

“Compulsive Rapism”: Psychiatric Approaches to Sexual Violence in the 1980s

By

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ABBREVIATIONS

AAPL: American Association of Psychiatry and the Law
ACLU: American Civil Liberties Union
APA: American Psychiatric Association*
CSA: Child Sexual Abuse
CSC: Child Sensuality Circle
CSW: Christopher Street West
DSM: Diagnostic and Statistical Manual of Mental Illnesses
GAA: Gay Activists Alliance
GID: Gender Identity Disorder
GLAD: Gay and Lesbian Advocates and Defenders
ERA: Equal Rights Amendment
DDPD: Delusional Dominating Personality Disorder
DSM: Diagnostic and Statistical Manual of Mental Illnesses
ILGA: International Lesbian and Gay Association
LLPD: Late Luteal Phase Disorder (another name for PMDD)
MDSO: Mentally Disordered Sex Offender
MPD: Masochistic Personality Disorder (another name for SDPD)
NAMBLA: North American Association for Man/boy Love
NASW: National Association of Social Workers
NOS: Not Otherwise Specified (a DSM code for unlisted disorders)
NOW: National Organization for Women
ORTHO: American Orthopsychiatric Association
PCD: Paraphilic Coercive Disorder
PIE: Pedophile Information Exchange
PMDD and PDD (both are used in the literature): Premenstrual Dysphoric Disorder
PMS: Premenstrual Syndrome
PTSD: Post Traumatic Stress Disorder
SDPD: Self-Defeating Personality Disorder
SPD: Sadistic Personality Disorder
SSSS: Society for the Scientific Study of Sexuality
SVP: Sexually Violent Predator
WAP: Women Against Pornography

* APA also stands for the American Psychological Association. To avoid confusion, however, APA is only used in reference to the American Psychiatric Association and American Psychological Association will be written out in full.

Introduction

In 1984, America's premier treatment center for sex offenders claimed its clinicians had been able to rehabilitate 95% of the sex offenders that walked through its doors.¹ Just 6 years later, the center would shut down in the wake of numerous controversies.² In those intervening years, the American Psychiatric Association would try to formally diagnose sex offenders as mentally ill, via the introduction of a disorder called first "compulsive rapism" and eventually "paraphilic coercive disorder" (or PCD). This diagnosis would become a public relations nightmare, as women's advocates launched a very vocal campaign against the APA. At the same time, one group of sex offenders—pedophiles—would launch an increasingly vocal social movement of their own, and in turn become a public relations nightmare for the gay rights movement to which they tried to attach themselves. This dissertation traces various psychiatric attempts to treat and classify sex offenders, and the broader cultural discourse (feminist, legal, popular, and even pedophilic) around sex offenses that grew out of it.

Over the course of the 1980s, sexual violence became an increasingly public topic, as a variety of factors forced Americans to grapple with changing sexual mores. For decades, various groups had been attempting to widen what forms of sexuality were acceptable—from the Free Love movement of the 1960s, to the gay liberation movement of the 1970s, to the women's

¹ Gerri Kobren, "Sexual Deviancy: Clinic at Hopkins Fills a Need," *The Sun* (Feb 29, 1984). See chapter 3 for more discussion of these numbers—Berlin [who?] used different numbers at different times and the 5% rate is taken from the article listed here and various other statements he made to the press throughout the late 1970s-early 1980s (that 17 of 20 men had been rehabilitated, that 114 out of 120 had been rehabilitated, etc). It's worth noting here that the national recidivism rate for sex offenders at that time was believed to be 70-80%. The claim that this treatment center's failure rate was a mere 5% suggested an overwhelming success.

² The Johns Hopkins clinic closed down in 1990 or 1991, and Berlin (its lead psychiatrist) went into private practice treating sex offenders.

movement of the 1980s. Alongside this, the women's movement had raised questions about the nature, frequency and stakes of sexual violence—rather than being a rare occurrence committed by deviants, they argued that it was all too common and was reflective of commonly held American ideas about gender. Historically, such questions about the order of things (here, what kinds of sex were acceptable and unacceptable, alongside gender more generally) have come with renewed attention to marginal sexualities.³ The 1980s were no exception to this rule, and the multitude of social changes taking place resulted in sexual violence gaining newfound importance as a topic of discussion for the public, lawmakers, psychiatrists, and activists. The debate that ensued demonstrates the openness of this cultural moment—while the earlier debates over sex crime discussed by historians such as George Chauncey and Estelle Freedman involved the public, they ultimately hinged on expert knowledge from psychiatrists or legislators. During the 1980s, however, a more wide-ranging group of actors managed to present themselves as legitimate stakeholders and to shape the debate in meaningful ways (though not always the ways such groups would have liked, as in NAMBLA's case). At the same time, the result of these debates demonstrates that the difficulties of engaging across professional and theoretical divides could be insurmountable—despite attempts at engagement between feminists and psychiatrists or psychiatrists and the courts, sustained and productive collaboration rarely resulted.

In particular, this dissertation concentrates on the battle between psychiatric and feminist definitions of sexual violence. By this time, feminists had come to believe that sexual violence was an epidemic facing women (and, to some extent, children). Women's advocates worked

³ George Chauncey, "The Postwar Sex Crime Panic," in William Graebner, ed., *True Stories from the American Past* (McGraw-Hill, 1993); Estelle Freedman, "'Uncontrolled Desires': The Response to the Sexual Psychopath, 1920-1960," in Kathy Peiss and Christina Simmons, eds., *Passion and Power: Sexuality in History* (Temple University Press, 1989).

tirelessly in the 1980s to redefine rape as an act of violence rather than one of sex. This argument hinged on an understanding of gender roles as largely sociological—men and women were socialized in vastly different ways and the product of this socialization was a patriarchal system in which men expressed their dominance over women through acts of violence. This model was predicated on a very specific image of sexual violence: men were perpetrators and women were victims. While feminists and other observers increasingly acknowledged the existence of male victims, such victims played little role in the explanatory theories of sexual violence. Female perpetrators were essentially nonexistent. Here, sexual violence was not materially different from other forms of male violence against women—rape and domestic violence were similarly rooted in men’s socialization and women’s subjugation. Accordingly, solving the issue of sexual violence required wide-ranging changes in culture, the law, and other arenas.

For psychiatrists, however, sexual violence was a more specific problem and one that might be dealt with through psychiatric means. Attempts to research and theorize sexual violence—with PCD among those attempts—were simultaneously attempts to treat sexual violence by treating sex offenders. Psychiatrists involved in this type of work would consistently argue that existing solutions for sexual violence were not sufficient—incarceration did not solve the underlying disposition of the sex offender, and therefore neither did feminist legal advocacy that pushed for higher conviction rates—whereas psychiatric treatment might offer a more productive way forward in the long-term.

A striking part of this story is that feminists and many of the psychiatrists working with sex offenders at that time thought about rape in remarkably similar ways. Indeed, the psychiatrists responsible for PCD espoused a framework much indebted to feminist thought: PCD was the extreme outgrowth of a social order that required men to be aggressive and

portrayed women as inferior. Even treatment suggestions mirrored feminist discourse: one psychiatrist proposed “empathy training” for rapists, in order to help them see women as people. While feminists and psychiatrists rarely agreed completely, their interpretations of sexual violence existed along a spectrum, from purely social to purely individual/pathological. Psychiatrists working with sex offenders typically thought of sex offenders as pathologically motivated, but generally believed that social messages about gender played a significant role in those pathologies. In other words, pathology was not purely an individual question—both social and individual factors (biology included) produced mental illnesses.

By 1986, however, feminists would conceive of psychiatric theories of sexual violence as directly oppositional to feminist theories—there was no spectrum, but instead an insurmountable division. That year, feminist opposition to the diagnosis had reached a fever pitch: thousands of letters of protest poured into the APA, and the diagnosis was ultimately dropped from the *DSM* that year. Ultimately, there would be no middle ground between these two groups. Despite some theoretical similarities, feminist advocates perceived the concept of PCD as being directly oppositional to their work—feminist theories of gender and sexual violence were increasingly gaining public traction and psychiatrists’ attempts to put forward their own oppositional definition threatened a key pillar of the women’s movement. Meanwhile, psychiatrists occasionally acknowledged feminist criticism, but only in superficial ways—such criticism was rarely used to fundamentally rethink psychiatric approaches to sexual violence. While both groups were in search of a way to deal with sexual violence, and while they shared a number of assumptions about sex offenses, the two groups would talk past one another rather than work together toward a joint solution.

This dissertation argues that these two groups became caught up in a shortsighted political battle that focused on somewhat semantic differences (rape as sex versus rape as violence, when in reality both groups weighed both factors) and legal questions (how rape-as-mental-illness would affect conviction rates), rather than working together to offer alternative solutions to America's problem with sexual violence. This debate ultimately distracted from the issue of how society could best deal with rape, and became instead a space for both groups to talk about gender roles, and the importance of socialization in shaping mental illness.

Literature Review

This dissertation draws primarily on two bodies of literature: work on the history of science and social movements, and work on sexual violence specifically.

Historians of American psychiatry have increasingly focused on how social roles (gender, sexuality, race) influence diagnostic criteria. Some of the most incisive work in the history of psychiatry over the last few decades has focused on homosexuality's status as a mental illness prior to 1973.⁴ These works have examined the role of social movements and organized interest groups in constructing and influencing psychiatric theories. In the case of homosexuality, interest groups (or, to use sociologist Peter Conrad's terminology, organized lay interests⁵) lobbied the APA to delete homosexuality as a mental disorder from the *Diagnostic and Statistical Manual of Mental Illnesses (DSM)*. Other groups have lobbied in favor of various disorders—in particular, the debate over Premenstrual Dysphoric Disorder (PMDD in the psychiatric literature, and

⁴ Jennifer Terry, *An American Obsession: Science, Medicine and Homosexuality*, 1st ed. (University of Chicago Press, 1999); Steve Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (University of California Press, 1996); Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton University Press, 1987).

⁵ Peter Conrad and Joseph Schneider, *Deviance and Medicalization: From Badness to Sickness* (Temple University Press, 1992).

Premenstrual Syndrome or PMS in popular culture) as a mental illness drew many such organized lay interests, both for and against the concept.⁶ Anne Figert's book on this topic demonstrates the cleavages in opinions among these lay interests, as well as among the scientific parties involved. Figert argues that the attitudes towards PMS relied on broader opinions about gender, medicalization, and professional roles (in the context of PMS, this meant an ongoing battle between gynecologists, endocrinologists and psychiatrists over who was best suited to define the concept of PMS). Such schisms among scientists have been important in creating scientific knowledge—Steven Epstein argues that “knowledge emerges out of credibility struggles” and Elizabeth Armstrong that dissenting views, even if they are never widely adopted, are crucial in constructing scientific knowledge, particularly in regard to disorders with strong social components (rather than those conceived of as primarily rooted in brain chemistry).⁷ This dissertation draws on that framework, and argues that the battle over PCD (from both the interested laity and mental health professionals for and against the diagnosis) was instrumental in constructing psychiatric opinions about sexual violence, and also became an important site in which women's advocates advanced their own ideas about sexual violence and gender more broadly. In addition to suggesting that psychiatrists were rightful stakeholders in the debate over

⁶ Anne Figert, “Women and the Ownership of PMS: The Structuring of a Psychiatric Disorder” (Aldine Press, 1996); C. Amanda Rittenhouse, “The Emergence of Premenstrual Syndrome as a Social Problem,” *Social Problems* 38 (1991).

⁷ Epstein, *Impure Science*, 3. See also: Elizabeth Armstrong, *Conceiving Risk, Bearing Responsibility: Fetal Alcohol Syndrome and the Diagnosis of Moral Disorder* (Johns Hopkins University Press: 2008). The distinction between socially-derived and biologically-derived mental illnesses is constantly changing, as psychiatric knowledge changes. For instance, most people think of schizophrenia as an imbalance in brain chemistry today. Prior to the 1950s (when neuroscientific knowledge leapt forward), however, schizophrenia was believed to have a great deal to do with socialization. Even today, that distinction is fuzzy—it's increasingly clear that schizophrenia has both genetic and environmental causes. A similar history could be given of homosexuality and the move from social understandings to increasingly genetic and brain-based ones over the course of the twentieth century.

sexual violence, the APA's backing of PCD flattened out differing psychiatric opinions about sex offenses. The battle over PCD increased psychiatry's public role in broader social discussions about sexual violence, but also empowered a relatively small group of psychiatrists to speak. As well, by launching into such a highly politicized fray in which feminism clearly had a stake, the APA inadvertently allowed feminists the space to suggest that the APA was less than credible as an organization.

In keeping with this framework, my dissertation examines the process by which psychiatric diagnoses come to be accepted or rejected. It thus necessarily deals with the question of scientific objectivity, which haunted psychiatrists at a time when few psychiatric diagnoses were rigorously supported, but when empiricism (or at least the language and appearance of empiricism⁸) was becoming increasingly important. I argue that this shift was particularly difficult for psychiatrists working on sexual disorders. This was because the majority of disorders listed within the paraphilias section of the *DSM* relied on small case studies and speculative theorizing rather than long-term or large-scale empirical studies. In this context, PCD became a staging ground for this question. While other paraphilias might not be controversial enough to warrant questions about their objectivity from outside the psychiatric sphere, sexual violence was enough of a public topic that PCD could not be justified without more empirical backing. I argue that the APA's ultimate rejection of the formulation rape-as-mental-illness was an attempt to circumvent the difficult question of objectivity in sexual diagnoses.

As well, many of the foregoing historians have noted the APA's often baffling responses to social pressures. This surfaces sharply in the literature on the depathologization of homosexuality. Scholars note the ways in which the APA was sympathetic enough to activists in

⁸ On this (and the *DSM* itself as a site of contention), see Stuart A. Kirk and Herb Kutchins, *The Selling of DSM: The Rhetoric of Science in Psychiatry* (Aldine de Gruyter, 1992).

the 1970s to withdraw homosexuality as a diagnosis, yet not sympathetic enough to forego replacing it with the theoretically unsound “ego dystonic homosexuality.” In brief, if a patient was gay and believed that their gayness was a mental illness, a clinician could diagnose them as mentally ill due to their gayness; the disorder acted as a workaround that attempted to satisfy gay rights activists as well as those psychiatrists who sincerely believed that homosexuality was indeed a mental illness. Much to the APA’s surprise, the replacement disorder pleased neither of these groups—gay rights activists saw it as precisely what it was (a way to continue diagnosing gay men and women as mentally ill) and clinicians who did not agree with the deletion of homosexuality saw it as a stopgap that proved that the APA had merely capitulated to political pressure in deleting homosexuality.

The APA’s response to the controversy over PCD is in keeping with this larger history. The organization was sympathetic enough to women’s advocates’ criticisms to withdraw the disorder, but not sensitive enough to engage with the larger conversation protesters wished to have—they had no wish to discuss whether sex offenders were primarily motivated by hatred of women versus biology nor whether sex offenders were fundamentally different from average men versus emblematic of American masculinity. And, as with the battle over homosexuality, the APA’s solution pleased no one: those who supported PCD (and, before it, homosexuality) as a diagnosis felt the organization’s leadership had sold out to political pressure. Those who didn’t support either diagnosis felt the APA was making surface-level changes without engaging with deeper criticisms about the objectivity of the *DSM* and the insularity of the APA’s process. As such, the saga of PCD adds to the literature on the APA’s political modus operandi—limited engagement, superficial changes, and a hope that these two pieces would allow any public controversies to blow over of their own accord. That the APA is still involved in similar

controversies (and has consistently been since the 1990s) is no surprise—most notably, the organization has used similar tactics in the face of controversy over Gender Identity Disorder.⁹

The literature on sexual violence is voluminous, and much has been written by feminist scholars in particular. Historians have documented the ways in which women, and particularly black women, have been constructed as willing rape victims.¹⁰ As well, feminist scholars have discussed rape as an act of violence dependent upon male socialization—Susan Brownmiller’s foundational *Against Our Will* is notable here, as is Diana Russell’s work.¹¹ Feminist scholars have been particularly concerned with legislation surrounding rape—the relatively low percentage of rape cases that end in convictions—and the ways in which various social institutions (legal, medical) often re-victimize women.¹² Ann Wolbert Burgess (a nurse and colleague of one of the better-known psychiatrists working with sex offenders) is a notable early scholar on this topic and lobbied extensively for medical professionals to be more sensitive towards rape victims during medical examinations. Burgess would go on to found one of the first hospital-based crisis counseling programs at Boston City Hospital in the mid-1970s and to publish extensively on the subject.¹³

⁹ Karl Edward Bryant, “The Politics of Pathology and the Making of Gender Identity Disorder (unpublished dissertation, University of California—Santa Barbara, 2007).

¹⁰ Angela Davis is one of the earlier writers on this topic; see her article, “Rape, Racism and the Myth of the Black Rapist” in Davis’ *Women, Race & Class* (Random House, 1981). Sociologist Patricia Hill Collins is a more recent scholar on this subject; see Collins’ *Black Sexual Politics: African Americans, Gender, and the New Racism* (Routledge, 2004).

¹¹ Susan Brownmiller, *Against Our Will: Men, Women and Rape* (Bantam Books, 1975); Diana Russell, *The Politics of Rape* (Stein and Day, 1975).

¹² For a discussion of revictimization in the legal sphere, see Vivian Berger, “Man’s Trial, Woman’s Tribulation: Rape Cases in the Courtroom,” *Columbia Law Review* 77, no. 1 (Jan. 1977). Berger’s article is one of the earliest scholarly discussions of rape shield laws.

¹³ See Robert R. Hazlewood and Burgess, *Practical Rape* (New York, NY: Elsevier), 1987. This manual has been updated 4 times and remains a popular resource for legal and mental health professionals.

Historians of the women's movement have cited a marked shift from the late-1970s radicalism that characterized grassroots feminism to the liberal politics that characterized feminism as it gained political traction in the 1980s.¹⁴ Of particular interest to the history and politics of sexual violence is Rose Corrigan's work on anti-rape activism in the late twentieth century.¹⁵ Corrigan argues that this shift from radicalism to liberalism proved detrimental in a few ways, despite the significant strides made by anti-rape activists. By sloughing off a more radical critique that rooted sexual violence in gendered inequality, activists in the liberal tradition have focused on state responses to rape. These responses now provide additional legal and medical ways to deal with rape (most notably, training for professionals on how to approach rape victims sensitively, as well as legal reforms concerning the definition of rape and how rape cases

¹⁴ A similar story can be told of the shift from gay liberation movement to the gay rights movement. Chapter 4 discusses this from the viewpoint of one group—NAMBLA—trying to latch onto the freewheeling gay liberation movement and ultimately being ejected from the more narrowly-conceived gay rights movement. A number of contemporary observers criticized this shift; see Gayle Rubin, "Sexual Politics: The New Right & the Sexual Fringe," originally in *The Leaping Lesbian*, republished in *MAGPIE* 16 (Autumn 1981); Pat Califia, "Women Against the New Puritans," *The Advocate* (Oct 30, 1980). Observers at the time were well aware of the pushing out of pedophile advocates as part of this shift; see: "Douglas Sanders, "Getting Lesbian and Gay Issues on the International Human Rights Agenda," *Human Rights Quarterly* 18, no. 1 (February 1996); Joshua Gamson, "Messages of Exclusion: Gender, Movements, and Symbolic Boundaries," *Gender and Society* 11, no. 2 (April 1997). For historical discussions of this shift (and the role pedophilia played in it), see: Gillian Frank, "'The Civil Rights of Parents': Race and Conservative Politics in Anita Bryant's Campaign against Gay Rights in 1970s Florida," *Journal of the History of Sexuality* 22, no. 1 (January 2013); Patrick McCreery, "Miami Vice: Anita Bryant, Gay Rights and Child Protectionism" (unpublished dissertation, New York University: 2009).

¹⁵ Rose Corrigan, *Up Against a Wall: Rape Reform and the Failure of Success* (NYU Press, 2013). Corrigan also argues that many of the touted legislative successes of the anti-rape movement belie a more incomplete reform movement: the problems cited by feminists in the 1980s (poor treatment of victims by law enforcement and medical professionals) still exist today. Kristen Bumiller has put forward a related argument that the feminist movement against sexual violence has been complicit in growth of a "criminalized society," which targets and over-incarcerates minorities and immigrants and which, paradoxically, scrutinizes those women who are subject to the welfare state. See: Bumiller's *In an Abusive State: How Neoliberalism Appropriated the Feminist Movement Against Sexual Violence* (Duke University Press, 2008).

are prosecuted), but little in the way of radical reform. In other words, while such reforms might help individual rape victims, none were geared at fundamentally overthrowing a system of male domination—regardless of how kindly a doctor approached a rape victim, the underlying issue (sexual violence as a manifestation of male dominance) remained. As well, Corrigan argues that state systems actively undermine radical feminist theories about sexual violence—legislative systems focus, structurally, on individual claims rather than broader social ones and thus put forward a view of rape as an individualized crime. This dissertation offers additional evidence in favor of Corrigan’s central thesis: just as this legalistic approach undermined some of its own goals, women’s advocates protesting PCD undermined potentially beneficial treatment programs for sex offenders in favor of concentrating on legislative questions regarding conviction rates.

In addition to these explicitly feminist works, a handful of historians have discussed sex crimes and criminals in the 20th century.¹⁶ These authors argue that society has often used sexual violence as a surrogate to address (or, in some cases, suppress) deeper fears—rather than merely responding to concerns for the victims of sexual violence, public discourse around sexual violence has historically represented a moral panic that was as much concerned about broader ideas of gender and sexuality as about victims and perpetrators. Estelle Freedman cites a shift from the Victorian image of women as pure and asexual to the twentieth century image of women as sexual. This shift necessitated that society redraw the boundaries around appropriate sexual behavior—by constructing and vehemently condemning the sexual psychopath,

¹⁶ See Estelle Freedman, “‘Uncontrolled Desires’: The Response to the Sexual Psychopath, 1920-1960,” in Kathy Peiss and Christina Simmons, eds., *Passion and Power: Sexuality in History* (Temple University Press, 1989); Stephen Robertson, “Separating the Men from the Boys: Masculinity, Psychosexual Development, and Sex Crimes in the United States, 1930s-1960s,” *Journal of the History of Medicine and Allied Sciences* 56, no. 1 (January 2001); George Chauncey, “The Postwar Sex Crime Panic” in William Graebner, ed., *True Stories from the American Past* (McGraw-Hill, 1993); Philip Jenkins, *Moral Panic: Changing Concepts of the Child Molester in Modern America* (Yale University Press, 1998).

Americans simultaneously marked sexual violence as wrong and non-violent forms of sex (many of which would have been condemned by Victorians) as acceptable. Likewise, Philip Jenkins cites growing public awareness about child sexual abuse (due largely to advocacy from the women's movement) in the 1980s and 1990s. To anti-child abuse advocates, it was clear that the majority of offenders were individuals who knew their victims—family members and family friends. Jenkins argues that the “stranger danger” panic of the 1990s was a way to redirect these fears about familial child sexual abuse onto a nebulous stranger, thus preserving the safety and sanctity of the family.¹⁷

In addition to discussions of specific sex crime panics, a few authors have focused on legislation surrounding sex crimes and the role of psychiatric knowledge in such legislation.¹⁸ Most of this literature focuses on individual jurisdictions—for instance, Simon A. Cole looks at New Jersey, Stephen Robertson at New York City, and Chrysanthi S. Leon at California (although Leon does discuss broader national trends).¹⁹ These authors generally argue that legislative responses to mentally ill sex offenders have changed radically over the course of the 20th century: from the 1950s until 1980, courts were predisposed towards treating sex offenders,

¹⁷ See Jenkins, *Moral Panic*. Stephen Robertson also argues that public concern over child sexual abuse was, in part, a response to modern views of childhood sexuality—the sex crime panic was a way to reassert the existence of childhood innocence by placing the source of child sexuality onto sex criminals rather than children themselves (Robertson, “Separating the Men from the Boys”). Levine makes a similar argument, albeit from a less historical and more activist standpoint, in *Harmful to Minors: The Perils of Protecting Children from Sex* (University of Minnesota Press, 2002).

¹⁸ Simon A. Cole, “From the Sexual Psychopath Statute to ‘Meagan’s Law’: Psychiatric Knowledge in the Diagnosis, Treatment and Adjudication of Sex Criminals in New Jersey, 1949-1999,” *Journal of the History of Medicine and the Allied Sciences* 56, no. 1 (July 2000);

¹⁹ Cole, “From the Sexual Psychopath;” Stephen Robertson, *Crimes Against Children: Sexual Violence and Legal Culture in New York City, 1880-1960* (Chapel Hill, NC: University of North Carolina Press, 2005); Chrysanthi S. Leon, *Sex Fiends, Perverts, and Pedophiles: Understanding Sex Crime Policy in America* (NYU Press, 2011). Leon takes California as a test case, but offers a more comprehensive view of sex crime legislation than the other authors listed here.

and from 1980 onward to punishing them. Leon offers a more comprehensive view of sex crime legislation. While she, like the authors discussed above, argues for a rapid shift from rehabilitation to punishment, she also argues that both eras offered rhetoric that they failed to live up to—the rehabilitation era offered little in the way of actual rehabilitation, and the tough on crime era offered punitive policies that looked good on paper but failed to adequately address the nature of sex crimes (and in some cases, supported legislation that actively undermined public safety).²⁰ Although I follow Leon’s framework that the rhetoric and results of sex crime legislation don’t always match up, I argue that this timeline downplays the upheaval of the early 1980s. Such upheaval is important in that it set the stage for later developments like the Sexually Violent Predator laws of the 1990s. In addition, these connections suggest that legal discussions surrounding sexual violence in the 1980s produced many specific statutory changes, but failed to solve broader issues affecting the entanglement of psychiatry and the law.

In all, I argue that the 1980s were an extraordinarily open moment where discourse on sexual violence flourished through the participation of numerous actors and domains. But while my work supports historical arguments regarding the ability of lay actors to affect institutions and theories (as did, in this case, feminists with psychiatry), I argue that this type of engagement is often limited. As much as the APA has been a target for social and political activists, the organization has been persistently insular. Even in moments when engagement peaked, there were ongoing attempts to withdraw—the APA’s deletion of PCD and the other controversial disorders was as much an attempt to stave off further criticism as it was an honest attempt to respond to and engage with the APA’s critics. Historians have discussed many instances where organizations like the APA have become entangled in sociopolitical debates, whether over

specific diagnoses (homosexuality, gender identity disorder) or over broader theoretical questions (feminism, anti-psychiatry). My argument here is that such scholarship has underplayed the difficulties that accompany such moments, and the ways in which these moments of upheaval often fail to translate into longer-term engagement or change. In this specific case, the difficulties of dealing with sexual violence, the role of gender and socialization within psychiatry, and the increasing overlap between psychiatry and the law would remain persistent issues throughout and after the 1980s. Though the debates discussed here grappled with these broad issues, they never fully solved them. Moreover, the very openness that allowed these discussions to flourish had a counterproductive effect: despite offering a wealth of differing opinions, each domain found it difficult to engage across its own professional and theoretical boundaries.

Chapter Outline

Chapter 1 chronicles the APA's attempt to introduce PCD into the *Diagnostic and Statistical Manual of Mental Illnesses (DSM)*, the organization's listing of mental disorders. This grew out of broader attempts to expand the *DSM*, along with the arenas over which psychiatrists had power. Psychiatric work with sex offenders was, at this moment, often based on exigency—psychiatrists working on other types of sexual disorders increasingly found themselves with patients who expressed desires to commit acts of sexual violence. From this, it seemed increasingly apparent that psychiatry needed some formal way to deal with such patients. The presence of a number of such psychiatrists on the Work Group for Paraphilias—and the way in which the APA's revisions process relied on such small groups of psychiatrists—meant that the addition of PCD would strike the APA as sound. This chapter, along with chapter 2, relies on

archival materials from the APA's archive—internal documents from the APA, correspondences between APA members, and protest mail from feminists, legal scholars, and concerned citizens. The APA's leadership initially uniformly agreed that PCD was a reasonable diagnosis, but responded to feminist pressure in 1986 by dropping the disorder altogether. I argue that the APA folded to outside pressure not because it no longer stood behind the validity of the diagnosis, but because these protests raised difficult questions about the objectivity of the *DSM* and psychiatry itself. PCD was no more and no less empirically supported than many other disorders (and particularly other sexual disorders) included in the *DSM* without controversy. However, protests drew attention to the shortcomings of the research and the revisions process itself. Rather than confronting questions about how to empirically verify sexual disorders, psychiatrists chose to drop the controversial diagnosis in order to preserve the appearance of objectivity.

This chapter also compares PCD to other contemporary theories of sexual violence. In particular, the women's movement put forward a sociological theory of rape, where sexual violence was an extreme expression of hatred towards women. A number of APA members involved with the *DSM* revisions process engaged with this feminist-sociological theory of rape. I argue that, amongst those concerned with sexual violence, there was a spectrum of theories, from purely social to purely individual, and that these distinctions mirrored the spectrum of biological to sociological seen amongst the clinicians discussed in this chapter.

Chapter 2 focuses on the protest movement against PCD that began in the early 1980s and peaked over the summer of 1986. I employ a rich base of protest materials: the APA's archive contains nearly two thousand pieces of mail sent by feminist organizations, professional organizations, and individual women opposed to PCD. I also employ institutional records from some of the organizations behind these protests—most notably, the National Organization of

Women, the Committee Against Ms. Diagnosis, and Women Against Violence—to demonstrate how feminist networks connected women psychiatrists with women’s advocates and the ordinary women who wrote the APA in protest.

The protest movement was not concerned solely with PCD. Rather, it emerged in response to three disorders and the perception that the three disorders, taken together, represented a generally sexist outlook on the part of the APA. The other two disorders were Self-Defeating Personality Disorder (SDPD) and Pre-Menstrual Dysphoric Disorder (PMDD). The controversy around each of these disorders has been thoroughly examined (by Paula Caplan and Anne Figert respectively), while the story of PCD remains largely untold. I argue that PCD occupied an uneasy place alongside these two disorders. The criticism that SDPD and PMDD unfairly targeted women was a straightforward one and one easily conveyed to observers outside the mental health sphere—PMDD clearly pathologized women’s biology, and SDPD played into social perceptions that women were natural masochists. PCD didn’t target women in such a straightforward way—indeed, it focused on men even if women were the presumed victims of men thought to be suffering from the disorder. Moreover, if the idea was that diagnosing women as mentally ill was detrimental, then explaining why diagnosing rapists as mentally ill represented a boon for the rapists was a difficult task.

