emphasized these points in Crane, and, in fact, seemed to imply that the diagnosis of APD in particular might be too imprecise. Crane, 534 U.S. at 410, 412-13. Moreover, Hendricks and Crane both relied upon the Court's earlier decision in Foucha; as noted above, some believed that Foucha had already placed APD off limits as a basis for involuntary commitment.

In light of the substantial Supreme Court precedent suggesting and implicitly supporting Mr. Ayers's due process claim, that claim must be regarded as significant and obvious.

Finally, counsel's failure to raise Mr. Ayers's significant and obvious due process claim resulted in prejudice. That is, as discussed above, Mr. Ayers has established far more than a "reasonable probability that, but for counsel's [failure to raise his due process claim], the result of [his civil commitment] proceeding would have been different." Strickland, 466 U.S. at 694.

b. Counsel was ineffective for failing to request a Frye hearing or challenge the expert testimony under ER 702. As discussed above, expert testimony regarding novel psychiatric diagnoses is deemed unreliable and inadmissible if it cannot meet the standards established by Frye. Greene, 139 Wn.2d at 70. The diagnosis must be generally accepted by the psychiatric community as a recognized mental condition that is regularly diagnosed and treated. Id. at 71. This may be established if the diagnosis is included in the DSM, which "reflect[s] a *consensus* of current formulations of evolving knowledge in the mental health field." Id. (quoting DSM-IV at xxvii). But if "there is a significant dispute between qualified experts" as to the validity of the diagnosis, Frye is not met and the expert testimony is not admissible. Id. at 70.

Here, at the time of Mr. Ayers's trial in 2005, Doren's diagnosis of paraphilia NOS (hebephilia) was not included in the

DSM-IV-TR and was not generally accepted by the psychiatric community as a valid diagnosis. It was certainly not a mental condition that was regularly diagnosed and treated by psychiatrists, and even today the diagnosis has not been recognized outside of the SVP commitment context. Zander, Civil Commitment Without Psychosis, supra, at 49. Finally, there are no peer-reviewed studies reporting interrater reliability of the diagnosis in clinical practice or research settings. Id. In sum, the psychiatric community is far from recognizing the validity or reliability of the diagnosis of hebephilia. Trial counsel should have requested the diagnosis be subjected to a Frye hearing.

Further, counsel was ineffective for failing to challenge Dr. Doren's testimony regarding APD under ER 702. As discussed above, APD is insufficient to distinguish the dangerous sexual offender whose serious mental disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case. The Supreme Court suggested in Hendricks that APD is simply "too imprecise a category to offer a solid basis for concluding that civil detention is justified." 521 U.S. at 373 (Kennedy, J., concurring). Later, in Crane, the Court recognized that APD applies to a majority of the prison population

and therefore is insufficient to distinguish the dangerous sexual offender from the typical but dangerous recidivist. 534 U.S. at 412-13. For these reasons, counsel should have objected to the testimony under ER 702 as unhelpful to the trier of fact.

F. CONCLUSION

Because Mr. Ayers's civil commitment rests on diagnoses that are either not generally accepted within the psychiatric community or are too broad and imprecise, his commitment violates due process. Further, trial counsel was ineffective for failing to challenge the diagnoses at trial on due process grounds, and for failing to request they be subject to a Frye hearing or to argue they were objectionable under ER 702. For these reasons, the trial court's order denying the motion to vacate judgment must be reversed and the matter remanded for a new trial.

Respectfully submitted this 31st day of December 2008.


MAUREEN M. CYR (WSBA 28724)
Washington Appellate Project - 91052
Attorneys for Appellant

APPENDIX A

SCANNED

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FILED
SEP 12 2005
JoAnne McBride, Clerk, Clark Co.

**STATE OF WASHINGTON
CLARK COUNTY SUPERIOR COURT**

In re the Detention of:

LENIER RENE AYERS,

Respondent.

NO. 01-2-00713-4

FINDINGS OF FACT,
CONCLUSIONS OF LAW,
AND ORDER OF COMMITMENT

A trial was held in this matter pursuant to chapter 71.09 RCW, on May 16, 17, 18, 24, 25, 26, 31, and June 1, and 2, 2005, to determine whether the Respondent, LENIER RENE AYERS, is a sexually violent predator. The Respondent waived his right to a jury trial and elected to have the case tried to the Court. Petitioner, State of Washington, was represented by counsel, KRISTA K. BUSH and MELANIE TRATNIK. The Respondent was present and was represented by counsel, DONALD LUNDAHL. The Court, having heard the evidence presented by the parties and the argument of counsel, hereby determines that the Respondent is a sexually violent predator as that term is defined in RCW 71.09.

I. FINDINGS OF FACT

1. The Respondent was born on May 19, 1959.
2. On December 26, 1991, the Respondent was convicted, pursuant to his pleas, of Child Molestation in the Second Degree and Communicating with a Minor for Immoral Purposes for offenses against Jami M., a 13 year old girl, in Clark County Superior Court (Cause #90-1-1100-3).

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1 3. On December 26, 1991, the Respondent was convicted, pursuant to his pleas, of Child
2 Molestation in the Second Degree involving Sherry D., a 12 year old girl, in Clark County
3 Superior Court (Cause #91-1-1048-0).

4 4. On December 26, 1991, the Respondent was convicted, pursuant to his pleas, of Child
5 Molestation in the Third Degree involving Marlo L., a 14 year old girl, in Clark County
6 Superior Court (Cause # 91-1-0147-1).

7 5. The terms of the Judgment and Sentence documents for the Respondent's 1991
8 convictions referenced in Findings of Fact 2, 3, and 4, prohibited the Respondent from having
9 unsupervised contact with minor females for a period of 2 years after his release from
10 confinement.

11 6. The Respondent was still subject to the terms of his Judgment and Sentence documents
12 for his 1991 convictions when he engaged in contact with minors in July 2000 in Clark
13 County, Washington.

14 7. On August 2, 2000, the Respondent was arrested for his July 2000 contact with
15 Stephanie A., a 14 year old girl, Mikaela J., a 19 year old girl, and Ebony H., a 16 year old girl.

16 8. The Respondent was originally charged on August 4, 2000, with Felony
17 Communicating with a Minor for Immoral Purposes (after a Felony Sex Offense), Stalking,
18 and Assault in the Fourth Degree, for his contact with Stephanie A., a 14 year old girl,
19 Mikaela J., a 19 year old girl, and Ebony H., a 16 year old girl.

20 9. On April 19, 2001, the Respondent was convicted, pursuant to his pleas, of two counts
21 of Assault in the Fourth Degree in Clark County Superior Court (Cause # 00-1-0407-4), for his
22 offenses against Stephanie A., a 14 year old girl, and Ebony H., a 16 year old girl.

23 10. Subsequent to the Respondent's sentencing for his July 2000 offenses against
24 Stephanie A. and Ebony H., he has been continuously incarcerated and was incarcerated on the
25 date the State filed the petition in this case.

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1 11. The Petitioner filed a petition alleging the Respondent is a sexually violent predator,
2 pursuant to chapter 71.09 RCW on February 15, 2001.

3 12. On the issues of whether the Respondent has committed a sexually violent offense and
4 what the nature of his sexual offending has been in the past, the Court heard testimony from
5 the victims of the Respondent's 1991 and 2000 adjudicated offenses: Jami M., Sherry D.,
6 Marlo L., Stephanie A., and Ebony H., as well as from the Respondent.

7 a. Jami M. testified that when she was 13 years old and living in Clark County,
8 Washington, the Respondent raped her. She testified that she was kicked out of her house and
9 didn't have any place to go, so she called a friend, who gave her the Respondent's telephone
10 number. After she called him, the Respondent and his mother picked her up and drove her to
11 the Respondent's home. This was the first time Jami M. had met the Respondent. Once at the
12 Respondent's home, he provided her alcohol, she became intoxicated, and passed out. When
13 she regained consciousness, the Respondent was on top of her with his penis inside her vagina.
14 The next morning, she made up a story about going to get some drugs so that he would her
15 leave his home, then she ran to a nearby school and reported the rape. She testified that she
16 was scared of the Respondent at the time of the assault and was scared when she testified on
17 May 16, 2005.

18 b. Sherry D. testified that in December of 1990, when she was 12 years old, she
19 and her friend Marlo L. went to a party at the Respondent's home. She testified that it was the
20 first time she'd met the Respondent. At the Respondent's home, she began drinking alcohol,
21 smoking marijuana, and she became intoxicated. She remembers her friend Marlo L. and the
22 Respondent going into the Respondent's bedroom, Marlo L. calling her name and attempting
23 to leave the bedroom, but the Respondent refusing to allow her to leave. When Marlo L. came
24 out of the Respondent's bedroom, she was crying. Sherry also testified that the Respondent
25 sexually assaulted her. She told him, "What are you doing? Don't touch me. Stop." She
26 pushed him away and told him to leave her alone. He didn't stop, as she instructed him to do.

1 He removed her clothes and his own clothes. He grabbed her and made her do things she
2 didn't want to do, such as kiss him. The Respondent touched her breasts and her genital area.

3 c. Marlo L. testified that she met the Respondent as the "Little General Store," a
4 place where young people gathered, when she was 13 years old. At first, the Respondent
5 seemed to be a nice and trustworthy friend. When he invited her, on December 1st or 2nd of
6 1990, to come to his home with some friends to drink alcohol, she agreed. It was the first time
7 she had been to the Respondent's home. At his home, the Respondent poured some alcohol for
8 her and asked her to come into his bedroom. She sat on the end of his bed and he closed the
9 door. He asked her to move up toward the head of his bed, closer to him. When she did so, he
10 put his arms around her, started "messaging with" her stomach, and moved his hand up to her
11 breasts. She did not want him to do this and she told him to stop. He put his hands down her
12 pants. She pulled his hands out and told him to quit. He didn't stop until her friend Sherry D.
13 knocked on the door. The Respondent got up, opened the door, and yelled at Sherry D. for
14 interrupting him. Marlo L. tried to go out the door, but the Respondent wouldn't let her.
15 Another friend pushed the door open and Marlo left the bedroom, crying.

16 d. Stephanie A. testified that on July 22, 2000, when she was 14 years old, she was
17 walking with her older sister, Mikaela J. (18 or 19 years old), and her niece, Zakiah, near
18 Evergreen Park, in Vancouver, Washington, toward her home. The Respondent pulled up in a
19 truck right next to us and began talking with them. He asked them how old they were; they
20 told him and walked away. Stephanie A. testified that she could tell that the Respondent was
21 "interested" in them and thought they were pretty. They later noticed that he was following
22 them, so they ran around some neighboring homes to reach their home, so that he wouldn't see
23 where they lived. Once the girls reached their home, Stephanie looked out the window and
24 saw the Respondent sitting in his truck in the parking lot. She thought that the Respondent was
25 "creepy" and he made her feel "uneasy." A few days later, Stephanie A. saw the Respondent
26 again. She was in the park with some friends when the Respondent walked up behind her and

1 pulled on her leg. She pulled her leg away from him. She saw him several more times both
2 before and after the incident in the park where he pulled on her leg, parked in the parking lot in
3 a location where he could see her front door from his truck. Sometimes he was eating lunch.
4 He was always alone. Stephanie testified that she never left her home when she noticed the
5 Respondent in the parking lot because she didn't want him to know where she lived. When she
6 told her mother about the Respondent being parked outside and how he'd followed the girls
7 home, her mother called the police.

8 e. Ebony H. testified that on July 14, 2000, she was living in Vancouver,
9 Washington, and was 16 years old. She came into contact with the Respondent in a park near
10 her home. Ebony H. testified that this was the first time she'd ever met the Respondent. He
11 was sitting under a tree with a yellow tobacco bag and he had marijuana and beer with him.
12 She was with a friend, LaToya A. The Respondent asked the girls how old they were. When
13 they told him they were 16 years old, he said something about "penitentiary chances." The
14 Respondent offered the girls cigarettes and offered to buy them "weed" (meaning marijuana)
15 and alcohol. Ebony got into his truck with the Respondent and started talking with him. The
16 Respondent talked with her about how he takes care of his women, buying them clothes, and
17 taking them to get their nails done. He told Ebony that he lived in the mountains and he
18 wanted to get some marijuana and go watch a movie. When he told her that he lived in the
19 mountains, she became frightened. In an attempt to manipulate the Respondent into taking her
20 back near her home, she pretended to make some telephone calls to arrange a marijuana
21 purchase and convinced the Respondent to drive her back to the park, where she'd met him.
22 She testified that she no longer felt safe and she wanted to go home. The Respondent told her
23 to move closer to him in the truck and put his arm partially around her to pull her closer to him.
24 He then placed his hand between her legs, on her inner thigh near her knee and ran his hand up
25 her inner thigh toward her genital region. She slapped his hand away and exited the truck.

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1 f. The Respondent testified in person, by video deposition, and through
2 admissions made pursuant to CR 36(b).

3 (1) Jami M.:

4 (a) The Respondent admitted that he engaged in oral and vaginal intercourse
5 with Jami M., a 13 year old girl, at his home in December 1990, while she was intoxicated, and
6 after she vomited in his shower.

7 (b) The Respondent asserted that Jami M. initiated the sexual contact.

8 (c) The Respondent admitted that he removed both Jami's clothes and his
9 own.

10 (d) The Respondent admitted that Jami said "no" and was crying or
11 whimpering during their sexual intercourse.

12 (e) The Respondent admitted that he threatened to slap Jami if she didn't
13 stop screaming.

14 (f) The Respondent admitted that he was convicted on December 26, 1991
15 of Child Molestation in the 2nd Degree and Communicating with a Minor for Immoral
16 Purposes for the offenses against Jami M., under Clark County Cause #90-1-01100-3.

17 (2) Sherry D.:

18 (a) The Respondent admitted that he was alone with Sherry D.

19 (b) The Respondent admitted that he was convicted on December 26, 1991,
20 of Child Molestation in the 2nd Degree for offenses against Sherry D., under Clark County
21 Cause #91-1-01048-0.

22 (c) The Respondent denied engaging in any sexual contact with Sherry D.

23 (3) Marlo L.:

24 (a) The Respondent admitted that he was alone with Marlo L., a 14 year old
25 girl.

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1 (b) The Respondent admitted that he touched Marlo L.'s breasts, under her
2 clothing.

3 (c) The Respondent admitted that he was convicted on December 26, 1991,
4 of Child Molestation in the 3rd Degree for the offenses against Marlo L., under Clark County
5 Cause #91-1-01047-1.

6 (4) Stephanie A.:

7 (a) The Respondent admitted that he approached Stephanie A., a 14 year old
8 girl, in Evergreen Park on or about July 26, 2000.

9 (b) The Respondent admitted that he knew Stephanie A. was 14 years old
10 because she told him her age.

11 (c) The Respondent admitted that he pled guilty to, in conjunction with a
12 plea agreement, and was convicted of, a reduced charge of Assault in the Fourth Degree under
13 Clark County Cause #00-1-01407-4 for his offense against Stephanie A.

14 (5) Ebony H.:

15 (a) The Respondent admitted that he approached Ebony H., a 16 year old
16 girl, in Evergreen Park in July 2000.

17 (b) The Respondent admitted that he knew Ebony H. was 16 because she
18 told him how old she was.

19 (c) The Respondent admitted that he offered Ebony H. a ride in his truck,
20 after knowing that she was 16 years old.

21 (d) The Respondent admitted that he was arrested in August 2000 and
22 charged with unlawful imprisonment, luring a child, and communicating with a minor for
23 immoral purposes after a felony offense, for his offenses against Ebony H.

24 (e) The Respondent admitted that he pled guilty to, in conjunction with a
25 plea agreement, and was convicted of, a reduced charge of Assault in the Fourth Degree under
26 Clark County Cause #00-1-01407-4 for his offense against Ebony H.

1 (f) The Respondent denied placing his hand between Ebony H.'s legs.

