

# Hebephilia as a sexual disorder

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## **ABSTRACT**

### *Background*

The term “hebephilia” describes the sexual preference for minors at an early pubertal body age (Tanner stages 2 and 3)). For most clinicians the definition of hebephilia as a sexual disorder is not obvious and not integrated as a separate sexual disorder in the DSM-5.

### *Method*

In all assessed males participating in the Prevention Project Dunkelfeld at the Institute for Sexual Medicine at the Charité between 2005 and 2011, who met the inclusion criteria such as the erotic preference for prepubescent and pubescent minors and showed no exclusion criteria such as psychiatric illness or currently being under judicial proceedings (n = 222), the existence of hebephilia was examined.

### *Results*

Approximately two-thirds of the present sample (n=153) showed a sexual interest in pubescent minors (Tanner stages 2 and 3). Of these, only 15% were exclusively attracted to the pubescent body age. 85% showed patterns of mixed attraction. Concerning the clinical aspects of the sexual preference disorder, approx. 95.4% reported having sexually abused children and/or having used child abusive images at least once in their lifetime. Notably, hebephiles reported a higher level of clinically relevant distress and personality characteristics significantly different from norm samples. In terms of risk factors, hebephiles showed more offense-supportive attitudes compared to a male control sample.

## *Conclusion*

Hebephilia as a sexual preference for minors bearing the early pubertal Tanner stages 2 and 3 can be clinically differentiated from pedophilia, defined as sexual interest in prepubescent minors (Tanner stage 1), although mixed patterns are frequent. The decisive main difference concerns the responsiveness toward a certain developmental age of the body scheme (either the prepubescent or the early pubescent one). Associated personal distress, deviant personality characteristics and cognitions as well as sexual behavior problems suggest that hebephilia is a sexual disorder. Its rejection for the DSM-5 appears unfavorable against this background and should be reconsidered for future editions as well as for ICD-11.

## **INTRODUCTION**

[This paper is an English translation and adaptation of the German study “Hebephilie als sexuelle Störung” (Beier et al., 2013), which was as well published in this journal. Thereby, the authors wish to update the discussion regarding developments since the publication of the DSM-5 last year and to contribute to recent discussions on considering Hebephilia for inclusion in the ICD-11.]

## **Terminology and Phenomena**

### *Sexual Preference*

Human sexual preference can be described as being sexually attracted towards the gender and (developmental) body age (hereafter described as ‘body scheme’) of one’s partner and also the responsiveness concerning certain sexual interaction and practice with the partner. Besides the individual’s self-concept, these characteristics are clinically revealed through the exploration of sexual fantasies and behaviors. Due to cultural norms, self-concept and behavior may differ from sexual fantasies. Social desirability regarding deception of oneself and others is important if characteristics of the sexual preference are socially sanctioned and have to be kept private.

### *Characteristic of Preference: Body Scheme*

The relevance of the physical developmental age for the description of sexual preference has been widely accepted [1,2,3]. Often, this body

scheme preference is determined by mature secondary sexual characteristics of an adult. The sexual preference for the adult, fully developed body scheme is referred to as teleiophilia (gr. “teleos” – fully grown) [4]. In addition to teleiophilia, there is a distinguishable sexual responsiveness toward the sexually immature or not fully mature body scheme, especially among men.

Since Krafft-Ebing [5] the sexual preference for prepubertal minors (Tanner stage 1) is referred to as pedophilia (gr. “pais” – child). Sexual preference for early pubertal minors was termed hebephilia (from the Greek goddess of youth “Hebe”) by Glueck [6]. This sexually preferred body scheme can be characterized by the stage of transition from prepubertal to an early pubertal body scheme, represented by the development of the secondary sexual characteristics (according to Tanner stages 2 and 3). Typical for this transition is the incipient breast development with a slight warp in glandular tissue around the areola (so-called breast buds; i.e. “thelarche”). The beginning genital development is characterized by a small amount of pubic hair in form of downy hairs with slight pigmentation around the labia majora or around the root of the penis with no or only little growth of the penis or the labia. The term hebephilia has to be distinguished from ephhebophilia (gr. „ephebos” – young man) and parthenophilia (gr. “parthenos” – virgin). Both refer to the sexual preference for male or female adolescents with mostly late pubertal/adult body scheme (Tanner stages 4 and 5) [7] and are subtypes of teleiophilia [4].