As a result of these rhetorical complications (as well as the professional inclinations of leading protesters, who tended to be mental health professionals not focused on sex offenders or men at all, but instead on women patients and their issues), the protest movement focused most of its energies on PMDD and SDPD. When protesters did talk about PCD, they focused on its potential uses in the courts and argued that it might reduce the number of rape convictions. As well, they argued that it placed the blame for rape on men’s biological sex drives, rather than on

misogyny and men's socialization. This was, in some respects, true—as discussed in chapter 1, John Money, one of America's leading authorities on the psychiatry of sexuality, certainly thought this way. However, it missed the ongoing theoretical debates surrounding PCD.

I argue as well that the controversy over PCD allowed women working in mental health fields to argue for greater professional legitimacy. Women professionals put forward two linked arguments: the APA had failed to consider social issues and women's needs in crafting PCD (and the two other disorders being protested at that time), and the APA had failed to give the very professionals who were sensitive to such needs a voice in the *DSM* revisions process; sociologists and psychologists were instrumental in making these arguments, and both professions tended to employ more women than did psychiatry. PCD became a wedge issue for women in mental health fields to demand a greater role in the revisions process while simultaneously putting forward deeply held beliefs about gender, and the role of socialization in shaping mental health. This tactic—along with the fact that women's advocates had targeted the APA in the first place—suggests that by the mid-1980s, the APA had become a common site for political agitation. Women's organizations had followed the prior controversy over homosexuality and had even lobbied the APA in regards to the ERA, and understood the APA to be an attainable target for effecting social change. It also suggests that there was increasing public awareness of the power of psychiatry and other mental health disciplines in shaping both public and legal attitudes on a variety of matters, sexual violence and gender roles included.

Chapter 3 concentrates on one of the largest and best-known treatment centers for sex offenders in the 1980s—Johns' Hopkins Sexual Disorders Clinic, headed by Fred Berlin. I compare Berlin's work at Johns Hopkins with his contemporaries, including John Money, who was also a psychiatrist at Johns Hopkins though not directly involved with the Sexual Disorders

Clinic. Money and Berlin were both major contributors to the concept of PCD. Both saw rape as the result of both social and hormonal pressures, a framework heavily indebted to both researchers' earlier work with transsexual and transgender individuals. This framework demonstrates that, from the beginning, psychiatrists drew on feminist theories about gender-role socialization. Other important researchers were also involved in PCD research; although they did not leave papers, I have included their work where possible through their published studies and their correspondences with Money, Berlin and the APA.

I argue that clinicians who supported the concept of PCD used a wide variety of treatment approaches, from medications to traditional talk therapy to group therapy to various aversive therapies. Moreover, while medication (hormone therapy, in this case) played a significant role in the rhetoric of treatment centers, I argue that such medications were used on passingly few patients. Altogether, treatment centers enjoyed a number of successes, but these successes were tentative and clinicians' claims of curing large numbers of patients were not reflected in their work. As well, the theoretical orientation of clinicians varied widely, despite a mutual belief that PCD was a viable concept. Clinicians were divided over the relative roles of biology versus socialization in creating sexually violent behavior. John Money, for instance, erred on the side of biology—not only were offenses determined almost entirely by the offender's biological sex drive, but they could likewise be cured through biological interventions alone without any psychological counseling or therapy. Others, among them Fred Berlin and Paul Walker, believed that the psychology of the offender (and socially gendered expectations) played a more significant role and that sex offenders needed to be treated on both fronts. By the mid-1980s, however, this difference of opinion would be essentially invisible to feminist critics. The politics around sexual violence at that time led critics to treat PCD as universally promoting

a biologized view of sex offenders and privileging the role of the male sex drive over gendered social expectations as the explanatory mechanism behind sex crimes.

Finally, I argue that as treatment centers gained more publicity and thus more patients, they became increasingly embroiled in controversies. The Johns Hopkins clinic is illustrative here—as Berlin gained more patients, and particularly as more patients were remanded by the courts to his clinic, more cracks emerged. After a number of patients were released and reoffended—and after Berlin deliberately skirted lawmakers’ attempts to impose mandatory reporting standards on psychiatrists—the clinic was closed down. This story demonstrates the paradoxical nature of success. On the one hand, any treatment center for sex offenders was going to experience some failures. Even if Berlin’s recidivism rate had been his claimed 5%, that meant that out of every one hundred patients Berlin released, five would go back into the general public and reoffend. In this sense, a 95% success rate represented both a stunning breakthrough and a still too-high number of dangerous men allowed to walk free. As well, the mandatory reporting debacle represents its own paradox. Lawmakers wanted to ensure that actively dangerous patients were reported to the authorities and, due to their efforts in the 1980s, we generally accept such practices as best practices today.²¹ At the same time, Berlin’s fear that

²¹ While today few people question the benefit of mandatory reporting laws in general, some controversies do still remain. In particular, there’s been an ongoing question regarding reporting past child abuse disclosed by adult patients, rather than just ongoing abuse disclosed by children or abusers. In brief, the idea here is that an adult disclosing previous abuse may or may not know whether their abuser still has access to children or still abuses children. In the absence of definitive evidence that no abuse is ongoing, therapists should—according to this viewpoint—report all instances of abuse, no matter what the age of the person disclosing the abuse. Whether such stringent mandatory reporting procedures are followed varies from state to state and profession to profession. The American Psychological Association, for instance, has taken a consistent position that reporting past abuse disclosed by adults is not necessary in the absence of evidence that there is ongoing abuse of another child being committed, though with the caveat that all psychologists should consult their state’s particular statutes (see, for instance, “Ethics Rounds: Reporting Past Abuse,” *Monitor on Psychology* 33, no. 5 (May 2002)). On the other

mandatory reporting laws would stifle his ability to offer treatment to unincarcerated sex offenders was borne out—the number of men who contacted his clinic dropped precipitously after the law was implemented. The underlying question in both of these cases was how to balance protecting communities (and women and children specifically) in an immediate sense with protecting communities in the long run. From the standpoint of clinicians, treatment offered a long-term solution and some failures came with that as a matter of course. For lawmakers, community organizers and activists, and regular citizens, such failures represented a lack of caring for the immediate safety of the women and children such men might victimize. This disconnect wasn't solved in the 1980s, nor has it been solved today. In particular, a discourse on pedophilia has arisen since 2000 that criticizes the ways in which social stigmas (and, indeed, mandatory reporting laws with fuzzy boundaries) make it difficult for non-offending pedophiles to access treatment.

Chapter 4 looks at attempts by NAMBLA (the North American Man/boy Love Association, America's largest pedophile self-advocacy group) to define itself as a social movement and to insert itself into broader discussions about the nature of sexuality, sexual violence and consent. The men who constituted NAMBLA's leadership were generally self-identified gay men who were educated and politically active—as such, they attached themselves to the gay rights movement with gusto. Moreover, they read and referenced academic literature on paraphilias, child sexuality, the history and anthropology of sexuality, and other fields. As

hand, Maryland's Attorney General concluded in 1993 that reporting *all* abuse was necessary, even if the abuser is believed to be deceased (Doory, Ann Marie, 78 Md. Op. Att'y Gen. 189, December 3, 1993). An additional wrinkle is whom a state law designates as a mandated reporter. While particular professions (mental health, medical, educational) are universally subject to such laws, some states additionally require *all* citizens to report suspected child abuse. Given that no society-wide training exists on how to recognize the signs of child abuse, such broad statutes are very difficult to enforce.

such, NAMBLA offered a wide-ranging critique of American society in the 1980s—from police power, to sexism and homophobia, to the oppression of children. If pedophilia could be somehow subtracted from NAMBLA’s platform, what would be left would largely resemble the platforms of other, contemporary social and political movements. This demonstrates that NAMBLA engaged both sincerely and savvily with a variety of arenas—gay liberation, the women’s movement, anti-fascist and anarchist circles, academia, and the social sciences. Despite the distaste with which the vast majority of people viewed pedophiles, NAMBLA saw itself not as a deeply isolated fringe movement, but as integrally linked to (and able to comment upon) the boundaries around acceptable forms of sexuality.

In addition to their theoretical investment in gay rights, this chapter examines NAMBLA’s actual participation in the gay rights movement to understand the turbulent politics around sexuality, power and consent in this era. In the early 1980s, the organization represented a tacitly accepted part of the movement—its members marched in parades, had meetings in gay community spaces, and joined (and in some cases, even created) gay political groups. As the gay rights movement began to gain political and popular traction in the mid-1980s, however, NAMBLA’s presence became increasingly controversial. This chapter traces NAMBLA’s ejection from a handful of major gay rights organizations as those organizations gained increasing social and political capital. Numerous scholars have discussed the gay rights movement’s “politics of respectability.”²² By this, such authors mean that high-level

²² This concept was originally used in reference to black women’s feminism; see Evelyn Brooks Higginbotham, *Righteous Discontent: The Women’s Movement and the Black Baptist Church, 1880-1920* (Harvard University Press, 1994). It has since been adopted to describe attempts by various social movements to police its membership in order to present a publicly acceptable face. On respectability politics in the gay community specifically, see: John d’Emilio, *Sexual Politics, Sexual Communities: The Making of a Homosexual Minority in the United States, 1940-1970*

organizations pushed out various groups perceived to be non-normative (chiefly transgender men and women, but also gay men and women interested in sadomasochism and bondage or perceived as overly sexual). However, I suggest that there is a less sinister side to the politics of respectability. Part of the respectability gay rights groups were striving towards involved cutting out groups like NAMBLA (by defining pedophilic men interested in male children as primarily sexual deviants, rather than primarily as gay men) and numerous gay fascist groups (by defining these as political groups rather than ones based on sexual identity). These moves were important and arguably necessary for the gay rights movement to succeed.²³ Yet such moves did, as groups like NAMBLA were quick to point out, fly in the face of gay liberationist rhetoric of freedom for all and polymorphous perversity.²⁴ As such, the shift from liberation to political rights was a tumultuous one marked by both positives and negatives. If the 1970s had been a period of openness and transformation, the 1980s were an attempt to grapple with where that openness ended and how to draw boundaries in a climate where groups like NAMBLA were attempting to claim a public voice in discussions surrounding sexuality.

This chapter draws almost exclusively on documents written by NAMBLA members, or documents quoted and reproduced by NAMBLA (including works by feminists and historians). As such, the chapter is double-edged. It offers an insiders' view of how one particular group of sex offenders saw themselves and demonstrates that in the social milieu of the 1980s, such men felt entitled to shape the discourse around sexual violence and consent. At the same time, these

(University of Chicago Press, 1983); Michael Warner, *The Trouble with Normal: Sex, Politics, and the Ethics of Queer Life* (First Harvard University Press, 2000).

²³ In some cases, very directly so: at least one gay rights organization was denied United Nations status until it booted NAMBLA. See Sanders, "Getting Lesbian and Gay Issues on the Agenda."

²⁴ This concept, birthed by Freud and filtered through the likes of Foucault, resonated deeply with both gay liberationists and NAMBLA. See Jeffrey Escoffier, "Left-wing Homosexuality: Emancipation, Sexual Liberation and Identity Politics," *New Politics* 12, no. 1 (2008).

sources are limited. NAMBLA was insistent that it was an unobjectionable part of the gay liberation movement. It is certainly true that NAMBLA's presence was accepted for some time. However, it is less clear from these sources whether and to what extent that acceptance was begrudgingly offered. One avenue for further research is to look at responses within gay men's organizations to NAMBLA's presence in their communities and spaces in the early 1980s.

Chapter 5 examines legislation around mentally ill sex offenders, or MDSOs, as they were termed in much state-level legislation during this period. Historians who have surveyed legal treatment of mentally ill sex offenders across the twentieth century cite a rapid shift, where courts were predisposed to treating these men from the 1950s to 1980, and punishing them after 1980. I argue that this binary timeline misses the upheaval of the early- to mid-1980s. During this period, courts did begin instituting increasingly punitive measures. However, such measures flowed from the rhetoric of treatment: courts claimed that the indefinite civil commitment of accused sex offenders was appropriate because such civil commitment was not in fact a punishment, but instead a treatment. From the court's perspective, this may have been true. From the perspective of an accused offender, however, indefinite civil commitment was effectively the same as prison in terms of limitations to one's liberty. Moreover, it might (and often did) last longer than a fixed prison term. And while a prison sentence necessitated a trial where certain standards of proof existed, the standards for civil commitment proceedings were much lower—guilt needn't be proven beyond a reasonable doubt, but merely demonstrated via a preponderance of evidence. This hybrid system, where punishment and treatment coexisted rhetorically and in practice, set the stage for what came later. In the mid-1990s, courts began to introduce Sexually Violent Predator (SVP) Laws, which allowed for sex offenders to be indefinitely committed after they had served their prison terms. Such laws superficially resemble the practices of the early

1980s, but their justifications differ greatly. Most importantly, the idea that civil commitment is a form of treatment is largely absent from justifications for SVP laws. Instead, such laws are justified in the interest of protecting the public. In this light, the ways in which legislators in the 1980s talked about the nature of treatment versus punishment is important for what came next.

I also argue that the courts placed psychiatrists (and other expert witnesses) in a difficult position. Psychiatrists were asked to testify as to accused MDSOs' mental state, but courts often misconstrued psychiatric testimony. As well, the courts asked psychiatrists to speculate on the likelihood that an accused party would commit additional crimes in the future. For psychiatrists, this represented something outside their professional expertise; many argued that the courts were asking them to do the impossible by predicting the future. While individual psychiatrists could choose not to perform as expert witnesses in court cases, the very structure of the laws discussed here—both MDSO statutes and SVP laws—required psychiatric testimony of one sort or another. In other words, by the early 1980s, psychiatry was inextricably intertwined with the legal system. Juxtaposing this with the APA's earlier isolationist stance that PCD's potential inclusion in the *DSM* had nothing to do with the law or society more broadly, this is both ironic and explanatory. The irony was that the majority of psychiatrists working with sex offenders were well aware of the practical overlaps between psychiatry and criminal justice, no matter how much they denied theoretical ones. It is also explanatory in the sense that psychiatrists—and the APA itself—were increasingly displeased with such practical overlaps and felt that they had, in some sense, lost control of how their professional output (the *DSM*, for instance) was interpreted. While not an excuse for the APA to disregarding questions about the practical effects of PCD and similar diagnoses, it does help make sense of why the APA was so keen to wall itself off from social and legal questions about psychiatric diagnoses.

A Note about Language

This dissertation deals with a number of professional organizations—not just the American Psychiatric Association, but also the American Psychological Association, the National Organization for Women, the National Association of Social Workers, and others. At the beginning of relevant chapters, such organizations are written out in long-form but subsequently referred to by the appropriate acronym (the American Psychological Association being the lone exception; to avoid confusion, “APA” will always refer to the American *Psychiatric* Association). I have treated diagnostic terminology the same way—Paraphilic Coercive Disorder will appear at the beginning of chapters as such, then subsequently by PCD. A list of these terms appears on page v.

I use the terms “rape” and “sexual violence” interchangeably, for the most part. The term sexual violence has its roots in the women’s movement’s attempt to redefine rape as an act of violence rather than one of sex (see chapter 2 on this). However, my use of it here is less ideological and more practical. Much of the sexual violence discussed by actors in this project concerns more than the stereotypical act of rape (penetrative sex forced upon a woman by a man). Psychiatrists and women’s advocates were equally concerned about child sexual abuse (which may or may not be penetrative in any given case), non-penetrative nonconsensual sex acts, and so on. When one term is used by historical actors or is more appropriate, I employ that term.

Throughout the dissertation, I use the term “sex offender” to capture the breadth of men (and, in the mid-1980s, the perception among psychiatrists, feminists and the general public was that sex offenders were men, even as people were increasingly acknowledging the existence of

male victims) discussed by my historical actors. Treatment centers housed not just rapists, but also pedophiles, voyeurs, flashers, obscene telephone callers, and a host of other sexual deviants. Likewise, while feminists talked primarily about rapists and pedophiles, they considered the above listed men to be engaging in behavior rooted in a similar hatred of women, and male entitlement to women's bodies. When appropriate, I use more specific terminology.

Finally, in chapters 1 and 2, I discuss feminist opposition to the APA at length. Much of this opposition came from women working in mental health fields—social workers, feminist psychiatrists, and so on. I have referred to this insider group as “feminist mental health professionals,” which is somewhat unwieldy terminology. In other places, I refer simply to the women's movement or to feminist opposition to the APA—in most cases, that opposition consisted of both mental health professionals and women completely uninvolved in mental health (as well as professional activists and women who were only casually involved with the feminist movement). I do not wish to imply that there was a sharp divide with women's advocates and nonprofessionals on one side and professionals on the other side. These spheres overlapped almost constantly, as Ann Figert discusses at length in her book. In terms of writing a readable manuscript, however, I have erred on the side of simpler language when possible.

Chapter 1

Diagnosing Rape: Paraphilic Coercive Disorder in the *DSM*

302.90* Paraphilic Coercive Disorder: Over a period of at least six months, recurrent preoccupation with intense sexual urges and arousing fantasies involving the act of forcing sexual contact (e.g. oral, vaginal or anal penetration; grabbing a woman's breast) on a non-consenting person.²⁵

Paraphilic Coercive Disorder²⁶—variously called Rapism, Sexual Assault Disorder, and Paraphilic Rapism²⁷—is a disorder with a peculiar history. The diagnosis pops up again and again, never fully accepted nor vanquished. Initially proposed in 1976, it was deleted from *DSM-III* drafts a year later.²⁸ It was proposed again in 1982, at the beginning of revisions for *DSM-III-R*, only to be again deleted in 1986. When the *Diagnostic and Statistical Manual of Mental Disorders* went into its fifth edition in 2013, Paraphilic Coercive Disorder was still being proposed as an addition.

PCD has proved a particularly mobile and malleable disorder. Given the instability of the very idea of paraphilias (in this period this category of sexual deviations

²⁵ “Paraphilias Draft [revised 12/3/85,]” December 3, 1985. *DSM* Collection, Melvin Sabshin Library & Archive, American Psychiatric Association, Alexandria, VA (hereafter, *DSM* Collection).

²⁶ When applicable, I will use the language used by the author in question. Otherwise, I will generally refer to this disorder as PCD for the sake of brevity.

²⁷ This list is not exhaustive. These are merely the official titles that make it into *DSM* draft language at one point or another. A variety of other names were suggested, typically on the basis of being more etymologically sound, and were rejected as being cumbersome and not immediately legible. They include archagophilia, viasmophilia, violerism, violism and stastophophilia.

²⁸ The *DSM* is the *Diagnostic and Statistical Manual of Mental Disorders*, the major guidebook for psychiatric diagnoses. It is published by the American Psychiatric Association (hereafter referred to as the APA), and periodically revised to include new research findings, as well as to correspond to the *ICD*—the *International Classification of Diseases*, a European manual that serves largely the same purposes as the *DSM*. The third edition of the *DSM* (*DSM-III*) was published in 1980, and a revised version (the *DSM-III-R*) in 1987.

was renamed, radically redefined and made to contain wildly disparate disorders), PCD threatened nothing in particular. Instead, psychiatrists who worked with sex offenders saw a need to include rape somewhere in the *DSM* and found this diagnosis logical, if perhaps imperfect. And, indeed, the logic behind the disorder could be expanded beyond individual pathology to encompass a sociological reading of masculinity and male aggression. As for PCD's refusal to ever fully disappear, the chair of the *DSM-III* and *III-R* revisions process himself stated that it "could be removed very late in the process, if necessary, without having any significant impact on the rest of the classification."²⁹ If a last minute subtraction wouldn't upset the fundamentals of the *DSM*, this equally meant that a subsequent inclusion of the disorder was never quite out of the question.

While psychosexual disorders were seen as one of the least important parts of the *DSM*, they emerged as the site of some of the most controversial debates in psychiatry of the 1970s and 1980s. Homosexuality,³⁰ Premenstrual Dysphoric Disorder (PMDD hereafter) and Paraphilic Coercive Disorder were controversial not just within the APA, but also among a wider community of feminists, lawmakers, and concerned citizens. PMDD and PCD, along with Masochistic or Self Defeating Personality Disorder (SDPD), garnered lasting protests from women's groups and would eventually be deleted from the *DSM-III-R* as a result. While historians, social scientists and feminists have explored homosexuality, PMDD and SDPD, PCD has not been written about outside of a psychiatric context.³¹ Much of the historical literature has been concerned with the

²⁹ Robert Spitzer, "Dear Revisionists," September 25, 1985. *DSM* Collection.

³⁰ And homosexuality's many diagnostic permutations: dyshomophilia, ego-dystonic homosexuality, and sexual orientation disorder.

³¹ Of the three, homosexuality has garnered the most scholarly interest. On this subject, see: Jennifer Terry, *An American Obsession: Science, Medicine, and Homosexuality in*

moment in which psychiatry ceased to be a closed sphere. The 1970s and 1980s saw not only political protests against the APA, but also the continued interpenetration of psychiatry and the legal sphere.³² Building off of this framework, I use PCD to explore psychiatry's response to the revelation that psychiatry could no longer function separately from social, legal and political concerns. Responses varied from acceptance of psychiatry's newfound role as an arbiter of social and legal concerns, to harried attempts to maintain a bright line between psychiatry and these others spheres. Whatever their response, psychiatrists in this period were forced to reevaluate their roles as psychiatrists and their perceptions of the profession more largely.

As much as this is a story of the divisions between an ostensibly closed psychiatric sphere and an ostensibly external sphere where social-political concerns circulated, it is equally a story of divisions within the APA itself. PCD was not the only way to understand rape; indeed other psychiatric theories of rape flourished in this period. Rather than simply asking to what extent non-psychiatrists would be allowed to shape the *DSM*, this story also reveals a debate over who *within* the APA would be responsible for

Modern Society (University Of Chicago Press, 1999); Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (University of California Press, 1996); Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis*, Princeton Paperbacks (Princeton, N.J: Princeton University Press, 1987). The authoritative text on PMDD is Anne E. Figert's *Women and the Ownership of PMS: The Structuring of a Psychiatric Disorder (Social Problems and Social Issues)* (Aldine Transaction, 1996). SDPD has been a topic of interest primarily among feminist scholars. For an in-depth discussion of Self Defeating Personality Disorder in the *DSM*, see Paula J. Caplan, *They Say You're Crazy: How The World's Most Powerful Psychiatrists Decide Who's Normal* (Da Capo Press, 1996).

³² The practice of using psychiatrists and other mental health workers as expert witnesses in criminal and even civil trials, though it began earlier in the twentieth century, grew exponentially in this period. Additionally, these decades witnessed a continued debate about the shape and function of criminal insanity statutes, and a number of new laws regarding sexual predators that would function to bring sexual offenders under the auspices of the psychiatric sphere. See chapter 5 on this point.

shaping it. Ultimately, the duty would fall to an exceedingly small group of specialists and to the APA's leadership, the Board of Trustees. Finally, this debate implies some underlying differences in how APA members viewed the *DSM* and their roles within the Association—some members saw the *DSM* as nothing more than an empirical document rightfully shaped by specialists, while others saw the *DSM* as a constructed artifact in which non-specialists and politics played an important role.

This chapter will explore the history of PCD, from its proposal in 1976 to its eventual deletion from *DSM-III-R* in 1986. The chapter is divided into six sections: a discussion of the *DSM-III* and paraphilias in general, a discussion of PCD and other theories of rape, a brief discussion of Rapism's position in the *DSM-III*, a discussion of its longer stay in the *DSM-III-R*, and a more theoretical discussion of the role of politics and social issues in the APA, and finally a discussion of how various observers within the APA thought about defining the *DSM* as a result of the controversy over PCD.

Paraphilias & The DSM-III

The Diagnostic and Statistical Manual of Mental Disorders, first produced by the American Psychiatric Association in 1952, is the major guidebook for psychiatric diagnosis in the United States. The first and second editions were concise documents with an etiological bent and scholastic language.³³ In 1974, however, the APA began the

³³ The first and second editions of the *DSM* relied heavily on a neo-Kraepelinian system of classification. This system was based more on presumed etiology of disorders rather than on their clinical presentation—for instance, a few of the first diagnoses listed in the *DSM-I* are “Acute Brain Syndrome associated with intercranial infection,” “Acute Brain Syndrome associated with circulatory disturbance,” and “Acute Brain Syndrome associated with intercranial neoplasm” (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Second Edition* (Arlington, VA: American

process of producing a third edition. This edition was envisioned from the beginning as a significant departure from prior editions. Intended to be more accessible and more detailed, the process would eventually take six years to complete. While the second edition was less than 150 pages long, the third was a whopping 494 pages and added nearly one hundred new diagnoses, bringing the total number of listed mental disorders to two hundred and sixty five. Subsequent revisions to the *DSM-III* (referred to as the *DSM-III-R*) would add another seventy pages and thirty diagnoses. The third edition, with its plain English descriptions of mental disorders, was enormously successful and appealed not only to psychiatrists, but non-specialists as well. It has been described as “a surprising runaway best-seller, primarily because of sales to non-psychiatrists.”³⁴ Of course, this wider appeal meant that the APA would be opened up not just to praise but also to criticism from outside the Association.

Spearheading the revisions process was Robert Spitzer, elected chair of the Task Force to Revise the *DSM*. Spitzer was instrumental in engineering the massive changes to the *DSM*—not just the rewriting of the descriptions of most of the disorders, but also the undertaking of a prolonged number of field trials and the introduction of a new multiaxial classification system. As chair of the Task Force, Spitzer quickly emerged as a strong presence in the revisions process. Contemporary authors have described Spitzer as one of the most influential psychiatrists of the twentieth century, due in large part to his role in

Psychiatric Publishing, 1968).). Little, to the untrained eye, differentiates these three disorders but a presumed physical cause. The third edition of the *DSM* sought to present legible descriptions of the clinical presentation of patients, making the volume more accessible to psychiatrists with a variety of specializations. On this nosological shift between the second and third editions of the *DSM*, see Robert M. Galatzer-Levy and Isaac R. Galatzer-Levy, “The Revolution in Psychiatric Diagnosis: Problems at the Foundations,” *Perspectives in Biological Medicine* 50, no. 2 (2007).

³⁴ Kirk and Kutchins, *The Selling of DSM*, 194.

shaping the *DSM*.³⁵ His colleagues at the time jokingly diagnosed his “compulsion” to reorganize the *DSM* and coin new terms,³⁶ and noted his propensity to assign his colleagues to the revisions.³⁷ Overall, Spitzer exerted a great deal of control over the revisions process, but his colleagues generally seemed to have had few problems with his leadership.³⁸

Spitzer, in addition to leading the overall revisions process, led the Work Group on Psychosexual Disorders, a small group of specialists tasked with revising the disorders related to sexuality. This section of the *DSM* comprised a broad, disparate group of disorders, including those related to sexual orientation and gender (homosexuality, transsexuality), disorders resulting in primarily physical manifestations (e.g., vaginismus, premature ejaculation), and various fetishes (masochism, sadism, and so on). While Spitzer had initially put together a Work Group to revise the category holistically, within

³⁵ On Spitzer’s importance, see Alix Spiegel, “The Dictionary of Disorder,” *The New Yorker*, January 3, 2005; Christopher Lane, *Shyness: How Normal Behavior Became a Sickness* (Yale University Press, 2008), 6.

³⁶ John Racy to Robert Spitzer, 1978, *DSM* Collection. Among the terms Spitzer coined is “homodysphilia,” which replaced homosexuality temporarily. On this particular term, Stoller wrote to Spitzer, “I doubt anyone in the world could have done better... I think you handled the running battle about homosexuality in that clear explanations are given for what, to almost everyone, will seem an odd decision. But I must say, ‘dyshomophilia’ is an invitation for a shit storm” (Robert Stoller to Spitzer, April 21, 1977, *DSM* Collection.) Here, again, we can see that Spitzer exercised a great deal of power in shaping the *DSM*, but was respected by his colleagues.

³⁷ Richard Green to Spitzer, December 14, 1976, *DSM* Collection.

³⁸ The only real fight over Spitzer’s methods of running the revisions process (controversies over specific disorders notwithstanding) was Green’s annoyance at Spitzer’s inserting his own colleagues into the Work Group on Psychosexual Disorders. More often, colleagues sympathized with the difficult work of revisions. For example, one colleague wrote that he “appreciates” the difficulties posed by the revisions process and does not “envy” Spitzer’s task (C. Knight Aldrich to Spitzer, July 16, 1975, *DSM* Collection.) Stoller, more effusive in his praise, writes that the *DSM-III* had “undoubtedly been a massive and exhausting job, but you (obviously more than anyone else) and your colleagues have gone about the job with the greatest care, intelligence, forbearance, and honorableness” (Stoller to Spitzer, April 21, 1977, *DSM* Collection.)

a year it was clear that different Work Groups would have to be created to deal with each of these groupings separately. Accordingly, by January of 1977, there were three Work Groups: one for “Psychosexual Dysfunctions,” one for “Gender Identity or Role Disorders,” and one for “Paraphilias.” The Paraphilias Work Group for *DSM-III* consisted of Spitzer, Paul Gebhard (an anthropologist), Robert Stoller and Richard Friedman. Stoller specialized in gender and transsexuality, and Friedman was interested in sexuality more broadly.

Most notable here is the murkiness of the categories. While the cordoning off of Psychosexual Dysfunctions makes some sense given that they had clear physical components, the line between the other two subgroups is less clear. For instance, homosexuality was listed as a paraphilia at this point, but could potentially be considered to be an issue of gender identity (in a psychoanalytic framework, for example) and would at one point in the revisions process occupy its own category called Sexual Orientation Disorder. The same is true of transsexualism, a distinction that was later split in two: transsexualism as a Gender Identity Disorder and transvestitism as a Paraphilia. In any event, Spitzer wasn’t satisfied with these groupings. In late 1976, he would try to reorganize the entire Sexual Disorders category into two broad groups (Sexual Situation Disorders and Sexual Arousal Disorders), much to the chagrin of all three Work Groups.³⁹

³⁹ “Workshop on Sexual Disorder, Summarized by Richard C. Friedman, M.D., Secretary,” September 1976, DSM Collection.