2 (6) Other Sexual Offending:

3 (a) The Respondent admitted that when he was 15 years old, he pulled his
4 12 year old sister, Roshawn, down on a bed in their home and pulled her pants down.

5 (b) The Respondent admitted that when he was 17 years old, he engaged in
6 sexual intercourse with a 13 year old girl on approximately three (3) occasions.

7 (c) The Respondent admitted that in 1987, when he was 28 years old, he
8 had sexual contact with a girl who was under the age of 16.

9 13. The Court heard testimony from Dr. Kirk Johnson, a psychologist who evaluated the
10 Respondent in 1991 for a possible sex offender sentencing alternative and who supervised the
11 Respondent's community sex offender treatment in 2000.

12 a. Dr. Johnson testified about his interviews with the Respondent and the
13 disclosures that the Respondent made to him about his sexual offending and his sexual
14 attraction to minor girls.

15 b. Dr. Johnson testified that he did not recommend that the Respondent receive a
16 sex offender sentencing alternative because he was of too high a risk to the community to be
17 treated in an outpatient program.

18 c. Dr. Johnson testified that during the Respondent's 2000 community treatment,
19 the Respondent signed a treatment contract, in which the Respondent agreed to abide by
20 treatment conditions, including: no unsupervised contact with minors; no grooming behavior,
21 including putting himself in a position of taking advantage of vulnerable persons; no high risk
22 behaviors, including wandering or frequenting areas where children may be; and no use of
23 alcohol or drugs.

24 d. Dr. Johnson further testified that if an individual offends after having treatment,
25 it shows that the treatment failed and that the person is at high risk for reoffense.

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1 14. On the issue of whether the Respondent has a mental abnormality and/or personality
2 disorder which cause(s) him serious difficulty controlling his sexually violent behavior, the
3 Court also heard testimony from Dr. Dennis Doren and Dr. Richard Wollert.

4 a. Dr. Doren, a psychologist with considerable experience in the evaluation,
5 diagnosis, and treatment of sex offenders beginning in 1982, was called to testify by the
6 Petitioner.

7 (1) Dr. Doren testified that, in conducting his evaluation of the Respondent,
8 he reviewed several thousand pages of documents, including Department of Corrections
9 records, court documents, police reports, administrative records, and prior psychological
10 records.

11 (2) Dr. Doren testified that all of the materials he considered were of the
12 type upon which he and other professionals who conduct evaluations of individuals similar to
13 the Respondent commonly rely and that he did rely upon them in conducting his evaluation of
14 the Respondent.

15 (3) Dr. Doren further testified that he interviewed both the Respondent and
16 the Respondent's Special Commitment Center treatment provider, Dr. Baertschy.

17 (4) Dr. Doren testified that, in his professional opinion, the Respondent
18 suffers from several disorders which are classified in the Diagnostic and Statistical Manual,
19 Fourth Edition, Text Revision (DSM-IV-TR): Paraphilia, Not Otherwise Specified (NOS),
20 involving sexual attraction to adolescents (also known as Hebephilia); BiPolar I Disorder;
21 Polysubstance Dependence; and Antisocial Personality Disorder.

22 (5) Dr. Doren testified that the Respondent's Paraphilia NOS constitutes a
23 mental abnormalities, as that term is defined in RCW 71.09.020(8), that is:

24 (a) It is either congenital or acquired;

25 (b) It affects the Respondent's emotional or volitional capacity; and,

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1 (c) It predisposes the Respondent to the commission of criminal sexual acts
2 to the degree constituting him a menace to the health and safety of others.

3 (6) Dr. Doren testified that the Respondent's Paraphilia NOS and Antisocial
4 Personality Disorder, both independently and in combination, cause him serious difficulty
5 controlling his sexually violent behavior.

6 (7) Dr. Doren explained that the cardinal qualities of a Paraphilia are that
7 the person experiences intense, sexually arousing fantasies, sexual urges, or behaviors
8 involving nonhuman objects, the suffering of oneself or one's partner, or children or other
9 nonconsenting persons for more than six months.

10 (8) Dr. Doren testified that Paraphilias are chronic, lifelong, and by their
11 nature, compromise volitional control and emotional capacity.

12 (9) In Dr. Doren's opinion, the Respondent's Paraphilia causes him to target
13 adolescent girls for sexual contact.

14 (10) In Dr. Doren's opinion, the Respondent's offenses have also involved
15 nonconsensual sexual activity.

16 (11) In Dr. Doren's opinion, the Respondent will use grooming, age
17 dominance, manipulation, or coerciveness to achieve sexual contact with his targeted victims.

18 (12) Dr. Doren testified that the Respondent's personality disorder takes the
19 form of Antisocial Personality Disorder.

20 (13) Dr. Doren explained that the cardinal qualities of a personality disorder
21 are an enduring pattern of experience that deviates from the expectations of the person's
22 culture in at least two of the following ways: cognitive, affective, interpersonal, and impulse
23 control; the pattern of behavior is pervasive and inflexible; and, it results in clinical distress or
24 impairment.

25 (14) Dr. Doren testified that the essential feature of Antisocial Personality
26 Disorder is that it involves the pervasive disregard for violation of the rights of others.

1 (15) Dr. Doren testified that, while a diagnosis of Antisocial Personality
2 Disorder is warranted under the DSM-IV-TR when an individual meets three of seven listed
3 diagnostic criteria, the Respondent meets all seven of these criteria: failure to conform to
4 social norms; deceitfulness; impulsivity or failure to plan ahead; irritability and aggressiveness;
5 reckless disregard for the safety of self or others; consistent irresponsibility; and lack of
6 remorse.

7 (16) Dr. Doren testified that the diagnosis of Antisocial Personality Disorder
8 is also supported by the Respondent's score on the Psychopathy Checklist - Revised (PCL-R).

9 (a) Dr. Doren was certified to administer the PCL-R by Dr. Robert Hare, the
10 creator of this psychological test.

11 (b) Dr. Doren testified that he scored the Respondent as a "33" on the PCL-
12 R and he explained his rationale for the individual scoring on each item.

13 (c) Dr. Doren testified that the research literature indicates that scores of 25
14 and above are indicative of a high level of psychopathy.

15 (17) Dr. Doren further testified that the synergy between Respondent's
16 Paraphilia NOS and his Antisocial Personality Disorder results in a more serious condition
17 than either condition alone.

18 (18) Dr. Doren testified that the Respondent's mental condition of
19 Polysubstance Dependence essentially means that he has an addiction to the use of various
20 substances, rather than only one.

21 (19) Dr. Doren testified that the Respondent's Polysubstance Dependence
22 does not, by itself, predispose the Respondent to the commission of criminal sexual acts, but
23 because it makes it easier for him to act on his urges and impulses, it is a factor that increases
24 the risk that the Respondent will sexually offend.

25 (20) Dr. Doren further testified that the Respondent suffers from BiPolar I
26 Disorder, a mood disorder formerly known as Manic-Depressive Illness which involves

1 significant, usually rapid, mood changes and is marked by agitation, a need to keep moving,
2 increased energy, the tendency to have an exaggerated self perspective, and the appearance of
3 delusions or hallucinations.

4 (21) Dr. Doren testified that the Respondent's BiPolar I Disorder does not, by
5 itself, predispose him to the commission of criminal sexual acts.

6 (22) In support of his diagnoses concerning the Respondent, Dr. Doren
7 testified that he considered the Respondent's criminal history, the matters the Respondent
8 revealed to him in the interview process, and the matters contained in the documents provided
9 to him, including depositions and the Respondent's answers to requests for admission.

10 b. Dr. Wollert, a psychologist who also has considerable experience in the
11 evaluation, diagnosis, and treatment of sex offenders beginning in the early 1980's, testified on
12 behalf of the Respondent.

13 (1) Dr. Wollert conducted an evaluation of the Respondent in 2002.

14 (2) In conducting his evaluation, Dr. Wollert reviewed the discovery
15 materials provided to him by the Respondent's counsel and interviewed both the Respondent
16 and the Respondent's mother.

17 (3) Dr. Wollert testified that he originally diagnosed the Respondent with
18 Paraphilia NOS, involving sexual attraction to adolescents (Hebephilia), as reflected in his
19 written report and in his deposition by the Petitioner's counsel, but that he later determined that
20 Hebephilia is not a valid diagnosis in general and is not an appropriate diagnosis for the
21 Respondent.

22 (4) Dr. Wollert testified that if the Respondent does suffer from Paraphilia
23 NOS, involving sexual attraction to adolescents (Hebephilia), that condition is in remission
24 because during the Respondent's most recent period in the community (1999 to 2000), he was
25 able to keep himself from seeking out minor girls for sexual activity and because he denies any
26 current sexual fantasies about adolescents.

1 (5) Dr. Wollert testified that he diagnosed the Respondent with
2 Polysubstance Dependence, in partial remission.

3 (6) Dr. Wollert testified that he disagreed with Dr. Doren's diagnosis of the
4 Respondent as suffering from BiPolar 1 Disorder as, in his opinion, a diagnosis of
5 Schizoaffective Disorder was more appropriate.

6 (a) Dr. Wollert relied heavily on the opinion of Dr. Kolden, a psychiatrist
7 who diagnosed the Respondent with Schizoaffective Disorder in 1997, after the Respondent
8 informed Dr. Kolden that he was experiencing hallucinations.

9 (b) Dr. Wollert admitted that Dr. Kolden was the only other mental health
10 professional in a period of over 20 years to diagnose the Respondent with Schizoaffective
11 Disorder and that the majority of the mental health professionals who evaluated the
12 Respondent diagnosed him with BiPolar Disorder and Antisocial Personality Disorder.

13 (c) Dr. Wollert testified that the Respondent told him that he had lied to
14 Dr. Kolden about experiencing hallucinations, but that Dr. Wollert did not believe the
15 Respondent.

16 (7) Dr. Wollert testified that neither the Respondent's Polysubstance
17 Dependence (in partial remission) nor his Schizoaffective Disorder predispose him to the
18 commission of criminal sexual acts.

19 (8) Dr. Wollert testified that, in his opinion, the Respondent does not suffer
20 from Antisocial Personality Disorder.

21 (a) Dr. Wollert testified that many of the behaviors that Dr. Doren cited as
22 support for a diagnosis of Antisocial Personality Disorder appear to be caused by the
23 Respondent's Schizoaffective Disorder.

24 (b) Dr. Wollert testified that the Respondent's score on the PCL-R is only a
25 "22," which does not indicate a high level of psychopathy.

26 ///

1 (c) Dr. Wollert testified that, in his opinion, the Respondent scores at the
2 highest level on the following PCL-R items: poor behavioral control, criminal versatility,
3 coercive sexual behavior, and revocation of conditional release.

4 (d) Dr. Wollert testified that he discounted the Respondent's score on a
5 significant number of the items on the PCL-R because he believed the etiology of those items
6 was Schizoaffective Disorder, rather than Antisocial Personality Disorder or Psychopathy.

7 (e) Dr. Wollert testified that he disagrees with the scoring instructions in the
8 PCL-R Technical Manual which indicate that the scores on individual items should not be
9 discounted because the evaluator believes the etiology of those items is something other than
10 Psychopathy.

11 (9) In reaching his opinions in this case, Dr. Wollert testified that he relied
12 heavily on self-reports of the Respondent.

13 (a) Dr. Wollert acknowledges that the Respondent's reports are not
14 consistent with his prior disclosures, yet in both the Static-99 and PCL-R scoring, Dr. Wollert
15 places an overabundance of reliance on the Respondent's own reporting.

16 (b) Dr. Wollert acknowledges that the Respondent is not a credible reporter.

17 c. The Court finds that the Respondent suffers from a mental abnormality and a
18 personality disorder.

19 (1) The Court finds that the Respondent suffers from mental disorders that
20 include Paraphilia NOS, involving sexual attraction to adolescents (Hebephilia), Polysubstance
21 Dependence, BiPolar Disorder, and Antisocial Personality Disorder.

22 (2) The Court finds the testimony of Dr. Doren to be more reliable than that
23 of Dr. Wollert on the question of whether the Respondent has a mental abnormality and/or
24 personality disorder that causes him serious difficulty controlling his sexually violent behavior.

25 (3) The Court finds that both the Respondent's Paraphilia NOS, involving
26 sexual attraction to adolescents (Hebephilia), and his Antisocial Personality Disorder are

1 congenital or acquired conditions, that they affect the Respondent's emotional or volitional
2 capacity, and that they predispose him to the commission of criminal sexual acts to the degree
3 constituting him a menace to the health and safety of others.

4 (4) The Court finds that both the Respondent's Paraphilia NOS, involving
5 sexual attraction to adolescents (Hebephilia), and Antisocial Personality Disorder,
6 independently and in combination with each other, cause him serious difficulty controlling his
7 sexually violent behavior.

8 (5) The Court finds a pattern of conduct by the Respondent of isolating
9 adolescent girls for the purposes of sexual contact that is grounded in his mental abnormality
10 and/or personality disorder.

11 (a) This pattern includes the Respondent's actions toward his 1991
12 adjudicated victims, Jami M., Sherry D., and Marlo L., the additional three victims that the
13 Respondent admitted to Dr. Johnson that he had come to his apartment to drink and smoke
14 marijuana, then "felt them up," and the Respondent's actions toward Ebony H. in July 2000,
15 when he placed himself in an area where he would come into contact with young girls, isolated
16 Ebony H. under the guise of getting marijuana and/or tobacco, then progressed to "feel her up."

17 (b) This lack of control follows a pattern of conduct that Dr. Doren has
18 attributed to the Respondent's mental abnormality and/or personality disorder.

19 (c) This lack of control is attributed by Dr. Wollert to the Respondent's
20 Schizoaffective Disorder, although he does not believe that such disorder constitutes a mental
21 abnormality.

22 15. On the issue of whether the Respondent's mental abnormality and/or personality
23 disorder make him likely to commit predatory acts of sexual violence if not confined to a
24 secure facility, the Court also heard conflicting testimony from Dr. Doren and Dr. Wollert.

25 ///

26 ///

1 a. Dr. Doren testified that, in his professional opinion, the Respondent's mental
2 abnormality and personality disorder, both independently and in combination, make(s) him
3 likely to commit predatory acts of sexual violence if not confined in a secure facility.

4 (1) In reaching this opinion, Dr. Doren testified that he anchored his opinion
5 by considering several actuarial risk assessment instruments and one psychological test.

6 (2) Dr. Doren testified that he used the Static-99, the Minnesota Sex
7 Offender Screening Tool – Revised (MnSOST-R), the Rapid Risk Assessment for Sex Offense
8 Recidivism (RRASOR), and the Psychopathy Checklist – Revised (PCL-R).

9 (3) Dr. Doren testified that these instruments are widely used and relied
10 upon among psychologists in his field, that he uses and relies upon them in his practice, and
11 that he used and relied upon them in this case.

12 (4) Dr. Doren testified that the Respondent's score on the Static-99 was an
13 "8," which is in the highest risk group (scores of "6" and above).

14 (5) Dr. Doren testified that of the offenders in the Static-99 development
15 sample who scored a 6 or above, 52% of them were reconvicted of a new hands on sex offense
16 within 15 years of their release.

17 (6) Dr. Doren testified that the Respondent's score on the RRASOR of "4"
18 is in the highest risk group for future sexual reoffense.

19 (7) Dr. Doren testified that of the offenders in the RRASOR development
20 sample who scored a "4," 49% of them were reconvicted of a new sex offense within 10 years
21 of their release and 58% within 17 years of their release.

22 (8) Dr. Doren testified that the Respondent's score on the MnSOST-R of
23 "12" is considered "high."

24 (9) Dr. Doren testified that 54% of the offenders studied by the MnSOST-R
25 who had a score of "12" were rearrested for a new physical contact sexual offense within six
26 years of their release.