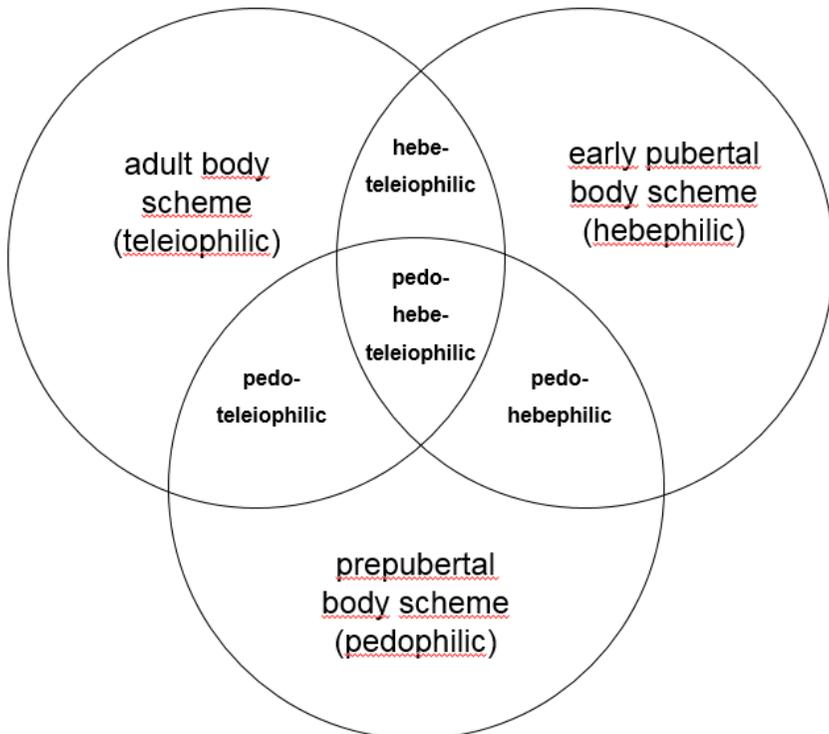
Sixteen years ago, the onset of puberty (male genital development/female breast development) was around the age of eleven in Germany. Studies suggest an earlier onset of puberty as well as an acceleration of physical maturation. At the age of ten, half of the girls and more than one third of the boys report a beginning growth of pubic hair. The average age for reaching the late pubescent or adult pubic hair (Tanner stages 4 and 5) was age 12.3 or 13.4 for girls and age 13.4 or 14.1 for boys [8]. Blanchard and colleagues [9] were able to distinguish pedophilic, hebephilic and teleiophilic preferences with penile Plethysmograph measurement in large groups of delinquent sex offenders (n = 881), but also reported an overlap between these preference patterns. In earlier studies, the same work group showed that men with hebephilic preference revealed characteristics of IQ, education, left-handedness, body height and head injuries before the

age of 13 exactly between the group of pedophiles and teleiophiles (overview at [9]).

### *The Berlin Classification*

The exploration of the sexual preference for the body scheme based on sexual fantasies often leads to a variety of different preferred body schemes. In addition to the exclusive types of sexual preference for a prepubertal, an early pubertal or an adult body scheme, men report several fantasized body schemes, e.g. proportionally existing sexual fantasies regarding the prepubertal and the early pubertal body scheme in one individual. In figure 1, possible combinations of preference are schematically displayed and exemplified in the following case studies.

*Fig. 1. Sexual preference for body schemes according to the Berlin classification: teleiophilic - hebephilic – pedophilic including mixed forms*



### *Case 1: A Hebe-teleiophilic Type*

A 45 year old freelance artist.

Living in a relationship with a 10 years younger man, with whom he regularly has sexual contacts (anal intercourse active, oral intercourse active and passive).

Reporting numerous additional sexual contacts alongside the relationship (more than 300 adult partners so far).

Presenting problems: Consumption of child abusive images of adolescent males with early pubertal body scheme („ideal age 13“).

„Addictive“ consumption, feels „like being at the mercy of this compulsion“, lacking control.

### *Case 2: A Pedo-hebephilic Type*

A 43 year old business man, married, one daughter (8 years old).

Self-referring to the treatment, because of the sexual abuse of his daughter (touching her vagina).

His wife is 30 years old (married at age 18) and shows a juvenile body scheme.

During treatment he approached female pubescent minors, dated for sexual contacts, and realized once more touching the vagina of a 13 year old girl.

Additional pharmaceutical treatment with cyproterone acetate and later triptorelin.

### *Sexual Preference Disorder*

Both the DSM and ICD list sexual preference for physically immature sexual partners with different diagnostic criteria in differently headlined groups [10,11]. In DSM-5 the term is “Pedophilic Disorder” defined as “sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger)” and belongs into the category “Paraphilic Disorders”.

In the ICD-10 pedophilia is defined as a “sexual preference for children, boys or girls or both, usually of prepubertal or early pubertal body scheme” and belongs into the category “Sexual Preference Disorders”. A sexual preference for early pubertal children as a separate diagnostic category is not provided in the DSM-5. In the ICD-

10 this preference is summarized under “pedophilia”. The ICD-10 classification has, on the one hand, the advantage of considering the prepubertal as well as the early pubertal body scheme, and on the other hand, the disadvantage of not allowing for a terminological differentiation. In the ICD-10 as well as in the DSM-5 a sexual preference or a paraphilic disorder is not diagnosed unless the sexual preference or paraphilia goes along with a clinically significant degree of distress or impairment or has been acted upon. It needs to be taken into account that pedophilia fulfills characteristics of a disorder even without the existence of a threat of endangering others (real offenders vs. non-offenders). Comparing pedophilia to other paraphilias, the acting out of the preference can be seen as an idiosyncratic clinically relevant criterion. [12]