As for the paraphilias, the term itself was a new designation.⁴⁰ Prior to this, these disorders had been classified as “Sexual Deviations” and commonly referred to as deviations or perversions. The Work Group for *DSM-III* found these terms needlessly judgmental. Spitzer proposed instead that they use the terms “sexual object choice disorders” and “disorders of sexual preference.” His colleagues roundly rejected these as unwieldy and inaccurate. Instead, they introduced the term “Paraphilia.” This term had the benefit of being nonjudgmental, being etymologically descriptive, and of fitting into the Latinate terminology of the paraphilias themselves.⁴¹ One contributor writes, “the term Paraphilia is preferable because it correctly emphasizes that the deviation (para) is in that which the individual is attracted to (philia).” Spitzer was skeptical that re-naming the category would have any long-term benefits. “Sexual deviation” expressed nearly the same meaning, but had gained a pejorative meaning over time, and Spitzer thought that the term Paraphilia “also lends itself to the kind of pejorative use that we wish to avoid... in time, paraphiliac will have the same unacceptable connotation that the term sexual deviation has now.” Despite Spitzer’s concerns, the Work Group decided on the term

⁴⁰ Paraphilia refers to the fetish itself—a person who has a fetish for feet may have a paraphilia. A paraphiliac is the person with the fetish—the foot fetishist is a paraphiliac. Paraphilic is the adjectival form, as in Paraphilic Coercive Disorder.

⁴¹ Along with renaming the paraphilias category, the *DSM-III* Work Group noted that paraphiliacs were capable of maintaining affectionate relationships and were capable of arousal without/outside of their paraphilia. That is, paraphiliacs were capable of relatively normal functioning, despite their sexual disorder and were not defined solely by it. This too was part of the larger project of destigmatizing the paraphilias. This was likely, in part, a strategy: the less stigmatized a diagnosis, the more likely those suffering from it would be willing to see a psychiatrist. But beyond this, there was a real desire to destigmatize sexual disorders. In many cases, paraphiliacs were harmless—the Work Group acknowledged, in particular, that transvestites often had happy marriages or were not terribly distressed by their transvestitism. Of course, this trend towards destigmatization rested somewhat uneasily with the designation of things like pedophilia as paraphilias, but nonetheless the dominant trend in this period was towards destigmatization.

Paraphilia, with the acknowledgement that almost any terminology used held the potential for pejorative connotations.

PCD: A Theory of Rape

Rapism was introduced in 1976, along with a laundry list of new paraphilias, by John Money. Money, a member of the Gender Identity and Role Disorder Work Group, headed the John Hopkins' Phipps Clinic for Gender Disorders and worked primarily with transvestites and transsexuals. In addition to this patient group, he saw patients with a wide variety of sexual disorders and, accordingly, interjected himself into the Paraphilias revisions process. Among his more colorful proposals were apotemnophilia (a “self-amputee” fetish), autoassassinophilia (a fetish for “own murder staged”), gerontophilia (“elders”), coprophilia (“feces”) *and* klismaphilia (“enema”) *and* autonepiophilia (“diaperism”) (all apparently separate fetishes in need of distinction), symphorophilia (“disaster”) and urophilia (“urine”).⁴²

Only three—Rapism, Frotteurism and Obscene Communication Disorder—were ever considered for inclusion in the *DSM*. The reason the others were rejected was not an objection to their existence per se, but rather skepticism that they were common enough

⁴² These examples constitute less than one quarter of Money’s proposals. For a full list, see John Money, “Psychosexual Disorders - Paraphilias,” March 25, 1977, DSM Collection. Money was dogged in his belief that additional paraphilias should be listed and sent another list to Spitzer in 1984, despite the failure of his first attempt. For a case study on apotemnophilia, see John Money, Russell Jobaris, and Gregg Furth, “Apotemnophilia: Two Cases of Self-demand Amputation as a Paraphilia,” *Journal of Sex Research* 13, no. 2 (1977). This article clearly demonstrates the overlap in Money’s thinking about gender disorders and other paraphilias—the desire for amputation discussed here is likened to transsexuality. In Money’s estimation, the amputation would, in the mind of the patient, produce a stump which functions as a symbolic vagina, allowing the man to retain his maleness while gaining the desired femaleness through a proxy.

to require a diagnostic code in the *DSM*. Out of this grew a category of “Paraphilia Not Otherwise Specific” or NOS, intended to include anything uncommon. Obscene Communication Disorder was swiftly relegated to the status of an NOS disorder. Frotteurism, however, remained in *DSM* drafts for some time. Like Rapism, it pops in and out of official drafts—present in early drafts of *DSM-III*, downgraded to an NOS disorder by the time *DSM-III* was published, and present again with the revisions of *DSM-III-R*.

Frotteurism and Rapism were defined in contradistinction to one another. Money defined Frotteurism as the urge or fantasy of rubbing against strangers, typically in public and typically while imagining an exclusive relationship with that stranger. For Money, the chief component of Frotteurism was the rubbing and not the lack of consent, though Frotteurism was nearly always non-consensual in practice. Rapism, on the other hand, was primarily defined by coercion—that is, it was not the sex act per se that was arousing; the very act of coercing a victim provided sexual arousal to the coercive paraphiliac.⁴³ Rapism further included non-penetrative acts—in the draft language, the example of “grabbing a woman’s breast” is given. Thus the distinction between Rapism and Frotteurism is one of intention and arguably power. The frotteur, per Money’s definition, fantasizes himself as a lover while groping his victim. The man suffering from Rapism (rapist is etymologically the term, but not quite correct in meaning⁴⁴) could commit the same act, but would be aroused primarily by his power over his victim, and

⁴³ Strangely, while this distinction was part of Rapism’s definition from the beginning, this language did not appear in *DSM* drafts until 1985. I do not have the draft language for the *DSM-III*, but can make this assumption on the basis of drafts from 1982 that lack the direct, explicit connection between arousal and nonconsent.

⁴⁴ While all individuals acting on their Rapism are rapists, not all rapists suffer from Rapism.

his ability to override her wishes. While my reading here pushes these definitions to their limits, it does suggest a surprising, if small, commonality between Rapism as defined by Money and rape as theorized by feminists.⁴⁵ This commonality would not, however, be enough to unite feminists and psychiatrists behind a common theory of rape.

In the end, the difference between Frotteurism and Rapism proved confusing to many psychiatrists—why should two acts that were nonconsensual be classified so differently? Spitzer writes, “My own feeling is that we will have so much difficulty convincing people about Paraphilic Rapism that Frotteurism will only confuse the issue.”⁴⁶ Accordingly, he would downgrade Frotteurism to an example of NOS in *DSM-III* and again in *DSM-III-R* in an attempt to save the diagnosis of Rapism.

While a number of Money’s proposals were based solely on clinical experience (that is, no empirical studies were ever done on amputee or “own murder staged” fetishes, as far as I can tell), Rapism had somewhat more empirical support than the others. PCD was supported as a valid diagnosis on two major bases: phallometric measurements of rapists and men with rape fantasies, and the emergence of hormonal treatments for rapists and other sexual deviants.

Phallometric measurements were used chiefly as a way to ‘prove’ that coercive paraphiliacs existed as a class of men. This vein of research involves measuring the degree of erection when a subject is exposed to certain stimuli (in this case, degree of erection when exposed to auditory descriptions of rape as compared to degree of erection

⁴⁵ Most simply put, feminists saw rape as an act of power, not sex. This is an overly simplistic rendering, and a fuller discussion will be given later in this chapter, as well as in chapter 2.

⁴⁶ Robert Spitzer, “Memo to Advisory Committee on Paraphilias,” November 22, 1985, DSM Collection. When Spitzer downgraded Frotteurism for the last time, the PCD criteria were rewritten to explicitly connect nonconsent to arousal.

when exposed to a control stimuli describing consensual sex).⁴⁷ Until the mid-1970s, there had been little research of this type involving rapists, although there was a growing body of literature on other sexual deviations and particularly on pedophilia.⁴⁸ Gene Abel (who would join the Work Group on Paraphilias for *DSM-III-R*) and his colleagues were the first to demonstrate a clear difference between rapists and nonrapists using phallometric measures in 1977.⁴⁹ Abel found that a higher degree of arousal to rape stimuli corresponded not only to whether or not the subject had committed a rape in the past, but also to how many rapes the individual had committed—when he plotted degree

⁴⁷ The device of choice for this type of research appears to have been a Parks Electronic Plethysmograph which, according to advertisements, could also be used as a blood pressure cuff. There's a 'more bang for your buck' pun in there somewhere. For the lengthy advertisement/users guide, see: "Model 270 Plethysmograph," Parks Electronics Lab (Beaverton, OR, n.d.). Accessed February 28, 2013, http://w140.com/parks_model_270_plethysmograph.pdf.

⁴⁸ See Elaine Yanow and Clive Davis, "A Cumulative Index of 'The Journal of Sex Research': 1965-1977," *The Journal of Sex Research* 14, no. 3 (August 1978). The *Journal of Sex Research* also publishes a number of studies on normative arousal patterns in this period.

⁴⁹ Gene G. Abel et al., "The Components of Rapists' Sexual Arousal," *Archives of General Psychiatry* 34, no. 8 (1977): 895. Additional studies of this type include Neil Malamuth and J. V. P. Check, "Sexual Arousal to Rape and Consenting Depictions: The Importance of the Woman's Arousal," *Journal of Abnormal Psychology* 89 (1980); and Vernon Quinsey and Terry Chaplin, "Stimulus Control of Rapists' and Non-Sex Offenders' Sexual Arousal," *Behavioral Assessment* 6 (1984). Although all the studies cited here replicated Abel's general findings—a statistically significant difference in arousal to rape stimuli between rapists and nonrapists—not all researchers interpreted the findings in the same way. The most significant departure is that of Marshal Barbaree (Barbaree and R.D. Lanthier, "Deviant Sexual Arousal in Rapists," *Behavioral Research & Therapy* 17). Barbaree and Lanthier concluded that rapists were nearly equally aroused at all stimuli—rape and consensual sex—and that nonrapists evidence a change in arousal, therefore they could not conclude that rapists were particularly aroused at rape stimuli, but that their arousal was not inhibited as it was in nonrapists. This suggested that PCD was an interpretation not strictly supported by the evidence at hand. They suggested these alternative explanation: rather than a sexual fetish for rape, the rapists might have a lack of empathy for the victim, a lack of awareness of social mores against rape, or a lack of voluntary control over sexual arousal. The researchers mentioned here (Abel et al., Malamuth et al., Quinsey et al, and Barbaree et al.) produced almost all the research of this type in this period.

of erection against number of rapes, he found a clear and nearly linear curve, with serial rapists at the highest end and markedly different not just from non-rapists but from rapists who had committed rape only once or twice.

There was nothing inherent in these numbers to suggest any etiology or treatment regime, but they *were* the first “objective measure of urges to rape,” where earlier evaluations had “traditionally rested with subjective clinical impressions.” Moreover, Abel argued that his data demonstrated that rapists were still aroused by rape, no matter how far removed they were from the stimuli—that is, after years in prison (and thus away from women), rapists still experienced the desire to rape. Rapists had an underlying problem that prison did nothing to treat. Not only did his data imply, then, that such a class of men existed, but it also implied that they must be dealt with in some other way besides incarceration. For Abel, the duty of dealing with rapists naturally fell to psychiatrists.

Abel was sanguine about the possibilities phallometric measurements offered. Not only would therapists be able to objectively track the progress of their patients, but it seemed to Abel that these devices might also be used one day to establish, with a great deal of certainty, whether rapists had committed multiple crimes (i.e., to establish whether or not a rapists had committed fewer than ten rapes, or a great deal more) and/or caused a great deal of injury to the victim(s).⁵⁰ Phallometric measurements might be used not just as a treatment tool, then, but also as a tool for law enforcement and prosecution.

⁵⁰ Abel determined this by comparing his measurements with the rapists’ criminal charges and testimony. As always, there is the issue of self-reported activity being dubiously provable. Unsurprisingly, phallometrics would never, to my knowledge, be used in the ways Abel proposes in the court system (though it would be used in court-ordered psychiatric evaluations for sex offenders suspected of being mentally ill). It is interesting,

Equally important, the apparent success of hormonal treatments for rapists represented a serious breakthrough. Prior to this, rape had been considered particularly untreatable, and rapists particularly prone to recidivism.⁵¹ Paraphilias were typically treated with extended psychotherapy, a process requiring years of treatment in order to be beneficial.⁵² Moreover, there was “no real evidence” that psychotherapy was effective in treating rapists. According to one psychiatrist who worked with sex offenders, psychotherapy’s efficacy relied on the patient’s intelligence, ability for self-observation, motivation to change, and willingness to work with a therapist, but “none of these qualities is prominent among the majority of men who rape.”⁵³ There was the additional problem of getting rapists into treatment: as with any disorder that was connected to criminal behavior, the perpetrators were unlikely to bring themselves into a psychiatrists’ office to discuss their crimes. Those that did end up in treatment were typically remanded to therapy by the courts, or pressured by others. Because they were not self-referred, rapists were likely to “regard the clinician as an adversary.”⁵⁴ Given these difficulties and without any reliable treatment, rapists were perhaps best left to the prison system. A

however, that this type of research on rape was almost entirely segregated from hormone treatments. These treatments were largely considered sufficient in and of themselves, and were not “objectively” tested with phallometrics.

⁵¹ Abel gives a recidivism rate of 35% without treatment, and 6-35% with treatment (Abel et al., “The Components of Rapists’ Sexual Arousal.”). Prior to this, rape was generally thought of as something so far outside of normal human behavior that it was essentially psychopathic. Psychopathy, although considered a mental illness, is generally thought of as fundamental to a person’s identity and thus incurable.

⁵² Abel, “Components.” Groth states that the most common treatment for sex offenders is psychotherapy (Nicholas Groth and H. Jean Birnbaum, *Men Who Rape: The Psychology of the Offender* (Plenum Press, 1979), 216.).

⁵³ Groth, *Men Who Rape*, 217.

⁵⁴ Groth, *Men Who Rape*, 194.

reliable treatment method, however, would place rapists more firmly within the grasp of psychiatry.

Hormone therapy became the first apparently reliable treatment method for rapists, emerging in the mid-1970s. Money was one of the primary researchers responsible for hormone therapy. This grew directly out of his work with transsexuals, whose disorder psychiatrists in this period increasingly believed to be at least partially biological. Given his work with transsexuals, Money was less dedicated to a purely psychological reading of sexuality than a biological one, and thought about and attempted to treat rapists in the same ways as his other patients. He pioneered endocrine and hormonal treatment for sexual disorders, under the belief that while psychological problems were present, an underlying physical mechanism that had connected these problems to the physical sex act must exist. Money believed that if he could temporarily interrupt this feedback mechanism, the sexual disorder would remit and whatever psychological problems remained could be dealt with more easily. Moreover, if sexual desires were temporarily removed—hormonal therapy causing what Money refers to as a “temporary functional castration”—the link between desire and the paraphilia could be severed, triggering a “psychic realignment” in which the patient would revert back to a normal sexuality.⁵⁵ Money believed that this treatment was viable for almost any type of sexual disorder; among those he used this type of therapy on were transvestites, pedophiles, exhibitionists, transsexuals, and masochists, all of whom ranged from individuals with “extensive police records” to those who were merely “public nuisances” or who were disturbed by their own private desires but had not acted on them at all.

⁵⁵ John Money, “Use of an Androgen-Depleting Hormone in the Treatment of Male Sex Offenders,” *Journal of Sex Research* 6, no. 3 (1970).

Money was not alone in seeing rape in this way. A former colleague at the Phipps Clinic, Paul Walker opened a similar treatment facility for sex offenders at the University of Texas Medical Branch (UTMB) in Galveston in 1977.⁵⁶ Walker stated that “sexually offensive behavior is best treated, non-judgmentally, as a medical condition.”⁵⁷ His patients came to share this belief; one referred to hormone therapy as “like insulin for a diabetic,” likening his deviant desires to a common medical disorder.⁵⁸ Walker’s understanding of sexual deviance was similar to Money’s: hormone therapy “lowers sex drives in male sex offenders to a more manageable level.” The implication here was that part of the problem in sex offenders is a sex drive so high as to be unmanageable. Further, “the medication serves as a vacation” from that high sex drive, which “allows time for relaxing counseling sessions that help modify behavior.”⁵⁹ In other words, it was only by removing the overactive sex drive that the sex offender could be rendered clear-headed and calm enough to benefit from counseling. This was Walker’s major difference from Money: he believed that counseling was necessary to the treatment process, whereas Money believed that in most cases removing the sex drive was treatment in and of itself. For Walker, therapy was necessary to facilitate Money’s “psychic realignment.”

With these patients, Walker used two types of therapy. The first he referred to as “rational-emotive therapy,” which enabled the patient to identify the stressors that had led

⁵⁶ UTMB’s clinic for sex offenders is unnamed in all the articles discussing it. It’s unclear why this is the case—whether the clinic was largely informal and thus didn’t have a name, or whether the name was kept under wraps for some reason. Walker also continued to work on gender identity and transsexuality, and ran UTMB’s Rosen Clinic at this time.

⁵⁷ Susannah Moore, “News Release,” The Blocker Archives and Manuscript Collection, University of Texas Medical Branch (hereafter, Blocker Archive).

⁵⁸ Jim Curran, “Success Is Reported with Drug to Curb Criminal Sex Drive,” *Houston Chronicle*, April 7, 1979.

⁵⁹ Moore, “News Release.”

to his illegal sexual behaviors— Walker noted that “most sexual offenders carry out their illegal acts during periods of non-sexual stress, such as job stress or marital stress.”⁶⁰

Recognizing his particular stressors would allow a patient to better avoid those stressors and thus not put himself in positions where he was more likely to commit sex offenses.

The second was referred to as “covert sensitization.” This relied on similar assumption as Money’s—that there was a feedback loop between arousal and fantasy that must be severed. Here, Walker helped the patient create a “script” for future masturbation sessions in which the patient would fantasize about whichever illegal activity interested them as usual, but at climax would actively think about the negative consequences of that activity (arrest and imprisonment, public humiliation, etc). In this way, the patient would “establish negative mental associations with his illegal activities.”

While psychotherapy was important to his treatment regime, Walker suggested that therapy alone was near useless. He observed that “no form of psychotherapy was consistently working until medication was combined with counseling,” and considered his combination of medication and therapy “unlike” any other treatment regime for sex offenders.⁶¹ Yet after two years, the program was only treating thirteen of its forty-three patients with hormone therapy. The other thirty received only psychotherapy. That less than a third of the patients received hormones at a facility where hormone therapy was touted as the only effective treatment suggests the difficulties of implementing this type of therapy.⁶² Moreover, even after two years, Walker’s center had released only one

⁶⁰ Charley Bankhead, “News Release,” Blocker Archive.

⁶¹ Bankhead, “News Release.”

⁶² Walker implies that patients refused hormone therapy for a variety of reasons: some did not feel that their desires were so overwhelming that they required medical treatment, some claimed to be innocent, and some worried that their wives would find out about

patient and was adamant that an additional two-year follow-up period would be necessary to determine if the patient had truly been rehabilitated. That UTMB was lauded as at the cutting edge of hormone therapy with basically no record of success suggests that hormone therapy was still in its infancy.

As of 1980, these two centers were the only significant hormone therapy programs in the United States.⁶³ They totaled perhaps thirty patients (and not all of these patients were rapists), and had very limited data on rehabilitation. Moreover, both Walker and Money specialized in gender (i.e., transsexualism and transvestitism), rather than in rape. While their work in the area of hormone therapy was pioneering, neither was particularly focused on rape and neither had strong data on the subject. Likewise, phallometric data was based on an extremely limited set of studies: by 1986, only six publications with an estimated 140 subjects (and this number includes the control subjects) had demonstrated statistically significant differences between rapists and nonrapists.⁶⁴ Nevertheless, this is the basis upon which PCD was suggested for inclusion

their crimes because the hormone injections had to be administered by a physician (it's not clear why they wouldn't have the same fear with therapy, but nonetheless, Walker lists this as a common reason). Moreover, many of the men who would have been eligible for this type of treatment were in prison, and their access to hormone therapy was limited by federal laws that strictly regulated the participation of prisoners in experimental research. Finally, though Walker did not give this explanation, we can assume that hormone therapy would have been threatening to patients in a way that therapy was not. This was a bodily intervention and one that they may have felt struck at their very sense of themselves as men, by both lowering their sex-drives and lowering their testosterone levels, both of which are often very much connected with masculinity in popular thinking.

⁶³ Groth, *Men Who Rape*, 217. Some additional work with Depo-Provera had been done in France and individual practitioners in the US used Depo-Provera sporadically, but the Johns Hopkins' clinic and the unnamed center at UTMB were the only organized centers in America systematically using the drug.

⁶⁴ The three studies discussed here include seventy total subjects (thirty eight rapists and thirty two control subjects). I have been unable to obtain the other three studies, but

in the *DSM*. Because more solid empirical data didn't exist on the other paraphilias already included in *DSM-III*, the data on Rapism were sufficient to qualify it for inclusion in the *DSM*. By the standards set for other psychiatric conditions, however, the data were suggestive but inconclusive.⁶⁵

Moreover, PCD was only one theory of rape; other psychiatrists thought about rape in very different ways. Among them was Nicholas Groth, one of the most prolific psychiatrists working with sex offenders not involved with the *DSM* revisions. Groth willingly conceded that rape was a “sexual deviation,”⁶⁶ but not at all like other paraphilias. He argued that the paraphilias were described in terms of sexual object, mode, or frequency (pedophilias, exhibitionism and nymphomania are his respective examples). Groth, however, conceptualized “sexual deviation as sexual behavior in the service of nonsexual needs,” thereby positing that sexual arousal was merely a byproduct, rather than the fundamental core of the issue. Rape, for Groth, was a “pseudosexual act” dependant not on sexual arousal, but on the “expression of power and anger” and on a need for “status, hostility, control and dominance.”⁶⁷ This view of rape is in some ways the opposite of PCD, where by definition those with PCD rape because they are sexually aroused by non-consent.

believe the number of subjects would be roughly similar, given that the type of research is the same.

⁶⁵ This discrepancy can be seen throughout the revisions process. The *DSM-III* involved a sustained field trial project to test the new diagnostic criteria. Only 3.5% of these field trials were concerned with Psychosexual Dysfunctions. Of these, probably only one-third concerned paraphilias. For a list of these field trials, see “DSM III Field Trials,” November 30, 1978, DSM Collection.

⁶⁶ This is the term Groth uses for sexual pathologies, rather than the more current term ‘paraphilia.’

⁶⁷ Groth, *Men Who Rape*, 13.

Groth clearly considered rapists to be mentally ill. He thought that 56% of the rapists he treated suffered from a personality disorder and further referred to rape as something of a “compulsion,” noting that 53% had at least one prior conviction and that many of the “first offenders” admitted to previous assaults for which they had not been caught.⁶⁸ Based on his clinical experience, however, he thought PCD was an inadequate and incorrect interpretation of sexually assaultive behavior. Rather, Groth saw rapists as men with personality disorders who were compulsively acting out non-sexual aggression or frustration by means of rape. The actual act of rape was only important inasmuch as it indicated that the men had chosen it as a means to express unrelated frustration or had internalized the social message that masculinity was best expressed through sexual dominance; in neither case was sex truly central to the offender’s psychopathology.

It might seem, at first glance, that Groth and the *DSM* Work Group were simply talking about different groups of rapists. The evidence for this is that Groth argues that rapists tended to recall little or no sexual arousal during their assaults, and frequently experienced difficulty becoming aroused during the crime (Groth states that 34% of men he worked with experienced “erectile inadequacy or ejaculatory incompetence”).⁶⁹ This would seem to contradict phallometric research, either suggesting that rape and sexual arousal were not as clearly connected as the Work Group thought or perhaps suggesting differences between sex offenders. In support of such differences, the Paraphilias Work

⁶⁸ Groth, *Men Who Rape*.

⁶⁹ Groth, *Men Who Rape*. Lest we think that this is merely self-reported, and thus unreliable, data from convicted rapists, Groth offers some corroboration: the presence of sperm was only detected in 32% of rape victims.

Group would claim, in the mid-1980s, that their diagnosis was actually intended to diagnose a particular type of rapist, rather than rapists in general.⁷⁰

Yet despite suggestions that rapists might be comprised of many different groups with different motivations, the idea that Groth and other psychiatrists were merely discussing different groups is insufficient for two reasons. First, Groth and the researchers previously discussed worked with ostensibly similar subjects—generally, those who had been found guilty of rape in the court system.⁷¹ Even more suggestive, Groth and Raymond Knight (a member of the *DSM-III-R* Paraphilias Work Group and one of the strongest supporters of PCD) both worked at the Massachusetts Treatment Center for Sexually Dangerous Persons and thus worked with *the same* patient population. While Groth believed that personality disorders were sufficient to explain their crimes, Knight vehemently disagreed. He noted that only 12% of the rapists at the Massachusetts Treatment Center “can be diagnosed as having deviant sexual behavior”

⁷⁰ More than anything else, this seemed to be an attempt on the part of psychiatrists to temper PCD and to hedge their bets. The claim did not emerge until relatively late in the revisions process and did not appear in the research itself. More importantly, multiple researchers implied that they saw rapists as a group, rather than as a group comprised of subtypes.

⁷¹ I would speculate even more similarities here, given the state of legal statutes regarding rape in the 1970s and 1980s. The men involved in these studies were likely guilty of violent rapes committed against strangers. In most cases, acquaintance rape, date rape or marital rape would not have resulted in prison sentences; accordingly, these types of rapists would have been excluded from research. As well, Abel, Groth, and Scully and Marolla all give similar demographic information for their research participants (predominantly white, more educated than the general prison population, and aged in their twenties and thirties). While there might still be differences among incarcerated rapists (and rapists more generally), we can assume that the research participants were a relatively homogenous group.

by *DSM* standards.⁷² While he agreed that most suffered from personality disorders, he found this “inadequate to address their sexual pathology.”⁷³ Implicitly, sexual crimes required sexual diagnoses.

Second, Groth addressed those researchers who saw rape as primarily sexual in nature and stated baldly that he did “not agree” and, in his clinical experience, had found “rape to be more a hostile than a sexual act.”⁷⁴ Groth additionally discussed hormone therapy and phallometric measures, indicating that he was indeed aware of the relevant research supporting PCD, but regarded this data as tentative at best. Taken together, these discrepancies indicate that PCD was not the only classificatory possibility for rape. Groth’s work indicates that psychiatrists could work with similar—even the same—patient populations and form very different theoretical lenses for thinking about sexual assault.

Outside of psychiatry, other theories proliferated. The most important one for my purposes can be referred to as a sociological or feminist theory of rape. Feminists saw rape as an act of violence, rather than of sex, which grew out of normative social values that encouraged male dominance and female submission. Rape, rather than representing a pathological aberration, was the natural outcome of a patriarchal society—the “All

⁷² Raymond Knight, “Problems with Paraphilias in *DSM III*,” n.d., *DSM Collection*. This letter is undated, but cites material from 1985; I presume it to have been written sometime in 1985 or 1986.

⁷³ Knight, “Problems.” Quinsey similarly notes that personality disorders are not sufficient and implies that all sex offenders must be diagnosed with some sort of specifically sexual dysfunction (Quinsey and Chaplin, “Stimulus Control of Rapists’ and Non-Sex Offenders’ Sexual Arousal.”).

⁷⁴ Nicholas Groth and Ann Burgess, “Rape: a Sexual Deviation,” *American Journal of Orthopsychiatry* 47, no. 3 (July 1977).

American Crime.”⁷⁵ This view was not merely political, but increasingly reflected in a number of sociological studies in the 1970s and 80s. One widely cited study of male college students found that 53% of the young men surveyed would consider raping a woman if they were sure of not being caught.⁷⁶ A number of sociologists also turned their attention to pornography, arguing that the normalization of violence and degradation in pornography reflected (and likewise further normalized) a society-wide fusion of sex and violence. Sociologists and feminists found common ground with the argument that violence against women—whether real or symbolic—was a social problem that grew out of normative American values and affected nearly everyone.

Of particular interest here are the sociologists Diana Scully and Joseph Marolla. Over the course of two years in the early 1980s, they interviewed 114 convicted rapists and, using extensive testimony, attempted to demonstrate the connections between how rapists talked about their crimes and how society envisioned sexuality. In particular, they noted that rapists were prone to arguing that women secretly “wanted” to be raped, implying a familiarity with cultural ideas of sexual brinkmanship and male responsibility for initiating sexual contact. Alongside this, Scully and Marolla directly attacked the idea that rape was pathological. They interpreted rape as “an extension of normative male behavior, the result of conformity or overconformity to the values and prerogatives which

⁷⁵ Susan Griffin, referenced as “representative of the feminist view,” in Diana Scully and Joseph Marolla, “Riding the Bull at Gilley’s’: Convicted Rapists Describe the Rewards of Rape,” *Social Problems* 32, no. 3 (February 1985). Scully and Marolla additionally cite the following feminist texts: Susan Brownmiller, *Against Our Will: Men, Women, and Rape* (Bantam Books, 1975); and Diana Russell, *The Politics of Rape* (Stein and Day, 1975).

⁷⁶ Neil Malamuth, Maggie Heim, and Seymour Feshback, “Sexual Responsiveness of College Students to Rape Depictions: Inhibitory and Disinhibitory Effects,” *Social Psychology* 38 (1980).

define the traditional male sex role.”⁷⁷ Not merely a difference of opinion, they argued that a pathological model of rape was actively detrimental:

A central assumption in the psychopathological model is that male sexual aggression is unusual or strange. This assumption removes rape from the realm of the everyday or ‘normal’ world and places it in the category of ‘special’ or ‘sick’ behavior. As a consequence, men who rape are cast in the role of outsider and a connection with normative male behavior is avoided. Since, in this view, the source of the behavior is thought to be within the psychology of the individual, attention is diverted away from cultural or social structures as contributing factors.

Scully and Marolla were not interested in diagnosing individual men, but sought instead to diagnose a social problem. As evidence for this view, they noted that the frequency of rape “makes it unlikely that responsibility rests solely with a small lunatic fringe of psychopathic men.”