1 (10) Dr. Doren testified that the Respondent's score of "33" on the PCL-R
2 indicates that the Respondent meets the criteria for classification as a Psychopath.

3 (a) Dr. Doren explained that scores of "25" or higher on the PCL-R indicate
4 a high degree of psychopathy.

5 (b) Dr. Doren explained that the concept of psychopathy comes down to the
6 idea that the person seems to do what he wants when he wants to do it and does it in part
7 because he doesn't have an emotional connection to others.

8 (c) Dr. Doren testified that research has repeatedly demonstrated that when
9 psychopathy is found in combination with sexual deviance, it is associated with a particularly
10 high risk for sexual recidivism.

11 (d) Dr. Doren testified that the Respondent has both sexual deviance and
12 high psychopathy, so falls into the high risk category.

13 (11) Dr. Doren testified that he also considered other research supported
14 clinical risk factors in assessing the Respondent's future risk, including the Respondent's
15 treatment history and his current age (46), neither of which he found to constitute protective
16 factors which would decrease the Respondent's risk for future sexual offending.

17 (12) Dr. Doren testified that the actuarial risk assessment instruments and his
18 evaluation of the clinical factors all indicate that that the Respondent is more likely than not to
19 reoffend in a sexually violent manner if not confined in a secure facility.

20 (13) Dr. Doren testified that even if he did not consider the actuarial risk
21 assessment instruments, it would still be his opinion that the Respondent is more likely than
22 not to reoffend in a sexually violent manner if not confined in a secure facility.

23 b. Dr. Wollert testified that, as Respondent does not have either a mental
24 abnormality or a personality disorder, he is not likely to commit predatory acts of sexual
25 violence if not confined in a secure facility.

26 ///

1 (1) Dr. Wollert indicated that he does not use most actuarial risk assessment
2 instruments because they are not valid for risk assessment in cases pursuant to chapter 71.09
3 RCW; however, he does use the Static-99, with some adjustments, based upon the age of the
4 individual in question.

5 (2) Dr. Wollert testified that he scored the Respondent as a "4" on the
6 Static-99.

7 (3) Dr. Wollert testified that he scored the Respondent as a "1" on the
8 RRASOR.

9 (4) Dr. Wollert testified that he does not use the MnSOST-R and does not
10 believe it is a valid risk assessment instrument for purposes of assessing risk of future sexual
11 reoffense.

12 (5) Dr. Wollert testified extensively about the effect on rates of recidivism
13 among offenders as they advance in age.

14 (a) Dr. Wollert testified that he believes that recidivism rates decline as
15 offenders become older.

16 (b) Dr. Wollert testified that this concept is true regardless of the specific
17 type of criminal activity; it is true of violent offenses, sexual offenses, prison infractions, and
18 "behavioral management reports," which are similar to prison infractions in the context of
19 secure mental health facilities, such as the Special Commitment Center.

20 (c) Dr. Wollert argued that recidivism of any type is almost non-existent by
21 felons who, like the Respondent, are over 40 years old.

22 (d) Dr. Wollert acknowledged that the Respondent committed over 45
23 infractions while in prison and that while he has been at the Special Commitment Center, he
24 has committed numerous acts of aggression, especially against female staff.

25 ///

26 ///

1 c. The Court finds that the Respondent, as a result of his mental abnormality
2 and/or personality disorder, is likely to engage in predatory acts of sexual violence if not
3 confined in a secure facility.

4 (1) The Court finds that the actuarial risk assessment instruments used by
5 Dr. Doren are widely accepted in the scientific community to help in the evaluation of future
6 risk of reoffense.

7 (2) The Court finds that the results of these actuarial instruments are
8 accepted as being scientifically reliable in predicting/determining/assessing sexually violent
9 recidivism.

10 (3) The Court finds that Dr. Doren's scoring of the Static-99 more
11 accurately complied with the provisions of that instrument's Coding Rules than did the scoring
12 by Dr. Wollert.

13 (4) The Court further finds that the Respondent's actions toward Ebony H.
14 in 2000 constitute the "Index Offense" for purposes of scoring the Static-99.

15 (5) The Court finds that Dr. Doren's scoring of the PCL-R is reliable and
16 that Dr. Wollert's scoring of that test is not reliable.

17 (6) The Court finds that all of the actuarial results calculated by Dr. Doren
18 indicate that the Respondent is more likely than not to reoffend in a sexually violent manner if
19 he is unconditionally released.

20 (7) The Court finds that the actuarial findings, coupled with the
21 Respondent's high PCL-R score, place the Respondent at the highest risk factor to engage in
22 predatory acts of sexual violence if not confined to a secure facility.

23 (8) The Court finds that although rates of recidivism may generally decrease
24 as offenders age, this does not hold true for the Respondent, based upon his continued acts of
25 aggression, which have resulted in discipline within both prison and mental health facility
26 environments, across time.

1 (9) The Court finds that Dr. Wollert's age-factored recidivism analysis does
2 not apply to the Respondent.

3 (10) The Court finds that the Respondent's assurances that, if released, he
4 would seek and complete treatment for his problems, does not reduce his risk of committing
5 predatory acts of sexual violence below the "more likely than not" level.

6 (11) The Court finds that the Respondent, whether in confinement or in the
7 community, has a history of rule violations, probation violations, and refusal to participate in
8 treatment.

9 16. On the issue of whether the Respondent has committed a Recent Overt Act, the Court
10 heard testimony from Stephanie A., Ebony H., Dr. Kirk Johnson, Dr. Dennis Doren, and
11 Dr. Richard Wollert concerning the Respondent's contact with minor girls in July 2000.

12 a. The Court finds that the Respondent's actions toward 16 year old Ebony H. in
13 July 2000 constitute a recent overt act.

14 b. In finding that the Respondent's actions toward Ebony H. in July 2000
15 constitute a recent overt act, the Court specifically finds that:

16 (1) The Respondent placed himself in an area where he knew he would
17 come into contact with young girls;

18 (2) The Respondent was under conditions, imposed by the Court pursuant to
19 his 1991 convictions, which prohibited him from having unsupervised contact with minors;

20 (3) The Respondent had agreed to treatment conditions, as described by
21 Dr. Kirk Johnson, that prohibited contact with minors, being in an area where minors
22 congregate, and using drugs and/or alcohol;

23 (4) The Respondent had unsupervised contact with 14 year old Stephanie A.
24 and 16 year old Ebony H.;

25 (5) The Respondent was alone in his truck with Ebony H.;

26 ///

1 (6) The Respondent told Ebony H. that he wanted to take her to his "place
2 in the mountains" where they would smoke "weed" and watch movies;

3 (7) The Respondent moved Ebony H. closer to him in his truck;

4 (8) The Respondent placed his hand on the inside of Ebony H.'s leg;

5 (9) The Respondent started to work his hand up Ebony H.'s inner thigh
6 when she slapped his hand away;

7 (10) The Respondent's behavior toward Ebony H. is consistent with his prior
8 pattern of sexually offensive conduct against minor girls;

9 (11) But for the actions of Ebony H., the Respondent would have completed
10 his intended sexual molestation of Ebony H.;

11 (12) The Respondent acknowledged that being with Ebony H. exposed him
12 to "penitentiary chances."

13 II. CONCLUSIONS OF LAW

14 1. This Court has jurisdiction of the subject matter and the Respondent in this cause.

15 2. The crime of Child Molestation in the Second Degree, for which the Respondent was
16 twice convicted in 1991, is a sexually violent offense, as that term is used in
17 RCW 71.09.020(15) and (16).

18 3. Paraphilia NOS, involving sexual attraction to adolescents, from which the Respondent
19 suffers, is a mental abnormality as that term is used in RCW 71.09.020(8) and (16).

20 4. Antisocial Personality Disorder, from which the Respondent suffers, is a personality
21 disorder, as that term is used in RCW 71.09.020(16).

22 5. The Respondent's mental abnormality and personality disorder cause him serious
23 difficulty controlling his sexually violent behavior.

24 6. The Respondent's mental abnormality and personality disorder, both independently and
25 in combination, make(s) him likely to engage in predatory acts of sexual violence if not
26 confined in a secure facility.

1 7. The Respondent's actions toward Ebony H. in July 2000 constitute a recent overt act, as
2 that term is used in RCW 71.09.020(7) and (10); that is, they create a reasonable apprehension
3 of harm of a sexually violent nature in the mind of an objective person who knows of the
4 Respondent's history and mental condition.

5 8. The evidence presented at Respondent's trial proved beyond a reasonable doubt that
6 Respondent is a sexually violent predator who has committed a recent overt act as those terms
7 are used in chapter RCW 71.09.

8 Based upon the foregoing Findings of Fact and Conclusions of Law, the Court hereby
9 enters the following:

10 **ORDER**

11 IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that the Respondent,
12 LENIER RENE AYERS, is a sexually violent predator as defined in RCW 71.09.020. Having

13 ///

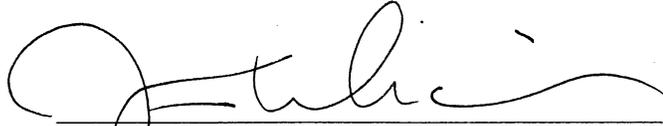
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1 so found, the Court therefore ORDERS that the Respondent be committed to the custody of the
2 Department of Social & Health Services for placement in a secure facility for control, care, and
3 treatment.

4 DATED this 7 day of Sept., 2005.

5
6 

7 THE HONORABLE JOHN F. NICHOLS
8 Judge of the Superior Court

9 Presented by:

10 ROB MCKENNA
11 Attorney General

12 
13 KRISTA K. BUSH, WSBA # 30881
14 MELANIE TRATNIK, WSBA # 25576
15 Assistant Attorney General
16 Attorneys for Petitioner

17 Copy received; Approved as to Form;
18 Notice of Presentation Waived:

19
20 *Respondent objects to entry of any findings & conclusions*
21 DONALD LUNDAHL, WSBA # 21424
22 Attorney for Respondent
23
24
25
26

APPENDIX B



In the News:

Forensic psychology, criminology, and psychology-law

Wednesday, October 31, 2007

Invasion of the hebephile hunters

Or, the story of how an archaic word got a new lease on life

Stop a random passerby and ask what "hebephilia" means, and you'll get a blank stare.

A few years ago, you would have gotten the same blank look from a forensic psychologist. Even from many who did risk assessments of sex offenders.

Not anymore. The obscure Greek word is gaining in popularity, and (for reasons I'll explain in a moment) may even be on the fast track to becoming a *de facto* psychiatric diagnosis. For that reason, it's a word worth knowing - and tracking.

Defining hebephilia is not as easy as you might think. I couldn't find it in my copy of Webster's dictionary, nor is it listed in several online dictionaries that I checked. Wikipedia defines it as a variant of the word *epehebophilia*, meaning "sexual attraction to adolescents." *Epehebia* was the ancient Greek institution in which young men were trained as citizens and soldiers. *Philein* is the Greek "to love," as in *philosophy* (the love of wisdom) or *philology* (the study of literary texts).



Pioneering German sexologist [Magnus Hirschfeld](#) is credited with coining the term around 1906-1908, as part of his efforts to catalogue the varieties of sexuality (the word *transvestism* is also his). A tireless campaigner for the rights of sexual minorities, Hirschfeld would roll over in his grave to see how his term is being used today - in the service of involuntarily committing people to state psychiatric hospitals.

Perhaps the most avid proponent of this creative new use is Dennis Doren, a psychologist who evaluates sex offenders for civil commitment and has authored a popular how-to manual for government experts, aptly named *Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond*.

In his manual, Doren defines hebephilia as a "paraphilia." Another esoteric Greek word, paraphilia is a sexual deviancy characterized by sexual fantasies, urges, or activities involving nonhuman objects, suffering or humiliation of oneself or one's partner, or nonconsenting partners such as children. The paraphilias listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* include exhibitionism, fetishism, frotteurism, voyeurism, sexual masochism, sexual sadism, and pedophilia. Poor little hebephilia is absent.

Since hebephilia is excluded from the diagnostic bible, Doren trains evaluators to give hebephiliacs a diagnosis of "Paraphilia Not Otherwise Specified." This is but one of several efforts by Doren to broaden the diagnostic categories under which sex offenders can be civilly detained; in a [previous post](#) I discussed his use of the "Paraphilia NOS" diagnosis with rapists.

Hebephilia came close to extinction in 1933, when the Nazis plundered Magnus Hirschfeld's [Institute of Sexual Science](#) in Berlin and torched its massive archives in a public bonfire. Yet suddenly, 70-some years later and probably not coincidentally to the 2002 publication of Doren's manual, we are seeing a growing interest in the archaic construct.

In 2003, for example, a student researcher at the University of Montreal described "hebephiles" as an "alarming clinical reality" that was "almost completely absent from the scientific literature." In an unabashed display of self-promotion, she promised to "lift the veil of silence" on hebephilia through [her research](#) with Canadian men who had

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KAREN FRANKLIN, PH.D.

Dr. Franklin is a forensic psychologist in Northern California and an adjunct professor at Alliant International University. She is a former criminal investigator and legal affairs reporter. This blog highlights news and commentary relevant to forensic psychology, criminology, and psychology-law. If you find the information useful, you are invited to subscribe to the daily email newsletter.

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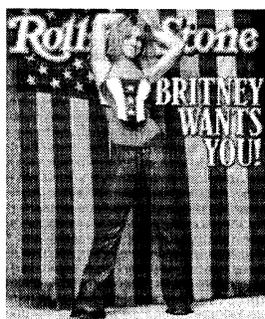
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sexually offended against teens.

According to a 2007 publication by the esteemed Mayo Clinic, hebephilia is rapidly "becoming a generic term" to describe sexual interest in adolescents who are under the legal age of consent. The article defines a *hebophile* as someone interested in teenage girls, with *ephebophile* denoting attraction to post-pubescent boys. Basing a diagnosis on the legal age of consent seems to imply that a person could have a mental disorder in one jurisdiction but not in another, since the age of consent varies widely and adults may even marry teens under age 18 in many countries and U.S. states.

Hebephiles were the topic of another research study published this month in *Sexual Abuse: A Journal of Research and Treatment*. The study focused mainly on physical characteristics that purportedly distinguish pedophiles - men who are primarily attracted to prepubescent children - from normal men (who now have their very own label - *teleiophiles*). The study found that Canadian pedophiles are shorter on average than teleiophiles, with hebephiles somewhere in the middle of the height spectrum. This follows an earlier finding by the same research team, out of Toronto's *Kurt Freund Laboratory*, that pedophiles were more likely than teleiophiles to be left-handed. The researchers did not find any statistically meaningful relationship between hebephilia and handedness when using phallometry (penile erections) to measure primary erotic attraction. However, they still hypothesize that a neurological abnormality may underlie some men's sexual attraction to teens.



The absurdity of describing erotic attraction to adolescents as a mental abnormality is that most normal heterosexual men are sexually attracted to teenage girls (who happen to be at the peak of their reproductive fertility). This fact is well established by multiple research studies over the past several decades. Such findings are certainly no surprise to the moguls of popular culture or to the advertising industry, which uses provocative images of teen girls and boys to sell everything from clothes to cars.

Given the scientifically unsupported nature of this emerging diagnosis, I suspect that clinicians will apply it arbitrarily, and especially to men who are sexually involved with male teenagers. I am already seeing this trend informally, in my reviews of forensic reports on sex offenders. Ironically, any such biased application will further turn the tables on Magnus Hirschfeld and the ancient Greeks' aesthetic appreciation for the adolescent male body.

Painting: "The Death of Hyacinth" by Jean Broc. Hyacinth was the young lover of the God Apollo. Wikipedia public domain.