The underlying consideration is that refraining from this socially sanctioned form of sexual interaction constitutes sufficient impairment of social functioning inevitably causing psychological distress to the person involved. DSM-5 claims that the individual has to be at least age 16 years and at least 5 years older than the sexually abused child. Distress in pedophilically inclined persons may result from the perceived stability of their often unwanted and internally rejected sexual preference over a longer period of time. According to the authors’ clinical experience, the sexual preference of a person with its individual characteristics mostly manifests during puberty and is marked by constant sexual fantasies over life span. Accordingly, Seto [13] recently discussed the conceptualization of a sexual preference for minors as a “sexual orientation”, similar to gynaeophilia (attraction to females) or androphilia (attraction to males). He identified a pubertal onset, associated sexual and romantic behaviors with the desired partner and the relative stability over life time as core features of a sexual orientation and described some relevant empirical data on detected offenders that support this conceptualization. Therapeutic efforts to change characteristics of preference such as the preferred gender of one’s partner showed no effects, especially not in the long-term [14]. Regarding the possibility of therapeutically influencing characteristics such as the body scheme or the sexual practice preference, there is disagreement concerning the consistency; nonetheless, there has been no evidence so far as to the ability of changing this preference [15][13].

## **Aims of the Study**

The conclusion of Blanchard and colleagues [9] concerning hebephilia as an independent clinical phenomenon has been criticized among experts. Above all, their study lacks evidence of distress specific for this sexual preference. Clinically relevant distress could result from specific impairment of social functioning, but also from the perception of sexual fantasies with prepubertal or early pubertal minors. Since studies involving sexual offenders with a pedophilic preference disorder show a higher risk of recidivism for sexual abuse [16,17], the present study aims to examine to what extent hebephilia is associated with offenses such as child sexual abuse and the use of child abusive images. Given the fact that sexual preference is not equivalent to sexual behavior, this study furthermore investigates the presence of risk factors in hebephilia, such as socio-affective deficits and offense-supportive cognitions.

## **METHODS**

### **Procedure**

Between 2005 and 2011 men with problem awareness of their sexual interest towards children were reached by the help of a media campaign within the Prevention Project Dunkelfeld (PPD). It drew attention to the opportunity of making use of free, anonymous and confidential diagnostic expertise and qualified counseling, respectively therapy (compare Fig. 2).

*Fig. 2 Poster of the media campaign, which attracted help-seeking potential and undetected offenders who had a problem awareness and were motivated for treatment by offers in the Prevention Project Dunkelfeld (PPD). Conception: Scholz & Friends.*



Interested participants who contacted the PPD office via email or telephone were invited to a semi-structured clinical interview followed by a questionnaire measurement. Information on the individual's sexual preference was gathered during the clinical interview, additional information regarding criminal offense history was assessed by both the interview and the self-report questionnaires. All the data collected was anonymized [18]. All presented data was part of the research and therapy project PPD which had been approved by the ethics commission of the Charité – Universitätsmedizin Berlin.

## **Clinical Interview**

The main part of the sexological assessment is the comprehensive sexual anamnesis exploring the sexual preference of each PPD participant (compare [19], S. 513). Here, the exploration of the fantasized partner's body scheme during masturbation is of utmost importance. The category 'pedophilic' was assigned to men exclusively

fantasizing sexual interactions with partners of a prepubertal body scheme (Tanner stages 1); 'hebephilic' for fantasizing sexual interactions with partners of an early pubertal body scheme (Tanner stages 2 and 3); 'teleiophilic' for respective partners with a late pubertal/adult body scheme (Tanner stages 4 and 5). Hybrid forms like pedo-hebephilic, pedo-teleiophilic, hebe-teleiophilic, pedo-hebe-teleiophilic were coded corresponding to the respective combination.

## Measures

To assess the degree of distress and risk factors, following measures were used in this study:

*Brief Symptom Inventory (BSI, [20,21])*. The BSI measures subjective impairment in physical and psychological symptoms. As a short form of the Symptom Checklist (SCL-90-R) it can be used for screening purposes. 53 items with statements regarding symptom severity comprise nine subscales (somatization, compulsivity, insecurity in social contacts, depressivity, anxiety, aggressivity/hostility, phobic fear, paranoid thinking, psychoticism) and a global sum score.

*NEO Five-Factor Inventory*<sup>1</sup> (NEO-FFI, [22,23]). The NEO-FFI was developed to measure the basic factors of personality: neuroticism, extraversion, openness to experience, agreeableness and conscientiousness. Each of the 60 items was rated on a 5-point Likert-type scale. Higher scores indicate a higher extent of a certain personality factor. Norms were provided by a German standardization study [24].

*UCLA Loneliness Scale – revised (UCLA-LS-R, [25,26])*. The scale assesses problems ascribed to intimacy deficits and loneliness via 20 items, rated on a 4-point Likert-type scale. Higher scores indicate greater feelings of loneliness. Russell et al. (1980) reported normative data for a sample of male students.