These explanations can be viewed along a spectrum: from purely social to purely individual/pathological. There was no apparent room for social forces shaping illicit desires in Walker’s program (for Walker, this broad question just wasn’t his purview).⁷⁸ Likewise, feminists were generally uninterested in how social misogyny manifested in individual psychopathology. For feminists, these explanations and attempts to treat individual rapists were too narrowly tailored to address a problem that permeated American society. Even worse, a pathological model diverted energy from finding a sociological answer.

Along these lines, Scully and Marolla cited Groth directly as representative of the pathological view of rape and thus as their primary antagonist. Groth and Scully and

⁷⁷ Scully and Marolla, “‘Riding the Bull at Gilley’s.’”

⁷⁸ Some of the work on phallometrics took this a step further and posited that rapists are grossly unaware of social and interpersonal cues, and thus were not unaroused by nonconsent (see footnote 49 on this). This tangled definition, however, fell far afield from strict definitions of PCD.

Marolla actually had much in common—their work grew out of a concern for rape victims and they equally sought to remove responsibility from the victim.⁷⁹ Groth also worked closely with Ann Wolbert Burgess, a nurse and victims’ advocate who had edited at least one of Scully and Marolla’s articles.⁸⁰ On a more theoretical level, Groth certainly didn’t ignore social factors for rape and notes multiple times in his book that rapists sought to reaffirm their masculinity, clearly agreeing that the American cultural ideal of manhood involved sexual dominance. In fact, Groth stated that the typical rapist was “handicapped by stereotyped impressions of what are appropriate male and female role behaviors and expectations.” Scully and Marolla noted that, for many rapists, the victim “merely represents the category of individual being punished” (they refer to this as the “collective liability of women”); in turn, Groth’s therapeutic treatment of sex offenders included “empathy training” designed to enable sex offenders with a warped view of women to see individual women as people with whom they could empathize.⁸¹ While not the overarching social fix Scully and Marolla were searching for, Groth’s view of rape as a psychological problem indebted in part to social issues concerning gender and sexuality should have been able to fit with Scully and Marolla’s views. That Scully and Marolla

⁷⁹ The difference here is that Groth removes the onus from the victim and places it on the internal psychological operations of the perpetrator, while Scully and Marolla place it on society as a whole. According to Groth, rape “stems more from the internal dynamics operating in the offender than the external, situations events occurring outside him.” This apparent turning away from social factors would be dissatisfying to Scully and Marolla, although what Groth really meant in this case was, for example, what the victim was wearing. There is an order of things that goes from social to immediately circumstantial to psychological, with Scully and Marolla and society/popular views of rape representing one end and Groth/PCD representing the other.

⁸⁰ This brief description does not do Burgess justice. She co-founded one of the first sexual assault response unit in the country, was a major force for victim advocacy, and has published widely on the subject of rape.

⁸¹ Groth, *Men Who Rape*.

could not find common ground even with Groth indicates that there would be a fundamental, irresolvable clash between a feminist-sociological understanding of rape and a psychiatric diagnosis like PCD.

That said, most psychiatrists' views of rape fell closer to the middle than to either extreme. Walker acknowledged that rape often occurred during periods of non-sexual stress, aligning him somewhat with Groth. Abel, while considering sexual arousal a central part of rape, likewise noted that many rapists "carried out [the act] not for its sexual satisfaction" but to demonstrate membership in a group (as in gang rape) or to express anger towards women as a group.⁸² Knight even proposed that PCD could incorporate Scully and Marolla's criticisms, stating,

Feminist critique (e.g., Brownmiller 1975; Scully and Marolla, 1985)... has rightly emphasized the cultural contribution to rape and eschews the use of diagnosis for a cultural problem, [but] we might incorporate those concerns by adopting... a distinction between role-supportive and idiosyncratic rape, and create a new name for idiosyncratic rape (e.g., agriophilia or some equivalent).⁸³

While it's not clear how Knight would differentiate these two groups—the idiosyncratic, agriophilic rapist and the role-supportive coercive paraphilic rapist—nor which group Knight believed to be larger, his statement did indicate some willingness to listen to and deal with external, non-psychiatric criticism.⁸⁴ Finally, although later protest suggests otherwise, the biological view of rape that spawned PCD was not initially seen as

⁸² Abel et al., "The Components of Rapists' Sexual Arousal."

⁸³ Knight, "Problems."

⁸⁴ Even Knight's awareness of these critiques is notable here, in comparison to some of his colleagues. In 1986, after working on PCD for four years and with protest letters inundating Spitzer, Quinsey would write to Spitzer that he was "only aware of the concerns you mention regarding the coercive paraphilia category in a general way." (Vernon Quinsey to Spitzer, June 2, 1986, DSM Collection.)

threatening to a feminist project. The APA's Committee on Women was amenable to, if perhaps taken by surprise by, the diagnosis in the late 1970s.

The Women's Committee's involvement in this issue was roundabout—Ann Laycock Chappell began soliciting women in the APA for opinions on a variety of diagnoses in 1977. While none of these women were formally involved with *DSM* revisions, they were specialists in a variety of psychosexual issues. In particular, a number specialized in childhood gender identity issues, which was their chief concern with *DSM* revisions in the 1970s.⁸⁵ Gender identity issues had been theorized and researched almost entirely in regards to boys; the Women's Committee was concerned with what this meant for girls. They believed that “tomboyism” was perfectly understandable in a culture that devalued femininity. The tomboy wasn't maladjusted, but instead keenly read and adapted to what American society valued most.

The Women's Committee had a broad view of its mandate, and was interested in reconciling individual psychopathology with a feminist viewpoint that framed these same problems as sociological in nature. The Women's Committee was broadly interested in social justice issues and in gender as an expansive concept (other letters between Committee members discussed homophobia, racism and classism), rather than narrowly interested in diagnoses affecting only women. Their familiarity with Spitzer, despite the fact that they were not formally involved in the revisions process, indicates their comfort with inserting themselves into the revisions process. They saw themselves as expert specialists with valuable insights to offer, and saw the revisions process as an open one.

⁸⁵ On GID, see Karl Edward Bryant, *The Politics of Pathology and the Making of Gender Identity Disorder* (unpublished dissertation, University of California-Santa Barbara, 2007).

Moreover, this exchange evidences a preexisting network of professional women that extended beyond the APA to encompass women in other disciplines.⁸⁶

All of this indicates that the Women's Committee would have been interested in the prospective diagnosis of Rapism. Given sociological and feminist opposition to the disorder, we might assume that they would also come out against PCD. Indeed, by the mid-1980s, the Women's Committee would be one of the chief opponents to the disorder.⁸⁷ But upon its initial introduction, the Women's Committee actually offered tentative support for the diagnosis and agreed that rape was an appropriate subject for the *DSM*. With regards to a suggestion that Rapism be subsumed under the category of Sexual Sadism, Natalie Shainess, a feminist psychoanalyst, wrote "I do not like to see the term 'rape' written out of *DSM-III*—this is more than sexual sadism, and different in some aspects."⁸⁸ Elissa Benedek, then chair of the Women's Committee, agreed that "perhaps rape ought to be a special diagnosis in itself as Natalie Shainess suggests."⁸⁹ Carol Wolman's concern here was that subsuming rape under the category of sadism implied that rape was primarily sexual and wrote to Spitzer that she was "distressed that rape is included only under this heading... Rape is primarily an aggressive, rather than sexual act... I believe it deserves a separate heading."⁹⁰

⁸⁶ The Women's Committee maintained contact with women in the American Psychological Association's Women's Division, beginning as early as 1977.

⁸⁷ Some would also go on to hold positions of power within the APA. Elissa Benedek would go on to become member of the APA's Board of Trustees in the 1980s (and president in 1990). Carol Nadelson, who was involved in this exchange with the Women's Committee but was not a member of the group, would go on to become president of the APA in 1986. Nadelson was the organization's first female president.

⁸⁸ Natalie Shainess to Spitzer, April 21, 1977, DSM Collection.

⁸⁹ Elissa Benedek to Ann Chappell, June 8, 1977, DSM Collection.

⁹⁰ Carol Wolman to Spitzer, May 30, 1977, DSM Collection.

Of course, in addition to being generally amenable to the idea of a diagnosis, there was some disagreement on how to classify rape. Carol Nadelson worried that its classification as a paraphilia over-emphasized the “sexual aspects of rape rather than other aspects of it, i.e., as an impulse disorder... The problem of need gratification and lack of impulse control should be included in any consideration of rapists.”⁹¹ Viola Bernard, though she agreed that “rape is by no means primarily an expression of sexual lust,” saw no other satisfactory way to classify rape in the *DSM* and wrote, “perhaps the best bet would be to have another category added to the sexual deviations.”⁹²

Overall, members of the Women’s Committee agreed that rape was a sexual crime motivated by nonsexual factors (generally in line with a feminist theory of rape) *and* that its classification in the *DSM* was suitable. Unlike those who would lead the Committee in the 1980s, most did not believe that classifying rape as a paraphilia implied that it was a primarily sexual crime; rather, they believed that rape-as-paraphilia could encompass non-sexual motives.

Ultimately, PCD was a very particular understanding of rape based on research and treatment regimes only in their infancy. While certainly constructed in a way that fit with the other paraphilias, there was no reason why PCD had to appear in the *DSM* at this early date. It was conceivable that rape could have been theorized in some other way, though that raised different questions as to whether or not the *DSM* could encompass social—rather than only psychological—factors. Still, the researchers discussed here provided a number of different ways to classify rape, most of which were purely psychiatric. Personality disorders were a possibility, according to Groth and also

⁹¹ Nadelson to Ann Chappell, June 13, 1977, DSM Collection.

⁹² Viola Bernard to Dr. Chappell, May 27, 1977, DSM Collection.

tentatively suggested by Bernard. Members of the Work Group considered, initially, that PCD might be a subset of Sexual Sadism. Nadelson and Groth also suggested that rape could be thought of as a compulsion or impulse control disorder. Altogether, PCD emerged as only one of many classificatory possibilities.

Rapism in *DSM-III*

Having set up PCD as a tentative, but generally accepted, disorder, I must now throw a wrench into the works. In 1979, PCD was removed without explanation from the *DSM-III* draft.⁹³ There are two tentative explanations I can offer here. As the exchange with the Women's Committee indicates, the disorder was so new that it may have simply been tabled until it could be further disseminated. There is further evidence for this explanation in Spitzer's discussion of Frotteurism, another tentative paraphilia introduced in *DSM-III* revisions. Spitzer states that he had trouble making other psychiatrists understand the difference between Frotteurism and PCD, given that both involve sexual actions taken against a non-consenting partner. Given that both disorders enjoyed broad support among members of the Work Group and other specialists, Spitzer may have chosen to shelve both until a wider psychiatric audience could be made to understand them.

A second tentative explanation is that PCD was tabled due to legal concerns. The American Association of Psychiatry and Law later claimed to have been instrumental in

⁹³ Archival records for the *DSM-III* are spottier than those for the *DSM-III-R*. While I cannot say for certain why this is the case, I suspect it has something to do with the number of changes within the Work Groups for psychosexual disorders and paraphilias that took place during the revisions process. Those numerous changes (in both organization and membership) may have resulted in much of the documentation for their processes being lost.

getting PCD removed from *DSM-III*, which indicates that legal concerns were raised about PCD early on. Simply put, many feared that PCD would allow rapists to plead insanity or otherwise escape jail time. This objection would play a significant role in protests in the 1980s. Despite its later importance, I find this explanation unlikely. Spitzer and his colleagues consistently argued that legal concerns were simply not their domain. Spitzer's most direct response to this in the 1970s implies that he was generally unconcerned with any of the diagnoses' legal implications. In response to a letter about sexual sadism and masochism, he writes:

I do not know what the medical legal significance of these categories will be. My understanding is that a psychiatric diagnosis by itself does not have much relationship to whether or not an individual is regarded as being responsible for the violation of various legal statutes... Whether or not the legal systems will decide that an individual who has one of these disorders is not responsible for his behavior is outside of our professional responsibility.⁹⁴

This general stance did not change at any point during the revisions process for *DSM-III* or *DSM-III-R*. If Spitzer had deleted the disorder from *DSM-III* in response to the AAPL's concerns, it seems unlikely that he would have so completely failed to grapple with the legal implications of PCD before reintroducing it to *DSM-III-R*. Given his glib dismissal of any responsibility for legal concerns in the above letter, I find it unlikely that he would have listened to the AAPL's objections at all.

⁹⁴ Robert Spitzer to Dr. Lawrence Mass, September 4, 1979, DSM Collection.

PCD in DSM-III-R

Despite whatever reasons led to its deletion from *DSM-III*, PCD was again suggested for inclusion in the *DSM-III-R*, this time by Raymond Knight.⁹⁵ PCD had roughly the same shape and was offered up with roughly the same justifications (phallometrics and hormone therapy), implying that the diagnosis held continued appeal for specialists in sexual deviancy and that whatever factors had worked against it in 1979 had failed to dampen support for the disorder by the time it was reintroduced in 1982. If, however, PCD had flown under the radar in *DSM-III* until the last minute, this time it would become a constant source of controversy. Despite an awareness of the objections to PCD, Spitzer's Work Group never came up with a convincing argument for its inclusion in the *DSM*. Or perhaps more accurately, their arguments were too narrowly based in psychiatry, as evidenced by their failure to deal with social and legal concerns about the disorder.

By late 1985, the Work Groups and Ad Hoc Committee⁹⁶ had begun to really buckle down on the issue of controversial diagnoses.⁹⁷ An open meeting on Masochistic

⁹⁵ Raymond Knight to Spitzer, May 8, 1986, DSM Collection. Along with Knight and Abel, the Work Group also welcomed new members Judith Becker, Vernon Quinsey, Janet Williams, Fred Berlin and Park Dietz. David Barlow would also join the Work Group in 1986. Friedman, Stoller and Gebhard were not involved with the *DSM-III-R* revisions process, meaning the entire group roster had changed, with the exception of Spitzer.

⁹⁶ The *DSM* revisions used a three-tiered system. The Board of Trustees, a democratically elected Board that oversaw the APA as a whole, appointed an Ad Hoc Committee to oversee the revisions process. The Ad Hoc Committee then appointed specialized Work Groups to compose individual sections of the *DSM*. Each Work Group would approve the disorders, and then send them to the Ad Hoc Committee for approval. The Board would then be given the power to approve or alter the revisions.

⁹⁷ As noted in the introduction, PCD is not the only controversial diagnosis in this period. Homosexuality was still a source of ongoing debate, as were the newly introduced disorders of PMDD, SDPD and Sadistic Personality Disorder (SDP).

Personality Disorder resulted in a name change—Self-Defeating Personality Disorder—to avoid the sexual and gendered baggage of the term ‘masochist’ and perhaps also to step away from an increasingly pitched battle with women’s groups and victims’ advocates. PMDD was also given yet another new name; this was a favored tactic of *DSM* Work Groups and one for which they were roundly criticized by feminists such as Paula Caplan.⁹⁸ At this point, Rapism officially became “Paraphilic Coercive Disorder,” emphasizing the central role of coercion and leaving behind the baggage of the term ‘rape.’⁹⁹

Still, despite these name changes and (slightly) reformulated criteria, the Ad Hoc Committee was not yet convinced and a meeting was convened on December 4, 1985. The Work Group and the Ad Hoc Committee both approached the meeting with entrenched viewpoints. Spitzer entered into the meeting expecting all the controversial disorders to be stricken from the *DSM-III-R*. He would later accuse the Ad Hoc Committee of knuckling under and refusing to discuss the issues—according to him, they had merely repeated the same objections that these disorders had the potential to be abused, but failed to provide any evidence for their view.¹⁰⁰ For their part, the Work Group for Paraphilias merely repeated the same arguments for the disorder—phallometric studies demonstrated that this group existed, and newly effective treatments had been

⁹⁸ This new name was the unwieldy “Late Luteal Phase Dysphoric Disorder.” On criticisms of the APA’s name-changing tactics, see Caplan, *They Say You’re Crazy*. For an explanation of the name change from the perspective of the APA, see Figert, *Women and the Ownership of PMS*.

⁹⁹ “Report of the Ad Hoc Committee of the Board of Trustees and Assembly to Review the Draft of *DSM III R*,” December 7, 1985, DSM Collection.

¹⁰⁰ Robert Spitzer, “Where We Are,” December 11, 1985, DSM Collection.

found.¹⁰¹ Here, the Work Group also clarified that paraphilic rapists were merely one particular type of rapists, thus sidestepping the concern that the disorder would be used to pathologize all rapists.¹⁰² Rather than dealing head-on with legal concerns, Spitzer dismissed them with the pat assertion that legal concerns shouldn't influence scientific thinking. More strongly, Spitzer stated, "there was never any question about whether this was a category" and acknowledged that their primary concern had always been "whether we could pull it off politically."¹⁰³

Though the Work Group introduced no new support for the existence of PCD, their argument was enough to convince the Ad Hoc Committee. In a memo written a week later, Spitzer registered pleased surprise at this. Not only had they won on all the controversial disorders, but the Ad Hoc Committee had also agreed to "bite the various bullets associated with the controversial categories that have taken up so much of our time recently."¹⁰⁴ By the end of 1985, then, the Work Group saw PCD as a done deal. Three months later, a revised draft was produced and circulated. PCD was included,

¹⁰¹ "Meeting of Ad Hoc Board-Assembly Committee to Air Controversies in Revision of *DSM-III* - 12/4/85," December 4, 1985, DSM Collection.

¹⁰² Despite the fact that nearly all research on PCD had involved incarcerated serial rapists, one psychiatrist present at this meeting spent some time questioning whether or not the diagnosis could be used to deal with the problem of marital rape. While this diversion is strange, it's also representative of what a poor job the Work Group had done in publicizing PCD to APA members outside the revisions bubble. The term 'rape' called to mind vastly different things for different people, but the Work Group never successfully clarified to their colleagues what rape meant in the context of PCD. The marital rape discussion was a peculiar digression that makes it clear that the Work Group had done a poor job of making psychiatrists understand what they meant with PCD. Moreover, the assertion that PCD was meant to apply only to some rapists was never thoroughly discussed and the obvious questions (which rapists, how would the APA strictly define them, and how would the APA prevent other non-paraphilic rapists from being diagnosed?) were never answered.

¹⁰³ "Meeting of the Ad-Hoc Board to Air Controversies." Spitzer attributes this sentiment to Park Dietz.

¹⁰⁴ Spitzer, "Where We Are."

albeit with a code shared with the Paraphilia Not Otherwise Specified designation. An official vote taken by Spitzer's Work Group on this draft garnered complete approval for PCD.¹⁰⁵

By this time, the revisions process was ostensibly winding down. At this point, the Board of Trustees declined to take on formal liaisons with new groups, stating that the Work Group to Revise would only be meeting once or twice more.¹⁰⁶ The APA's expectation was that the March draft was, more or less, what would be published in 1987. The rest of the year would be dedicated to fine-tuning and double-checking, with the major controversies having been resolved. Little did they realize that professional objections were about to be parlayed into major protests.

By June, women's groups across the country had mobilized against the three controversial diagnoses. These protests were widespread and included mental health professionals, regular citizens, and even legal groups. The protests give some idea of the permeability of the psychiatric sphere: many of the protests trickled out through feminist psychiatrists and mental health workers into the general public. Others were the result of the APA's attempts to publicize the *DSM* revisions.¹⁰⁷ Paula Caplan's letter (on behalf of

¹⁰⁵ Robert Spitzer, "Ballot," March 15, 1986, DSM Collection. I have ballots from each committee member; all voted 'affirmative' to Paraphilic Coercive Disorder as written in the March draft, as well as to all other paraphilias listed in that draft. This further indicates that the Work Group was in agreement on the criteria as they stood in the March draft and that the revisions process was winding down. The only change made or suggested by the Work Group at this point was a suggestion on Raymond Knight's ballot that PCD's criteria differentiate between acts and fantasies (this stipulation had been removed earlier, but was put back in at his request).

¹⁰⁶ Robert Pasnau to Leonard Goodstein, March 21, 1986, DSM Collection.

¹⁰⁷ In particular, a number of protesters cite an interview given by Carol Nadelson in 1985 on the three proposed diagnosis discussed here. I have not yet located the interview, but it appears to have been given not to a psychiatric publication, but to a publication designed to introduce specialized issues to a general audience (think here of something like NPR).

the Coalition Against Misdiagnosis, sometimes styled as the Coalition Against Ms. Diagnoses) to Robert Pasnau (President-Elect of the Board of Trustees) gives some indication of the extent of the protests.¹⁰⁸ Caplan writes that 2,800 signatures had been collected on various petitions, and that the membership of mental health organizations formally protesting the disorders totaled one hundred thousand (included here were the American Psychological Association, the American Orthopsychiatric Association, work groups from the Surgeon General, the National Association of Social Workers and so on).¹⁰⁹ She states that, combining professionals and non-professionals, the number of protestors in North America surpassed three million. While this may have been an exaggeration, the protests were certainly substantial enough to cause concern.¹¹⁰

Moreover, these protests were directed towards not just the Work Groups and Ad Hoc Committee to Revise DSM, but also to the APA's Board of Trustees. I will examine these protests at length in chapter 2, but for now I want to look at the APA's response to them.

With an avalanche of protests letters coming in that summer, the Board of Trustees intervened. The Board of Trustees had been aware of PCD prior to the protests. The Work Group and Ad Hoc Committee had been hammering out the wording for PCD at meetings throughout the past months and, on March 14 and later on May 11, Spitzer

¹⁰⁸ Paula Caplan wrote to Pasnau, as well as to the Board of Trustees. See Caplan to Pasnau, June 23, 1986; Caplan to the Board of Trustees, June 23, 1986; Coalition Against Misdiagnosis and Lenore Walker to Pasnau, May 1, 1986; all part of the , DSM Collection.

¹⁰⁹ The National Association of Social Workers and the Orthopsychiatric Association were particularly successful at mobilizing their members to protest. The APA's archive contains at least one hundred letters written by members of these two organizations.

¹¹⁰ Just to give an estimate, the protest letters held by the APA number probably near 500, with as many petitions mailed in. These petitions have anywhere between five and fifty signatures, so a conservative estimate would be 5,000 signatories. Stacked together, all the protest mail sent to the APA would have easily filled a two-inch binder.

had submitted the *DSM* drafts for PCD (as well as PMDD, SDPD, etc.) to the Ad Hoc Committee and the Board of Trustees. The Board had approved PCD without comment at that time.¹¹¹

If Spitzer thought the Ad Hoc Committee had been difficult, he found the Board of Trustees not only unreasonable but also perfectly willing to use their status to veto the Work Group's recommendations without any discussion. Once protests began in earnest in June, the Board's decision was initially to delete all three diagnoses from the *DSM* in early July. Spitzer complained bitterly that the Board had chosen to ignore the months of work put in by his Work Group. The Work Group members "uniformly expressed disappointment and even outrage" at the Board's decision and the unilateral process by which they had reached it.¹¹² Moreover, the Board chose to ignore "its own" Ad Hoc Committee's recommendation. Spitzer noted that the Board of Trustees had personally appointed the Ad Hoc Committee, making the Ad Hoc Committee's inability to control any part of the process even more frustrating.¹¹³ Spitzer and his colleagues felt this set "an unfortunate precedent" and attempted to nail the Board down on a more collaborative process by which they could reach a compromise. By this point, however, the revisions process had become tense and bitter. Despite requests to meet with the Board, Spitzer realized a compromise was unlikely.

¹¹¹ "Excerpt from the "Report of the Ad Hoc Committee of the Board of Trustees and Assembly to Review the Draft of *DSM-III-R* to the Assembly of District Branches for Their May 9-11, 1986 Meeting," n.d., DSM Collection. While the Board suggested changes to both Self-Defeating and Sadistic Personality Disorder, they approved PCD without further comment.

¹¹² Harold Pincus to Melvin Sabshin, July 8, 1986, DSM Collection.

¹¹³ Spitzer to Bob Pasnau, July 9, 1986, DSM Collection.

Politics & Social Issues in the APA

This was not the first time the Board of Trustees had been embroiled in a political conflict; the 1970s and 1980s were a fraught period for the APA. In the 1970s, they had been subject to sustained protests by gay rights activists, leading eventually to the removal of homosexuality from the *DSM*.¹¹⁴ And, in 1980, the APA became involved in battles over the Equal Rights Amendment. In support of the ERA, the Board of Trustees made two decisions: to fund pro-ERA activities¹¹⁵ and to move the APA's annual meeting away from New Orleans because Louisiana had not yet ratified the ERA. A large number of APA members reacted negatively. They argued that the APA should not be involved in overtly political actions, and that the Board's decisions had been unilateral and "arrogant, anti-democratic and foolhardy."¹¹⁶ As a result of protests from their membership, the Board reversed its earlier decision on the conference location.

Here, we have a precedent of the Board acting unilaterally *and* of the Board ultimately learning that it would be forced to listen to criticisms (this time from within the APA's membership). This saga demonstrates some sympathy on the part of the Board for women's political issues, it is not entirely clear what the ERA saga meant for the Board's mode of governance in subsequent years. The response of the APA's membership, as demonstrated in surveys, indicated that the majority were more concerned with democratic governance within the organization than with the ERA issue

¹¹⁴ The history of homosexuality in the *DSM* is long and tangled. Its "removal" (commonly cited as occurring in 1979) was really its replacement with "ego dystonic homosexuality." Protests over this diagnostic category, though never as large as the protests in the 1970s, continued well into the 1980s.

¹¹⁵ This appears mostly to have included funding advertisements for the ERA placed in national publications.

¹¹⁶ "Meeting Minutes of the Ad Hoc Committee of the Board/Assembly to Recommend Actions Relevant to the 1981 Meeting," July 24, 1980, DSM Collection.

itself, which they saw as political or social issue external to the organization.¹¹⁷ What ultimately came out of the ERA debacle was a promise by the Board to be more sensitive to divisive issues, to listen better to the APA's membership, to act with a "spirit of compromise" and to develop procedural rules for dealing with such issues.¹¹⁸ By 1986, however, these promises seemed unmet. With the PCD controversy, the Board was placed in a position from which it could not fulfill all these requirements simultaneously. Unlike the ERA issue, PCD produced deep divisions not just between the Board and the membership of the APA, but within the APA membership itself—despite consensus within the Work Group, little consensus among the APA's broader membership existed in regard to PCD or the other controversial disorders. Moreover, the Board's actions in disregarding the Work Group on Paraphilias and the ensuing lack of collaboration with either the Work Group or the Ad Hoc Committee indicates that the Board had largely failed to put in place procedures for dealing with intra-organizational conflict.

Regarding the ERA issue, Elissa Benedek, president of the Women's Committee, noted that there had been "an increasing squeak to the wheels of the APA around the

¹¹⁷ Pennsylvania Psychiatric Society, "ERA Questionnaire," September 29, 1980, *DSM* Collection. Of 546 responses received, 350 responded, "Primarily concerned about governance of APA by majority of membership." An additional 118 "Do not favor passage of ERA amendment," and thus obviously did not support the Board's actions. 121 would have favored moving the meeting "were it not for signed contracts," and 84 "were it not for intimidation tactics." Comments attached to the poll "mentioned almost three to one that ERA was either a political or social issue and not the responsibility of the APA." A number of respondents threatened to drop their membership in the APA over the debacle.

¹¹⁸ "Meeting Minutes of the Ad Hoc Committee of the Board/Assembly to Recommend Actions Relevant to the 1981 Meeting." Another ERA memo gives, under long-term goals, this suggestion: "Role of professional societies in dealing with social and public policy matters. What is legitimate and what is not. Need for more effective development of the rationale of our involvement." Despite this, the Board never effectively clarified why it had responded to political agitation to drop PCD from the *DSM-III-R*.

women's issues" and believed that this had "produced forces to destroy the 1981 meeting." More strongly, she felt there was a "danger of this leading to the destruction of the APA itself," and that "each side apparently feels that the other is having this effect, but both sides are quite concerned about it."¹¹⁹ Here, we can see a precedent for thinking about political issues posing a very serious danger to the APA's very existence, as well as some confusion about where to place the onus for that danger. Was the problem merely that the Board had failed to consult members on its actions? Or was the Board's very responsiveness to political issues the heart of the issue? Benedek's apocalyptic fears would resurface with the debates over PCD, which brought forth these same questions.

In an attempt to stave off confrontation in the summer of 1986, Board member Lawrence Hartmann proposed a compromise: rather than removing the diagnoses entirely, they could be placed in an appendix. That summer the relationship between the Board and the Work Group had become acrimonious enough that many urged the Work Group to accept the appendix compromise. Roger Peele wrote that "it would be nice not to have to go back to the Board," and asked Spitzer if there was "a way to live with the Board decision" to move the controversial diagnoses to an appendix.¹²⁰ Ultimately, for Peele, accepting an imperfect compromise would be "far better" than having a "Work Group—Board confrontation." This was partly an acknowledgement that in a confrontation, the Work Group was bound to lose; accordingly, acquiescing on the appendix was the only way that the diagnoses could be included in the *DSM* at all. But at the same time, those involved genuinely worried that a confrontation might really

¹¹⁹ "Meeting Minutes of the Ad Hoc Committee of the Board/Assembly to Recommend Actions Relevant to the 1981 Meeting."

¹²⁰ Roger Peele to Janet and Bob Spitzer, July 1, 1986, DSM Collection.

fracture the APA, especially given Spitzer's position within the organization. Spitzer was well known to everyone involved with *DSM-III* revisions and, from all indications, rather well liked. This is not to say that Spitzer might have been able to mobilize support within the APA against the Board or anything of that nature, but merely that those within the organization were invested in preventing an all-out fight between Spitzer and the Board. Given that some bad feelings must have remained after the ERA debacle, it is possible that Spitzer could have painted the excision of PCD from the *DSM* as another example of unfair governance, thus reopening old wounds.

While moving PCD to an appendix was intended as a compromise to satisfy all parties involved, it would quickly become clear that neither Spitzer nor the protestors had any intention of compromising. Only one member of the Work Group "felt he could live with" an appendix; others preferred the diagnoses be deleted entirely rather than be placed in an appendix.¹²¹ As for the protestors, letters would continue to flow into the APA in August, protesting the inclusion of the disorders even in an appendix.¹²² The failure to compromise here was due partly to the haziness of Hartmann's proposal. The appendix was unique to this situation, having never appeared in the *DSM* before, and no one involved had a clear idea of what the exactly the proposed appendix would look

¹²¹ Harold Pincus to Melvin Sabshin, DSM Collection.