Labels: diagnosis, forensic psychology, gender + sexuality, sex offenders

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Pedophilia, Hebephilia, and the *DSM-V*

Ray Blanchard · Amy D. Lykins · Diane Wherrett · Michael E. Kuban ·
James M. Cantor · Thomas Blak · Robert Dickey · Philip E. Klassen

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Abstract The term *pedophilia* denotes the erotic preference for prepubescent children. The term *hebephilia* has been proposed to denote the erotic preference for pubescent children (roughly, ages 11 or 12–14), but it has not become widely used. The present study sought to validate the concept of hebephilia by examining the agreement between self-reported sexual interests and objectively recorded penile responses in the laboratory. The participants were 881 men who were referred for clinical assessment because of paraphilic, criminal, or otherwise problematic sexual behavior. Within-group comparisons showed 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. Between-groups comparisons showed that penile responding distinguished such men from those who reported maximum attraction to prepubescent children and from those who reported maximum

attraction to fully grown persons. These results indicated that hebephilia exists as a discriminable erotic age-preference. The authors recommend various ways in which the *DSM* might be altered to accommodate the present findings. One possibility would be to replace the diagnosis of Pedophilia with Pedohebephilia and allow the clinician to specify one of three subtypes: Sexually Attracted to Children Younger than 11 (Pedophilic Type), Sexually Attracted to Children Age 11–14 (Hebephilic Type), or Sexually Attracted to Both (Pedohebephilic Type). We further recommend that the *DSM-V* encourage users to record the typical age of children who most attract the patient sexually as well as the gender of children who most attract the patient sexually.

Keywords *DSM-V* · Ephebophilia · Hebephilia · Paraphilia · Pedophilia · Penile plethysmography · Phallometry · Sexual offending · Sexual orientation · Teleiophilia

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Introduction

The *DSM-IV-TR* (American Psychiatric Association, 2000) defines *pedophilia* as the erotic preference for prepubescent children. A substantial body of evidence indicates that this definition, if taken literally, would exclude from diagnosis a sizable proportion of those men whose strongest sexual feelings are for physically immature persons. Before we present this evidence, we will first consider the classification of children as pubescent or prepubescent.

The average age of menarche for American Caucasian females is 12.9 years (Herman-Giddens et al., 1997). There are various other indicators of pubertal onset, however, which usually appear before menarche. In females, the first stage of pubic hair development (sparse growth along the

labia) appears at an average age of 11.0 years, and the first stage of breast development (breast buds) at 11.2 years (Roche, Wellens, Attie, & Siervogel, 1995). In males, the first stage of pubic hair development (sparse growth at the base of the penis) appears at 11.2 years, and the first pubertal changes to the penis and testes (e.g., changes in texture and coloration of the scrotal skin) also at 11.2 years (Roche et al., 1995). In females, adult-pattern pubic hair (inverse triangle spreading to the thighs) appears at 13.1–15.2 years, according to different studies, and adult-type breasts (projection of the papillae only, after recession of the areolae) develop at 14.0–15.6 years (Grumbach & Styne, 1998, Table 31-2). In males, adult-pattern pubic hair (inverse triangle spreading to the thighs) appears at 14.3–16.1 years, and the genitalia attain adult size and shape at 14.3–16.3 years (Grumbach & Styne, 1998, Table 31-4). The pubertal growth spurt in height begins around age 10 in females and age 12 in males; it ends around age 15 in females and age 17 in males (Grumbach & Styne, 1998, Fig. 31-11). In summary, pubescent children are generally those from age 11 or 12 years to about 14 or 15; prepubescent children are those who are younger.

The modal age of victims of sexual offenses in the United States is 14 years (Snyder, 2000, Fig. 1; Vuocolo, 1969, p. 77), therefore the modal age of victims falls within the time-frame of puberty. In anonymous surveys of social organizations of persons who acknowledge having an erotic interest in children, attraction to children of pubescent ages is more frequently reported than is attraction to those of prepubescent ages (e.g., Bernard, 1975; Wilson & Cox, 1983). In samples of sexual offenders recruited from clinics and correctional facilities, men whose offense histories or assessment results suggest erotic interest in pubescents sometimes outnumber those whose data suggest erotic interest in prepubescent children (e.g., Cantor et al., 2004; Gebhard, Gagnon, Pomeroy, & Christenson, 1965; Studer, Aylwin, Clelland, Reddon, & Frenzel, 2002). The foregoing findings are consistent with the results of large-scale surveys that sampled individuals from the general population and included questions regarding sexual experiences with older persons when the respondent was underage. These results suggest that a substantial proportion of respondents who had had such experiences reported ages at occurrence that fall within the normal time-frame of puberty (Boney-McCoy & Finkelhor, 1995; Briere & Elliott, 2003; Finkelhor, Ormrod, Turner, & Hamby, 2005). The precise proportion, however, cannot be calculated from the published data.

The existence of men whose erotic interest centers on pubescents has not, of course, been totally ignored. Glueck (1955) coined the term *hebephiles* to refer to them. This term has not come into widespread use, even among professionals who work with sex offenders. One can only speculate why not. It may have been confused with the term *ephebophiles*, which denotes men who prefer adolescents around 15–

19 years of age (Krafft-Ebing & Moll, 1924). Few would want to label erotic interest in late- or even mid-adolescents as a psychopathology, so the term hebephilia may have been ignored along with ephebophilia.

A second possible reason why the term hebephilia has not become more common has to do with female reproductive physiology. The temporally discrete and developmentally unique event of menarche seems to divide females naturally into two classes; thus, the obvious distinction among men is between those who prefer females before their first menses and those who prefer females who have passed this milestone. Such a division is consistent with various cultural and religious attitudes towards menarche. It would also appear consistent with an evolutionary psychology position that the adaptive partner-preference is for fecund females (although females are actually subfecund for 1–2 years after menarche; Wood, 1994, p. 407). In any event, this distinction may have more to do with the ideological meaning of menarche for the labelers than with the erotic preferences of the man being labeled. From the man's point of view, the sexual attractiveness of a girl one year after menarche (e.g., age 14) may equal that of a girl one year before menarche (e.g., 12), not that of a girl five years after menarche (e.g., 18).

A third possible reason for the disuse of hebephilia is a general resistance or indifference to the adoption of a technical vocabulary for erotic age-preferences. There may be as many mental health professionals who have heard of "granny porn" as have heard of *gerontophilia* (the erotic preference for the aged), although the term gerontophilia was introduced at least 80 years ago (Hirschfeld, 1920). It is only a few years since anyone finally proposed a term—*teleiophilia*—to denote the erotic preference for persons between the ages of physical maturity and physical decline (Blanchard et al., 2000), even though the word *normal* has been effectively off-limits for describing erotic interests for decades.

Several studies have demonstrated the utility of specifying a hebephilic group, at least for research purposes. These studies have compared pedophilic, hebephilic, and teleiophilic men on a variety of dependent measures. The results have shown hebephiles to be intermediate between pedophiles and teleiophiles with regard to IQ (Blanchard et al., 2007; Cantor et al., 2004), completed education (Blanchard et al., 2007), school grade failure and special education placement (Cantor et al., 2006), head injuries before age 13 (Blanchard et al., 2003), left-handedness (Blanchard et al., 2007; Cantor et al., 2005), and stature (Cantor et al., 2007).

The finding that the groups designated "hebephiles" were intermediate in IQ, handedness, and so on, is consistent with the notion that they were also intermediate in their erotic preference, but it does not prove it. The designated hebephilic groups might simply have been a mixture of pedophiles and teleiophiles; in that case, one would also expect to observe

intermediate values on all these dependent measures. What is needed to establish hebephilia as a legitimate diagnostic entity is convergence between two or more lines of evidence bearing directly on a man's sexual interest in children, pubescents, and adults.

The present study sought to validate the concept of hebephilia by examining the agreement between self-reported and psychophysiological assessed erotic responses. Psychophysiological assessment consisted of phallometric testing, an objective technique for quantifying erotic interests in human males. In phallometric tests for gender and age preference, the individual's penile blood volume is monitored while he is presented with a standardized set of laboratory stimuli depicting male and female children, pubescents, and adults. Increases in the examinee's penile blood volume (i.e., degrees of penile erection) are taken as an index of his relative attraction to different classes of persons.

Our specific research questions were straightforward: Do men who report maximum sexual attraction to pubescent children have greater penile responses, in the laboratory, to depictions of pubescent children than to depictions of younger or older persons? Can such men be distinguished from those who report maximum attraction to prepubescent children, on the one hand, and from those who report maximum attraction to fully grown persons, on the other? Positive answers to these questions would argue for the recognition of hebephilia as a clinically and perhaps theoretically significant erotic preference. They would also imply that the current *DSM* definition of pedophilia is excluding from specific diagnosis a considerable proportion of men who have a persistent preference for humans at an incomplete stage of physical development. In contrast, negative answers would suggest that the hebephilic groups studied in previous investigations have merely been mixtures of pedophiles and teleiophiles, and that this explains why the hebephiles' results (for IQ, handedness, and so on) were intermediate between those of homogeneously classified pedophiles and teleiophiles. Negative results would moreover indicate that the *DSM* diagnosis of Paraphilia Not Otherwise Specified is probably adequate for the diagnosis of many men who do not quite satisfy the *DSM* criteria for Pedophilia.

The research design sketched above is simple in principle but challenging in practice. The great majority of men with an erotic preference for children deny this to mental health professionals and researchers, as they do to police, lawyers, and judges. Perhaps 40% of "nonadmitting" pedophiles (and hebephiles) are able to manipulate their phallometric test outcomes sufficiently to avoid a diagnosis of pedophilia (e.g., Blanchard, Klassen, Dickey, Kuban, & Blak, 2001). It is likely that many nonadmitters who fail to avoid a diagnosis of pedo- or hebephilia nonetheless distort their phallometric data somewhat in the attempt. Thus, nonadmitting pedophiles (and hebephiles) are not useful for theoretical studies like the present one, which depend on high-quality phallometric data from cooperative

participants. The present study was possible because the very large volume of assessments carried out at the authors' clinic enabled us to collect, over an 11-year period, a sufficient number of men who acknowledged an erotic preference for persons at some level of physical immaturity.

Method

Participants

Between August 1995 and April 2006, 2,868 male patients were referred to the Kurt Freund Laboratory of the Centre for Addiction and Mental Health (Toronto, Ontario, Canada) because of paraphilic, criminal, or otherwise problematic sexual behavior. The purpose of these referrals was to determine what kinds of sexual partners (or sexual victims) and what kinds of sexual activities were most arousing to these individuals. The assessment usually included testing for erotic age-preference (pedophilia, hebephilia, teleiophilia), even when the presenting problem did not involve offenses against children. That is because paraphilias tend to cluster, and because men who present with no known sexual offenses or offenses solely against adults sometimes prove to have an erotic preference for the immature phenotype. The identical phallometric test for erotic age-preference was administered to 2,591 of these men; this test also assessed their erotic gender-preference (Blanchard et al., 2001).

Excluded from eligibility for the study were 191 men whose phallometric test results were spoiled by technical problems or whose responses were too low (see later), 58 men whose sexual history information was incomplete or had not yet been computerized at the time of the data retrieval, and 38 men who did not give consent for their clinical assessment data to be used for research purposes. The initial pool of potential patient participants therefore included 2,304 men, with a mean age of 37.75 years ($SD = 13.24$ years), and a median education level of Grade 12.

The sources of the referrals included parole and probation officers, prisons, defense lawyers, various institutions (ranging from group homes for mentally retarded persons to regulatory bodies for health or educational professionals), and physicians in private practice. As would be expected from the preponderance of criminal justice sources, the majority of patients had one or more sexual offenses. The phrase *sexual offenses*, in this article, includes charges, convictions, credible accusations, and self-disclosures of criminal sexual behavior. *Credible accusations* were defined by default, that is, all accusations excepting those that were made by an individual who stood to gain in some way from criminal charges against the accused, that had no corroborating evidence, and that were not voiced at the time the alleged offense or offenses occurred. Only a small proportion of accusations were not considered

credible; typical examples were allegations, not followed by criminal charges, from estranged spouses in child custody-and-access disputes.

The patient pool comprised approximately 10% men with no known sexual offenses; 10% with offenses involving the possession, distribution, or manufacture of child pornography; 18% with offenses against children age 5 or younger; 39% with offenses against children age 6–10; 12% with offenses against children age 11; 32% with offenses against pubescents age 12–14; 15% with offenses against teenagers age 15–16; and 27% with offenses against adults age 17 or older. These percentages add up to more than 100%, because many patients had offenses in more than one category. Offenses against adult victims included some that involved physical contact (e.g., rape, frotteurism) and others that did not (e.g., exhibitionism, voyeurism, obscene telephone calling). Men who had no involvement with the criminal justice system and who initiated referrals through their physicians included patients who were unsure about their sexual orientation, patients concerned about hypersexuality or “sex addiction,” patients experiencing difficulties because of their excessive use of telephone sex lines or massage parlors, clinically obsessive patients with intrusive thoughts about unacceptable sexual behavior, and patients with paraphilic behaviors like masochism, fetishism, and transvestism.

Added to the initial pool of 2,304 patients were 51 men with criminal offenses of a nonsexual nature, who were not patients but paid research volunteers (Cantor et al., 2008). They were included because they had all the same data as the patients; because there was no reason to exclude them, given the goals of the study; and because some of them reported pedophilia or homosexuality, although they had not been recruited on that basis. Thus, the total number of potential participants was 2,355.

Materials and Measures

Sexual History

A standardized form, which has been employed in the Kurt Freund Laboratory since 1995, was used to record the patient’s history of sexual offenses. Most of that information came from objective documents that accompanied his referral, for example, reports from probation and parole officers. The offense-history data were cross-checked against, and supplemented by, information provided by the patient himself. This included the number and nature of any additional sexual offenses that were admitted by the patient but for which he was never charged. The patient’s information was solicited by the laboratory manager in a structured interview, which was conducted, in the great majority of instances, immediately before phallometric testing.

The patient’s sexual history was quantified and recorded using a large number of predetermined categories, some pertaining to the gender and ages of his sexual victims (if any) and others pertaining to the nature of his criminal or other sexual activities (e.g., indecent exposure, rape, consenting intercourse). Of present relevance were the patient’s numbers of female victims in six age-ranges—5 and younger, 6–10, 11, 12–14, 15–16, and 17 or older—and his numbers of male victims in the same six age-ranges. The numbers of female and male victims 11 years of age were recorded as separate variables because it was unclear at the time that the structured interview and its companion database were designed whether children of this age should be classed with younger children as prepubescent or with older children as pubescent. Also recorded as separate variables were the patient’s criminal charges and self-admissions regarding the use, manufacture, or distribution of child pornography.

Self-Report of Erotic Preferences

The interviewer recorded the patient’s self-reported sexual interest in other persons, using 12 separate variables: the patient’s degree of sexual interest in females age 5 or younger, 6–10, 11, 12–14, 15–16, and 17 or older, and in males in the same six age-ranges. In some cases, this required a great deal of exploration: “Are you more attracted to adults or to children?” “Are you more attracted to boys or to girls?” “Are you more attracted to girls before they commence puberty or after they have entered puberty?” “Do you find 11-year-old girls more attractive than 14-year-old girls, less attractive, or equally attractive?” “Do you feel any interest at all in 11-year-old boys?” In many instances, however, the process was relatively brief and straightforward, because the patient stated that his primary sexual interest was in females age 17 or older, sometimes with a lesser degree of attraction to females age 15–16, and that he had no attraction to females under the age of 15 or to males of any age.

The interviewer quantified the patient’s self-reported sexual interest in each of the 12 gender-age categories, using a rating from 1 to 5. A rating of 5 indicated that persons of a given gender and age (e.g., males age 15–16 years) stimulated as much sexual interest as the participant was capable of feeling (toward another person). A rating of 1 indicated that the participant felt no sexual attraction for persons of that age and gender. If the patient was willing and able to discriminate multiple levels of sexual attraction, ratings of 2, 3, and 4 were used to record middling levels of erotic interest. Any given rating-number could be used for more than one gender-age category. A patient who reported an erotic preference for pubescent males, for example, might get ratings of 5 for 11-year-old boys and for 12–14 year-old boys and ratings of 4 for 6–10 year-old boys and for 15–16 year-old boys. This complicated method of assessing

erotic age-preference was used because its original purpose in the structured interview was not to pinpoint the age or physical maturation of persons for whom the participant reported the strongest attraction, but rather to assess whether—or to what extent—he admitted an erotic interest in persons of the same chronological age and gender as his known sexual victims.