*Coping Inventory for Stressful Situations (CISS [27,28])*. The inventory assesses emotional-, avoidance-, and task oriented coping styles in response to stress, with 24 items (8 items per scale). The present study focuses on the subscale "emotion-oriented coping style". Higher

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<sup>1</sup> Only in the beginning of the PPD (2005/2006) data from the NEO-FFI was gathered. Therefore for this personality questionnaire only a subsample of hebephilic project participants exists with a data set of  $n=37$ . Due to the small size of this sample no comparison between subtypes of hebephilic sexual preference was calculated but a comparison was made with sex related normative data.

scores indicate a stronger reaction with negative emotions in stressful situations, as well as a higher degree of self-preoccupation. Kälin [28] reported normative data for a sample of career starters.

*Bumby Molest Scale* (BMS; [29]). This 38-item scale is a measure of maladaptive cognitions and offense-supportive beliefs about children and sex with children, rated on a 4-point Likert-type scale. Higher scores indicate more offense-supportive attitudes and a greater tendency to justify sexual offending. Marshall and colleagues reported functional norms for a small male sample [30].

## **Sample**

Within a time period of six years, 1473 men contacted the project office. Clinical assessment was completed for 626 of these men. A sub-sample of 222 (35.3%) participants fulfilled the inclusion criteria of this study (diagnosed with pedophilia/or hebephilia), exhibited complete clinical diagnostic data and did not show any of the exclusion criteria (current involvement with the legal authorities because of child sexual abuse and/or child pornography offenses; untreated axis-I diagnoses).

Another clinical sub-sample of  $n = 23$  teleiophilic participants was used as a comparison group. These individuals were not diagnosed with pedophilia or hebephilia and did not meet any other exclusion criteria. Most of these teleiophilic men were parents or a close caring person for a child ( $n = 19$ ) and involved in a partnership. With respect to their currently undetected sexual offenses against children, the majority ( $n = 11$ ) admitted child sexual abuse offenses and five men had used child abusive images. The concerned men felt at risk to offend though they did not show a sexual preference of pedophilia or hebephilia according to the results of their clinical assessment. The experts rated the admitted offenses as acts by surrogate-type offenders, i.e. persons without any preference disorder. In these cases, no other exclusion criteria were met, such as previous legally registered offences, psychiatric diagnosis, mental retardation, drug abuse.

Table 1 shows the distribution of the clinical diagnoses of the 222 included participants. An exclusive preference for a certain body scheme was found in 46 (20.7%) participants who preferred a prepubertal body scheme (Tanner stage 1) only and 24 (10.8%)

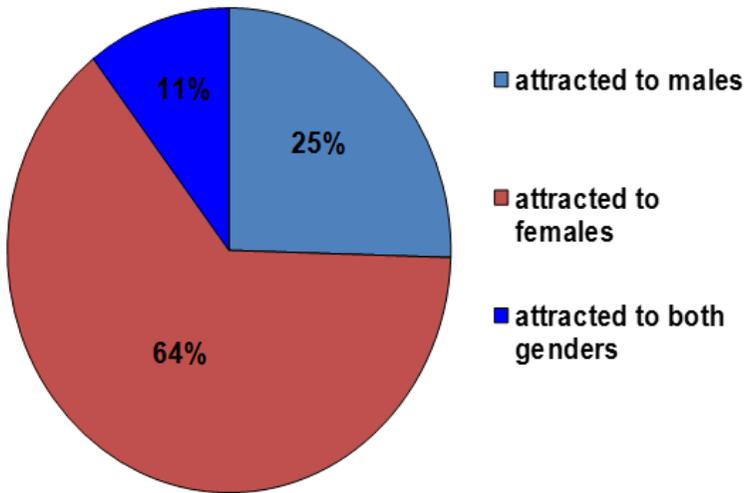
participants who preferred an early pubertal body scheme (Tanner stages 2 and 3) only. Mixed forms spread as follows: 14 (6.3%) pedo-hebephilic men, 23 (10.4%) pedo-teleiophilic, 46 (20.7%) pedo-hebe-teleiophilic and 69 (31.1%) hebe-teleiophilic.

In the sample, 153 participants responded exclusively or not exclusively to an early pubertal body scheme. The average age of this subgroup was 37.2 years (SD = 10.87, range: 18-66). Regarding their educational background and current income situation, 56.6% of the participants reported higher educational achievement (at least 11 school years) and approx. three-quarters (71.7%) reported to be employed or to study at a university. Furthermore, most of the men were single (57.5%), childless (70.6%) and living alone (56.6%). Half of the included project participants (54.0%) travelled, on average, more than 100 km to take part in the counseling and therapy sessions provided by the PPD.