¹²² While the appendix didn't garner the same reaction as the disorders themselves, there are still some important protestors. Among them was G. M. Gazda, President of the American Psychological Association's Division of Counseling Psychology. See G. M. Gazda to President Pasnau, August 4, 1986, DSM Collection. Part of the discrepancy in reaction can probably be attributed to the APA's ability to spin the appendix as akin to deleting the disorders. There was a similar lull in protests about the inclusion of homosexuality, because the APA was able to say that it had deleted the disorder, without publicizing the fact that it was replaced with "ego dystonic homosexuality." Accordingly, many of the protests by non-psychiatrists dropped off after the appendix solution was accepted, while a number of mental health professionals continued to protest.

like.¹²³ Rather than ending the controversy, the ambiguity of the proposal prolonged it: each side saw the appendix not as a compromise, but an outright failure of their position. Women's groups worried that even an appendix would lend PCD some level of legitimacy. From psychiatrists, the reactions were more related to what the presence of an appendix would imply about the *DSM* itself. Would acknowledging the controversial and unsettled nature of some diagnoses undercut the *DSM* as a whole? For many, it seemed better to leave the diagnoses out entirely and table the discussion until revisions for *DSM-IV* began.

As for those who supported the idea of an appendix, suggestions varied. Roger Peele proposed that the controversial disorders be left in the text of *DSM-III-R*, but that the codes and titles be bracketed with an asterisk leading to an appendix. They would merely have a note that would lead the reader to an appendix titled "Disorders to be used with Caution." Peele included in his proposal the following text for the appendix:

These three controversial conditions are to be used with caution... They are available in this classification to facilitate further study and to enhance the differential diagnosis of patients who may present with conditions suggestive to these disorders.¹²⁴

That is, the disorders would still be in the full text, would still be assigned a diagnostic code, and would still be valid for diagnosing patients. They would merely receive a cautionary note with no real change to their status.

¹²³ According to Spitzer, "conversations with several board members... yielded vastly divergent views concerning the nature of the appendix. There clearly needs to be some greater specification of the form and intent of an appendix" (Pincus to Melvin Sabshin). Board members' ideas about the appendix ranged from "the categories would have no code numbers and they could not be used as an official *DSM-III-R* diagnosis' to 'the categories should have code numbers and could be used as an official diagnosis with the recognition that they had less status than the other categories'" (Spitzer to Bob Pasnau).

¹²⁴ Peele to Janet and Bob Spitzer.

From this proposal emerged a debate over what should be emphasized in the appendix—the potential of the diagnoses to be abused, or the need for further study. The Board of Trustees believed that the need for further study should be emphasized, in opposition to Peele’s proposal. Peele, however, felt that this was an attempt to side step the current debate. He argued that further studies were unlikely to stem the debate: critics “will counter that there may be ‘something’” to the diagnoses, but that they lack “clinical specificity,” and “we are back to where we were last year.”¹²⁵ Instead, an explicit acknowledgement that the disorders were controversial because of their potential for abuse “places the question beyond the reach of the research, points out the irrelevance of further papers and gives those of us in the Work Group less of a ‘scientific’ foundation upon which to stand.” That is: the Work Group for Paraphilias had been arguing all along that PCD was as empirically supported as any other listed paraphilia. Acknowledging that the disorder could potentially be abused allowed that PCD was by no means unique in needing further research and provided a way for the Work Group to stop attempting, in vain, to “prove” the disorder to an audience skeptical more of its implications than its mere existence.

Peele’s proposal was an acknowledgement that the Work Group had become caught up in an unwinnable battle: they regarded the disorder as already proven and felt increasingly embattled as they continually presented the same—to them, sufficient—evidence with increasing frustration. On the other side, critics were only sometimes talking about proof; usually, they were concerned with the social and legal implications of the disorder, which is something else entirely. In this sense, Peele thought the battle to

¹²⁵ Roger Peele to Mel Sabshin and Bob Pasnau, July 14, 1986, DSM Collection.

prove or disprove PCD was a useless diversion from the real issue. The Work Group felt that empirical proof was enough to justify PCD's inclusion in the *DSM*, but others recognized that it was only by acknowledging the political implications of the disorder that any progress on the issue could be made.

Defining the *DSM*

Put upon from above by the Board of Trustees, Spitzer also found his Work Group suddenly split at the height of the protests. Vernon Quinsey was the first to jump ship. In a letter to Spitzer, Quinsey reiterated his belief that much of the empirical research done on PCD was valid. Like his colleagues on the Work Group, he found the evidence conclusive that a subset of men with an empirically measurable interest in coercive sex and rape existed, and that PCD was an “appropriate” classification.¹²⁶ Yet, according to Quinsey, these findings “do not demand” such a diagnosis. Rather, because research could be interpreted and shaped in different ways, PCD could potentially be considered a subset of sadism or classified in some other way. That is, the group of men the Work Group referred to as coercive paraphiliacs objectively existed, but the name by which *DSM* referred to them could be different. Quinsey, then, explicitly acknowledged the *DSM* as an artificially constructed document. As such—as a document not based on entirely objective scientific claims—he saw its implications for public policy and society more broadly as valid concerns.

Alongside this, Quinsey saw non-psychiatrists as rightful stakeholders in the debate over psychosexual classifications in the *DSM*. He wrote, “the issue of how best to

¹²⁶ Quinsey to Spitzer, June 2, 1986, DSM Collection.

accommodate this observation within the *DSM III* is a perfectly valid question to debate from both a scientific and policy point of view,” and “non-specialists have every right to question this classification.” Still, he agreed that PCD had some validity as a diagnosis, and was skeptical that protesters were correct about the implications they claimed PCD had. Cautioning Spitzer not to be “defensive or doctrinaire,” he wrote, “Those who object to the category should be asked what scientific information it would take in order to change their mind.” Like Peele, he believed the debate to be stymied by protesters’ lack of concern with empirical data.

This was by no means the only view of *DSM*. In a letter written a few weeks later, Park Dietz wrote to Spitzer that he was now convinced that PCD should be stricken from the *DSM*. Dietz, according to Spitzer, had been instrumental in convincing the Ad Hoc Board to approve PCD back in March.¹²⁷ Dietz’s letter to Spitzer was conflicted, perhaps even confused. Dietz stated first that he, like Quinsey, found the phallometric evidence “conclusive” that “some proportion of repetitive rapists” are aroused by coercive imagery, but that not enough research had been done in the “general population” to demonstrate a strong connection between this arousal pattern and sexual assault.¹²⁸ Yet, according to Dietz, this lack of evidence was “equally applicable to our knowledge of... pedophiles and other paraphiliac groups currently recognized in *DSM-III*. Indeed, many of the long-established paraphilia diagnoses have undergone less scientific scrutiny” than had Coercive Paraphilic Disorder. PCD, then, was based on assumptions not entirely supported by empirical research, but was also every bit as scientifically established as anything else already approved as a paraphilia.

¹²⁷ Spitzer, “Where We Are.”

¹²⁸ Park Dietz to Spitzer, June 23, 1986, DSM Collection.

The logical assumption is that Dietz's change of heart was political, rather than professional. Yet that was not what he claimed. Instead, Dietz argued, "the most important consideration in determining what action to take at this time is the lack of acceptance of the diagnosis in the psychiatric community." Because most psychiatrists disagreed with the disorder, Dietz felt it should be left out of *DSM-III-R*. Unless a consensus was reached among mental health professionals, it did not belong in the *DSM*. Implicit in Dietz's argument is a very particular understanding of the *DSM*. For Dietz, the manual should be a tool that reflected majority understandings of mental illness. This was a somewhat peculiar reading. Despite a certain amount of openness on the part of the Committees and Work Groups to revise the *DSM-III*, the power to write the manual ultimately came down to those on individual Work Groups (and, by extension of their approval and veto power, the Ad Hoc Committee and the Board). Had protests not been mobilized, the Paraphilias section would have been written, voted on and approved by a small group of specialists. This structure relied on an understanding of psychiatric specialization—whatever any given member of the APA thought, if specialists in psychosexual dysfunction overwhelmingly agreed that PCD was a valid diagnosis, why should non-specialists (simply because they held a majority) be able to erase PCD? For Dietz, however, the *DSM* was a democratic document and the fight over PCD should take place and be settled before it was introduced to the manual.

Ray Knight offered a third view of the *DSM*. Knight viewed PCD and, implicitly the *DSM*, in nearly the opposite way as Dietz. In writing to Spitzer, Knight used nearly the same disclaimer that Dietz had:

As a category [PCD] is as defensible as the remaining paraphilias, and probably more defensible than most Axis II disorders. If you apply the

same criteria across the board... and decide not to include Coercive Disorder, many other categories should be dropped with it.¹²⁹

But rather than arguing that it should be dropped for lack of acceptance, Knight thought its inclusion in the *DSM* would actually allow for more research to be done. He wrote that “the identification of Coercive Disorder Paraphiliacs in *DSM-III-R* would allow more data to be gathered about these individuals and would speed taxonomic understanding of their hypothesized pathology.” Knight implicitly acknowledged that the current understanding of PCD was incomplete, but argued that the *DSM* was a necessary tool in the process of defining and understanding mental illnesses. Rather than a document reflecting majority opinions (whether of those within or outside of the APA), Knight saw it as a mechanism that shaped psychiatric research.

These three letters are exemplary for a few reasons. They reveal that the Work Group on Paraphilias was in near total agreement about the existence of PCD, as well as its empirical support relative to other disorders. They were in total agreement that legal objections were irrelevant, both in the sense that legal concerns had no place in their view of science and in that legal concerns about PCD had been overstated to begin with.¹³⁰ Yet despite this strong consensus on PCD, there were very disparate opinions about the *DSM* itself. It is notable as well that while these fractures only came to light once massive protests were mobilized, neither Quinsey nor Dietz, despite agreeing that PCD should be removed, agreed with the particular objections put forth by protesters. Rather, their objections were based primarily on how they viewed the *DSM*.

¹²⁹ Knight to Spitzer.

¹³⁰ Quinsey stated that any legal concerns should be easy to evaluate empirically. His example was pedophilia: if the presence of pedophilia in the *DSM* has led to lesser prison sentences for pedophiles, then perhaps PCD should be deleted from the *DSM*. He did not, however, think this was the case.

At this point, the discussion in the Work Group became less about whether or not PCD existed as a valid disorder, but about institutional power and purpose: who inside the APA held the power to shape the *DSM* and to what extent were outsiders able to claim a similar power? To what extent was specialization more important than democratic engagement and governance? Moreover, what was the purpose of the *DSM* itself? Superficially, it was merely a document intended to list mental disorders. But did that mean it should reflect common psychiatric understandings of those disorders or be used to shape and guide those understandings? Moreover, as the APA was beginning to realize, such disorders are politically and socially shaped. The debate in the summer of 1986 reveals confusion about what purpose the *DSM* was supposed to serve both within the APA and outside it. Despite the apparently united front of the Work Group, the protests forced its members to confront their very different understandings of the *DSM* and their roles as advisors to it.

Conclusion

Over the course of the 1970s and 1980s, psychiatrists referred to rape as a paraphilia, a compulsion, a subset of sexual sadism, an impulse control disorder, and the result of a personality disorder. Clearly, no one definition of rape satisfied a majority of psychiatrists. While this may not have been the dominant reason for PCD's eventual deletion from the *DSM*—the protests were primarily responsible—the lack of majority support for the disorder among the APA's membership played an important role. With the ERA debacle, the Board of Trustees was convinced to reverse its actions because a clear majority of APA members demanded it. No such clear majority demanded the

inclusion of PCD in the *DSM*. Accordingly, protesters were able to mobilize and convince the Board to act in their favor. That psychiatrists were so divided on the issue of rape additionally meant that protesters were able to convince many psychiatrists that PCD was an unsupported and dangerous disorder.

What this debate indicates about fractures within the APA is equally as important as what it says about the moveable line between the APA and outsiders. Under pressure, the Work Group on Paraphilias revealed major differences of opinion on the role of specialists within the APA, the place of social concerns within psychiatry, and even the purpose of the *DSM* itself. Tasked with creating an ostensibly empirical catalogue of sexual dysfunctions, the Work Group found almost nothing about this process straightforward: from the very terminology used to how or even if disorders could be “proven” to exist, every aspect of PCD was debated and hardly anything resolved. Indeed, more than twenty years later, *DSM* Work Groups continue to debate the existence of PCD and the place of social concerns in a psychiatric manual.

Chapter 2

“As a Woman and a Mental Health Worker”: Protesting the *DSM-III-R*¹³¹

In 1986, the American Psychiatric Association attempted to add three new diagnoses to its *Diagnostic and Statistical Manual of Mental Disorders*: Paraphilic Coercive Disorder (PCD), Premenstrual Dysphoric Disorder (PMDD, later LLPDD¹³², and even later PMS), and Self-Defeating Personality Disorder (SDPD). In brief, PCD deemed a subset of rapists to be mentally ill; their sexuality was dictated by a compulsive and pathological desire to rape. PMDD was defined much the same as PMS is today—that is, some women suffered from emotional disturbances (anger, irritability) during or around the luteal phase of their menstrual cycle and that such symptoms were the result of an underlying psychiatric disorder. SDPD, formerly known as Masochistic Personality Disorder, was used to diagnose patients who engaged in a pattern of self-defeating behaviors—excessive self-sacrifice, consistently choosing situations or individuals who lead to disappointment, rejection of positive situations or people, and so on.

Although these proposals enjoyed strong support from the APA’s *DSM* Work Groups and leadership, they sparked a wave of protests from mental health workers, feminist organizations, and the public. This chapter discusses those protest materials. I argue that the protest movement rallied against the APA in the summer of 1986 is indicative of a broad and rapidly mobilized feminist network. That a mere handful of women’s organizations—the National Organization of Women (NOW), the Canadian Committee Against Misdiagnosis, the National Association of

¹³¹ Material from this chapter has been adapted for publication in the *History of Psychology*. See: Jenifer Dodd, “The Name Game”: Feminist Protests of the *DSM* and Diagnostic Labels in the 1980s, *History of Psychology* 18, no. 3 (2015). It is reproduced here with permission from the publisher.

¹³² Late Luteal Phase Disorder, and later Periluteal Phase Disorder.

Social Workers (NASW), the American Orthopsychiatric Association (ORTHO), etc.— were able to mobilize enough dissent in the space of a few months to ultimately force the APA to alter its manual is impressive. Yet, as this chapter will demonstrate, the breadth of these networks does not necessarily indicate depth. While numerous women took part in these protests, it's clear that the majority had little information beyond the talking points provided by these organizations. And, despite the close working relationship between feminist organizations and professional women's mental health organizations, many of these talking points relied on incomplete information or mistaken understandings of the proposed diagnoses. These protests ultimately demonstrate that psychiatry and feminists enjoyed an ambivalent relationship in the 1980s. While psychiatry was a particular target of the women's movement and women's groups enjoyed significant successes in shaping psychiatry, the protests against the APA in 1986 indicate that feminist organizations did not share any particularly strong understanding of psychiatry.

Alongside this somewhat superficial branch of the protests, women in mental health fields mobilized as a means not just to protest the three proposed disorders, but to lobby the APA as an institution. They saw the protests as an encapsulation of longer-standing issues, both professional and theoretical, with mental health organizations. As well, though they shared a general feminist orientation, they approached the APA (and psychiatry more broadly) in very different ways. These differences indicated ambivalence towards psychiatry, even among professionals in related mental health fields. While there were certainly instances of sexism within psychiatry, there was no universal opinion among professionals on whether or not such sexism was overwhelming or what psychiatry had to offer women in return. Despite their ambivalence, mental health professionals used the protests as a means to gain a greater role within the *DSM* revisions process and operated off a belief that the APA could mitigate many of

its issues (sexism within diagnostic categories, professional and theoretical insularity) by including a wider range of mental health professionals in subsequent revisions. For women in mental health professions, then, the protests were as much a wedge issue to discuss professional concerns as they were a more general feminist issue.

That women's groups at this time targeted the APA is largely unsurprising. By the 1980s, the APA had proven itself receptive to social and political issues—as discussed in chapter 1, NOW had lobbied the APA in 1980 to move its annual meeting out of Louisiana, a state that did not support the Equal Rights Amendment. Moreover, the gay liberation movement had succeeded in lobbying the APA to remove homosexuality from the *DSM* in the 1970s.¹³³ These concessions marked the APA as a convenient target for protesters, and the ultimate success of the 1986 protest movement underscores the APA's investment in social politics.

Moreover, feminists had a contentious relationship with psychiatry and mental health fields in the 1980s. As this chapter will demonstrate, this was a moment when mental health workers were increasingly embracing both politics and sociological explanations for mental illness.¹³⁴ As well, the 1980s witnessed the birth of consumer- and survivor-based antipsychiatry movements, led not by experts but by regular citizens.¹³⁵ Along these lines, the APA's critics were not just concerned with gender but also called for the APA to think more deeply about the role of socialization in the development of mental illnesses, and asked whether pathologizing

¹³³ See: Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis* (Princeton, NJ: Princeton University Press, 1987); Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley: University of California Press, 1996).

¹³⁴ The invocation of sociological explanations for mental illness played a significant role in the counterculture of the 1960s. In the 1970s and 1980s, political activists from the gay rights movement and the women's movement consciously invoked this framework. See Michael Staub, *Madness is Civilization: When the Diagnosis was Social, 1948-1980* (Chicago: Chicago University Press, 2011).

¹³⁵ David J. Rissmiller and Joshua H. Rissmiller, "Evolution of the Antipsychiatry Movement into Mental Health Consumerism," *Psychiatric Services* 57, no. 5 (2006).

social problems might be detrimental. Likewise, with PCD, critics asked what was at stake in designating criminal behavior as pathological. In this sense, these protests raised a larger theoretical question about diagnostic labels. The *DSM* had expanded significantly over the last three decades and the addition of so many new disorders raised questions about what could rightly be considered a mental illness and what was at stake (legally, culturally, or otherwise) in labeling a person mentally ill.

Finally, feminist mental health professionals drew on a robust feminist discourse that framed psychiatry as a male-dominated, antiwoman field.¹³⁶ Most broadly, feminists cited evidence that women were overdiagnosed and overmedicated, and suggested that male psychiatrists' propensity for diagnosing women with disorders like depression was little different from earlier ideas of women as hysterical.¹³⁷ Yet only two of the APA's proposals pathologized female behavior; PCD was targeted at male behavior, even if its victims were female. Although objections to SDPD and PMDD indicated that feminists generally thought of psychiatry as antifeminist, objections to PCD reveal a more complicated relationship between feminist politics and psychiatric diagnoses. In some cases, feminist mental health professionals argued that diagnosing men as mentally ill could be beneficial and perhaps even feminist. Looking at these perspectives on the pathologization of male behavior, then, upsets simplistic readings of feminist theories of psychiatry. Rather than demonstrating a clear desire to do away with psychiatric readings of social and gendered behavior, this protest movement indicates that feminist mental

¹³⁶ For two examples of feminist criticism of psychiatry, see: Phyllis Chesler, *Women and Madness* (Garden City, NY: Doubleday, 1972); Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1930-1980* (New York: Pantheon Books, 1985). Nancy Tomes offers a historical overview in "Feminist Histories of Psychiatry," in *Discovering the History of Psychiatry*, ed. Mark S. Micale and Roy Porter (New York, NY: Oxford University Press, 1994).

¹³⁷ See Jonathan Metzl, *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs* (Durham, NC: Duke University Press: 2003).

health professionals in the 1980s struggled with where to draw the line between social and psychological issues.

Paula Caplan and Ann Figert have written extensively on opposition to SDPD and PMDD, respectively, yet little historical literature on PCD exists.¹³⁸ This chapter looks first at feminist anti-rape activism, then the protest movement as a whole, and then at opposition to PCD specifically. Finally, I turn to the larger questions raised by the protest movement and feminist mental health professionals' opinions on psychiatric diagnoses as a whole. As part of this discussion, I look at alternate suggestions made by protesters for additional disorders that might be added to the DSM, in order to examine the various stakes raised by psychiatric diagnoses aimed specifically at men.

Anti-Rape Advocacy in the 1970s and 1980s

While psychiatrists were attempting to diagnose and treat rapists, feminists had been working towards a variety of legal and cultural reforms since the 1970s. That these two goals be enacted simultaneously was “paramount” to the movement, as “traditional attitudes and assumptions concerning rape [were] both reflected and reinforced by existing laws.”¹³⁹ This two-pronged process reflected a sociological-feminist view of rape, where legal reforms were a necessary and pragmatic step to protect women, but where cultural changes were equally important both in preventing rape and in creating an environment in which said legal reforms would be adequately enforced.

¹³⁸ Paula J. Caplan, *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal* (Da Capo Press, 1996); Ann Figert, *Women and the Ownership of PMS: The Structuring of a Psychiatric Disorder* (Hawthorne, NY: Aldine de Gruyter, 1996).

¹³⁹ Vicki McNickle Rose, “Rape as a Social Problem: A Byproduct of the Feminist Movement.” *Social Problems*, Vol. 25, No. 1 (Oct. 1977)

Most of this work began at the local level, but had rapidly expanded by the mid-1970s. The first rape crisis line had opened in Washington, D.C. in July 1972, and within five years, nearly all major cities and college communities had rape crisis lines. By 1977, the National Organization of Women (NOW) had established 200 rape task forces in the United States, with one at the national level.¹⁴⁰ Accompanying these were a variety of suggestions for policy reforms regarding hospital treatment (chiefly, standardization of rape examinations and sensitivity on the part of the hospital staff administering them) and police work (again, sensitive treatment of victims to replace the often poor and biased treatment victims received from police). Susan Brownmiller, a prominent feminist theorist, additionally suggested that achieving parity in law enforcement would lower rape rates, though empirical evidence on this was not clear. According to one study, cities with more female police officers actually had higher rape rates. The authors speculated, however, that female officers “facilitated rape reporting,” which was “representative of the ironic ways in which feminist attempts to deal with rape seemed, to many observers, to uncover or create more rapes than previously had been known.”¹⁴¹

In the legal arena, there was a nationwide trend towards reform of rape laws,¹⁴² with which feminists were directly involved.¹⁴³ These reforms addressed numerous different aspects of rape and rape laws.¹⁴⁴ Rape sentencing was of particular interest, with a number of legal

¹⁴⁰ McNickle Rose, “Rape as a Social Problem.”

¹⁴¹ Lee Ellis and Charles Beattie, “The Feminist Explanation for Rape: An Empirical Test,” *The Journal of Sex Research* 19, no. 1 (February 1983).

¹⁴² See Grace Lichtenstein, “Rape Laws Undergoing Changes to Aid Victims,” *New York Times* (June 4, 1975); Jerrold K. Footlick, “Rape Alert,” *Newsweek* (Nov 10, 1975).

¹⁴³ See Laurie Johnston, “NOW Elects Syracuse Lawyer as Head,” *New York Times* (May 28, 1974); Noreen Connell and Cassandra Wilson, *Rape: The First Sourcebook for Women* (New American Library, 1974).

¹⁴⁴ Jury trials were also of particular interest. The mid-1970s marks the beginning of the end of the need for corroboration to ‘prove’ the testimony of rape victims (this is commonly referred to as the Hale instructions). As well, trials typically introduced personal information about the

scholars calling for re-evaluation and the creation of treatment and study centers to aid “both victim and offender.” Conviction rates for rape in the 1970s were extremely low—less than one quarter of rapes reported to police produced a conviction.¹⁴⁵ The problems here were many: rape was both under-reported and under-prosecuted. But as well, juries were not overly likely to convict rapists—Brownmiller estimated that roughly half of rape trials ended with the acquittal of the accused. As a result, some legal scholars pushed to redefine rape by degrees, in a bid to increase conviction rates. Likewise, others pushed for mandatory short sentences, under the belief that juries would be more likely to convict rapists if criminal penalties were not so severe.

As well, the very definition of rape was being culturally and legally redefined. Chiefly, a number of states began to move away from the common law definition of rape (penetration) to a wider definition. The Michigan Women’s Task Force on Rape proposed that object penetration and “offensive sexual contact” also be considered rape.¹⁴⁶ A number of states adopted related legal reforms to re-term “rape” as “sexual assault” or “criminal sexual conduct,” in an attempt to get rid of the common law baggage that came with the term rape.¹⁴⁷ These broader definitions of rape also meant some limited acknowledgement of male victims. For instance, the Michigan Women’s Task Force concentrated on the perpetrator, rather than the victim. This meant, in turn, that the gender of the victim was not specified in the language of their proposal. Still, in the 1970s and 1980s, gender continued to play a role in most legal statutes. For instance, the

victim—sexual history, etc. Women’s advocates worked to change this as well. On these aspects of legal reform, see: Lisa M. Cuklanz, *Rape on Trial: How the Mass Media Construct Legal Reform and Social Change* (Philadelphia: University of Pennsylvania Press, 1995).

¹⁴⁵ Susan Brownmiller, *Against Our Will: Men, Women and Rape* (New York, NY: Bantam Books, 1975).

¹⁴⁶ Susan Estrich, “Rape,” *The Yale Law Journal* 95, no. 6 (May 1986).

¹⁴⁷ Estrich objected to these changes. She writes, “these changes risk obscuring the unique meaning and understanding of the indignity and harm of ‘rape.’” The APA’s Committee on Women made similar comments regarding the change from “Compulsive Rapism” to “Paraphilic Coercive Disorder.” On this, see Chapter 1.

American Law Institute's model penal code, drafted in 1955 but not formally adopted until 1980, defined rape as a crime committed by a man against a woman. Perhaps less obviously, attempts to define sexual assault in gender-neutral terms also raised questions about the dominant feminist theory of rape. Where feminist understandings of rape were fundamentally predicated on a theory about male and female power differentials, male victims posed something of a theoretical problem.¹⁴⁸

At a broader level, the women's movement was seeking to fundamentally redefine rape as an act of violence rather than one of sex. Traditionally, rape had been framed as a product of overwhelming sexual desire on the part of the perpetrator—in other words, some men could not control their sexual urges and thus committed sexual assault against nonconsenting women. Violence was not absent from this analysis—it was the method by which men satisfied their sexual desires. Feminists, however, inverted this reading of rape: Sex was the means by which men expressed their power over women, and this expression of power was itself a form of violence. Focusing on violence and power rather than sex was important for two reasons. First, power and violence lent themselves to a preexisting political reading of gender and social relationship more broadly. Historian Beryl Satter writes that feminists drew upon leftist arguments that framed violence “not simply as acts of physical abuse but as all aspects of society that demeaned women and created female alienation.”¹⁴⁹ Second, as historian Ann Cahill argues,

¹⁴⁸ I would argue that today male victims have been increasingly integrated into theories of rape predicated on male power and aggression, though concern for male victims hasn't caught up on a practical level and many outreach efforts for victims continue to assume that victim to be female. Suffice it to say that in the 1970s and 1980s, most observers (this includes feminists, sociologists, legal scholars and psychiatrists) were fairly narrowly focused on male perpetrators and female victims, though male victims were acknowledged in a superficial way. The existence of female perpetrators was, at this point, almost entirely unacknowledged.

¹⁴⁹ Beryl Satter, “The Sexual Abuse Paradigm in Historical Perspective: Passivity and Emotion in Mid-Twentieth Century America,” *Journal of the History of Sexuality* 12, no. 3 (2003), 448.

attempts to excise sex from rape relied on the assumption that sex was a natural and biological matter, whereas violence was a socially mediated and political one.¹⁵⁰ A focus on sex implied, to many feminists, that rape was the product of a normalized male biological drive and was thus resistant to social change. The aphorism that rape is an act of violence and not sex, then, was a heavily political move. The politics therein would eventually pit feminists against the psychiatrists working with sex offenders who framed rape as the product of a mental disorder.

Yet while these theoretical debates raged, it wasn't always clear that feminist anti-rape activism would directly butt heads with the APA's attempt to pathologize rape. As demonstrated in chapter 1, the APA's Committee on Women initially felt that a disorder such as PCD might be beneficial, though most of the members disagreed on precisely how it should be classified. Moreover, the more concrete anti-rape initiatives discussed here dovetailed nicely with the APA's work: the APA did not advocate for treatment in lieu of jail time, and many of the psychiatrists involved echoed feminist calls for cultural reform. Indeed, some explicitly noted these parallels. According to one 1978 survey, 27% of American psychiatrists agreed that rape was "fundamentally rooted in our male dominance society."¹⁵¹ This was subsequently cited as an indication of "the growing popularity" of feminist theories of rape among "behavioral scientists."¹⁵² Moreover, the study's author noted that many treatment centers for rapists "trained [sex offenders] not to view females as inferior to males in status and power."¹⁵³ As well, psychiatrists working with rapists generally defined sexual assault in the same broad terms as did

¹⁵⁰ Ann J. Cahill, *Rethinking Rape* (Ithaca, NY: Cornell University Press, 2001).

¹⁵¹ "Sexual Survey #11: Current Thinking on Rape." *Medical Aspects of Human Sexuality* 12 (June 1978).

¹⁵² Ellis and Beattie, "The Feminist Explanation for Rape."

¹⁵³ The authors cite E. M. Brecher, *Treatment Programs for Sexual Offenders* (Washington, DC: US Government Printing Office, 1978). One imagines they have in mind something similar to Groth's work.

feminists: they acknowledged male-male rape, and a variety of sexually-assaultive acts that did not involve penetration.

And yet despite such similarities, throughout the summer of 1986, waves of protest mail would roll into the APA's headquarters. Women from across the United States, Canada and England wrote heartfelt letters about personal experiences and letters about their advocacy work; they signed petitions; they sent in mailgrams. For these women, there was something deeply unsettling about the way in which the APA sought to pathologize rape.