Phallometric Apparatus

All participants in this study underwent the standard testing procedures of the Kurt Freund Laboratory. The Laboratory is equipped for volumetric plethysmography, that is, the apparatus measures penile blood volume change rather than penile circumference change. The volumetric method measures penile tumescence more accurately at low levels of response (Kuban, Barbaree, & Blanchard, 1999). A photograph and schematic drawing of the volumetric apparatus are given in Freund, Sedlacek, and Knob (1965). The major components include a glass cylinder that fits over the penis and an inflatable cuff that surrounds the base of the penis and isolates the air inside the cylinder from the outside atmosphere. A rubber tube attached to the cylinder leads to a pressure transducer, which converts air pressure changes into voltage output changes. Increases in penile volume compress the air inside the cylinder and thus produce an output signal from the transducer. The apparatus is calibrated so that known quantities of volume displacement in the cylinder correspond to known changes in transducer voltage output. The apparatus is very sensitive and can reliably detect changes in penile blood volume below the threshold of subjective awareness.

Phallometric Procedure

The participant placed the glass cylinder over his penis, according to instructions from the test administrator. He then sat in a reclining chair, which faced three adjacent projection screens, and put on a set of headphones. After the set-up was complete, the participant's lower body was covered with a sheet to minimize his embarrassment or discomfort. During the test, the participant's face was monitored with a low-light video camera, in order to monitor stimulus avoidance strategies such as closing the eyes or averting them from the test stimuli.

The phallometric test used in this study has been described in detail elsewhere (Blanchard et al., 2001, 2007). The stimuli were audiotaped narratives presented through the headphones and accompanied by slides shown on the projection screens. There were seven categories of narratives, which described sexual interactions with prepubescent girls, pubescent girls, adult women, prepubescent boys, pubescent boys, and adult men, and also solitary, nonsexual activities ("neutral" stimuli). All narratives were written in the second person and present

tense and were approximately 100 words long. The scripts of sample narratives have been reproduced in previous articles (Blanchard et al., 2001, 2007). The narratives describing heterosexual interactions were recorded with a woman's voice, and those describing homosexual interactions, with a man's. Neutral stimuli were recorded with both.

Each test trial consisted of one narrative, accompanied by photographic slides on the three adjacent screens, which simultaneously showed the front view, rear view, and genital region of a nude model who corresponded in age and gender to the topic of the narrative. In other words, a narrative describing sex with an adult man would be accompanied by multiple images of nude adult men. A photograph that illustrates how the models were posed for the full frontal view may be found in Blanchard et al. (2007). The neutral narratives (e.g., "You climb down into the small rowboat, untie it, and push off from the dock with an oar...") were accompanied by slides of landscapes.

Each trial included three different models, each presented for 18 s. Therefore the total duration of a trial was 54 s, during which the participant viewed a total of nine slides, three at a time. For example, in a stimulus trial depicting physically mature females, the participant would hear one narrative describing sex with an adult woman, while he viewed photographs of woman A from three angles, followed by woman B from three angles, followed by woman C from three angles.

The full test consisted of four blocks of seven trials, with each block including one trial of each type in fixed, pseudorandom order. Although the length of the trials was fixed, the interval between trials varied, because penile blood volume was required to return to its baseline (flaccid) value before a new trial was started. The time required to complete a test was usually about 1 h.

Phallometric Stimuli

The narratives depicting sexual interaction with prepubescent children and pubescent children explicitly stated the age of the fictional child at the beginning of the script, for example, "You are babysitting a five-year-old girl for the evening. She is taking a bath before she gets ready for bed. Through the open bathroom door, she calls you to come in and scrub her back..." In the narratives about prepubescent children, the ages of the fictional children were variously stated as 5–9 years. In the narratives about pubescent children, the ages were given as 11–13 years. The narratives describing interaction with adult men and women did not state the age of the fictional sexual partner, although they were clearly portrayed as adults. There was no relation between the various activities described in the narratives and the uniform, static poses of the simultaneously presented models.

The original set of photographic models on which the present test was based comprised prepubescent girls age 5–

11, pubescent girls 12–14, adult women 22–26, prepubescent boys 5–11, pubescent boys 12–14, and adult men 19–25 (Freund, Langevin, Cibiri, & Zajac, 1973; Freund, McKnight, Langevin, & Cibiri, 1972). There have been some additions or substitutions of models in the intervening years, primarily involving the adults. The new models extended the ages of the prepubescent girls to 3–11 years, the ages of the adult women to 20–35 years, and the ages of the adult men to 19–41 years.

Because of the central importance of the pubescent stimuli in this study, the physical maturity of the photographic models was rated by one of the authors (D.W.), a pediatric endocrinologist, and the results are presented below. The rating system used the stages of sexual development originally identified by Tanner (1978). Tanner stages pertain to breast development and pubic hair growth in females, and to genital development and pubic hair growth in males. Tanner stages are rated from 1 (prepubertal) to 5 (fully mature), according to established criteria. Breast development and pubic hair growth are not always perfectly correlated in females, and genital development and pubic hair growth are not always perfectly correlated in males; therefore Tanner stages are rated separately for each feature.

According to Marshall and Tanner (1969), the criteria for female breast development are as follows: stage 1—prepubescent, projection of the papilla only; stage 2—breast bud stage, elevation of breast, papilla as a small mound, enlargement of areolar diameter; stage 3—further enlargement of breast and areola with no separation of their contours; stage 4—projection of areola and papilla to form a secondary mound above the level of the breast; and stage 5—mature stage, projection of papilla only, areola recessed to the general contour of the breast. The genital development stages for males (Marshall & Tanner, 1970) are as follows: stage 1—prepubescent, genitals are about the same size and proportion as in early childhood; stage 2—scrotum and testes have enlarged, scrotal skin shows a change in color and texture; stage 3—growth of the penis in length and girth, further growth of testes and scrotum; stage 4—penis is further enlarged, development of the glans; and stage 5—genitalia are adult in size and shape. With regard to both female and male pubic hair growth, the Tanner stages are as follows: stage 1—prepubescent, no pubic hair; stage 2—sparse growth of long, slightly pigmented downy hair, appearing mainly along the labia or base of the penis; stage 3—hair is darker and coarser, spreads over the junction of the pubes; stage 4—hair is adult in type, but area covered still significantly less than in a mature adult; and stage 5—hair is adult in type and quantity and distributed in an inverse triangle.

With only a few exceptions (one boy used as a prepubescent stimulus had Tanner stage 2 genitals and another had Tanner stage 2 pubic hair), all the prepubescent children were rated as Tanner stage 1's, and all the adults were rated as

Tanner stage 5's, for all body regions. The mean Tanner stage for the breasts of the pubescent girls was 2.67 (SD = 1.03, range, 2–4), and the mean Tanner stage for their pubic hair growth was 2.33 (SD = 0.82, range, 1–3). The corresponding Tanner stages for the pubescent boys were as follows: genital development, mean of 3.83 (SD = 0.75, range, 3–5), and pubic hair growth, mean of 3.33 (SD = 0.82, range, 2–4). Another of the co-authors (A.D.L.), who trained herself on Tanner ratings for this subproject, also rated the Tanner stages for the pubescent females and males; inter-rater reliability was $r = .87$ for female breast development, $r = .93$ for female pubic hair growth, $r = .87$ for male genital development, and $r = .83$ for male pubic hair growth (all were significant at $p < .05$).

Phallometric Response Processing

Penile blood volume change was sampled four times per second. The participant's response was quantified in two ways: as the extremum of the curve of blood volume change (i.e., the greatest departure from initial value occurring during the 54 s of the trial) and as the area under the curve. To identify participants whose penile blood volume changes during the test trials remained within the range typical of random blood volume fluctuations in nonaroused men, the mean of the three highest positive extremum scores—a quantity called the *Output Index* (Freund, 1967)—was calculated. The phallometric data of participants who failed to meet the criterion output index of 1.0 cc were excluded. As measured by the Laboratory's equipment, full erection for the average man corresponds to a blood volume increase of 20–30 cc.

Each participant's 28 extremum scores were then converted into standard scores, based only on his own extremum data, and the same operation was carried out on his area scores. Next, for each participant, the standardized extremum and area scores were combined to yield a separate composite score for each of the 28 trials, using the formula: $(Z_i^E + Z_i^A)/2$, where Z_i^E is the standardized extremum score for the i th trial, and Z_i^A is the standardized area score for the i th trial. These operations were carried out for the following reasons: (a) In phallometric work, some transformation of raw scores is generally required in combining data from different participants, because the interindividual variability in absolute magnitude of blood volume changes can otherwise obscure even quite reliable statistical effects. There are numerous sources of such variability, for example, the participant's age, his state of health, the size of his penis, and the amount of time since his last ejaculation from masturbation or interpersonal sexual activity. Empirical research has shown the Z-score transformation to be optimal (Earls, Quinsey, & Castonguay, 1987; Harris, Rice, Quinsey, Chaplin, & Earls, 1992; Langevin, 1985). (b) The (highly correlated) area and extremum Z-scores were averaged to obtain a composite that reflected both the speed and

amplitude of response and lessened the impact of anomalous responses, that is, large change from initial value but small area or vice versa (Freund, Scher, & Hucker, 1983).

In the last stage of basic processing, the data were reduced to seven final scores for each participant by averaging his four composite scores in each of the seven stimulus categories. These seven *category scores* were taken as measures of the participant's relative erotic interest in adult women, pubescent girls, prepubescent girls, and so on.

Results

The first task of data analysis was assigning participants to discrete groups according to the ages of their most desired partners. No single item in our recorded data contained the participant's response to the simple question, "What is the typical age of persons who most attract you sexually?" It was, furthermore, impossible simply to classify participants according to the gender-age category to which they gave the maximum attractiveness rating, because participants could—and sometimes did—report the maximum rating for more than one category. We therefore attempted to classify participants into non-overlapping age-preference groups according to some parameter of their overall attractiveness ratings profile. We investigated two different parameters for this purpose. The first parameter was the oldest age category whose attractiveness rating was greater than or equal to the mean rating of all younger categories. The second parameter was the youngest age category whose attractiveness rating was greater than or equal to the mean rating of all older categories. Use of the second parameter resulted in a better distribution of cases across the younger age-preference groups, and it was chosen on that basis. The complete algorithm for converting our attractiveness ratings into age-preference groups worked as follows.

If the mean of the participant's attractiveness ratings for all six categories of females (ages 5 and younger, 6–10, 11, 12–14, 15–16, and 17 or older) was greater than his mean for all six categories of males, then the participant was designated as heterosexual. If the mean of his attractiveness ratings for all categories of males was greater than his mean for all categories of females, then he was designated as homosexual. The 34 participants with exactly equal means (i.e., bisexuals) were excluded from further processing.

Heterosexual participants were then classified into six age-preference groups according to the following series of tests performed in the following order.

1. If the participant's attractiveness rating for females age 0–5 was greater than or equal to his mean attractiveness rating for the five older age categories, then he was classified as a *Pedophile 1*.
2. If the participant's rating for females age 6–10 was greater than or equal to his mean rating for the four older age categories, then he was classified as a *Pedophile 2*.
3. If the participant's rating for females age 11 was greater than or equal to his mean rating for the three older age categories, then he was classified as a *Hebephile 1*.
4. If the participant's rating for females age 12–14 was greater than or equal to his mean rating for the two older age categories, then he was classified as a *Hebephile 2*.
5. If the participant's rating for females age 15–16 was greater than or equal to his rating for females age 17 or older, then he was classified as an *Ephebophile*.
6. If the participant, having passed through all the foregoing tests, had no known sexual offenses against persons under the age of 15 and no child pornography offenses, then he was classified as a *Teleiophile*.

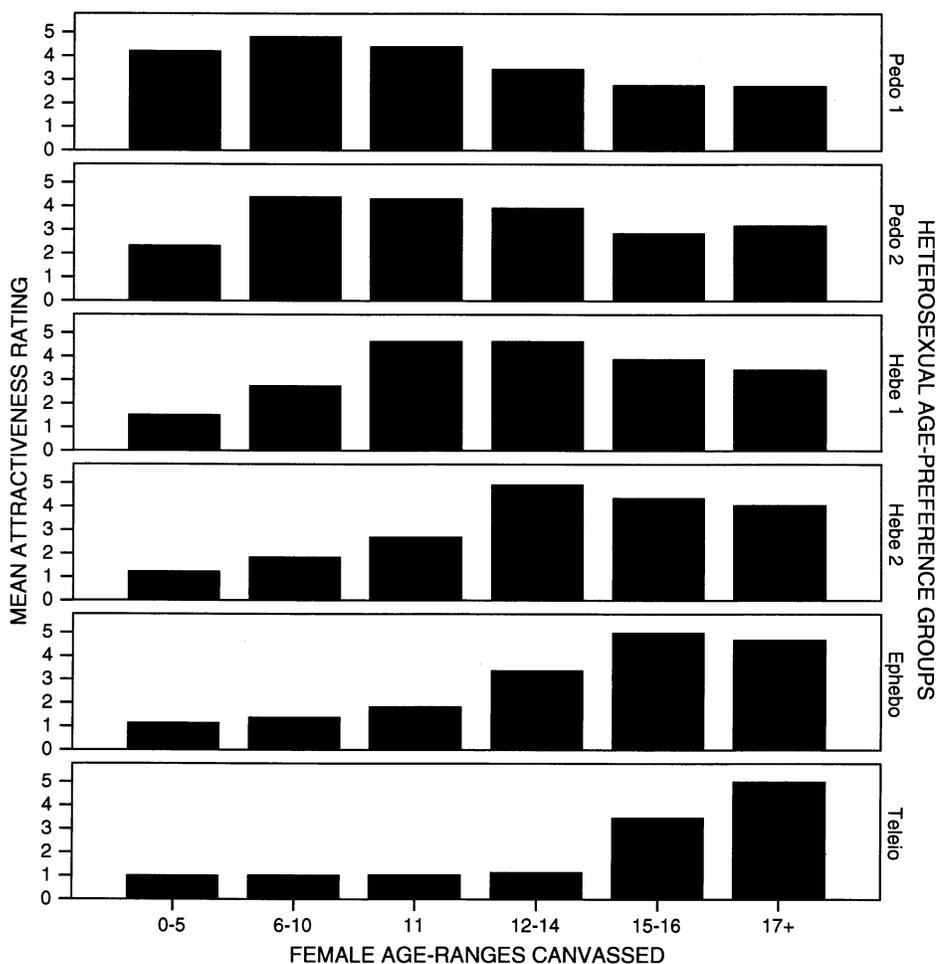
Homosexual participants went through a parallel series of tests, based on their attractiveness ratings for the six age-categories of males and on their known sexual offenses, and they were assigned to the corresponding six age-preference groups.

Figures 1 and 2 show the empirical relations between the computed age-preference groups and the attractiveness ratings on which they were based. Figure 1 shows the data for the heterosexual groups, and Fig. 2, for the homosexual groups. These data demonstrate that the classification algorithm worked as we had hoped and provide the empirical justification for the group-labels, *Pedophile 1*, *Pedophile 2*, and so on.