## **RESULTS**

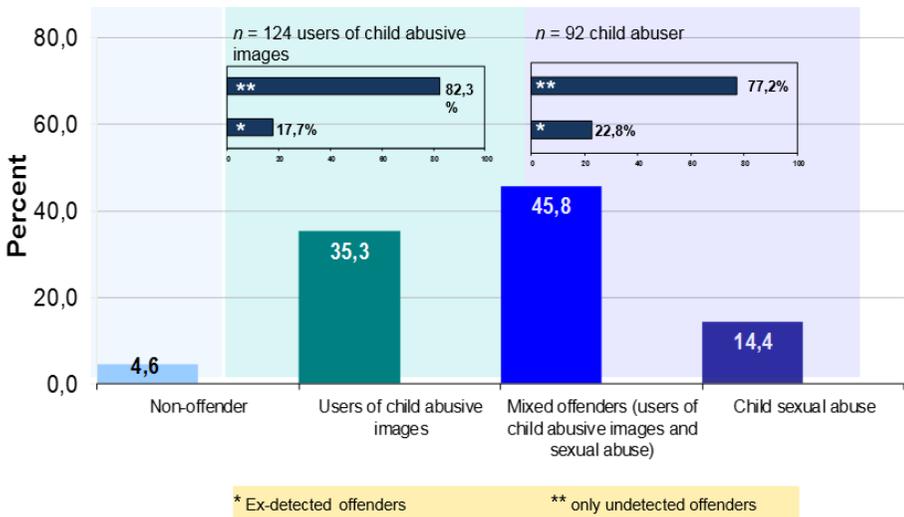
Concerning sexual preference according to the Berlin classification, it becomes clear that the preference for the early pubertal body scheme in its exclusive form is only found in a small part of the study population (n =24) and that a large part (n = 129) consists of mixed forms, i.e. the combination with prepubertal and/or late pubertal/adult body scheme. Of men with a sexual responsiveness to the early pubertal body scheme, the majority (64.1%) feels attracted to females, a quarter to males (25.5%) and 10.5% to both genders (compare Fig. 3).

Fig. 3. Sexual Orientation of Hebephilic Men (n = 153)



With regard to self-reported lifetime offense history, only 4.6% of men were without any offense at all. Approximately one third of this hebephilic sample (35.3%) used child abusive images exclusively, 14.4% had committed sexual assaults and a majority (45.8%) reported having used or to be currently using child abusive images as well as having committed sexual assault (compare Fig. 4). Approximately one fifth of all offenders had been prosecuted for the use of child abusive images (17.7%) and/or sexual assault of minors (22.8%) in the past. The vast majority of offenses and offenders were therefore not known to the authorities, i.e. in the juridical “dark field”. In an additional comparison on lifetime offense behaviors, diagnostic groups according to the Berlin Classification did not differ significantly.

Fig. 4. PPD participants with a sexual preference for minors with an early pubertal body scheme - classification according to lifetime offense history (n = 153)



## Distress and Behavior Moderating Characteristics

Differences between the subtypes of men with a hebephilic preference on the described psychometric measures were assessed with a non-parametric procedure for independent samples (Kruskal Wallis test). Applying a conservative level of significance ( $\alpha = .01$ ) no differences between these subtypes of hebephilic men were identified.

In a second step, again a non-parametric measure for independent samples (Kruskal Wallis test) was used to assess to what extent exclusive or non-exclusive hebephilic men differ from pedophilic and teleiophilic project participants concerning clinically relevant risk factors that may moderate their behaviors and the degree of distress.

Overall, significant group differences between the subtypes were found regarding self-reported emotional loneliness, offense-supportive cognitions and their current psychosomatic distress (Table 2).

After that, a pairwise comparison was calculated with the corresponding variables between all subtypes. Due to the high number of post-hoc single comparisons the p-values are reported Bonferoni-corrected for the significant results (significance  $\alpha = .05$ ), as well as the corresponding effect sizes. The size of statistical difference was measured by Cohen's d.

With regard to emotional loneliness, exclusively teleiophilic men reported significantly lower experience of loneliness than pedophilic ( $p = 0.001$ ,  $d = 0.99$ ) and hebephilic men ( $p = 0.046$ ,  $d = 0.87$ ). Teleiophilic men showed significantly less offense-supportive attitudes and cognitions than pedophilic ( $p = 0.000$ ,  $d = 1.16$ ), pedo-hebephilic ( $p = 0.001$ ,  $d = 1.44$ ) and pedo-teleiophilic project participants ( $p = 0.044$ ,  $d = 1.09$ ). Teleiophilic men furthermore reported lower psychosomatic distress during the last seven days in comparison to pedophilic ( $p = 0.005$ ,  $d = 1.13$ ), pedo-teleiophilic ( $p = 0.035$ ,  $d = 1.28$ ), pedo-hebe-teleiophilic ( $p = 0.005$ ,  $d = 1.15$ ) and to hebephilic project participants ( $p = 0.003$ ,  $d = 1.09$ ).

In a third step, means and standard deviation for the whole sample of hebephilic men ( $n = 153$ ) were calculated and compared to gender-related normative data using T-tests for independent samples. Thereby, significant differences were found in most clinical and risk variables (Table 3).

Hebephilic men from the PPD reported more acute symptom severity on all subscales of BSI in comparison to a male norm sample. For example, they reported more or more distinct symptoms regarding compulsivity, insecurity in social contact, depression, anxiety or psychoticism and showed a generally higher severity in clinical symptoms. Regarding personality characteristics a different pattern was revealed: hebephilic men from the PPD showed higher scores on the subscale “neuroticism” of the NEO-FFI in comparison to a male norm population, but lower scores on the subscales “extraversion” and “openness to experience”. Concerning characteristics of risk factors from research with detected offenders, it was found that hebephilic men from the PPD showed more emotional loneliness, a higher use of emotional coping mechanisms in difficult/stressful situations and more problematic attitudes in regard to sexual assault of children in comparison to the corresponding norm male sample.