Protests and Petitions

The protest movement began with criticism from within the APA, spearheaded by Jean Hamilton, an APA member and head of the Institute for Research on Women's Health, and Teresa Bernandez, chair of the APA's Committee on Women. Beginning in June 1985, the two would launch an extensive campaign against the three proposed disorders that involved networking with other women mental health professionals (among them, Lenore Walker, chair of the American Psychological Association's Women's Committee, and Paula Caplan, a psychologist whose book, *The Myth of Women's Masochism*, had recently made a popular splash).¹⁵⁴ The protests swiftly spread outside the purview of mental health fields when, in March 1986, Caplan drafted a petition that was subsequently distributed across the United States, Canada, and Britain. By May, every major mental health organization—among them, the Feminist Therapy Institute, the National Association for Social Workers (NASW), the American Orthopsychiatric Association (ORTHO), and the Association for Psychiatry and the Law (AAPL)—had gone on record as opposing the three proposals. An increasing array of other

¹⁵⁴ See Figert's work for a detailed discussion of the professional networking piece of the protests.

groups had also waded into the fray, including the National Association of Attorneys General and the National Organization for Women (NOW). By the summer of 1986, hundreds of petitions with more than two thousand signatures and more than five hundred letters had been sent to the APA, and Caplan would claim that more than three million people in North America opposed the three proposed disorders.¹⁵⁵

The majority of protesters were women in mental health professions (psychiatrists, psychologists, psychiatric nurses, social workers, and so on). These women account for 70% of petition signees in the US, and 40% in Canada. Nearly half of the letters written to the APA came from women connected to mental health organizations—ORTHO members, women belonging to various women’s committees in the American Psychiatric Association and the American Psychological Association, etc.¹⁵⁶ Though most protesters were connected to mental health fields, a significant percentage of protesters were not. Given that these protests drew heavily on feminist ideas, we might expect these protesters to be connected to feminist organizations. However, very few of the letter-writers explicitly stated any affiliation with feminist organizations and only a single letter references NOW.¹⁵⁷ There was at least one ad

¹⁵⁵ These numbers are my estimate for materials held by the APA. Caplan, in putting forward the claim for three million protesters, includes the membership of every organization that formally opposed the disorders—in other words, since the American Psychological Association released a statement against the proposals, she includes all its members rather than just those who made individual protests. Whether this is a fair approach is open to discussion. There may also be additional materials that didn’t make it into the APA’s archive—for instance, Paula Caplan’s papers (held at the Schlesinger Library) contain some protest mail. Most of these materials are related to the *DSM-IV*, but some may also be related to the *DSM-III-R*. In any case, the numbers that protesters like Caplan publicly claimed were extremely high and didn’t necessarily match the volume of mail that the APA received.

¹⁵⁶ I’ve included social workers in this number. Professional organizations like the National Association of Social Workers consistently presented themselves as rightful members of the mental health community, even if the APA had failed to integrate their work.

¹⁵⁷ Both Caplan and Rachel Josefowitz Seigal were involved with Jewish women’s organizations. Seigal circulated a handful of petitions in the Northeast. There’s no explicit reference to a

placed in a NOW newsletter soliciting protesters, but respondents either didn't think to reference the organization, or signed and sent petitions rather than letters.¹⁵⁸ Even in the case of petitions, women did not list membership in any women's organizations—rather, petitions requested a limited set of demographic information (generally name and address) and petitioners didn't add anything beyond this.

Often, however, petitioners did list their occupations. Some women listed themselves as mothers and homemakers. Others listed themselves as small business owners, architects (ten signees on one petition), stenographers, writers, x-ray techs, secretaries, court clerks, students, filmmakers, photographers, farmers, salespeople, account executives, and payroll workers. These women came to sign petitions in a few ways. In some cases, it's obvious that a petition was circulated in a workplace. For instance, a petition will list signees that identify as professors in a psychology department, along with signatures from the department's secretaries. In other cases, petitions were passed around non-related offices or conventions; for instance, one Ohio petition appears to have come from a word processing operator's convention (all twenty-two signees list this as their occupation). In other cases, it's not clear how a petition's signatories came together. Some petitions have signees that identify as housewives alongside signees that identify as psychologists. This implies that petitions were circulated along personal networks, rather than

connection between the two and I cannot verify whether or not Seigal's involvement with Jewish women's organizations was an avenue for her work with the protests. Still, this commonality suggests that women involved with the protests were often involved in unexpected ways.

¹⁵⁸ This ad solicited women to print out and sign a brief statement of opposition to the three disorders (without any additional context attached to the ad) and mail copies to Paula Caplan, who I'll discuss later in the chapter. While there were presumably additional ads in other NOW newsletters, I was not able to find further references to the protests in the Schlesinger Archive's collection. Most surprisingly, though protests were concentrated in California and New York, no other chapter newsletters from either state make reference to the controversy. See *Tompkins County NOW News*, April 1986, National Organization for Women Collection, the Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University (hereafter, NOW Collection).

strictly professional ones. About half of these kinds of petitions (i.e., those that contain a significant number of people with no apparent professional relationship) were circulated in settings not directly related to the protests (that is, they are not explicitly connected to a mental health or feminist venue). The remaining half, however, indicate that women who were not employed in mental health or other related professions were present at venues more obviously connected to the APA controversy, such as the 1986 NOW meeting in California where a number of speakers addressed the issue.

In terms of content, the rhetoric of letters and petitions was typically dramatic. Protesters characterized the proposals as “ominous,” “stigmatizing,” and “anti-woman.” The proposed disorders were evidence that “psychiatry does not have its act together” and represented “giant steps backward for mankind and the APA.”¹⁵⁹ Not only did the proposals make psychiatry “appear unenlightened and primitive,” but they would also be “the greatest setback to women in the past 100 years.”¹⁶⁰ One letter simply opined, “When I first heard of this months ago, I thought it was a joke, but it is a very bad one.”¹⁶¹

Despite these broad ideas about psychiatry and sexism, many of the petitions did not discuss specific disorders at all. Rather, they merely protest the “proposed revisions” to the *DSM*.¹⁶² Those that do list specific disorders generally list all three (PCD, PMDD, SDPD) together. The implication here is that protesters were less concerned with the specifics of each disorder, but with a pattern: they believed that the proposed revisions represented a clearly anti-woman bias within the APA. One petition in this vein stated that signees “believe that the three proposed

¹⁵⁹ Daniel W. Hicks to Spitzer, May 29, 1968, DSM Collection.

¹⁶⁰ Dierdre DeChanne to Spitzer, June 26 1986, DSM Collection.

¹⁶¹ Rhonda Barovsky, Mailgram to Robert Pasnau, May 9 1986, DSM Collection.

¹⁶² More than a quarter (35 of the 110 sampled letters) of the petitions do not list any specific disorder.

diagnoses... will perpetuate sexist bias in diagnosis, treatment and legal application.”¹⁶³ Another that, “These diagnostic categories have ominous implications for stigmatizing women and for establishing a way for rapists to escape accountability for their crimes.”¹⁶⁴ The letters sent to the APA were not entirely different—most contained only basic references to the proposed disorders. Only about a third of the letters contained additional content, beyond the type of information included in the petitions. Perhaps surprisingly, there was little difference between mental health professionals and other protesters in terms of the information they presented; professionals were no more likely to demonstrate any particular familiarity with the proposed disorders, or the *DSM* in general, than were their lay counterparts.

Still, some petitions did include substantive information on the disorders as separate entities. Paula Caplan, a Canadian psychologist, produced a document that accounted for a significant percentage of the petitions. Caplan’s statement, while a relatively brief five paragraphs, served as the primary, and likely only, way in which many protesters gained information about the proposal.¹⁶⁵ While PMDD and PCD received only a paragraph each in Caplan’s petitions, SDPD (Self-Defeating Personality Disorder, formerly Masochistic Personality Disorder) received a half page. There are a couple of reasons for this: Caplan’s professional focus was SDPD, so her petitions are naturally focused on this; the objections to SDPD were in some ways less obvious than the objections to PMDD and PCD, and thus required more explanation; and protests of the APA began with SDPD, so feminists may have had a more

¹⁶³ Paula Caplan, “Petition Re: Diagnostic and Statistical Manual – Proposed Revisions,” n.d., DSM Collection.

¹⁶⁴ Undated petition addressed to Robert Spitzer, DSM Collection.

¹⁶⁵ In a number of cases, even Caplan’s petitions were decoupled from any information on the disorders. Petitions often used only her introductory statement (that the undersigned request the removal of the three disorders), while leaving out the five paragraphs that follow on her specific objections.

fleshed-out argument against that disorder than the other two. On this latter point, while all the petitions addressed to the APA came in throughout the summer of 1986, a trickle of letters protesting SDPD had begun to roll in over the preceding six months. These letters came almost entirely from women staffing battered women's shelters. Still, PCD had received a significant amount of popular press in the lead-up to the protests (see chapters 1 and 3), so the relative absence of information in the petitions and letters is curious.

Within Caplan's petition (and the earlier letters from shelter workers), the basic objection to SDPD was that the diagnosis misattributed the cause of the symptoms. Women who were repeatedly drawn to negative characters in their life, who were overly self-sacrificing, and who could not seem to make themselves happy were not masochists suffering from a personality disorder. Rather, these symptoms were more likely the result of external factors, such as abuse. By diagnosing the issue as purely psychiatric rather than psychosocial, the APA implied that these women were responsible for their abuse. While the APA insisted that SDPD would not be applied to battered women, women's advocates had seen these behavioral patterns often enough to believe otherwise. Caplan and others noted that women often found it difficult to talk about their abuse, and were not always likely to introduce the topic in therapy. As well, therapists who weren't trained in recognizing domestic violence rarely even thought to ask if their patients had a history of abuse.¹⁶⁶ Accordingly, even if abuse victims were explicitly excluded within the language of diagnosis, it would still be applied to many victims of battery in practice.

¹⁶⁶ Caplan, "The Name Game: Psychiatry, Misogyny, and Taxonomy," *Women & Therapy* 6, no. 1-2 (1987). In this article, Caplan quotes Spitzer on the topic of SDPD: "Basically... [The feminists are] against what we are trying to do... They are so enmeshed in spouse abuse that they can't focus on what we see as a problem—that there are people whose pain and suffering can't be explained by objective reality."

Caplan's critique, however, went a few steps further than this. It was not merely that abuse at the hands' of a loved one might produce the symptoms of SDPD, but that that merely existing in society as a woman produced such symptoms. Caplan suggested that the "average" woman was self-denying, due to "society's dictates." To wit,

Much of the behavior included in the criteria for this category is a combination of adaptation to the misogyny in society and an obedient execution of the traditional female role, carried out in attempts to avoid rejection. It is bizarre and destructive for our society to train women to be self-denying and... then to call self-denying, unappreciated women pathological.

Stated more baldly in her petitions, "The systematic inculcation of that role in females by society does itself constitute chronic psychological abuse." Psychiatrists were not merely misdiagnosing women, but were in fact reifying the societal abuse from which they already suffered.¹⁶⁷ Here, Caplan suggested two things: first, that all sexism existed on a continuum wherein something like the devaluation of housework was not categorically different from spousal abuse; and second, that psychological explanations were inherently opposed to sociological ones. These were, again and again, the pegs upon which Caplan hung her hat.

In Caplan's petitions, PMDD received very little space compared to SDPD. Classifying PMDD as a mental disorder rather than a physiological one "fuels the notion that women are irrational victims of their hormones" and "stigmatizes women for their biology." Even more tellingly, men's hormonally-based changes in mood were not included. PMDD would be applied only to women and was therefore blatantly sexist. Finally, Caplan offered an economic reason: historically, PMS had been "misused to keep women out of powerful and well-paying jobs." Institutionalizing it in the form of PMDD threatened to create even more job discrimination.

¹⁶⁷ "Petition Re: Diagnostic and Statistical Manual--Proposed Revisions," DSM Collection.

Interestingly, a handful of protest letters share their personal experiences with PMS.¹⁶⁸ While these letters constitute a very small percentage of the letters overall, it's notable that none of the letters described any sort of personal experience with rape, nor even work done with rape victims.¹⁶⁹ While the feminist movement had made significant moves towards destigmatizing women's issues—domestic violence and PMS, while still stigmatized, might be discussed in select public arenas—rape remained so heavily stigmatized that discussions of personal experiences played no visible role in these protests. It's illustrative here to compare this to current anti-rape activism in America: women's personal experiences with rape are often publically shared as a form of protest and to build awareness. In 1986, however, those experiences did not yet feature in public protests or the public sphere.

PCD received the least space of all, both in Caplan's petitions and in the protest letters more generally. Caplan's petitions state, in full:

[PCD] does not belong in a manual of mental disorders, because it would clearly be used to 'prove' that a male who rapes has a mental disorder (by virtue of the fact that he says he felt compelled to rape) and, therefore, should receive psychotherapy rather than being confined where his potential victims are protected from him.

Given this relative lack of information on PCD, it's perhaps unsurprising that many protesters came up with a variety of objections based upon their own knowledge and that, for protesters not involved with mental health work, these objections would be based on a great deal of misinformation.

¹⁶⁸ One woman signed her letter "Gloria Cook, CSW, ACSW, PMS sufferer." See Gloria Cook to Spitzer, July 25, 1986, DSM Collection.

¹⁶⁹ One letter from a psychiatrist describes his work with incarcerated rapists (Paul Burns to Spitzer, July 16, 1986, DSM Collection). A handful of other letters detail professional—but not personal—experience with SDPD.

Many of the specific fears surrounding PCD demonstrate that the information available to letter writers varied significantly. Many women, receiving basic information from organizations like NOW or from Caplan's petitions, interpreted the proposed disorders according to what they knew rather than according to any particular familiarity with psychiatry. For PCD, this meant that they interpreted the disorder according to popular feminist ideas about rape. Many women believed the disorder to be an example of "victim blaming."¹⁷⁰ While numerous letters use this and similar language, only one letter explains the assumption. The author writes,

[PCD] makes me nervous because I cannot find a way of understanding what these words are intended to convey. If the idea is to label the patient as having caused the rape by some predisposition to being raped, the problem is more a societal one than an individual one. The only people who I know of who like being raped are in the movies—not in real life. We must therefore be careful, if possibly arming attorneys with tools which will make rape convictions even more difficult and/or humiliating for the victim.¹⁷¹

While this letter is an outlier, it does demonstrate one of the problems that marked these protests. If other protesters understood that the diagnosis was meant to pathologize rapists—rather than victims—they still worried that such a diagnosis would hand rapists yet another way to avoid criminal convictions. Even further, protesters could not imagine that this diagnosis *wouldn't* blame victims in some sense. Culturally, rape and victim-blaming went hand-in-hand. Yet the psychiatrists working with sex offenders generally didn't espouse any negative views of victims; in fact, they concentrated almost entirely on sex offenders with little to no discussion of victims and their roles at all. In regards to the courts, the underlying idea behind PCD was that a rapist with PCD was aroused specifically by the nonconsensual nature of the act. Logically, an attorney

¹⁷⁰ At a glance, at least four letters use this exact term ("victim blaming"). See Shari Baron to Pasnau, July 21, 1986; Robert M. Birkey to Spitzer, June 16, 1986; Lynn Christiansen and Marianne Winters (on behalf of the Massachusetts Coalition of Rape Crisis Services) to Pasnau, May 7, 1986; Betsy Smith to Carol Nadelson, April 22, 1986; all letters from the DSM Collection.

¹⁷¹ Peter Belding to Nadelson, April 28, 1986, DSM Collection.

would be hard-pressed to argue that a client had PCD *and* that his victim had enjoyed or asked for the assault. Still, if protesters failed to realize that the psychiatrists working with rapists were an exception to the pervasive discourse of victim-blaming, they could hardly be faulted for it. For its part, the APA had failed to circulate good information to the public, despite the protests' momentum. When the above author wrote that she "cannot find a way of understanding" PCD, she inadvertently highlighted the failures of both the APA and feminist organizations to inform the public of what the three proposed diagnoses, and PCD in particular, meant.

Along with the idea that PCD was victim blaming, a number of women assumed that PCD would be invoked as an example of temporary insanity. One letter stated, "The concern is that a compulsive rapist could be charged with temporary insanity, released, and allowed to continue to threaten children and women."¹⁷² It's not clear where this objection came from—there's no discussion of this either in feminist or psychiatric literature—but suffice it to say that it was misguided in more than one way. First, temporary insanity (usually the result of a psychotic break) was wholly different from a paraphilia (or a personality disorder). In particular, a diagnosis of PCD would require an ongoing pattern of thoughts or behavior.¹⁷³ This alone disqualifies it from the status of temporary insanity, where the break with reality is typically brief. More broadly, letter writers feared that the ability of rapists to claim insanity could prevent their convictions. In reality, insanity pleas are very rarely successful and require the defendant to meet very specific criteria. By the mid-1980s, such a defense was predicated on the defendant not knowing, by virtue of their mental state, that their crime had been wrong. PCD, in contrast, was predicated on the offender's awareness of the nonconsensual nature of the sex act and

¹⁷² Judith L. Alpert and Beeman N. Phillips to Pasnau, July 14, 1986, DSM Collection.

¹⁷³ Refer back to the draft language quoted at the beginning of chapter 1, where a diagnosis of PCD required recurrent thoughts for a period of at least six months.

indeed on his fetishization of that lack of consent. While PCD may have come to threaten conviction rates (indeed, a handful of judges ordered rapists to treatment centers rather than jail, even before the PCD controversy¹⁷⁴), insanity pleas was the least likely way it could do so. Moreover, even if such a defense were successful, it wouldn't translate into a get-out-of-jail-free card. Rather, insanity defenses typically carried with them the prospect of an indefinite stay in a locked mental ward, rather than a time-limited jail sentences. This series of misunderstandings are again indicative of the APA's failure to explain its disease classifications to the public, and of protesters' general lack of good information both about psychiatry and the law.

Despite these examples of misinformation, the legal objections (which form the bulk of objections to PCD) are worth examining further. These were not merely abstract concerns; many women were concerned with community safety.¹⁷⁵ Protesters argued that adding PCD to the *DSM* would give rapists an easy way to escape prison sentences for their crimes. The perpetrator, they worried, would be hospitalized and “discharge[d]... back to society after a short hospital stay,”¹⁷⁶ or worse: he might be “let off from the punishment” entirely.¹⁷⁷ This, in turn, meant that rapists would be free to commit more crimes against women. PCD, despite receiving the least coverage of the three proposals, arguably had the most obvious potential for immediate physical harm.

Robert Spitzer, head of the Work Group to Revise the *DSM-III-R*, had been aware of such concerns since at least 1977. At that time, the Ad Hoc Committee of the American Academy of Psychiatry and the Law (AAPL) presented the APA's *DSM-III* Revisions Task Force with reasons to exclude PCD (then referred to as “Sexual Assault Disorder”), obscene

¹⁷⁴ See chapters 3 and 5 on this.

¹⁷⁵ Community safety concerns featured heavily in discussions of treatment centers for sex offenders. See Chapter 3, on Fred Berlin's work.

¹⁷⁶ Virginia Accetta to Pasnau, May 28, 1986, DSM Collection.

¹⁷⁷ Cynthia Brown Smith and Deanna Pearlmuter, “The Women's Study Group of the American Orthopsychiatric Association Positions on the *DSM-III-R*,” May 1986, DSM Collection.

communication disorder, zoophilia, and pedophilia.¹⁷⁸ At that time, AAPL member Abraham Halpern wrote,

Classifying sexually assaultive behavior under a specific psychiatric diagnosis would have the effect of minimizing the wrongfulness of the perpetrator's conduct and would open the door to even more widespread misuse of psychiatry than exists at the present time... Sexual assault is not a disorder—it is a crime.¹⁷⁹

Likewise, protesters in 1986 would write, “rape is a legal term... I do not think the APA wants to lower the boundaries between the law and psychiatry and thereby attract the wrath of a public at large who already see psychiatrists as always on the side of the perpetrator and always obstructive to justice,” and that, “society as a whole is very upset with psychiatry explaining away criminal action.”¹⁸⁰

The APA's leadership superficially agreed—they did not wish to lower the boundary between psychiatry and the law. However, their method of maintaining this boundary was to doggedly refuse to engage with such criticisms and to insist they played no role in how the judicial system interpreted the *DSM*. As noted in chapter 1, Spitzer had stated in 1979 that he neither knew nor was responsible for knowing how the legal system would take up PCD or similar disorders.¹⁸¹ Similarly, notes from a meeting in 1985 indicate that Park Dietz, a member of the Paraphilias Work Group, stated that recognizing PCD as a disorder had “no

¹⁷⁸ Abraham Halpern to Spitzer, April 15 1978, DSM Collection.

¹⁷⁹ Abraham Halpern, Untitled document, n.d., DSM Collection.

¹⁸⁰ James R. Burnett, Jr. to Spitzer, June 12 1986, DSM Collection; “New Definitions of Mental Illness Hotly Protested,” *Sun Sentinel*, May 10, 1986. In 1982, the trial of John Hinckley, Jr., for the attempted assassination of Ronald Reagan—and the subsequent ‘not guilty by reason of insanity’ verdict—would make the role of psychiatry in the courts a hot-button public issue. At least one newspaper (“New Definitions”) explicitly invoked Hinckley’s trial in discussing PCD’s potential ramifications. On Hinckley’s trial and the public fallout, see Lincoln Caplan, *The Insanity Defense and the Trial of John W. Hinckley, Jr.* (Boston: David R. Godine, 1984).

¹⁸¹ Spitzer to Lawrence Mass, September 4 1979, DSM Collection.

implic[ations]” for “forensic issues.”¹⁸² In 1986, at the height of the controversy, APA spokesman John Bonnage would reiterate this position, stating, “We’re not responsible when [the *DSM*] is exploited by somebody else. People forget that psychiatry is a medical specialty.”¹⁸³ Throughout the mid-1980s, the AAPL would continue to be involved in the controversy. A 1986 letter from Lawrence Richards even suggested that Spitzer contact Richard Rada, editor of the AAPL’s *Bulletin*, who had made a “major review on rape/rapists and could be consulted if he’s not already on the Work Group.”¹⁸⁴ Despite these suggestions, neither Spitzer nor individual members of the Paraphilias Work Group ever solicited the formal involvement of the AAPL, other forensic psychiatrists, or legal experts. The consistent refusal to engage with legal questions would lead Brooklyn District Attorney Elizabeth Holtzman to accuse the APA’s leadership of “act[ing] as though they live in an ivory tower.”¹⁸⁵

Although the protests were intended to underscore the APA’s gender problem, they also inadvertently underscored another issue that plagued the APA: how to define the role of morality and criminal behavior in mental illness. Many mental illnesses—PCD included—are defined almost exclusively in terms of criminal behavior. Yet the APA has not offered a consistent framework on how or whether to regard criminal behavior as a sickness. Medical ethicist John Sadler argues that this represents an elision:

[The *DSM*] is not a the product of metaphysical deliberation and theorizing but rather the expression of what might be called a ‘folk metaphysics’—an amalgamation of metaphysical assumptions that are more-or-less socially conventional, and represent a loose, informal consensus of the profession.¹⁸⁶

¹⁸² “Meeting of the Ad Hoc Board-Assembly Committee to air controversies in revision of *DSM-III*,” December 4 1985, DSM Collection.

¹⁸³ “New Definitions.”

¹⁸⁴ Lawrence Richard to Spitzer, March 4 1986, DSM Collection.

¹⁸⁵ “New Definitions.”

¹⁸⁶ John Z. Sadler, “Vice and the Diagnostic Classification of Mental Disorders: A Philosophical Case Conference,” *Philosophy, Psychiatry, & Psychology* 15, no. 1 (2008).

Although it is true that the proposed revisions in the 1980s did not represent a formal consensus on the role of criminality or socialization in mental illness, the APA's responses to these issues evidence a fair deal of "metaphysical deliberation." The APA's leadership repeatedly responded that questions of how PCD would be used in a court of law were not their concern, despite the fact that sex offenders were already being sentenced to treatment in addition to (and sometimes in lieu of) incarceration.¹⁸⁷ In other words, the APA purposefully walled itself off from questions of legality, rather than merely failing to theorize about them.

Likewise, the APA's responses to criticism of SDPD and PMDD indicate that they had similarly failed to clarify the role of sociological and biological issues within the *DSM*. Ann Figert has framed the battle over PMDD as, in part, a battle between gynecologists and psychiatrists to define the disorder as, respectively, a medical condition versus a mental one. Spitzer's responses to gynecologists were largely similar to his responses to legal scholars. In an interview, he recalled, "In my own mind I had clearly decided that ideology was of no issue. So it was of no concern to me whether PMS had or did not have some kind of biological affinity."¹⁸⁸ When feminist mental health professional argued that SDPD reflected the ways in which women were socialized, the APA's leadership accused its opponents of trying to politicize what should be a scientific issue. At his most explicit, Spitzer would assert that his critics "would be as upset with almost any psychiatric diagnosis. They just don't like psychiatric diagnoses."¹⁸⁹ Rather than engaging with the question of how to integrate or separate out biology or sociology or the law from psychiatry, Spitzer chose instead to frame all opposition to the proposed disorders as

¹⁸⁷ See chapter 3 on Fred Berlin's center. Berlin was on record in opposition to this practice in the early 1980s, but accepted an increasing number of court-mandated patients thereafter. See also chapter 5 on legal approaches to mentally ill sex offenders more generally.

¹⁸⁸ Figert, 38.

¹⁸⁹ Figert, 79.

opposition to psychiatry as an enterprise. Here, again, the APA's leadership attempted to wall itself off from criticism and broader questions about psychiatry's place in a world where medical, legal and psychiatric knowledge was increasingly interconnected.

Speaking more broadly, women saw PCD as necessarily oppositional to a feminist reading of rape. In reference to John Money's work with sex offenders, an article in the feminist magazine *Off Our Backs* stated, "Money's view of rape as a purely sexual act—only out of his control—ignores the evidence that rape is generally an act of violence perpetrated by 'normal' men such as husbands, neighbors, dates, and friendly neighborhood policemen, priests and doctors."¹⁹⁰ Yet Money and his colleagues also commented extensively on the demographics of their patients, and those demographics largely reflected the above statement. In fact, therapists working with sex offenders commented almost compulsively on the demographics of their patient bases, partly because they flew in the face of popular perceptions. Very little of the literature on PCD—either psychiatric or popular—fails to make the observation that psychiatric centers for sex offenders were full of white, middle-class, seemingly innocuous men. Another prominent researcher on PCD, Gene Abel, also pointed out, "The people who molest your children are your neighbors. They didn't fly in from out of state."¹⁹¹ An *Off Our Backs* article on his work noted his argument that only one in eighty crimes led to arrest, and that the average sex offender served a mere three years in prison. Despite disagreements about the role of the sex drive in sex offenses, then, an attention to demographics and a general dissatisfaction with the legal treatment of sex offenders characterized both psychiatric and feminist rhetoric at this time.

¹⁹⁰ "Drugs for Rapists," *Off Our Backs*, February 1979. Ironically, the center where Money worked received a significant amount of press for treating a priest.

¹⁹¹ "Sex Offenders Studied," *Off Our Backs* 16, no. 8 (August -September 1986).

More seriously, Abel's general view of sex offenses fit with the feminist ideas noted above; for him, PCD represented a better way to deal with rapists, rather than a way to help them escape prosecution. And while the accusation that Money was unconcerned with the social context of rape and saw it instead as purely sexual was a fair one, it was by no means true of all psychiatrists employing the concept.¹⁹² That protesters were largely unaware of a strong tradition among psychiatrists of seeing sexual assault as a mixture of pathology, power, and male socialization again underscores the lack of information that characterized these protests. It also perhaps suggests a lack of interest on the part of the average protester. Fred Berlin, for instance, received extensive coverage in the popular press for his work treating sex offenders. Despite the controversies that followed his treatment center, few of the protesters speak to those *particular* concerns or events. Though protesters were concerned with sexual assault as it affected women, it seems that they were less interested in the offenders themselves (either in what drove them, or in the difficulties or potential benefits of treating them) as relayed by psychiatrists like Berlin and Abel.

Still, if much of the specifics of these objections were mis- or under-informed, their overall point was quite effective. Feminist protests spurred a number of legal organizations to action. Most importantly, the National Association of Attorneys General was persuaded to adopt a resolution against the proposed disorders in 1986. They urged that the APA withhold the proposed diagnoses "until the APA solicits more of the view of criminal justice professionals and considers thoroughly the effect the addition... will have on victims and the administration of criminal justice."¹⁹³ While ostensibly applicable to all three proposals, this was realistically more a concern with PCD. The APA, intransigent as ever, undertook no such solicitations. Rather than

¹⁹² See chapter 1 on this.

¹⁹³ Marvin, C. Raymond to Pasnau, June 27, 1986, DSM Collection.

wade into the mire, they ultimately chose instead to delete PCD from the *DSM* entirely. Shortly thereafter, they would also relegate PMDD and SDPD to an appendix.

Women in the Mental Health Professions

If potential legal ramifications were the specific outcomes feminists could point to, the protests also evince a broader critique of the APA. A number of protesters accused the APA of being not just anti-woman, but also of being far too insular. This was present in the legal protests—the APA considered itself to have no role in the criminal justice system, despite the increasing role of psychiatry in the court system. As a result, they had continuously refused to consider the possible legal ramifications of their proposed diagnoses at all. The critique ran deeper than this, however. The APA had not only failed to engage with spheres beyond psychiatry, but also with other mental health workers. The revisions put a spotlight on this and opened up an obvious place for women in mental health fields to lobby the APA on a broad scale. These women professionals were behind the bulk of the protests and two in particular, Paula Caplan and the National Association of Social Workers (NASW), will be discussed here.

Women professionals like Caplan and the members of NASW agreed that the APA was an insular and politically vested group. Judith Alpert, chair of the American Psychological Association’s Committee on Women in School Psychology, stated outright, “Diagnostic taxonomies like the *DSM* are both scientific and political documents,” and urged the APA to withhold the proposed diagnoses until more research had been done.¹⁹⁴ Further emphasizing the political nature of the revisions process, Caplan noted that there had been only two systematic studies on SDPD, both spearheaded by Robert Spitzer, the head of the *DSM* revisions committee.

¹⁹⁴ Alpert and Beeman to Pasnau, DSM Collection.