Most of the individual participants had attractiveness ratings profiles that resembled the mean profile of the age-preference group to which they had been assigned. Thus, for example, 90% of heterosexual *Hebephile 1* group gave the maximum attractiveness rating of "5" to females age 11 or 12–14 (or both), and 93% of the heterosexual *Hebephile 2* group gave the maximum attractiveness rating to females age 12–14 or 15–16 (or both). In the homosexual *Hebephile 1* group, 80% gave the maximum attractiveness rating to males age 11 or 12–14; in the homosexual *Hebephile 2* group, 100% gave the maximum attractiveness rating to males age 12–14 or 15–16. Because the ratings profiles were necessarily related to the age-preference groups via the computational algorithm, we did not perform any statistical comparisons of them.

The offenders against persons under age 15 and child pornography offenders were excluded from the teleiophilic groups (algorithm step #6) because men who claim a preference for adults but have committed offenses against children are often truly pedophilic or hebephilic (e.g., Blanchard et al., 2001, 2006; Freund & Blanchard, 1989; Seto, Cantor, & Blanchard, 2006). Thus, these participants were excluded on the grounds that their phallometric responses would be relatively likely to reflect deliberate attempts to manipulate the test outcome. The data of many of these excluded "nonadmitters" have been

Fig. 1 Attractiveness ratings for females of various ages, for the heterosexual age-preference groups. The age-preference abbreviations are interpreted as follows: Pedo, pedophile; Hebe, hebephile; Ephebo, ephebophile; Teleio, teleiophile. The anchor-points for the attractiveness ratings are as follows: 1, females of the canvassed age stimulate no sexual interest; 5, females of that age stimulate as much sexual interest as the participant is capable of feeling



analyzed in previous studies (Blanchard et al., 2001, 2006). The offense-history criterion excluded 1,387 participants from the heterosexual teleiophilic group and 53 from the homosexual teleiophilic group.

The number of participants in each age-preference group and their mean ages at testing are presented in Table 1. One-way analyses of variance revealed no significant differences in age among the heterosexual groups, $F(5, 739) = 2.15$, *n.s.*, or among the homosexual groups, $F(5, 130) < 1$.

Table 1 also shows the median ages of the victims of the participants' sexual offenses. The median victim age was determined, for each group, by summing their total number of victims in all age-ranges and then determining the age-range in which the median fell. Thus, for example, the heterosexual Pedophile 1 group had 109 (female) victims: 16 victims age 5 or younger, 52 victims age 6–10, 12 victims age 11, 12 victims age 12–14, 11 victims age 15–16, and 6 victims age 17 or older. The median age is the age of the 55th oldest victim, and the 55th oldest victim fell in the 6–10 age-range.

There was one restriction on computing the median victim age. In order to prevent the few participants with very large numbers of victims (usually exhibitionists) from dis-

torting the results, the participant's number of victims in any given gender-age category was artificially capped at 10.

Within-Groups Comparisons

The dependent measures of primary interest in this study were the participants' penile responses in the laboratory to stimulus depictions of prepubescent children, pubescent children, and adults. Figure 3 shows, for each heterosexual age-preference group, that group's mean penile response to prepubescent girls, its mean response to pubescent girls, and its mean response to adult women. Thus, for example, the topmost panel of Fig. 3 shows that the heterosexual Pedophile 1 group responded most to prepubescent girls, less to pubescent girls, and least to adult women. The next panel down shows that the heterosexual Pedophile 2 group responded slightly more to pubescent than to prepubescent girls but still least to adult women. Figure 4 shows the analogous data for the homosexual age-preference groups.

Our phallometric test did not include stimuli depicting persons in mid-adolescence or late adolescence. Thus, there

Fig. 2 Attractiveness ratings for males of various ages, for the homosexual age-preference groups. The age-preference abbreviations are interpreted as follows: Pedo, pedophile; Hebe, hebephile; Ephebo, ephhebophile; Teleio, teleiophile. The anchor-points for the attractiveness ratings are as follows: 1, males of the canvassed age stimulate no sexual interest; 5, males of that age stimulate as much sexual interest as the participant is capable of feeling

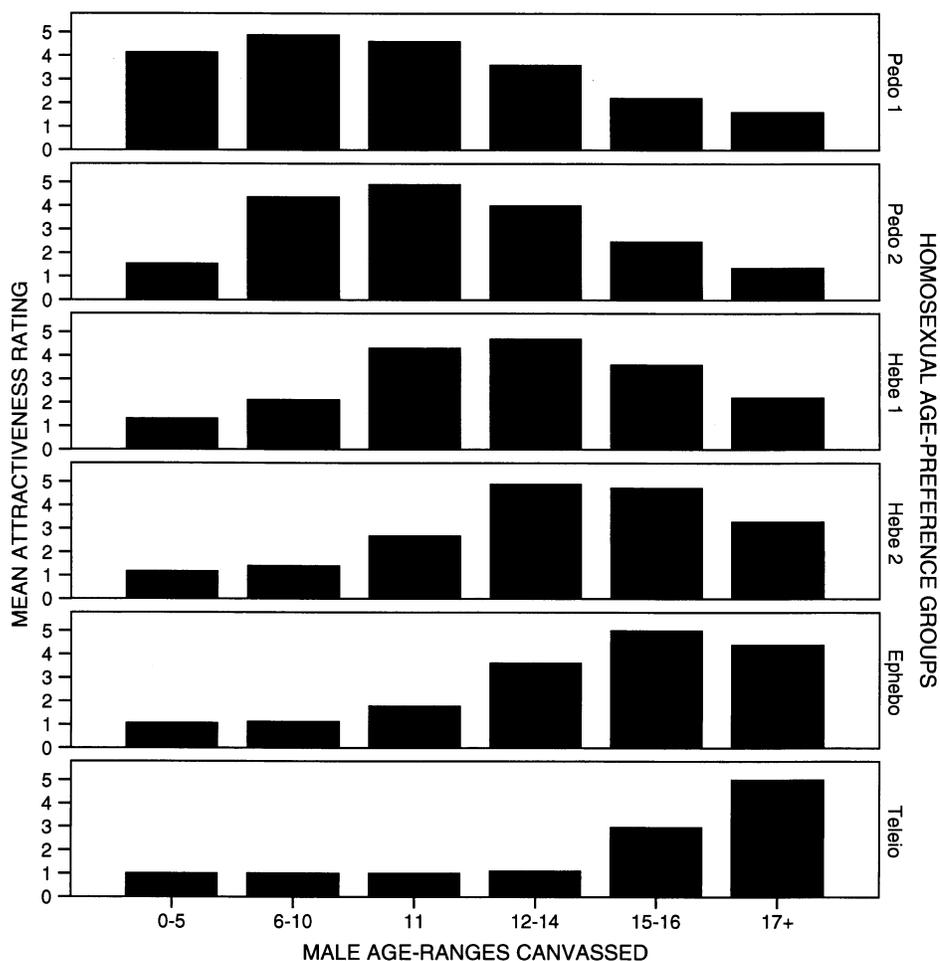


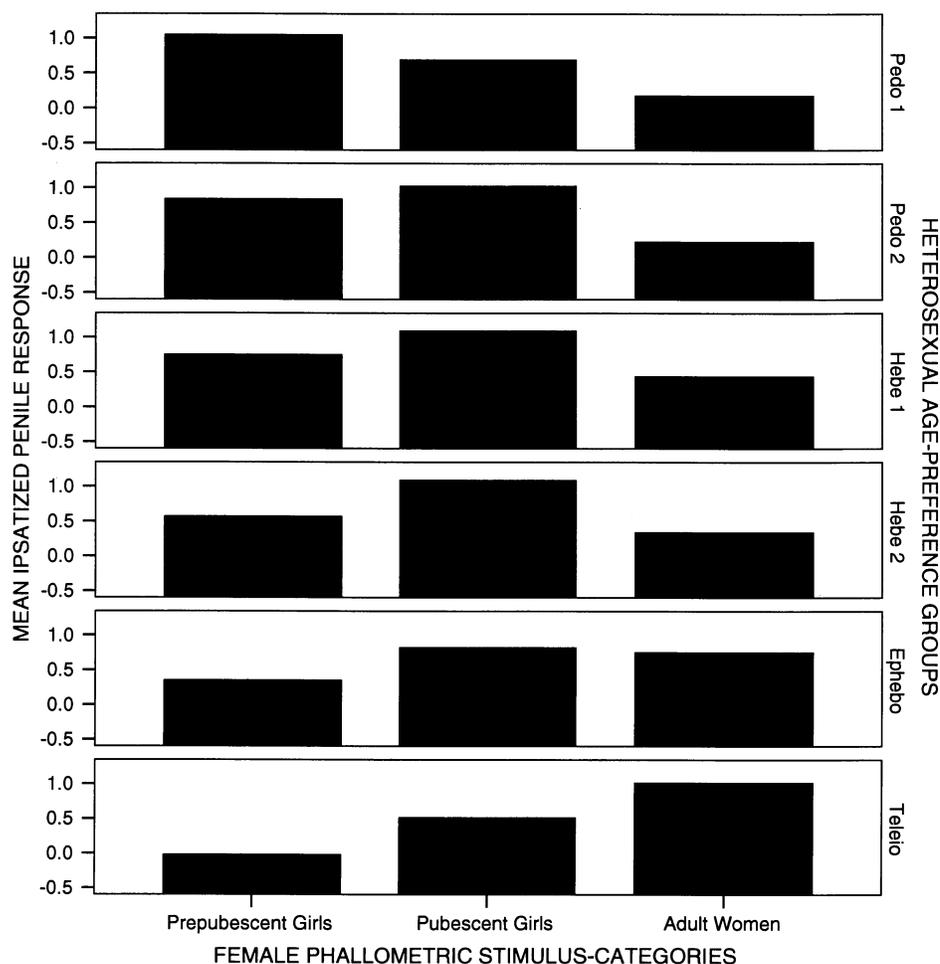
Table 1 Group size, mean age at testing, and median ages of the victims of the participants' sexual offenses

Gender-preference	Age-preference					
	Pedo 1	Pedo 2	Hebe 1	Hebe 2	Ephebo	Teleio
Heterosexual						
Group size	21	46	30	46	50	552
Age	33.14 (13.02)	30.48 (10.52)	35.30 (12.27)	34.96 (13.67)	33.68 (13.78)	35.85 (11.30)
Median victim age	6-10	11	12-14	12-14	12-14	≥17
Homosexual						
Group size	15	17	10	18	18	58
Age	36.00 (12.94)	40.41 (15.24)	40.30 (10.56)	39.00 (15.80)	35.39 (11.85)	39.12 (11.50)
Median victim age	6-10	11	12-14	12-14	15-16	≥17

was no optimal stimulus-category for the self-reported ephhebophiles to respond to. One might therefore expect that the ephhebophiles would respond about equally to pubescents and adults. These are the two age-categories adjacent to adolescence; the missing peak phalometric response between responses to pubescents and responses to adults would correspond to the missing adolescent stimuli. The data did, in fact,

show precisely this pattern for the heterosexual ephhebophiles (Fig. 3) but not for the homosexual ephhebophiles (Fig. 4). The phalometric profile of the homosexual ephhebophiles corresponded to the expected pattern for hebephiles, not to our hypothesized pattern for ephhebophiles. In fact, the phalometric profiles of the homosexual participants seemed generally to be shifted one category compared with the hetero-

Fig. 3 Mean penile response of the six heterosexual age-preference groups to laboratory stimuli depicting prepubescent, pubescent, and physically mature females. The means for the prepubescent, pubescent, and physically mature males are not shown



sexual participants. Thus, the profile of the homosexual Ephebophile group resembled that of the heterosexual Hehebophile 2 group; the homosexual Hehebophile 2 group resembled the heterosexual Hehebophile 1 group; the homosexual Hehebophile 1 group resembled the heterosexual Pedophile 2 group; and both homosexual pedophilic groups were shifted toward response to younger persons compared with the heterosexual Pedophile 1 group. It is unclear whether this result reflects a fact of nature, some specific properties of our phalometric stimuli, some specific properties of our sample, or simply the much smaller size of the homosexual group. In any event, the phalometric profiles of the homosexual and heterosexual teleiophiles were very similar, so the results did not reveal a uniform tendency for homosexual participants to respond in the laboratory to younger persons than they indicate in interview.

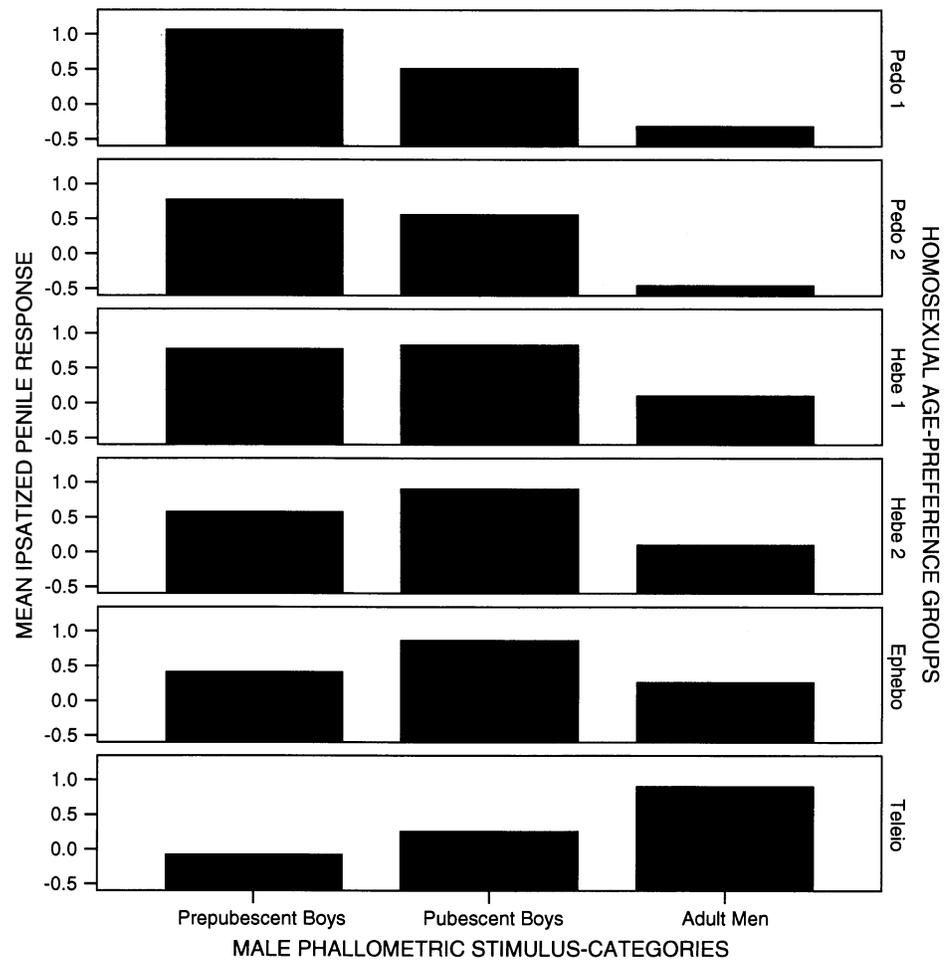
Statistical analyses were conducted on the data shown in Figs. 3 and 4 to ascertain whether the pedophiles responded significantly more to prepubescent children than they did to older persons, whether the teleiophiles responded significantly more to adults than to younger persons and—most

critically—whether the hebephiles responded significantly more to pubescent children than they did to both older and younger persons. These analyses used paired *t*-tests. For each age-preference group, three such *t*-tests were performed: response to pubescent children vs. response to prepubescent children, response to pubescent children vs. response to adults, and response to prepubescent children vs. response to adults.

The results for the heterosexual participants are presented in Table 2. Although the reader can determine from the signs of the reported *t*-statistics which of two compared means had the higher value, the table is most readily interpreted in conjunction with Fig. 3. In what follows, we comment only on the key findings in Table 2.

The Pedophile 1 group did respond more to prepubescent girls than to pubescent girls, but the Pedophile 2 group responded more strongly to pubescent girls. Both hebephilic groups showed exactly the pattern we expected. They responded significantly more to pubescent girls than to prepubescent girls or to adult women. The Ephebophiles, as previously noted, responded about equally to pubescent girls and adult women. They responded least to prepubescent girls.