## **DISCUSSION**

The present study showed that hebephilia can be discerned in a sample of help-seeking, self-referring men from the community and can correspond with factors of distress as demanded for a diagnosis of

a sexual preference disorder. From 2005 to 2011, a total of 153 men exhibiting this sexual preference were to look for therapeutic help in a publically advertised therapeutic offer under the slogan “Do you like children in ways you shouldn’t?” The analysis of diagnostic data from the PPD concluded that two thirds of males from the respective sample showed a responsiveness for the early pubertal body scheme - either in terms of an exclusive pattern (hebephilic type) or together with a responsiveness to the prepubertal body scheme (the pedo-hebephilic type), to the late pubertal/adult body scheme (the hebe-teleiophilic type) or to both body schemes (the pedo-hebe-teleiophilic type). The data of the present study showed no difference in the characteristics of distress factors between pedophilic and hebephilic subtypes on the one hand but a distinct difference to the teleiophilic men who had contacted the project on the other hand (i.e. those with a sexual responsiveness for a late pubertal/adult body scheme). The group of hebephilic men also showed significant differences to normal male comparison samples. Elevated scores in the subscales of the BSI indicated an acute severity of symptomatology within this group. Higher scores in the NEO-FFI concerning neuroticism revealed that hebephilic men more often tend to be emotionally unstable, nervous, anxious, sad and insecure and less capable of reacting appropriately in stressful situations. Furthermore, hebephilic men showed elevated scores in empirically relevant risk factors for child sexual abuse. Compared to data of functional males, hebephilic men within the PPD showed more emotional loneliness; more emotion-oriented coping in dealing with stressful situations (wishful thinking, drowning in self-pity, self-reproach, rumination) and stronger developed offense-supportive attitudes. Hebephilia (i.e. the sexual responsiveness toward the early pubertal body scheme; Tanner stages 2 and 3) thus appears as a sexual preference which can be distinguished from pedophilia (i.e. the sexual responsiveness for the prepubertal body scheme, Tanner stage 1) though accompanied by a similar degree of distress.

Following the criteria of the other paraphilias in ICD and DSM, the diagnosis of hebephilia and a hebephilic disorder can be justified by the data at hand. The DSM-5 [2] now designates that paraphilias are not principally seen as a disorder. The general criterion for the paraphilias now reads as “any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling

with phenotypically normal, physically mature, consenting human partners” [2, p. 685]. With hebephilia defined as sexually intense and persistent sexual interest in physically immature pubescent children at Tanner stages 2 and 3, this criterion is fulfilled. Paraphilic disorder in DSM-5 is specified as a “paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others.” [2, p. 685] Given the data presented in this study, both distress and impairment and risk of harm to others were present in the men bearing the hebephilic sexual interest. Criterion B was thus detectable in this sample, too. In DSM-5 such diagnosis can at best be coded under the residual category “Unspecified Paraphilic Disorder” (302.9) whereas in ICD-10 the category pedophilia (F65.4) comes into consideration (see above). A proposed alteration for the DSM-5 [33] for pedophilia would have met this missing level of differentiation. It was advised to differentiate between the pedophilic type (sexual responsiveness for prepubertal children – Tanner stage 1), the hebephilic type (sexual responsiveness for early pubertal children – Tanner stages 2 and 3) and the pedo-hebephilic type (sexual responsiveness for prepubertal and early pubertal children). In addition, according to DSM-5 it is not possible to explicitly capture the comparatively large group of hebe-teleiophilic men (in this study’s population represented with a proportion of 45%). Especially significant is that in most cases these men have acted out their preference with pubescent minors. While this study gives evidence for the clinical impact of a differentiation between pedophilia and hebephilia, future research should seek to verify further ramifications, e.g. for risk assessment.

As a general remark it appears unfortunately that Criterion A was not broadened to include the use of child abusive images (innocuously termed “child pornography”). This must be seen as a significant fail of chance, given that approximately 80% of the sample in this study admitted to the use of these materials which already before has been described as a valid indicator for a pedophilic inclination [34,35].