Moreover, she stated that around half of APA members surveyed didn't believe that SDPD was a helpful diagnosis. Caplan asks, "Does the Work Group believe it knows better than half of the Association's experts in the area, or does it simply feel free to disregard their opinions?"¹⁹⁵ The idea that the proposed diagnoses were not adequately supported by research was a common one throughout the letters. Even in cases where there was research, protesters believed that the diagnoses had been "created using clinical consensus of both non-representative clinicians and non-representative patients."¹⁹⁶ In fact, one of the two studies on SDPD had involved a mere eight patients, all of whom were treated by therapists at the same institution; Caplan argued that it was unsurprising that a small group of colleagues would share a similar unrepresentative theory. This again went back to the criticism that the APA was insular: the *DSM* had been constructed by a small handful of individuals and reflected the APA's politics more than any empirical research.

Despite these shared assumptions, women professionals approached the issue in different ways. NASW lobbied the APA as mental health professionals—that is, as insiders—in order to try to effect change from within. Chiefly, they argued that the APA should include social workers in the *DSM* revisions process.¹⁹⁷ In May 1986, NASW held its Second National

¹⁹⁵ Paula J. Caplan, "Why 'Self-defeating Personality Disorder' Should Not Be Included in the *DSM-III-R*," letter to the APA, June 11, 1986, DSM Collection.

¹⁹⁶ Lenore E. Walker and the Coalition Against Misdiagnosis to Pasnau, May 1, 1986, DSM Collection.

¹⁹⁷ Letters from NASW members account for about 20% of the total protest letters. They also overwhelmingly account for letters from individuals formally affiliated with an organization—self-identified NASW members wrote twenty eight letters, while ORTHO members (the second largest category of affiliates) wrote a mere seven. Moreover, forty-two mental health workers (mostly psychologists or professors in related fields) wrote letters, and a nearly equal number (thirty six) of social workers wrote in. An additional fourteen letters came from women involved in victim's advocacy (primarily battered women or abused children). These organizations frequently worked with social workers. In total, then, somewhere around one third of the letters are connected (whether directly or tangentially) to social work.

Conference on Women's Issues, with particular attention paid to the *DSM*. There, NASW president Dorothy Harris encouraged her fellow members to write letters of protest to the APA. Specifically, she advised them to identify themselves as members of NASW, and to "urge the inclusion of NASW on the Task Force to Develop DSM-IV as recommended by the Joint Commission on International Affairs." Harris, however, already had her foot in the door. Less than two weeks after NASW's conference, she participated in a panel at the 139th Annual Meeting of the APA.¹⁹⁸ In a subsequent letter to the APA's president, she stated that she was "encouraged by your willingness to have all mental health professionals formally involved in the diagnostic process." While it's not clear just how much her—and others'—formal involvement meant in terms of the actual revisions process, the APA was clearly attempting to be inclusive.¹⁹⁹ That NASW was already looking ahead to the *DSM-IV* months before the protests of the *DSM-III-R* were even underway was borne out of a determination to turn this modest beginning into an ongoing professional relationship with the APA.

While Caplan relied heavily on petitions to make her points, NASW members were more likely to write letters to the APA. This speaks to the audience and intention of the petitions. Caplan's petitions were intended to inform a non-specialist audience and demonstrate the breadth of the protests. Caplan leaned heavily on numbers, referencing them often and interpreting them in a somewhat loose manner. According to Caplan, nearly 3,000 signatures had been collected on various petitions; this number is more or less reflected by the materials sent to the APA. She also claimed that 100,000 members of mental health organizations and ultimately more than three million people in North America were opposed to the revisions. These numbers draws on

¹⁹⁸ Elissa Benedek, "Highlights," 1986, DSM Collection.

¹⁹⁹ As further evidence, two thousand of the nine thousand professionals who attended the APA's annual meeting that year were not members of the organization.

formalized protests from groups; that is, she takes a statement of opposition from the National Association of Social Workers or a group from within the American Psychological Association as representative of their entire memberships. Whether or not this is fair is debatable, but Caplan's motivation here was certainly political.²⁰⁰ This show of numbers was also theatrical: Caplan requested women send the petitions back to her so that, rather than trickling into the APA's offices one by one, a thick stack could be dropped there all at once.²⁰¹

NASW, on the other hand, designed its protests to demonstrate that NASW ought to be part of the *DSM* revisions process. Letters, in contrast to petitions, provided space for greater depth. Given NASW's desire to create an ongoing professional relationship with the APA, demonstrating the soundness of their objections was as important as a simple show of numbers. As well, NASW's aims may have also meant that listing brief objections in petition-format wasn't necessary and was perhaps even counterproductive. NASW may have seen a truncated list of objections as implying that those objections were easily summed up and dealt with, whereas what they truly wanted to suggest was that the problems that plagued the APA were complicated and required ongoing input from social workers.

While NASW undoubtedly used the controversy around the *DSM-III-R* as a wedge to gain professional stature, their protests were also sincere and served as a criticism of psychiatry as a whole. Social work in the 1980s was a woman-dominated field, and thus social workers had

²⁰⁰ As will be discussed later in the chapter, Caplan was troubled by the APA's failure to be representative of its membership. The assumption that a formally adopted statement necessarily represents all members of a professional organization seems to contradict her approach to the protests. That is, if Caplan believed the APA's leadership to be unreflective of its members' political views, there was little reason to assume that a statement from NASW's leadership reflected the views of every NASW member.

²⁰¹ The protest materials held at the APA's archive could easily fill a two-inch binder. One imagines them landing with a heavy thunk.

more experience with, and perhaps more empathy for, women.²⁰² One social worker identified herself and her fellow social workers as “in positions of de-victimizing women.”²⁰³ Another identified himself simply as “a social worker who is sensitive to the problems faced by women in society and in the mental health professions.”²⁰⁴ Moreover, it was not merely that NASW’s participation in future *DSM* revisions would afford them a level of professional power, but that their inclusion would allow them to “highlight the psycho-social implications of proposed diagnostic categories.”²⁰⁵ NASW members believed that the APA was too narrowly focused and had failed to consider the role of social conditioning in creating and shaping mental illness.

This failure was particularly egregious in regards to SDPD. NASW members argued that the symptoms of SDPD did not constitute a personality disorder, but were rather responses to abuse. SDPD, rather than dealing with the underlying causes of these behaviors, “sets up a cause-effect relationship between a woman’s low functioning and abusive situations which leaves her responsible for the violence.”²⁰⁶ Low self-esteem and feelings of helplessness (or martyrdom, as the APA might refer to it) were “the effects of sexual assault or battering and not the causes.”²⁰⁷ Another NASW member wrote that the symptoms of SDPD were a “method of coping with extraordinary stressors in the social environment... The proposed category implies a primarily intrapsychic etiology which is not supported by current research.”²⁰⁸ In other words, the APA had concentrated solely on women’s behavior and mental state, rather than looking at the environments and relationships which might shed more light on women’s situation. Social

²⁰² 79% of members in 2003 were women (“Demographics,” *PRN* 2, no. 2 (2003)). I don’t have demographic information for 1980s, but the field has historically been female-dominated.

²⁰³ Cynthia Avery to Spitzer, July 9, 1986, DSM Collection.

²⁰⁴ Robert Birkey to Spitzer, June 16, 1986, DSM Collection.

²⁰⁵ Ruth Bluestein to Spitzer, July 15, 1986, DSM Collection.

²⁰⁶ Birkey to Spitzer.

²⁰⁷ Birkey to Spitzer.

²⁰⁸ Arlene Bower Andrews to Spitzer, June 25, 1986, DSM Collection.

workers, however, were party to these external factors and better understood how and why the symptoms of SDPD manifested.²⁰⁹ In that sense, social work was a place where the social and the psychological butted up against one another in a very visible way; in dealing with both issues, social workers were prone to see the connections between the two, rather than attempting to separate them out as did the APA. NASW's language—terms like “psycho-social” in particular—and investment in working with the APA on a continued basis indicate a belief that these issues were both social *and* psychological.

While NASW believed labeling abused women with a diagnosis was misguided and harmful, they also allowed that psychiatry had something to offer on the subject. This stood in marked contrast to Paula Caplan. While NASW saw the protests as a way to claim professional legitimacy, Caplan saw them as a way to underscore what she saw as the APA's lack thereof. Moreover, while NASW attempted to change psychiatry from within (as an institution embedded in the mental health field), Caplan positioned herself firmly as an outsider (despite her professional background as a psychologist). Caplan was critical not just of the three proposed diagnoses, but also of the very concept of diagnosis, therapy and psychiatry in general.

Caplan saw each individual diagnosis as detrimental, but their greater importance was that the three related to one another and to the broader sexism of American society. Because SDPD was Caplan's chief concern, she wrote described PMDD and PCD primarily through the ways they connected to that disorder. On women's masochism, she wrote,

²⁰⁹ Battered women's shelters may have also been similarly situated. Feminist thought was part and parcel of the movement to create women's shelters, and workers were often dedicated to a feminist reading of battery as a social issue. At the same time, workers would have been dealing with the psychological effects of battery on women, and most likely at least thinking about the psychological state of the men involved. Given the similarity in social work and battered women's shelters, it's not surprising that women in the two professions supplied a significant number of letters and petitions to the APA.

There have been two tributaries to the myth: (1) the belief that women's anatomically-based pain (menstrual cramps, labor pains, the possibility of being raped, women's allegedly passive and suffering sexual experiences, etc) reflect our *enjoyment* of pain; and (2) the mislabeling as masochistic of much of women's learned behavior, especially being nurturant and self-denying, putting others' needs ahead of our own, etc.²¹⁰

Thus, for Caplan, defining PMS as a psychological disorder shored up the idea that women were, by nature, masochists. Similarly, in a society in which women were masochistic and drawn to suffering, classifying rapists as mentally ill would make it even easier to see women as victims of their own design.

Moreover, as her second point argues, labeling feminine behavior as pathological drew attention away from the social dimensions of that behavior. For Caplan, what was at stake in how to label the constellation of symptoms identified as SDPD by the APA was not just 'victim blaming' but the ways in which labels presupposed solutions. In labeling SDPD as a mental illness, the APA covered up all the social ills that caused those symptoms. Accordingly, the diagnosis left no reason to lobby for social change. As someone dedicated to social change and someone who saw society as the root of women's problems, a framework that relied on pathology was, at best, a distraction.

While Caplan acknowledged that women's socialization could cause mental illness, she argued that a sexist society increased disorders like depression and anxiety in women rather than that female socialization itself could be diagnosed as pathological.²¹¹ Even with depression, a social solution rather than a psychiatric one was necessary: "If women received equal pay for equal value, for instance, or if the work of childcare and housekeeping were respected and even remunerated, major contributors to the epidemic of poor self-esteem and depression among

²¹⁰ Caplan, "The Name Game."

²¹¹ As will be discussed later in the chapter, Caplan offered a very different reading of male socialization.

women would be curtailed.”²¹² Broadly speaking, then, women suffered from social oppression and not psychological illness. Accordingly, psychological treatment not only failed to address the root of the problem, but also actively distracted from that root. For Caplan, then, even relatively uncontroversial labels like depression could be indicative of a sexist orientation.

Not merely opposed to particular diagnoses or institutions, Caplan was also ambivalent about therapy in general and framed therapy as oppositional to social awareness and social action. If, as Caplan argued, therapists were generally sexist and ready to blame women for their problems, then a diagnosis like SDPD or PMDD might actually *increase* women’s levels of depression and self-blame rather than alleviating any psychological distress. But it was not just sexism on the part of individual therapists that gave Caplan pause. Rather, therapy was *structurally* sexist. Psychotherapy, by virtue of its one-on-one nature (a patient and a therapist, in other words), implied that the patient had an individual problem. By treating the individual *as an individual*, therapy distracted from the sociological issues that caused women’s suffering in the first place. She writes, “Are we unwittingly helping to ‘therapize’ oppression? ...The very act of working with women clients individually, in something we call ‘therapy,’ can carry with it the implication that it is the individual who *is* the problem.”²¹³ Even further, Caplan wondered whether individual psychotherapy could “belong on the continuum of victim-blame,” due to it placing the onus on women to understand and solve their problems.

Rather than individual therapy, Caplan suggested that social action would be better able to solve women’s mental suffering—such action was often “empowering,” and more likely to

²¹² Paula J. Caplan, “The Origins of Women and Mental Health in Canada: Strategies for Change.” *FTI Interchange: Publication of the Feminist Therapy Institute, Inc.* 7, no. 2 (Summer 1989).

²¹³ Paula J. Caplan, “Driving Us Crazy: How Oppression Damages Women’s Mental Health and What We Can Do About It,” *Women & Therapy* 12, no. 3 (1992).

solve whatever problems underlay a woman's suffering in the long run. Therapy was, at best, a band-aid that treated symptoms rather than causes. Accordingly, she urged her fellow feminist therapists to promote social action to their patients, rather than avoiding the subject for fear that it was too political a topic for therapy. Caplan argued that therapy itself was politically inflected—to promote to a patient that she should consider herself an equal partner in her romantic relationship, for instance, the therapist relied on a theory that women and men were equal. What separated that theory from the theory that women should engage in activism both for themselves and for other women? Moreover, Caplan suggested that “there are not and never can be enough good feminist therapists to pick up the pieces the misogynist cyclone leaves in its daily wake.” Women, rather than depending on therapists, had to engage in social action to solve their socially-induced problems.²¹⁴

Altogether, Caplan's criticisms of therapy point out the ways in which such an all-encompassing feminist theory could place women in a double bind. Caplan summed her sentiments up thusly: “I feel that we too often only *think* like Radical Feminists but *behave* like Liberal Feminists, as though we believed that the current structures were basically very good. How many of us really believe that?” While many women in mental health fields shared her reservations, a radical solution came at the price of pragmatism. Questions of pay are the most obvious here. Some colleagues shared her reservations about therapy, but wondered why they shouldn't be paid for engaging what might be considered a traditional feminine behavior, as well as how they would make money more generally.²¹⁵ Moreover, Caplan suggested that feminist

²¹⁴ One wonders whether therapists instructing women to, say, join NOW in order to solve not just their own problems but also the problems of womankind in general couldn't be placed on the same “continuum of victim-blame.”

²¹⁵ Caplan refers to a colleague's ambivalence on the subject of pay: “On the one hand, I deserve to be paid because women's nurturing and skills are always unpaid or underpaid and, on the

therapists should spend 10% of their time brainstorming about how to better implement feminism in their practice. While not a bad idea, it represented more time in which women wouldn't be earning money or advancing their careers. Caplan herself had suggested that not only should women's work be remunerated, but also that women's economic inequality contributed to their depression. Her position on feminist therapy suggests that she found such a profession so illogical that her more pragmatic feminist ideas ceased to matter in such a context. Altogether, Caplan emerges as both a radical and a polemicist. She could acknowledge the difficulties and shortcomings of her proposals, but maintained that sweeping theories and inflammatory statements best served the purpose of shaking up a system in desperate need of overhaul. While pragmatic issues formed the barrier to radical change, such tradeoffs were strangely easy for Caplan to make, at least rhetorically.

Alongside her objections to therapy as a practice, Caplan was critical of the *DSM* as a document. Much like therapy, it suffered from structural sexism. By the mid-1980s, the APA had begun placing a premium on objectivity. In the revisions process, this meant strong evidence for any new disorders, as well as an atheoretical stance on any given disorder. That is, something like "penis envy" couldn't be entered into the *DSM* because such a diagnosis would necessarily depend on an explicitly Freudian theory of gender rather than on more generalized psychiatric knowledge. Caplan claimed that the APA had failed to meet either of these standards with regard to SDPD especially.²¹⁶ Caplan's belief that the APA had failed to meet adequate standards for

other, I feel uncomfortable turning women away because they can't pay" (Caplan, "Driving Us Crazy"). This unnamed colleague demonstrated the ways in which a radical theory and pragmatic concerns often placed women in a bind.

²¹⁶ PMDD relied, implicitly, on a theory that such symptoms were not biological. Caplan doesn't talk much about PCD, but does note that the disorder had little empirical evidence to its name. As well, and as an aside, she noted that psychiatrists had little to offer women suffering from what they identified as PMDD. She writes, "A reporter from a women's magazine asked Spitzer

empiricism has been discussed earlier in the chapter. In regards to objectivity, she argued that SDPD relied on a preexisting belief that women were naturally masochistic. Thus SDPD was neither atheoretical nor well supported. Caplan's proposal for Delusional Dominating Personality Disorder (SDPD for men, essentially, as I will discuss later in the chapter) also indicates that she thought the APA's attempts to be atheoretical were misguided in the first place, as psychiatry was inherently theoretical. The issue, for Caplan, wasn't the presence of a theory but rather that the theory wasn't a sufficiently feminist one. At a moment when the APA was struggling with empiricism, Caplan was pushing to toss the entire concept out the window.

NASW and Caplan epitomize the multiple ways in which women professionals engaged with the APA. Caplan and NASW shared a number of theoretical similarities—a concern for women and especially abused women, a concern about the APA's insularity and sexism, and a general investment in popular feminist ideas that were primarily sociological in nature. Yet the differences between the two were immense. NASW operated on the charitable assumption that the APA was a worthwhile organization that would listen to and could benefit from the input of women professionals. Caplan, for her part and despite her brief tenure as an advisor to the *DSM-IV*, operated on the assumption that the APA and psychiatry as a whole were fundamentally and unsalvageably sexist. As well, these theoretical differences led to different ways of engaging with the protests. Caplan's ostensible status as an outsider spurred her to mobilize women outside mental health fields. Perceiving the APA to be deeply uninvested in women professionals, Caplan saw spreading information far and wide as an important component in her

whether psychiatrists had anything to offer women with PMS than what her magazine gives readers about the topic, and he was at a loss to provide a substantive reply" (Caplan, "DSM-III-R Controversy," unidentified and undated Canadian publication, Paula J. Caplan Papers, The Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University (hereafter, Caplan Papers)).

activism. NASW, however, was concerned more with legitimizing its own work, which is reflected in the more limited scope of their protests. In the end, the success of the protest movement relied on both Caplan and NASW, despite such contradictory concerns and diverse approaches.

Labeling (Bad) Behavior

By the time the *DSM-III-R* went into print, the APA was well aware of Caplan's opposition both to the *DSM* and their organization. Still, when the revisions process for the *DSM-IV* began—and SDPD, as well as PMDD, remained an issue—APA chair Allen Frances extended an invitation for Caplan to work as an advisor for the Personality Disorders Work Group. Despite her opinions on the APA, she accepted. Of her choice, she stated, “I do prefer to work *with* rather than against others, to search for common ground,” and that it “seemed worth attempting to help the APA.”²¹⁷ Part of this may have been due to the new leadership of the *DSM* revisions committee. Caplan's relationship with Robert Spitzer, Frances' predecessor, had been particularly acrimonious and she may have seen Frances as a chance for a fresh start. But while Caplan may have seen Frances' invitation as a positive step, her criticisms of psychiatry ultimately ran too deeply for her to engage in the revisions process in good faith. Caplan was not opposed merely to the three disorders or to the biases of the APA, but to the entire psychiatric enterprise. For Caplan, diagnostic labeling itself was a dubious pursuit. Put most baldly, Caplan and her colleague Margrit Eichler had “little stake (or faith) in diagnostic labeling.”²¹⁸ Yet here

²¹⁷ Paula J. Caplan, “What's Happening These Days with the DSM?” *Feminism & Psychology* 1, no. 2 (1991).

²¹⁸ Kaye-Lee Pantony and Paula J. Caplan, “Delusional Dominating Personality Disorder: A Modest Proposal for Identifying Some Consequences of Rigid Male Socialization,” *Canadian Psychology/Psychologie canadienne* 32, no. 2 (1991).

they were, proposing a new diagnostic label for a diagnostic manual. From Caplan's perspective, this proposal served as a way to use the APA's own language to draw attention to its shortcomings. From the APA's perspective, however, it more likely seemed like nothing more than bad faith on Caplan's part.

At the heart of Caplan and Eichler's proposal—and the debate over the *DSM* proposals in general—was a question about what was at stake in labeling behavior. Labels had power; naming something was a way of claiming it and, in the case of diagnostic labels, a way of implying particular kinds of solutions to a problem. This was, of course, nothing new; in fact, Caplan's colleague Kaye-Lee Pantony invoked Thomas Hobbes' statement that “ultimate power is the power to make definitions.” What *was* new, however, was that it was time for women “to use this power, presently wielded by the authors of the *DSM-III-R*, to make the absurd and destructive nature of sexism visible.”²¹⁹ Labels, then, could be used to distract from a problem (as women like Caplan argued in regards to SDPD), to draw attention to a previously unrecognized problem, or even to satirize a wrongheaded line of thinking. In the course of thinking about SDPD, Caplan became increasingly invested in this issue. The following section will discuss how Caplan—and other protesters—thought about diagnoses and the various ways in which they could help or harm.

As noted earlier, Caplan and others believed that labeling rapists as mentally ill would provide a legal defense. Conversely, labeling women with Self Defeating Personality Disorder would provide a legal case against them in prosecuting spousal abuse. Caplan also reported that, in some cases, women who accused their male partners of child abuse were diagnosed with Munchausen's by proxy—that is, those women were so desperate for attention that they had

²¹⁹ Pantony, “A Modest Proposal.”

made up the child abuse. The stakes Caplan presented here were straightforward: diagnoses demeaned women, but elevated men. In this sense, diagnoses were not unique, but merely another manifestation of sexism and the ways in which male power operated against women.

But Caplan also presented cases that complicated this idea. For instance, she noted that a PTSD diagnosis had benefited some women: in cases where battered women divorced their spouses and signed away large sums of money in the settlement, a diagnosis of PTSD provided an argument that these women had been unable to consent to the settlements at the time and thus a way to challenge the settlements in court. And if the fear with PCD was that abuse would be waved away as mental illness, a handful of court cases proved this could equally affect women. Most strikingly, a few women accused of murder argued that PMS had contributed to their actions; one was convicted of manslaughter, and the other sentenced to probation and hormone therapy.²²⁰ Though such cases were exceedingly rare and not always successful, they do demonstrate that diagnoses did not always reflect such a simplified theory of male power.

More importantly, Caplan's own aims contradicted such a straightforward reading in which diagnostic labels benefited men and harmed women. As part of her protests against the APA, Caplan proposed a new disorder to parallel SDPD: Delusional Dominating Personality Disorder (DDPD), which she also referred to as "Macho Personality Disorder," or "John Wayne Personality." The idea had started as a "consciousness raising" experiment between Caplan and Margrit Eichler.²²¹ In the course of criticizing SDPD as a mislabeling of female socialization, the two had begun to think about what a similar reading of male socialization would look like. The result was DDPD, wherein an individual (usually, though not necessarily, male) had bought

²²⁰ Marcia Chambers, "Menstrual Stresses as a Legal Defense," *The New York Times*, May 29 1982. This article also discussed similar cases in the US.

²²¹ Pantony, "A Modest Proposal."

wholesale into the idea of manliness. The patient was out of touch with his emotions, unable to feel empathy, saw women as lesser than himself, and so on. Caplan's proposal was less about seriously introducing a new disorder to the DSM, and more about offering a broader critique of sexism in American society and in psychiatry specifically. In a number of letters and papers, Caplan readily admitted that she was not particularly invested in getting DDPD into the *DSM*; rather, she saw it as a convenient vehicle for her theories.

The criteria Caplan proposed for DDPD reflected some of the major feminist tenets of the 1980s. Many of the criteria specifically referenced the denigration of women—"a need to deflate the importance of one's intimate female partner, females in general, or both," "the delusion of personal entitlement to the services of any woman with whom one is personally associated."²²² Others referenced the sort of casual sexism that divided women and men: "a pronounced tendency to categorize spheres of functioning and sets of behavior rigidly according to sex, e.g., belief that housework is women's work." A number of criteria were concerned with men's stereotypical inability to express their emotions.

Some of her criteria were highly specific and reflected protracted debates within the women's movement. One of the criteria Caplan listed was "the delusion that pornography and erotica are identical." This idea was indebted to a decade of feminist theorizing, and even in 1988 remained controversial. Its casual inclusion here indicates that Caplan was deeply embedded within the women's movement, rather than in mental health fields. As well, it's another indicator that, though she stated the criteria for DDPD were atheoretical in keeping with the stated aims of the *DSM*, Caplan had a very peculiar idea of what did and did not constitute a

²²² Paula J. Caplan, "Delusional Dominating Personality Disorder (DDPD)," *Feminism & Psychology* 1, no. 1 (1991).

theory.²²³ Moreover, while Caplan had previously criticized SDPD as a theoretically-rooted disorder—thus one that failed to meet the APA’s stated standards—DDPD made clear that her issue was not with the existence of a theory behind SDPD, but the existence of a *wrong* theory. In fact, Caplan was opposed to the idea that diagnoses needed to be atheoretical in the first place: “Unlike the *DSM* authors, we do not wish to disconnect the description of DDPD from theories or information about its etiology.”²²⁴ Rather than striving for an atheoretical *DSM*, Caplan wanted to infuse the document with feminist theory.

DDPD could be applied to any type of man, but as Caplan and Eichler continued with their thought experiment, it increasingly seemed that it might be best applied to men who abused their female partners.²²⁵ As part of their protests of the APA, they sent out descriptions of DDPD to a number of individuals working with battered women and/or their partners and solicited comments. These professionals were a logical audience for the proposal and not just in terms of theory. Batterers made sense as a group that might fall under the diagnosis. Equally important, however, was that women working with victims of abuse were already invested in the SDPD issue and many had been in dialogue with Caplan for some time. In a sense, they were a ready-made audience for what amounted to a fairly radical proposal. Their response was generally positive—correspondents agreed that the qualities described by DDPD were common in male batterers. Many agreed to write the APA to express support for the disorder’s inclusion in the

²²³ On this, refer back to her discuss of therapy, wherein she equates a therapist encouraging a patient to act as an equal partner in romantic relationships to a therapist explicitly advising her patient to join NOW.

²²⁴ Pantony, “A Modest Proposal”

²²⁵ Battery and physical violence are only explicitly mentioned once in Caplan’s proposed criteria for DDPD. The idea here wasn’t that DDPD and battery corresponded naturally, but that DDPD and male sexism corresponded and that battery was the darkest expression of that sexism. As well, focusing the criteria too narrowly on battery would have obscured Caplan’s larger argument about the nature of sexism.

DSM-IV, much as many in that field had previously written to express opposition to SDPD in the *DSM-III-R*.

In the case of DDPD, the power to name was the power to make something visible. One colleague wrote, “Until we make these dangers visible we cannot begin to change them... It is time to use this power [to name], presently wielded by the authors of the *DSM-III-R*, to make the absurd and destructive nature of sexism visible.”²²⁶ In regards to abuse specifically, pathologizing male batterers was a way to draw attention *away* from victims and *toward* perpetrators. But more generally, labeling a whole constellation of sexist behavior and thinking as a mental illness was simply another way to draw attention to sexism in general, rather than any particular or limited mental illness. What Caplan wanted to make visible was the idea that male socialization could *itself* be pathological. The converse was that, in her opposition to SDPD, Caplan had suggested that only the *consequences* of female socialization could be pathological. DDPD thus represented the complicated—and perhaps confused—ways that psychiatric labels could be used.

Caplan also suggested that DDPD “tends to characterize leaders of traditional mental health professions, military leaders, executives of large corporations, and powerful political leaders.” In addition to fitting with a feminist critique of male power, this statement underscores Caplan’s opposition to the APA as an organization. Combined with her general ambivalence regarding the *DSM*, this statement indicates that Caplan was attempting to use the language of the APA against it. By framing the problems that plagued the APA in the language of mental illness, perhaps she could effect some substantial change—after all, one had to name a problem

²²⁶ Pantony, “A Modest Proposal.”

in order to deal with it. And if the APA was only capable of thinking in terms of pathology, perhaps an emphasis on social factors was simply unlikely to hit home.

At the same time, suggesting that the APA (or at least its average member) might be mentally ill during a formal revisions process—essentially, requesting that the APA diagnose itself—implies a certain satirical tone. While the problems Caplan noted were serious ones, the diagnosis itself was also somewhat tongue-in-cheek. Some of the responses from feminist therapists to DDPD underscore this. Writes one supporter, “We feminists need all the laughs we can get.”²²⁷ Another colleague wrote to Caplan that, while he didn’t agree that DDPD should be included in the DSM, that he expected the APA’s opposition to the disorder to be overblown enough as to “prove” DDPD’s existence.²²⁸ His use of scare quotes suggests that he, like Caplan and others, saw the very concept of mental illness as messy and the lines between the sociological and pathological as hopelessly blurry. That Caplan glibly referred to a disorder she aimed at batterers in reference to a movie star (“John Wayne syndrome”) underscores the dual serious-satirical nature of DDPD.

Caplan was not alone in using this satirical mode, though DDPD was unique in the amount of attention it received. One protester wrote, “After careful review of the *DSM-III-R*, it is obvious that some new and worthwhile diagnoses have been added. These additions, however, have highlighted other gaps, which need to be addressed to really complete the new *DSM*.”²²⁹ Her suggestions? Castrationism (the “repetitive assault of men,” thus a “complimentary diagnosis [to PCD] for those women who take the law into their own hands”). And indeed why some bad behaviors and not others? The author didn’t stop there and muses that it would be

²²⁷ Marcia Hill to Caplan, July 12, 1989, Caplan Papers.

²²⁸ James Harrison to Caplan, December 21, 1989, Caplan Papers.

²²⁹ Linda Gay Paterson to Spitzer, December 3, 1985, DSM Collection.

strange to include only some antisocial and extreme behaviors, and further suggested murderism, assaultism, arsonism and larcenism.²³⁰²³¹

Perhaps ironically, a number of colleagues wrote to Caplan to protest DDPD, arguing that it was a social phenomenon rather than a psychological one. Such suggestions were also closely paralleled by Caplan's own objections to PCD and SDPD. One letter noted, "I think it will be almost impossible to not diagnose everyone with this disorder."²³² Caplan, however, saw this as a feature and not a bug. The disorder was meant to draw connections between the casual sexism men espoused in daily life, and more violent acts like rape and battery. More broadly, Caplan meant to suggest that the lines between 'normal' behavior and mental illness were not as clear as people liked to think. But for an audience invested in mental health work, Caplan's presentation of the disorder *as a disorder* obscured her point.