Fig. 4 Mean penile response of the six homosexual age-preference groups to laboratory stimuli depicting prepubescent, pubescent, and physically mature males. The means for the prepubescent, pubescent, and physically mature females are not shown



The Teleiophiles responded more to adult women than to pubescent girls, and more to pubescent girls than to prepubescent girls.

The findings for the homosexual participants are given in Table 3, which can be interpreted with the aid of Fig. 4. Both pedophilic groups responded more to prepubescent boys than to pubescent boys. Neither hebephilic group showed exactly the pattern we expected, in that neither group responded significantly more to pubescent boys than to prepubescent boys. This might have to do with small sample sizes and low statistical power, especially in the case of the Hebephile 2 group, which did show a trend in the expected direction. The Ephephile group, as previously mentioned, showed the pattern we expected for the hebephilic groups. They responded significantly more to pubescent boys than to prepubescent boys or adult men. The results for the homosexual Teleiophiles resembled those of their heterosexual counterparts: They responded more to adult men than to pubescent boys, and more to pubescent boys than to prepubescent boys.

In order to ensure that the key findings above were not an artifact of our method for assigning cases to age-preference

groups, we confirmed these findings using a much simpler method. We selected all heterosexual participants who gave the maximum attractiveness rating of “5” to girls age 11 or to girls age 12–14 (or to girls in both age categories). We ignored the participants’ algorithmically computed age-preference group assignment, and we ignored their attractiveness ratings for all other age categories. This selection criterion identified 115 participants. We used paired *t*-tests to compare their penile responses to pubescent girls vs. prepubescent girls, and to pubescent girls vs. adult women. The participants responded significantly more to pubescent girls than to prepubescent girls, $t(114) = 5.26$, $p < .0001$, and they responded significantly more to pubescent girls than to adult women, $t(114) = 12.23$, $p < .0001$. We similarly selected 49 homosexual men who gave the maximum attractiveness rating of “5” to boys age 11 or 12–14. These men did not respond significantly more to pubescent boys than to prepubescent boys, $t(48) < 1$, but they did respond significantly more to pubescent boys than to adult men, $t(48) = 8.89$, $p < .0001$. In summary, the alternative method of identifying hebephilic men led to the same conclusions as the data presented in Tables 2 and 3.

Table 2 Ipsatized penile response: within-groups comparisons of means for heterosexual participants

Age-preference	df	Comparison					
		Pubescent girls vs. prepubescent girls		Pubescent girls vs. adult women		Prepubescent girls vs. adult women	
		<i>t</i>	<i>p</i>	<i>t</i>	<i>p</i>	<i>t</i>	<i>p</i>
Pedophile 1	20	-2.62	.02	4.38	.0003	5.48	<.0001
Pedophile 2	45	2.64	.01	7.10	<.0001	5.14	<.0001
Hebephile 1	29	4.94	<.0001	7.42	<.0001	2.66	.01
Hebephile 2	45	4.95	<.0001	7.00	<.0001	2.02	.05
Ephebophile	49	5.46	<.0001	0.53	n.s.	-2.82	.007
Teleiophile	551	23.63	<.0001	-14.16	<.0001	-30.02	<.0001

Note: All *p*-values are two-tailed. A negative *t*-value indicates that the mean specified first in the column heading was lower than the mean specified second

Table 3 Ipsatized penile response: within-groups comparisons of means for homosexual participants

Age-preference	df	Comparison					
		Pubescent boys vs. prepubescent boys		Pubescent boys vs. adult men		Prepubescent boys vs. adult men	
		<i>t</i>	<i>p</i>	<i>t</i>	<i>p</i>	<i>t</i>	<i>p</i>
Pedophile 1	14	-3.00	.01	6.69	<.0001	6.94	<.0001
Pedophile 2	16	-2.97	.01	5.53	<.0001	6.81	<.0001
Hebephile 1	9	0.32	n.s.	4.12	.003	5.21	.001
Hebephile 2	17	1.83	n.s.	4.52	.0003	2.03	n.s.
Ephebophile	17	3.18	.005	2.70	.02	0.90	n.s.
Teleiophile	57	4.12	.0001	-5.82	<.0001	-8.18	<.0001

Note: All *p*-values are two-tailed. A negative *t*-value indicates that the mean specified first in the column heading was lower than the mean specified second

Between-Groups Comparisons

Figures 3 and 4 were designed to emphasize the isometry between the phallographic data and the self-report data presented in Figs. 1 and 2, and also to highlight the phallographic response-profile that was characteristic of each age-preference group. These bar graphs do not, however, provide the clearest illustration of the relations between groups. The data in Figs. 3 and 4 were therefore redrawn as line graphs in Figs. 5 and 6 to illustrate these relations. The data for the heterosexual groups are shown in Fig. 5, and the data for the homosexual groups are shown in Fig. 6. The mean penile responses of the six age-preference groups to prepubescent children are connected by dotted lines, the mean responses to pubescent children are connected by dashed lines, and the mean responses to adults are connected by solid lines.

Figures 5 and 6 suggest three findings: (a) The pedophiles had greater responses to prepubescent children than the hebephiles or teleiophiles, (b) the teleiophiles had greater responses to adults than the hebephiles or pedophiles, and—most importantly—(c) the hebephiles had greater responses to pubescents than the pedophiles or teleiophiles. These impressions were tested in analyses of variance using the default

polynomial contrasts provided by SPSS-15 (SPSS, Inc., Chicago, IL). The linear contrasts were used to demonstrate the first two findings, and the quadratic contrasts were used to demonstrate the third finding. The linear contrast coefficients, for the six age-preference groups from Pedophile 1 to Teleiophile, were $-.598$, $-.359$, $-.120$, $.120$, $.359$, and $.598$, and the quadratic contrast coefficients were $.546$, $-.109$, $-.436$, $-.436$, $-.109$, and $.546$. The quadratic contrasts were convenient for our purposes because the two “middle” means in the series belonged to the Hebephile 1 and Hebephile 2 groups; thus, the quadratic contrasts, in effect, tested whether the hebephiles’ penile responses differed from those of the other age-preference groups.

For the heterosexual age-preference groups, linear and quadratic contrasts were performed on mean penile responses to prepubescent girls, pubescent girls, and adult women. Similarly, for the homosexual age-preference groups, linear and quadratic contrasts were performed on mean penile responses to prepubescent boys, pubescent boys, and adult men. The results are presented in Tables 4 and 5.

Table 4 is readily interpreted in relation to Fig. 5. The table shows that the pedophilic groups responded more to the prepubescent girls than did the other groups (linear contrast), the

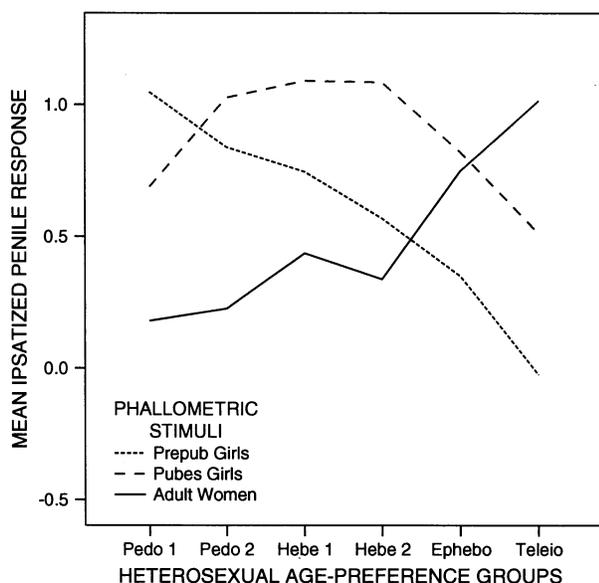


Fig. 5 Mean penile response of the six heterosexual age-preference groups to laboratory stimuli depicting prepubescent, pubescent, and physically mature females—redrawn to emphasize between-groups differences. Prepub Girls, prepubescent females; Pubes Girls, pubescent females; Adult Women, physically mature females

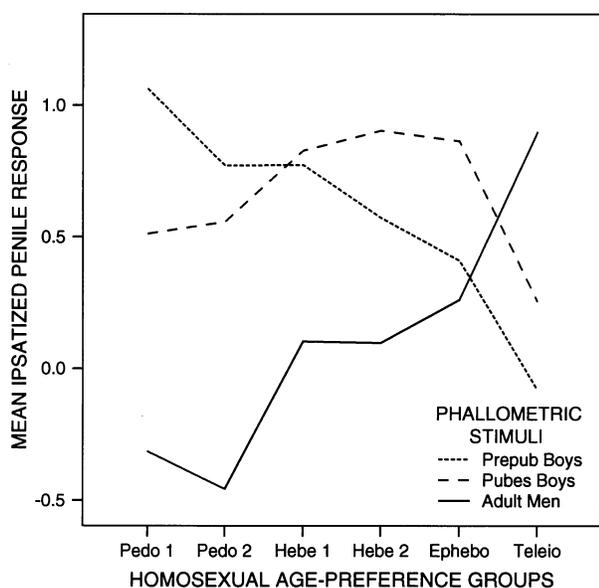


Fig. 6 Mean penile response of the six homosexual age-preference groups to laboratory stimuli depicting prepubescent, pubescent, and physically mature males—redrawn to emphasize between-groups differences. Prepub Boys, prepubescent males; Pubes Boys, pubescent males; Adult Men, physically mature males

hebephilic groups responded more to the pubescent girls than the other groups (quadratic contrast), and the teleiophilic group responded more to the adult women than the other groups (linear contrast). The p -values for these three contrasts were less than .0001.

There were a few “nuisance” results in Table 4 that require a word of explanation. There was a small but statistically significant linear contrast for mean responses to pubescent girls. That was because the inverted-U shape of the dashed line in Fig. 5 was slightly tilted; in other words, the mean response of the Pedophile 1 group was somewhat higher than the mean response of the Teleiophile group. There was also a small but statistically significant quadratic contrast for mean responses to adult women. That was because the increase in means from the Pedophile 1 group to the Hebephile 2 group was less pronounced than the increase from the Hebephile 2 group to the Teleiophile group.

Table 5 can be interpreted in relation to Fig. 6. The table shows that the pedophilic groups responded more to the prepubescent boys than did the other groups (linear contrast), the hebephilic groups responded more to the pubescent boys than the other groups (quadratic contrast), and the teleiophilic group responded more to the adult men than the other groups (linear contrast). The p -values for these three contrasts were less than, or rounded to, .0001. There were no other statistically significant results, possibly because the smaller sample size protected against “nuisance” results.

Discussion

The present study showed that hebephilia exists and—incidentally—that it is relatively common compared with other forms of erotic interest in children. This has two direct implications for the *DSM*, which also apply to clinical research. First, the *DSM-V* should expand the definition of

Table 4 Ipsatized penile response: between-groups comparisons of means for heterosexual participants

Phalometric stimuli	Polynomial contrast			
	Linear		Quadratic	
	$F(1, 739)$	p	$F(1, 739)$	p
Prepubescent girls	130.47	<.0001	3.61	n.s.
Pubescent girls	5.63	.02	39.09	<.0001
Adult women	56.33	<.0001	4.92	.03

Table 5 Ipsatized penile response: between-groups comparisons of means for homosexual participants

Phalometric stimuli	Polynomial contrast			
	Linear		Quadratic	
	$F(1, 130)$	p	$F(1, 130)$	p
Prepubescent boys	63.32	<.0001	2.44	n.s.
Pubescent boys	0.10	n.s.	17.38	.0001
Adult men	63.94	<.0001	3.56	n.s.

Pedophilia so that it includes erotic attraction to pubescent and prepubescent children or, alternatively, add a separate diagnosis of Hebephilia. If the latter option were chosen, patients attracted to both prepubescent and pubescent children more than to adults could be given both diagnoses (Pedophilia and Hebephilia). That would cover those individuals referred to by Freund, Seeley, Marshall, and Glinfort (1972) as “pedohebephiles.” Another possibility would be to completely replace the diagnosis of Pedophilia with Pedohebephilia and allow the clinician to specify one of three subtypes: Sexually Attracted to Children Younger than 11 (Pedophilic Type), Sexually Attracted to Children Age 11–14 (Hebephilic Type), or Sexually Attracted to Both (Pedohebephilic Type).

Second, the *DSM* diagnostic specifiers, which currently include the gender of children who most attract the patient sexually, should also include the typical age of children who most attract the patient sexually. This second point agrees with the suggestions of several authors that the *DSM-V* should include continuous measures of psychopathology as well as discrete diagnostic categories (Regier, 2007). The age of persons to whom the individual is most attracted would be an ideal continuous measure of erotic age-preference: It has a built-in metric, it corresponds to something in the real world, and it can be interpreted by any clinician without specialized training. It is true that a most-preferred-age item, whether incorporated into a self-administered questionnaire or a structured interview for sex offenders, will elicit many lies and distortions, but that is true of any self-report methodology, and this item has the virtue of simplicity. Examiners might find it useful, in determining the most attractive age for intellectually limited patients, to show them a standard set of nude photographs, line drawings, or silhouettes that illustrate the characteristic body shapes of males and females at all ages from infancy to senescence. Such a set of illustrations might conceivably be obtained from endocrinology texts or other medical sources. The patient could simply pick the image that represents his erotic ideal, and the examiner could record the associated age.

It is relevant here to consider the use of different age-ranges for boys and girls when dichotomously classifying men’s sexual targets as pubescent or prepubescent. As noted in the introduction to this article, the pubertal growth spurt in height starts about 2 years earlier for girls than for boys. Other signs of maturation, for example, pubic hair, begin to appear at about the same time in both sexes. One aspect of maturation—fecundity—actually appears earlier in boys than in girls (Wood, 1994, p. 404 and Fig. 9.4). Our study did not attempt to address the question of different age-ranges. One would probably not lose much precision in using the same age-range (e.g., 11 through 14) in designating both male and female children as pubescent, given that the onset of puberty varies from child to child and given that the boundaries of puberty are fuzzy to begin with. Thus, it does not seem absolutely

necessary to use different criteria when diagnosing hebephilia in homosexual and heterosexual men.

Our demonstration of heterosexual hebephilia was more clear-cut than our demonstration of homosexual hebephilia. Our first main conclusion—men who verbally report maximum sexual attraction to pubescent children produce greater penile responses to depictions of pubescent children than to depictions of younger or older persons—applies in full only to heterosexual men. We could not demonstrate that (self-reported) homosexual hebephiles respond more to pubescent boys than to prepubescent boys. One possible reason for this is insufficient statistical power: Our combined number of homosexual pedophiles and hebephiles was less than half our number of heterosexual pedophiles and hebephiles. There are at least two other possible methodological reasons for this discrepant finding: (a) Our prepubescent female models were age 3–11, whereas our prepubescent male models were age 5–11, and (b) the sexual development of the pubescent female models, according to their Tanner ratings, was somewhat less advanced than the sexual development of the pubescent male models. It is difficult to know how, or even whether, these seemingly small differences affected the outcome. It is, of course, conceivable that the results relate to some inherent difference between heterosexual and homosexual hebephiles, but it is impossible, given the above-mentioned inequalities, to conclude that.

The main methodological limitation of the present study was the absence of models age 15–18 (mid- to late-adolescence) among the phallometric stimuli. That made it impossible to directly validate self-reports of ephebophilia. On the positive side, our cumbersome method of pinpointing the participant’s erotic age-preference appears to have worked tolerably well, although we would not necessarily recommend it to other researchers. It seems probable that the simply query, “What is the typical age of persons who most attract you sexually,” would obtain the same information more simply, although it might require some follow-up questions before a single value could be recorded.