Decisive inclusion criteria in one of the groups were the revealed fantasies accompanying masturbation. Only if information concerning responsiveness to the different preferred body scheme(s) was at hand, an allocation to the various subtypes was possible. In this context it cannot be ruled out that the person being assessed unconsciously

emphasizes the conforming proportion more (i.e. the teleiophilic part) than it actually corresponds to his world of sexual experience, because he might be afraid of enhancing his pedophile or hebephile preference proportion. Furthermore, in the context of this study it has to be taken into account that assumptions can only be made about a help-seeking population and not about pedophiles and hebephiles in general. These could significantly differ from the examined sample. The criticism of Rind and Yuill [31] regarding the classification of hebephilia as a mental disorder has not been conclusively answered. Rind and Yuill examine hebephilia in regard to Wakefield's "Harmful Dysfunction" [32] model for mental disorders. According to this model, a variation of human behavior can only be classified as a mental disorder if there is a failure of an evolutionary functional mechanism. Against this background, Rind and Yuill came to the conclusion that sexual responsiveness toward the early pubertal body scheme alone cannot justify the view of hebephilia as a mental disorder. The present study does not allow causal conclusions as to what extent the distress found can be attributed to social stigmatization or an underlying dysfunction as determined earlier. Still, while Blanchard and colleagues [9] found statistical evidence for the discriminability of the constructs "hebephilia" and "pedophilia" [31], this study yields empirical evidence for an existing degree of distress, a higher severity of symptomatology and a higher risk for socially sanctioned behavior (use of child abusive images, sexual assault) associated with the sexual preference and responsiveness to the early pubertal body scheme.

A crucial limiting point in this study is that the preference structure was only gathered descriptively. To weight the preferred body schemes was not possible with the chosen procedure. Such weighting could be performed according, for example, to frequency or intensity of the corresponding content of fantasies. Two models of a dysfunction as described in the Wakefield's model [32] could be tested in future studies using a weighted assessment of preferred body scheme. On the one hand the absence of sexual responsiveness to the adult body scheme or on the other hand the limitation of sexual preference for only an early pubertal body scheme could be seen as an evolutionary dysfunction. The differences found between men with and without sexual responsiveness to the immature body scheme are indices for possible relevance but not evidence for such an explanation. Both

models comply with current tendencies in forensic sex research, that is, to distinguish sexual preference and sexual preference disorder as accounted for with the differentiation in paraphilia and paraphilic disorder in DSM-5. Further analysis of this question reaches beyond the extent of the present work and should be subject of further research.

Up to now, all data relating to this question had been collected in the “light field” (Hellfeld), i.e. from sexual offenders known to the authorities. The data from the PPD offered the opportunity of empirically describing hebephilia as a clinical phenomenon in the Dunkelfeld for the first time. This shows that hebephilia not only occurs as a phenomenon in convicted sexual offenders but can be discerned in men from the community as well. Given the differences to normal an clinical samples of teleiophiles lends further justification for its differentiation.

Concerning the update of the DSM (DSM-5) a category called „hebephilic disorder“ would have been appropriate, especially considering the given data which shows that in men with a hebephilic preference, who seek treatment, the disorder criteria of the DSM-5 (psychological distress, behavior endangering others) are given in many cases. In this respect there would be men with a hebephilia as well as men with a “hebephilic disorder”.

### **Implications for Clinical Practice**

Hebephilia, under certain circumstances, i.e. a clinically relevant degree of distress, meets the criteria of a sexual disorder and is potentially associated with endangerment of others. Hebephilia can readily be diagnosed through a clinical exploration as long as the patient has no interest in shielding his sexual experiences or behavior from others, as would be the case in offenders known to the authorities. In those not officially registered, i.e. in the Dunkelfeld, however, the experiences of the Berlin PPD have proven that self-motivated men, having turned to a specialized institution due to marked distress are, in most cases, highly cooperative and it is therefore assumable that characteristics of sexual preference can be successfully diagnosed by an exploration of sexual fantasies. From a clinical point of view it is not surprising that in this group of patients a correlation to diagnostically applicable activation patterns in imaging

procedures was found [3]. It is most unfortunate to face the fact that the chance of integrating hebephilia as a separate sexual disorder in the DSM-5 has been forfeited, although all relevant suggestions had been duly submitted.

It would also be wrong to suggest that pedophilia and hebephilia can simply be summarized. It is, on the contrary, necessary to assess both sexual preferences separately and then to categorize diagnostic allocations into the established disorder criteria. Even if in this study pedophilic disorders and hebephilic disorders showed more similarities than differences concerning several characteristics, this does not imply that a hebephilic disorder is not a disorder on its own. The crucial main difference concerns the responsiveness toward a certain body scheme (either the prepubertal or the early pubertal one), which is particularly relevant, as it may determine behavior directed towards minors of the preferred body scheme as well as the use of sexually abusive images depicting those minors. Clinically there are exclusive type pedophiles who would never be attracted by early pubertal minors as there are exclusive type hebephiles who would never be attracted by prepubertal minors. Despite the fact that the groups do not differ concerning their lifetime offense behaviors in general, they do, however, differ in terms of the body scheme of their victims, as has been shown in an earlier study in participants from the PPD, investigating their behavior with respect to the use of sexually abusive images. Men with a pedophilic preference significantly more often use imagery depicting children than men with a hebephilic inclination [36]. Evaluations based on a larger sample will be the subject of a separate publication.

Furthermore, experiences from the Berlin PPD indicate that a large number of men with sexual responsiveness to the early pubertal body scheme, who are suffering by their preference, feel impaired in social relationships and/or have acted according to their preference (sexual assault and/or use of child abusive images). This opens a window for preventive therapy aiming at behavioral control. It is most appropriate that the health care system catches on to this group of patients to initiate preventive therapeutic measures for behavior control. This helps to eradicate the flaw and increases the protection of children and adolescents concerning sexual abuse of any kind.

## Tables

**Table 1.** Sexual preference according the Berlin classification of all included PPD participants ( $N = 222$ ).

	Frequency ( $n$ )	Percent (%)
Pedophilia	46	20.7
<del>Pedo-Hebephilia</del>	14	6.3
<del>Pedo-Teleiophilia</del>	23	10.5
<del>Pedo-Hebe-Teleiophilia</del>	46	20.7
Hebephilia	24	10.8
Hebe- <del>Teleiophilia</del>	69	31.1
Total	222	100

**Table 2.** Kruskal-Wallis - Tests for group comparisons on relevant risk factors following sexual preference diagnostic ( $N = 245$ )

	Pedophilic ( $n = 46$ )	Pedo- Hebephilic ( $n = 14$ )	Pedo- Teleiophilic ( $n = 23$ )	Pedo-Hebe- Teleiophilic ( $n = 46$ )	Hebephilic ( $n = 24$ )	Hebe- Teleiophilic ( $n = 69$ )	Teleiophilic ( $n = 23$ )		
	$M (SD)$	$M (SD)$	$M (SD)$	$M (SD)$	$M (SD)$	$M (SD)$	$M (SD)$	$X^2(6)$	$p$
<b>Risk Factors</b>									
UCLA – Emotional Loneliness	52.11 (12.83)	51.21 (13.29)	49.34 (13.97)	48.33 (10.44)	50.46 (12.80)	45.59 (10.77)	39.65 (12.46)	19.84	0.003
CISS – Emotion-oriented Coping Strategies	25.43 (5.37)	27.79 (5.12)	27.09 (5.30)	26.48 (6.39)	25.79 (5.44)	25.64 (5.76)	24.00 (5.49)	5.87	0.438
BMS – Offense-supportive Cognitions	75.24 (20.83)	78.50 (20.59)	69.78 (14.94)	67.28 (18.13)	69.25 (20.01)	65.61 (17.09)	53.00 (16.53)	24.62	0.000
BSI – Global Symptom Burden	0.96 (0.56)	1.05 (0.53)	0.95 (0.53)	0.96 (0.55)	1.06 (0.79)	0.80 (0.58)	0.42 (0.28)	22.68	0.001

**Table 3.** Comparative standard clinical variables and dynamic risk factors for the partial sample of men with hebephilic sexual preference ( $N = 153$ )

	PPD participants with hebephilic preference		Standard or comparative sample	
	<i>M (SD)</i>	<i>N (Source)</i>	<i>M (SD)</i>	<i>t (df)</i>
<b>Brief Symptom Inventory</b>		300 (Franke, 2000)		
BSI - Somatization	0.52 (0.60)		0.23 (0.31)	6.76*** (448)
BSI – Obsessive-compulsive	1.16 (0.84)		0.50 (0.46)	10.76*** (448)
BSI – Interpersonal Sensitivity	1.11 (0.81)		0.35 (0.40)	13.33*** (448)
BSI – Depression	1.34 (0.98)		0.24 (0.32)	17.66*** (448)
BSI – Anxiety	0.93 (0.73)		0.29 (0.31)	13.03*** (448)
BSI – Hostility	0.72 (0.60)		0.29 (0.35)	9.58*** (448)
BSI – Phobic Anxiety	0.50 (0.60)		0.14 (0.23)	9.14*** (448)
BSI – Paranoid Ideation	0.75 (0.75)		0.33 (0.40)	7.75*** (448)
BSI – Psychoticism	1.04 (0.84)		0.19 (0.28)	15.87*** (448)
BSI – General Severity Index	0.91 (0.61)		0.28 (0.23)	15.80*** (448)

<b>NEO – Five Factor Inventory<sup>a</sup></b>		193 (Borkenau & Ostendorf, 1993)	
NEO-FFI Neuroticism	2.10 (0.76)	1.66 (0.67)	3.58*** (228)
NEO-FFI Extraversion	2.00 (0.65)	2.34 (0.56)	3.29** (228)
NEO-FFI Openness to Experiences	2.39 (0.52)	2.65 (0.53)	2.74** (228)
NEO-FFI Compatibility	2.44 (0.52)	2.35 (0.52)	0.96 (228)
NEO-FFI Conscientiousness	2.43 (0.59)	2.56 (0.62)	1.18 (228)
<b>Dynamic risk factors</b>			
UCLA – Emotional Loneliness		102 (Russel et al. 1980)	
	47.69 (11.34)	37.06 (10.91)	7.44*** (253)
CISS – Emotion-oriented Coping Strategies		505 (Kaelin 1995)	
	26.13 (5.83)	23.12 (5.44)	5.82*** (656)
BMS – Offense-supportive Cognitions		30 (Marshall et al., 2003)	
	67.86 (18.38)	51.80 (10.39)	4.64*** (181)

Note \* $p < .05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$

a. For this measure, only data of a PPD subsample ( $n = 37$ ) was available.

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