The study produced various findings that lay outside our main focus but are nonetheless of theoretical interest. First, the phallometric profiles of the homosexual participants generally paralleled those of the heterosexual participants. Thus, the homosexual pedophiles differentiated between prepubescent boys and adult men just as well as the heterosexual pedophiles differentiated between prepubescent girls and adult women; the homosexual and heterosexual teleiophiles also distinguished between children and adults of their preferred gender to similar degrees (compare Figs. 3 and 4). This parallelism had previously been demonstrated for homosexual and heterosexual teleiophiles (Freund et al., 1973), but not for homosexual and heterosexual pedophiles.

Second, there was a remarkable concordance between the participants’ self-reported age-preferences and their phal-

lometric profiles. This shows that penile response in the laboratory can be a fairly sensitive measure of erotic preferences in cooperative participants. The inherent limitations of the phallometric method are not the technical problems in measuring penile blood volume or the creative problems in devising effective stimuli for a range of paraphilics, but rather the willingness and ability of uncooperative men to affect the test outcome. Outside the criminal justice system and its associated clinics—where it is primarily used as a blunt instrument in diagnosing paraphilia in nonadmitters (e.g., Blanchard et al., 2001; Freund & Blanchard, 1989)—the phallometric method is probably underutilized for examining subtle theoretical questions regarding erotic preferences.

Third, our missing data on ephebophilia notwithstanding, erotic age-preferences appear to constitute a continuum rather than a series of discrete taxa. This is not surprising, when one considers the continuous nature of human physical development. Human beings, unlike butterflies, do not disappear in one form and reappear in another. The continuous nature of erotic age-preferences does not, however, tell us anything about etiology. It does not, for example, imply that pedophilia and hebephilia have the same etiology, with the difference between them reflecting some kind of dosage effect. It is quite possible, in fact, that both variant age-preferences have multiple etiologies (Blanchard et al., 2002; Seto, 2008, p. 210). This appears to be the case for variant erotic gender-preference: A substantial amount of evidence indicates that homosexuality has one cause (or set of causes) in right-handed men and another cause in non-right-handed men (Blanchard, 2008). It would almost be surprising if multiple etiologies did not contribute to pedo- and hebephilia.

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The Public Policy Implications of “Hebephilia”: A Response to Blanchard et al. (2008)

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Blanchard et al. (2008) present their article on “hebephilia” as an objective analysis of research data. In fact, it is a textbook example of subjective values masquerading as science. Avoiding the crucial public policy implications of their argument, Blanchard et al. advance hebephilia as if it exists in a cultural vacuum. Their recommendations are even more troubling in light of their study’s methodological flaws.

Blanchard et al. assert that their mere identification of hebephilia as a “discriminable erotic age-preference” qualifies it for inclusion in the forthcoming fifth edition of the American Psychiatric Association’s influential *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. They ignore a crucial question at the heart of the current debate over how the *DSM* should conceptualize sexual disorders (Kleinplatz & Moser, 2005): What makes hebephilia a pathology, as opposed to a normal variant of human sexuality? Indeed, Blanchard et al.’s logic applies equally well to homosexuality, which was gradually removed from the *DSM* between 1973 and 1987.

The absurdity of describing erotic attraction to adolescents as a mental disorder is that large proportions of heterosexual men are sexually attracted to young pubescent girls (Freund & Costell, 1970; Quinsey, Steinman, Bergerson & Holmes, 1975) and indeed such attractions are evolutionarily adaptive (Kenrick & Keefe, 1992). Even Blanchard et al. acknowledge that “few would want to label erotic interest in late- or even mid-adolescents as a psychopathology.” A diagnosis of

hebephilia would be even more unreliable than the current *DSM-IV* diagnosis of pedophilia (Marshall, 1997), thereby inviting arbitrary and biased application.

To fully appreciate the radical nature of this proposal, we must understand its context. Whereas Blanchard et al. express surprise at the dearth of previous research on hebephilia, it is actually the sudden interest in this ubiquitous and age-old phenomenon that merits explanation. The construct, which descends from German sexologist Magnus Hirschfeld’s efforts to catalogue the many varieties of sexuality back around 1906–1908, has only exploded into common parlance in the past few years. This timing is inextricably linked with the advent of modern sex offender civil commitment laws and a punitive era of “moral panic” (Jenkins, 2004).

Since 1990, 20 U.S. states and the federal government have enacted laws enabling the civil incapacitation of certain sex offenders. The legal requirement that these civil commitments be predicated on a mental disorder or abnormality (Kansas v. Hendricks, 1997) has spawned a booming cottage industry in the mental health field. Because many sex offenders do not suffer from traditional mental disorders, forensic evaluators have developed a highly contested—some would say pretextual—diagnostic nosology centering around the triad of Antisocial Personality Disorder, Pedophilia, and Paraphilia Not Otherwise Specified (Doren, 2002; First & Halon, in press; Zander, 2005). It is into this last category that some government-retained clinicians are attempting to shoehorn the unofficial diagnosis of hebephilia.

The study’s significant methodological flaws underscore its goal of legitimizing this quasi-diagnosis. The most conspicuous of these are the absence of a control group of non-deviant men and the curious omission of 15–18-year-old models as a target stimulus group. Also problematic is the exclusion of a majority of the eligible participants (1,440 of

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the original pool of 2,355, or 61% by my calculation). This was accomplished by labeling as potentially “noncooperative” any man who had sexually offended against children but claimed a sexual preference for adults. Blanchard et al.’s assumption that these men were being duplicitous runs counter to evidence from other studies that only about half of sex offenders against children are pedophiles (Seto, 2008). Thus, the finding of “a remarkable concordance between the participants’ self-reported age-preferences and their phalometric profiles” was predetermined by the researchers’ a priori selection procedure.

In the forensic arena, the *DSM* is increasingly used as a tool to legitimize the government’s capacities to civilly incapacitate unwanted citizens. Especially in light of mounting evidence of special-interest influence over the *DSM* (Lane, 2007), creating a controversial new diagnosis without compelling scientific support would set an alarming precedent.

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Are There “Hebephiles” Among Us? A Response to Blanchard et al. (2008)

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Blanchard et al. (2008) call for the addition of a paraphilic condition to the *DSM-V* termed hebephilia. Beyond the fact that there was no control group employed by Blanchard et al. in order to compare the obtained results against normative patterns of sexual arousal of men, there were multiple methodological issues that preclude a call for the establishment of hebephilia as a diagnostic entity in the *DSM-V*.

I find no problem with the plethysmography methodology employed by Blanchard et al.; however, I would note that Blanchard et al. did not specify whether the procedure for eliciting self-report of the subjects described as “a great deal of exploration” preceded or followed the physiological measurements. It would have been more sound for this procedure to follow physiological measurement so as not to serve as a potential sensitizing factor which could confound the results. Further, the grouping algorithm employed concerns me. There appears to be a significant amount of variability among the defined groups. Why not instead analyze those who reported exclusive or near-exclusive ranges of sexual responding to target age ranges? If none or too few of the participants indicated primary sexual attraction to pubescent males/females in the 11–14 year range in an original sample close to 3000, this is telling in and of itself. Blanchard et al. take Fig. 1 to be evidence that “the classification algorithm worked.” My inspection of the data does not leave me with this conclusion. On a 5-point Likert-type scale measuring a subjective factor, inspection of Fig. 1 reveals a significant amount of variability that may not, in the end, appropriately identify the subgroupings as described in

the text. I did not see any statistical analysis of the discriminability of the labels assigned other than gross percentage figures for maximum attractiveness. So the validity of the group memberships themselves is at issue here.

The absence of 15–18 year old stimuli also was problematic. I would also like to have seen more multivariate testing performed before charging in to a number of dependent sample *t*-tests (family wise error rate?). What I find astounding is how Blanchard et al. strongly word their discussion that these results mean “that hebephilia exists and—incidentally—that it is relatively common compared with other forms of erotic interest in children.” The data do not support the conclusions reached in this article, especially the inclusion of a significant change to the *DSM-V*. Again, the data do not support the conclusions reached in this article. There does not appear to be any homogeneity of groupings along the axes of sexual interest groups (alluded to above). If there are “hebephiles” among us, then this sexual interest/arousal pattern appears to be a very heterogeneous one. If it is heterogeneous, how can it have diagnostic specificity as Blanchard et al. state it has in their conclusion? Look at Fig. 3. In the pedophile groups (especially Pedo 2), there was significant overlap between physiological arousal to both pre-pubescent and pubescent girls. As a matter of fact, in their Pedo 2 group, there was more arousal to pubescent girls than to pre-pubescent girls. And this relation does not seem to hold for homosexual males (even though Blanchard et al. state that the hetero/homo groups were remarkably similar). How is that a diagnostic indicator of pedophilia? Also, there was a statistical difference in their *pedophiles* between pubescent girls and adult women. Is this a group primarily composed of non-exclusive pedophiles? If so, does this have different implication from groupings that would contain exclusive pedophiles? There is no way to answer that question given the data in the study. If their pedophiles show discrepant findings

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such that they are also showing sexual arousal to pubescent females, then this muddies up an established diagnosis, never mind a proposed new diagnosis such as hebephilia.

Further, both hebephile groups tended to show more in common with the physiological responding pattern of pedophiles than teleiophiles. That is unexpected and inconsistent with other research in this area (Plaud, Gaither, Rowan, & Devitt, 1999). Take a look at Fig. 3 again. The two pedo groups looked more similar to the two hebe groups in contrast to the ephebo and teleio groups. Blanchard et al. did some post-hoc contrasts among groups, but, in my opinion, they should have started their statistics with multivariate analyses with the groups to tease out more analysis between/among groups.

It would have been interesting to have a condition where just the faces (no evidence of actual secondary sexual characteristics) were displayed in order to examine whether subjects, for example, were responding to how “young” the person looked in the absence of the actual sexual characteristics of the person. What about the (possible) intercession between sexual history/conditioning and the results of the study? Since both hebephilia and ephebophilia involve pubescent children (the distinction is a social one involving age of consent more than physiological development), how do we disentangle physiological responding (sexual arousal)

from the social/legal contexts in which sexual behavior is allowed to take place? Given that the subjects all had either criminal or socially diagnosed “problematic sexual behavior,” there appears to be a lot more going on here than is being measured and talked about in this article.

In the final analysis, rather than establish the validity of a *bona fide* diagnostic category such as hebephilia for inclusion in the *DSM-V*, these data show that Blanchard et al. labeled Hebe groups tend to be more Pedo “light” groups than a separate class of sexual deviates, at least with the heterosexual subjects. Changes to the forthcoming publication of the *DSM-V* should not be based entirely or even in part on the results reported in this article, as more questions are raised than answered in the research methodology employed in this study.

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Should Hebephilia be a Mental Disorder? A Reply to Blanchard et al. (2008)

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Blanchard et al. (2008) suggest possibilities for expanding *DSM* to include a diagnosis for Hebephilia (mostly erotically attracted to 11- to 14-year olds), but they do not suggest the inclusion of a diagnosis for Ephebophilia (mostly attracted to 15- to 16-year olds), Teliophilia (mostly attracted to those 17 years old or older), or Gerontophilia (mostly attracted to the aged).

Although Blanchard et al. present data regarding whether reliable differences in erotic preference can be shown, they completely overlook the question of how we decide which sexual interest patterns should be considered a mental disorder. Pedophilia is a mental disorder. Homosexuality is not. Should Hebephilia or Ephebophilia or Gerontophilia be considered mental disorders? How about sexual preference for people with different (or with the same) ethnic characteristics as oneself?

The decision to classify a pattern of sexual attraction as a mental disorder (paraphilia) inevitably entails more than (1) reliable differences in patterns of sexual attractions and (2) checking law books to see which sexual activities are currently illegal in a particular jurisdiction. In their Discussion section, Blanchard et al. leap directly from "Hebephilia exists" to "The *DSM-V* should expand the definition of Pedophilia so that it includes erotic attraction to pubescent and prepubescent children or, alternatively, add a separate diagnosis of Hebephilia." They completely ignore the middle part of this syllogism: (A) Hebephilia exists. (B) Hebephilia is a mental disorder. (C) Hebephilia should be included in *DSM-V*.

Blanchard et al.'s findings are useful toward consideration of whether a pattern of erotic preference for pubescent

and/or early post-pubescent humans is reliable, stable, and identifiable. However, their discussion completely misses other necessary considerations regarding whether a stable pattern of differences (e.g., homosexual versus heterosexual; right handed versus left handed) constitutes a disorder.

One of the co-authors (James Cantor) has graciously responded to some queries on the Internet list *psylaw-l* (<http://listserv.unl.edu/>), clarifying his perspective regarding the recommendation that Hebephilia be listed as a mental disorder in *DSM-V*. As I understand Cantor's posts, listing Hebephilia as a specific paraphilia should not result in a greater number of people being diagnosed with paraphilia: "Hebephilia is well within the range of disorders already in the *DSM*, and my recommendation pertains not to pathologizing, but to replacing inaccurate labels (Paraphilia NOS and Pedophilia with an unrealistic definition of puberty) with an accurate label" (e-communication, August 30, 2008). Thus, a subset of those people who meet criteria for the general diagnosis of paraphilia would meet criteria for the specific diagnosis of Hebephilia. If, both in design and practice, listing a specific diagnosis of Hebephilia in *DSM-V* would not result in any more people being classified as paraphiles, then I would consider this proposal to be reasonable and noncontroversial.

In a follow-up *psylaw* post (e-communication, September 1, 2008), Cantor recommends that the label Hebephile be applied to people who show greater sexual arousal to pubescent people than to mature adults. But neither Blanchard et al. nor Cantor (in his posts to *psylaw*) articulate a plan for deciding which people who meet the criteria for the descriptive label of Hebephile (greater relative sexual arousal to pubescent people) should be considered to meet criteria for the proposed diagnosis of Hebephilia.

If criteria similar to the *DSM-IV-TR* criteria for Pedophilia are to be used for Hebephilia in *DSM-V*, then a person would

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get a diagnosis of Hebephilia if criteria similar to the following are satisfied: (a) over a period of at least 6 months, he or she has recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a pubescent child or children (generally age 11–14) and (b) the person has acted on these urges, or the sexual urges or fantasies cause distress or interpersonal difficulty, and (c) the person is at least 18 years of age and at least 5 years older than the child or children (but do not include an individual in late adolescence involved in an ongoing relationship with a 12- to 14-year-old). I consider it very likely that implementation of such criteria would expand the number of people diagnosed with paraphilia, to include people who fantasize about and/or engage in sex with 14-year-olds or with younger children who have entered puberty.

Any changes to *DSM* that would lead to more people diagnosed with a mental disorder should be carefully considered. Blanchard et al. recommend expansion of *DSM* to include Hebephilia without any explicit articulation of why Hebephilia should be considered a mental disorder, what diagnostic criteria should be used, whether Hebephilia can be diagnosed reliably in the field, and how inclusion of the new diagnosis would likely impact individuals and society. This is particularly disconcerting because in this article Blanchard is advising himself and the Editor of this journal; Dr. Blanchard

is a member of the *DSM-V* Sexual and Gender Identity Disorders Work Group, and the Editor of *Archives of Sexual Behavior*, Kenneth J. Zucker, is its chair (see <http://www.psych.org/MainMenu/Newsroom/NewsReleases/2008NewsReleases/dsmwg.aspx>). Further, according to Robert L. Spitzer, “Perhaps the best-kept-secret about *DSM-V* is that rather than being ‘an open and transparent process’ as has been claimed, it will essentially be developed in secret. Task Force and Workgroup members have been required to sign ‘confidentiality agreements’ prohibiting them from discussing with anybody anything having to do with *DSM-V*” (see http://taxa.epi.umn.edu/~mbmiller/sscpnet/20080909_Spitzer/).

In sum, any changes to the Paraphilia section of *DSM* should be carefully considered, and the entire *DSM* development process should be conducted in the open, as it is for the World Health Organization’s revision of ICD-10 (see http://www.who.int/mental_health/evidence/en/).

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