Those opposed to DDPD also argued that the disorder was a social, rather than psychological, phenomenon. This was, of course, part of Caplan's point. At issue was the way in which Caplan was using DDPD to do a lot of critical work—the disorder was intended to draw attention to sexism and interconnected nature of each individual instance of sexist thought or behavior, to critique the insular and male-dominated nature of power and institutions, to satirize attempts to draw lines between the psychological and the social, and to question whether or not empiricism was an attainable or desirable goal. For Caplan and many of the women she worked

²³⁰ The irony here is that the latter two are sometimes classified as mental disorders—pyromania and kleptomania.

²³¹ Likewise, the American Society of Adlerian Psychology formally petitions for the inclusion of a "Racist Personality" as a subtype of paranoid personality disorder (Robert Powers, "Resolution on Racism," May 24, 1974, DSM Collection; see also: Charles B. Wilkinson to Spitzer, June 24, 1975, DSM Collection). Both of these letters are from the mid-1970s, and thus predate the protest movement discussed here. It's not clear from these letters whether the suggestion was earnest, satirical, or both.

²³² Deborah Dale Putnam to Caplan and Margrit Eichler, September 1989, Caplan Papers. It's worth noting that Putnam worked with battered women.

with, these goals were obvious. For others, however, DDPD represented a confusing amalgam of psychiatric and feminist thought. Although Caplan was never particularly concerned with getting DDPD into the *DSM*, the mixed responses to the proposal demonstrate her failure to translate the concept to a broader audience.

This ambivalent relationship to labels is evident in looking at other protest materials. While many protesters—and indeed many proponents of DDPD—allowed for the possibility that diagnostic labels could be helpful and were not necessarily stigmatizing, others were more radically opposed to psychiatry. Some protesters were indebted to the anti-psychiatry movement, which had been growing since the 1970s. Its zeitgeist was this anti-labeling sentiment. Still, if many protesters shared these anti-labeling sentiments, they did not engage in any significant way with the anti-psychiatry movement.²³³ Rather, they remained an insular protest movement designed to engage solely with the APA and get the three proposals deleted from the *DSM*. The anti-psychiatric movement, in contrast, wanted nothing to do with psychiatry whatsoever. Indeed, the author of an *Off Our Backs* article lamented that the periodical's coverage of Caplan's Committee Against Misdiagnosis protests of the APA implicitly supported psychiatric reform, rather than its complete abolition.²³⁴ That even Caplan's interactions with the APA could be interpreted as capitulating to a sexist system points towards the kinds of battles that often characterize radical movements. Feminist therapy wasn't good enough for Caplan and Caplan wasn't good enough for women in anti-psychiatric movements. While each of these represent

²³³ The protest movement remained curiously isolated from mainstream feminist publications as well. While mainstream feminist organizations had spurred the protests, I found a mere handful of references to the APA or psychiatry more generally in *Off Our Backs* between 1985 and 1987 or to the protest movement specifically in NOW's publications. Although feminist publications were very much concerned with rape, the APA's attempts to pathologize rape failed to garner much attention outside of conventions and formally organized protests.

²³⁴ The same article discusses the institutionalization and over-medication of women, which Caplan commented on (briefly) as evidence for sexism in psychiatry.

different ideas about psychiatry and thus different approaches to the APA, there remains an underlying question about ideological purity. Perhaps the most surprising thing about these protests, then, is that they managed to unite so many different groups so successfully.

Given the above, it might be tempting to think about opposition to the proposed disorders as existing along a continuum from liberal to radical. However, while most of the protests espoused an anti-labeling position, some protesters suggested the exact opposite. Rather than concentrating on the social aspects of psychosocial problems, many called for the APA to do *more* to pathologize bad male behavior and its results. Unlike Caplan's ultimately satirical suggestions, these proposals were earnest. They relied on feminist theories about socialization and male power and aggression, but rejected the idea that these theories necessarily stood in opposition to pathological interpretations.

The letters in this vein took two approaches. Some argued that the APA need not include new diagnoses because these behaviors were, for the most part, already covered by existing taxonomies—PCD could just as easily be diagnosed as Sadism or Explosive Disorder.²³⁵ Likewise, the symptoms of SDPD did not require a new label, but could be better understood as manifestations of Post-Traumatic Stress Disorder.²³⁶ Whether or not these protesters agreed with the proposed diagnoses, then, they implicitly agreed that the problems were psychiatric ones.

Other protesters went in a different direction. Lenore Walker, on behalf of Caplan's organization, argued for the creation of two new categories, Situational Disorder Category and Abuse Disorders. These categories would include rape trauma syndrome, battered woman syndrome, child abuse syndrome, child sexual abuse syndrome, etc. While this was the only

²³⁵ Daniel E. Fast to Spitzer, June 5, 1986, DSM Collection. Sadism here refers to the paraphilia, Sexual Sadism.

²³⁶ H. H. Peter. Belding to Nadelson, April 28, 1986, DSM Collection.

letter to suggest such sweeping changes to the DSM, much of the debate over PCD and SDPD boiled down to whether or not aberrant, gendered behavior should be thought of as pathological. One NOW member stated her case most strongly: “Humanity would be far better served by addressing the globally rampant, still tacitly accepted sadism of males who physically, sexually and psychologically abuse their wives and children.” How? “Include a *DSM-III-R* category— Wife and Child Abuser Pathology.” And when ORTHO (a mental health consumers organization) lamented, “there is no proposed parallel diagnosis [to SDPD] for the aggressive, power-driven, exploiting personality and behavior patterns fostered by the culture in men,” the APA introduced Sadistic Personality Disorder to do just that.²³⁷ It’s clear from all this that a number of women believed male violence to be pathological in some sense.²³⁸ Moreover, the effects of male violence visited upon victims might *also* be pathological—rape and battering could cause PTSD, protesters conceded. The issue, then, was where to draw the line between the psychological and the social.

This was the nexus into which Caplan launched DDPD. For a select audience, the theories embedded within the disorder were clear and the disorder a sharp criticism of the APA. As well, Caplan’s choice to rely on inflammatory rhetoric seems to have been a smart one: while suggestions by women like Walker were completely earnest, Caplan received far more attention from the APA.²³⁹ For the most part, however, the question of labels was tricky for feminists and

²³⁷ Brownsmith, “Orthopsychiatric Association Position,” DSM Collection. It’s not clear why Sadistic Personality Disorder was rejected, either by the APA or by protesters. It’s especially curious that Sadistic Personality Disorder received a generally lukewarm response, in contrast to DDPD.

²³⁸ Another objection to PCD was that the short hospital stays such a diagnosis would result in would allow the “sociopathy and/or other pathology underlying this violent act [rape] to be overlooked” (Virginia Accetta to Pasnau, May 29, 1986, DSM Collection).

²³⁹ This is not to suggest that Caplan was more successful than Walker, however. Lenore Walker’s work has been widely adopted in popular culture and forms the basis for many legal

mental health professionals of all stripes, and DDPD failed to stick either as a satire or a serious proposal.

Male Pathologies: DDPD and PCD in Comparison

For the most part, women's opposition to psychiatry has been examined in terms of disorders that disadvantaged women—e.g., hysteria, depression—but the 1986 protests reveal that disorders that targeted men opened up a new set of questions. At issue was not just whether or not a diagnosis would disproportionately target women, but how disproportionately targeting men would play out politically. In considering this, feminist mental health professionals invoked a framework that juxtaposed psychiatry with politics, and tentatively found that pathology could be used both to normalize behavior and to suggest political solutions to gendered problems.

In some senses, DDPD's initial status as satire is critical. That a satirical disorder reflects different values than a serious one (PCD, in this case) is understandable. At the same time, juxtaposing these two disorders suggests a number of things about the protest movement. First, and perhaps most obviously, protesters were as concerned with controlling the process of the *DSM* revisions as with specific proposals. PCD and SDPD, having been formulated by male psychiatrists with little input from legal scholars, forensic psychiatrists, feminists, or women more generally, were bound to be used in harmful ways.²⁴⁰ Conversely, feminist-formulated

and therapeutic approaches to domestic violence. It is merely to say that, at this particular moment, Caplan's more forceful rhetoric was splashier and garnered more of a reaction.

²⁴⁰ Although I am unaware of any major cases in which PCD was used to mitigate a defendant's guilt, there were a few cases in which judges sentenced sex offenders to treatment centers in lieu of prison (see chapter 3). As well, other dubiously accepted mental disorders were used in criminal cases. PMDD was used as a defense in a variety of cases, though rarely with much success. More successfully, battered woman's syndrome (a disorder generally accepted by feminist mental health workers, but not included in the *DSM*) has been used in cases in which women have murdered their abusive partners. See Patricia Esteal, "Premenstrual Syndrome

diagnoses like Battered Women's Syndrome or DDPD might be used in a beneficial manner. The proliferation of feminist diagnostic proposals indicate that it was not just that the APA had been marked as a convenient site for protests, but that the growing connections between psychiatry and social movements made psychiatry seem like a logical tool for a variety of political ends.

As well, looking at these two disorders together suggests that feminist mental health professionals in the mid-1980s were torn between radical and liberal politics. Historians have cited a marked shift from the radicalism that characterized grassroots feminism up to the late-1970s to the liberal politics that characterized feminism as it gained political traction in the 1980s.²⁴¹ Caplan herself noted this duality, writing, "I feel that we too often only *think* like Radical Feminists but *behave* like Liberal Feminists, as though we believe that the current structures were basically very good. How many of us really believe that?"²⁴² For feminists working in mental health fields, this tension would be, perhaps, irresolvable.

In practical terms, the protests of the APA fall in line with liberal feminist politics; the APA's critics generally wished to reform psychiatry, rather than overthrow it. Despite some anti-labeling sentiment, the majority of the feminist mental health professionals involved in the protests believed that the APA's woman problem could be solved if the APA considered input from women and other mental health professionals like psychologists and social workers.

(PMS) in the Courtroom," presented at the Women and the Law conference at the Australian Institute for Criminology (September 24-26, 1991); Lenore Walker, *The Battered Woman Syndrome* (New York: Springer Publishing Company, 2009).

²⁴¹ Satter, "The Sexual Abuse Paradigm." See also: Maria Bevacqua, *Rape on the Public Agenda: Feminism and the Politics of Sexual Assault* (Lebanon, NH: Northeastern University Press, 2000); Rose Corrigan, *Up Against a Wall: Rape Reform and the Failure of Success* (New York, NYU Press, 2013); and Ruth Rosen, *The World Split Open: How the Modern Women's Movement Changed America* (New York: Viking, 2000).

²⁴² Caplan, "Driving Us Crazy."

Fundamentally, then, psychiatry was a good enterprise, but one which needed to be more sensitive to women's concerns.

Yet it is also true that radical theory was a fundamental driving force behind these liberal goals. Debates over the individual disorders had failed to produce any results. Years of discussion had resulted in nothing more significant than a series of name-changes for the three disorders.²⁴³ Before the protests started in earnest, a wave of letters protesting SDPD rolled into the APA, but were basically ignored. It was not until the three disorders were linked together and framed as part of a larger anti-woman project on the APA's part that the protests gained enough steam to force the APA's hand. Moreover, many of the women behind the protests were avowed radicals. Caplan, in particular, criticized the concept of psychiatric diagnoses, saw therapy as structurally sexist, and included an anti-pornography statement within the diagnostic criteria of DDPD. In this instance, radical rhetoric was a necessary element of success. Connecting the three disorders with an overarching theory of gender and power, and with more radical criticisms of psychiatry as an institution, managed to sufficiently broaden the appeal of the protests in order to achieve the liberal goal of reforming the *DSM*.

Finally, opposition to PCD suggests that feminists thought about sex and violence in radically different ways. Although the women's movement's aphorism that the personal is political had increasingly gained traction, sex resisted a political reading. For feminists like Scully and Marolla, the sticking point with PCD would always come down to the way in which it framed rape as a sexual issue: If rapists suffered from an overwhelming and uncontrollable sex

²⁴³ PCD had initially been known as "Rapism" and then "Compulsive Rapism." PMDD was known variously as "Late Luteal Phase Disorder" and "Periluteal Phase Disorder," and SDPD was "Masochistic Personality Disorder." Feminist critics charged that these changes in terminology were politically motivated and served to cover up the gendered aspects of the proposals (Caplan, *They Say You're Crazy*, 91).

drive, then there was nothing political action could do. It was only by reframing sex as an issue of socialization—that is, men were socialized to act upon their violent sexual urges toward women—that rape could become a political issue. Conversely, because DDPD framed male behavior as an issue of power and violence, it could be productively considered an issue of pathology. Because there was a preexisting political framework for considering the connections between violence and power, framing male violence as a mental disorder did not threaten to normalize that behavior.

Ultimately, the APA's proposals provided a space for feminist mental health professionals to debate definitions of both femininity and masculinity. The success of these protests relied on the appearance of a united front. Caplan's strategy of tirelessly spreading petitions as widely as possible rather than relying on a narrower group of mental health professionals proved more successful than the smaller campaign undertaken by activists working at battered women's shelters. Likewise, framing the three disorders as indicative of a larger anti-woman position within the APA proved more successful than protesting any one disorder on its own. Yet despite the appearance of a united protest movement, the differing responses to the APA's proposals demonstrate ongoing tensions in how both feminists and mental health professionals (and feminist mental health professionals) thought about male versus female behavior, pathology versus socialization, and sex versus violence.

Conclusion

Feminist organizations were ultimately successful in lobbying the APA to drop the proposed disorders—PCD was deleted entirely from the *DSM-III-R*, and SDPD and PMDD were placed in an appendix for further study rather than being included in the manual. The protests demonstrate that feminist networks (whether professional or personal) were able to mobilize and

circulate information very rapidly. Still, rapid mobilization came at a cost: mobilizing thousands of women in a few months meant that these women were often under-informed about the proposed diagnoses and relied heavily on popular feminist theories about sexism, rape and psychiatry.

Despite this general lack of information, the protests reveal a number of things about women professionals in mental health fields. While some engaged with the APA as professional equals, others offered radical criticisms of the APA that relied on a heavily theoretical understanding of psychiatry and sexism. These different approaches required different types of engagement with the women's movement outside mental health fields, as the contrast between NASW and Caplan demonstrate.

That the protest movement was able to encompass such a wide range of ideas suggests that the APA was something of an easy target, due in part to earlier controversies with the ERA and the gay liberation movement. It also suggests that some very basic feminist assumptions were popular enough to override internal tensions that could easily have overwhelmed the protests. While some women actively opposed the protests out of ideological differences, a broad desire to see these particular diagnoses removed and to see the APA place more emphasis on the sociological and on women's unique concerns allowed protesters to overlook their differences. As well, the rushed and often vague nature of the protests may have played a role in maintaining a unified front.

Ultimately, it's this sense of ambivalence that characterizes not just the protests but also feminists' relationship to psychiatry in the 1980s. Feminists sought ways to deal with bad male behavior, but did not agree on whether psychiatric solutions were an appropriate way to do so. For some, PCD offered a way to explain and treat rape; for others, it threatened a sociological-

feminist understanding of rape. Likewise, feminists wanted women to be regarded differently by society; whether this required them to reject psychiatric labels or to accept psychological help was also unclear. Although the protests initially appear to be united in their opinions towards the proposed diagnoses, they reveal that feminist protesters and mental health professionals alike disagreed on much. The ultimate deletion of the proposed disorders from the *DSM* did little to settle these questions.

Moreover, the responses of the APA's leadership to their critics throughout this process indicate a determination not to engage with broad theoretical questions about the nature of psychiatric diagnoses and the potential overlaps between psychiatry, sociology, criminal justice and medicine. As the *DSM* had become increasingly influential in society at large, these questions became more pressing.²⁴⁴ But rather than engaging with such issues in any rigorous way, the APA's leadership instead chose a simpler solution: dropping PCD altogether and placing SDPD and PMDD in an appendix. This action raises the question of whether or not the protests were successful in a broader sense. If their goal was simply to prevent the inclusion of the three disorders, then the answer is yes.²⁴⁵ If, however, protesters were seeking to force the APA to engage with other domains, the answer is more complicated. The protests did lead the APA to include more mental health organizations in the *DSM-IV* revisions process—and, as

²⁴⁴ See: Stuart Kirk and Herb Hutchins, *The Selling of DSM: The Rhetoric of Science in Psychiatry* (Hawthorne, NY: Aldine de Gruyter, 1992). Numerous news articles at the time cited the use of the *DSM* by insurance companies and in the courts; see, for example, Elizabeth Mehren, "Proposed Psychiatry Changes Draw Fire; Addition of Three New Diagnostic Categories Will 'Stigmatize' Women," *L.A. Times*, September 2, 1986.

²⁴⁵ Even this question receives only a tentative yes—although SDPD and PMDD were temporarily defeated, the question of whether to include them in the main text arose yet again with the *DSM-IV* revisions. SDPD would be deleted altogether, but PMDD would remain an open question. In 2013, it received official placement in the *DSM-5* with little public fanfare.

discussed in this chapter, to give Caplan a seat at the table.²⁴⁶ Yet in some senses, this appears to have been a superficial change. NASW and radicals like Caplan may have been given a voice within the revisions process, but the APA never offered any clear answers as to how it would differentiate between social, psychological and criminal issues.²⁴⁷ As discussed in chapter 5 and the conclusion, this would continue to cause numerous problems for the APA. In this sense, the protests' success was limited to concrete objectives (getting the three proposals dropped) and fell short of their broader theoretical goals (for the more radical protesters, reforming psychiatry as a whole).

²⁴⁶ Despite the increased interdisciplinarity of the *DSM-IV* revisions process, it's not clear whether such changes are longstanding ones. Allen Frances, head of the *DSM-IV* revisions process, has criticized the APA's approach to the *DSM-5* as being regressive and insular. See this dissertation's conclusion for a brief discussion of this cyclical shift. See also Figert (91) for a discussion of the APA's approach to the *DSM-IV* revisions process.

²⁴⁷ The coming years would witness the increasing interpenetration of psychiatry and criminal justice, particular in regard to sexual violence. In the 1990s, the passage of a number of legal statutes—generally referred to as Sexually Violent Predator laws—that relied on psychiatric criteria to incarcerate convicted sex offenders in mental hospitals after they had served their prison terms, would spark both psychiatric and constitutional controversies. See Cole, “From the Sexual Psychopath,” as well as chapter 5. Likewise, gender and how the APA did (or didn't) theorize it would continue to be a problem. While homosexuality had been the bugbear of the 1970s and the purportedly sexist diagnoses discussed here had been the bugbear of the 1980s, Gender Identity Disorder would become intensely controversial amongst transgender activists and their allies in the 2000s. On GID, see Bryant, “The Politics of Pathology.”

Chapter 3

Treating Sex Offenders at Johns Hopkins Hospital

This chapter discusses the Sexual Disorders Clinic at Johns Hopkins Hospital.²⁴⁸ The center, headed by Fred Berlin, was one of the most famous treatment centers of its kind in the United States.²⁴⁹ Opened in 1980, the center received a constant stream of press—first positive and then increasingly negative, as the result of a series of highly public controversies. The clinic would eventually be shut down in the early 1990s, and Berlin would go into private practice treating sex offenders. During its brief existence, the clinic would treat a wide variety of patients—rapists, pedophiles, exhibitionists, sadists, and so on. When it initially opened, it would treat patients on a mostly volunteer basis. By the late-1980s, however, the majority of its patients would come through the criminal justice system.²⁵⁰

Chapter 1 forms the background for this chapter—this chapter focuses on Berlin and the Johns Hopkins Clinic, but draws comparisons back to John Money and Paul Walker, who were

²⁴⁸ The choice of the Johns Hopkins clinic is partially pragmatic: None of the treatment centers I discuss here maintained archives of their operations. The University of Texas Medical Branch maintains a very small archive containing a few news articles on Paul Walker's clinic. John Money's papers are held at the Kinsey Institute, but they concern mainly his research and teaching, rather than his work as a clinician. The Johns Hopkins clinic also does not have an archive of its operations; however, Berlin's constant interaction with the press makes this clinic comparatively well documented.

²⁴⁹ The clinic was also one of the largest non-forensic centers for sex offenders. The division between forensic and non-forensic centers is fuzzy, as clinics like this one housed an increasing number of convicted criminals over the course of the 1980s. Here, I mean the clinic was not state-run nor attached to a prison system. Rather, it was run by Johns Hopkins Hospital and was thus a private institution.

²⁵⁰ An article from 1990 states that 80% of patients came through the criminal justice system—either post-conviction as a condition of parole or probation, or pre-conviction on the advice of lawyers or police. By this point, Berlin was estimating that only 10% of his patients were “walk-ins” seeking help of their own volition. (Frank Kuznik, “Johns Hopkins Has a Sex Problem,” *Baltimore Magazine*, September 1990).

discussed earlier. Berlin had worked with John Money for some time and it was Money's presence at Johns Hopkins that first began to draw sex offenders (and men who thought they might offend) to the hospital. Money's work with paraphilias and gender identity issues, alongside his outspoken public presence, had earned him a reputation as Johns Hopkins' "weird sex doctor," and patients suffering from a wide variety of sexual disorders arrived at the clinic by word of mouth throughout the 1970s. By 1980, there were enough patients that the hospital began to feel there was a need for a separate clinic. The formalization of what had been a de facto treatment program allowed for new approaches—before 1980, patients who came seeking Money's help were treated on an outpatient basis. After the clinic opened, they could be offered in-patient treatment. As well, follow-up and readmission (when patients who had completed treatment began to struggle) procedures became the norm, and an increasing number of psychiatrists at Johns Hopkins received training on diagnosing and treating sexual disorders.²⁵¹ When the clinic opened, Fred Berlin was appointed as its head. Berlin had been at Johns Hopkins since 1975 and had worked with Money for some time. His views on sexual deviance were similar. Like Money, he was a staunch supporter of the concept of PCD. Unlike Money, however, Berlin did not endorse a purely biological model of PCD. Instead, he felt that both hormone therapy and psychotherapy were necessary to treat sex offenders.

This chapter offers a discussion of the sorts of treatments Berlin employed, the arguments he put forward for the treatment of sex offenders, and the ethical issues his clinic encountered. I argue that, like many of his colleagues, Berlin's work was promising but tentative. Berlin was quite unlike his peers, however, in that he rarely acknowledged the tentative nature of his work. Rather, he presented his clinic as a straightforward success story and frequently talked with the

²⁵¹ See Kuznik, "Sex Problem," for Berlin's discussion of the advantages of having a separate clinic.

media. As this chapter will demonstrate, this pattern is both a reflection of and a counterpoint to the APA's battle over PCD. The APA had almost managed to fly under the radar; it was women's advocates' success in publicizing PCD at the last minute that led to its deletion from the *DSM*, rather than any widespread feeling from APA members that the science behind the concept was bad. In regards to the Johns Hopkins Clinic, Berlin repeatedly sought publicity for his work. This attention would translate into scrutiny as Berlin made a series of missteps. Yet it wasn't only this publicity that led to the closing of Berlin's clinic. It was also Berlin's failure to think past the immediate needs of his patients. When the clinic first opened, there wasn't a substantial public discussion regarding victims of sexual violence. By the mid-1980s, this dialogue was in full swing, which Berlin failed to acknowledge or incorporate into his work. While other clinicians working with sex offenders developed working relationships with victims advocates (Nicholas Groth, for example) or simply went about their work quietly without offering themselves up to public and feminist scrutiny (e.g., Paul Walker), Berlin continued to operate as though he were unaccountable to larger social forces. Despite the successes of the clinic (and, though Berlin overstated his success at every turn, the clinic did seem to do remarkable work), these factors would result in the closure of the clinic after only a decade.

Treatment Regimes

As discussed in chapter 1, hormone therapy was the breakthrough that allowed sex offenders to be effectively treated by psychiatrists. Most clinicians believed that psychotherapy alone was not effective in treating sex offenders: according to Nicholas Groth, psychotherapy's efficacy relied on the patient's intelligence, ability for self-observation, motivation to change, and willingness to work with a therapist, but "none of these qualities is prominent among the

majority of men who rape.”²⁵² With the introduction of hormone therapy, however, psychotherapy could become effective. According to many psychiatrists, the two had to be used in tandem; neither was effective on its own. However, there were different ideas about the relative importance of therapy and Depo-Provera (the hormone of choice for sex offenders), as well as different ideas about what type of psychotherapy worked best. While the rationale behind hormone therapy was largely similar across clinics (even if some clinicians used it more frequently than others), there was far more variation in terms of therapy. Treatments ranged from group to individual sessions, while some clinics didn’t emphasize therapy in the first place. The theories behind therapies varied immensely as well. Some clinicians wanted to build a sense of community among their patients to foster responsibility; others focused on empathy. Some treatment modalities were generally accepted and widely used, while others were more ad-hoc. This section compares Berlin’s approach with other clinicians’ approaches.

As discussed in chapter 1, John Money was one of the primary researchers responsible for the introduction of hormone therapy. Unlike most of his peers, Money believed that hormone therapy was an effective treatment in and of itself. This grew out of Money’s work on gender identity, which he believed to be a primarily biological (rather than psychological) problem. Money was inclined to treat a wide variety of disorders in similar ways and thus began to think of rapists in largely biological ways. The underlying issue was a sex drive that had run amok and was causing psychological problems—the biological issue was the root of the problem, and the psychological difficulties and any actual offenses committed were both merely its manifestations. Money believed that if he could temporarily interrupt the feedback process between sex drive and psychology and behavior, the sexual disorder would remit and whatever

²⁵² Groth, *Men Who Rape*, 217.

psychological problems remained could be dealt with more easily. Moreover, if sexual desires were temporarily removed—hormonal therapy causing what Money refers to as a “temporary functional castration”—the link between desire and the paraphilia could be severed, triggering a “psychic realignment” in which the patient would revert back to a normal sexuality.²⁵³ Money believed that this treatment was viable for almost any type of sexual disorder and he used it on individuals with different disorders (e.g., pedophilia, transsexuality, masochism) and different case histories (from nuisance offenders to those with extensive police records, and even on those who hadn’t actually acted on their desires but were merely disturbed by them). Such mixed groups of patients were common at sex offender treatment facilities, the Johns Hopkins Clinic among them.

Money was not alone in seeing rape in this way. His former colleague Paul Walker likewise saw sex offenses in biological terms and believed that the sex drive of the offender was the primary cause for the offenses. However, Walker disagreed that removing the sex drive was enough to cure the patient. For Walker, “the medication serves as a vacation” from that drive, which “allows time for relaxing counseling sessions that help modify behavior.”²⁵⁴ In other words, the clinician had to dampen the overriding sex drive in order to render the patient clear-headed and calm enough to benefit from counseling. This was Walker’s major difference from Money: Money believed that in most cases removing the sex drive was treatment in and of itself, while Walker thought therapy was a necessary, though secondary, step.

Money and Walker had worked at Johns Hopkins’ Phipps Clinic, but the clinic was not focused on sex offenders; rather, it was a general-practice psychiatric clinic. Additionally, both

²⁵³ John Money, “Use of an Androgen-Depleting Hormone in the Treatment of Male Sex Offenders,” *Journal of Sex Research* 6, no. 3 (1970).

²⁵⁴ Moore, “News Release,” The Blocker Archives and Manuscripts Collection, University of Texas Medical Branch (hereafter, Blocker Archives).

men were more focused on gender identity issues than sex offenses.²⁵⁵ Fred Berlin, a colleague who had worked with Money for nearly ten years, would go on to become the more influential of the three when Johns Hopkins open a clinic for the specific purpose of treating sex offenders in 1980 and appointed him head of the clinic.²⁵⁶ By 1983, Berlin's clinic had begun to garner local publicity, from which Berlin's theories can be discerned.²⁵⁷

Berlin believed that “knowing something about a person's sexual orientation tells us nothing about his character.”²⁵⁸ Even further, sex crimes didn't represent “any moral lapse or conscious decision.”²⁵⁹ Instead, like Money and Walker, he believed them to be uncontrollable compulsions. While popularly thought of as a matter of will power, Berlin stated, “We are not all created equal. We have this misconception that anyone can do what he puts his mind to.”²⁶⁰ But while a psychologically health person might be able to control themselves, his patients had such exceptionally high sex drives that they simply could not control the drive or their resulting actions.

²⁵⁵ Money is best known for his work with intersex children, and controversial for his use of sexual reassignment surgery on them. Walker, though he did work with sex offenders at UTMB, would go on to open an AIDS clinic in California.

²⁵⁶ The Johns Hopkins Sexual Disorders Clinic would remain open until sometime in the early 1990s. At this point, Berlin left Johns Hopkins and reopened the clinic as a private practice called the National Institute for the Study, Prevention, and Treatment of Sexual Trauma.

²⁵⁷ There are three potential source bases for this chapter: public media, private records, and published studies. Gaining access to private clinic records for this time period is generally impossible, given patient privacy laws. Berlin, unlike most of his contemporaries, did not publish much. While Groth published numerous articles and books, Berlin presented at a few conferences, but was mainly focused on treatment and public outreach. Accordingly, most of what I have access to for Berlin is news articles. Because Berlin was very much interested in publicity, these records actually contain a fair bit of information about the clinic's inner workings.

²⁵⁸ Karen L. Scrivo, “Drug Treatment Helps Some Sex Offenders,” *Morning News*, July 2, 1984.

²⁵⁹ David Simon, “Berkson Case Has the Look of a Failure, but Closer Inspection Shows It Isn't,” *The Sun*, April 26, 1987.

²⁶⁰ Scrivo, “Drug Treatment Helps Some Sex Offenders.”

Moreover, while Walker used a number of medical analogies²⁶¹, Berlin emphasized one²⁶²: addiction (and particularly alcoholism).²⁶³ By this time, psychiatrists thought seriously of addiction as a mental illness—rather than stigmatizing the behavior (drinking or drug use) as immoral, they treated it as the result of an underlying psychological disorder. Berlin simply extended this thinking to sex crimes. Indeed, he explicitly invoked the comparison:

Fifty years ago we looked at alcoholics as bad people. Now we have the Betty Ford clinic. Not long ago we put schizophrenics in chains because all we could see was their behavior and not the illness behind it. I would like to believe that we

²⁶¹ See chapter 1. In particular, there is a comparison between sex offenses and diabetes.

²⁶² Berlin also made a single reference to pedophiles as “modern day lepers.” See: Karen L. Scrivo, “Sex Offenders May Be ‘Modern Day Lepers’,” *The Banner*, July 2, 1984. Scrivo used this in her articles on Berlin’s work more than once, but there’s no indication that Berlin ever used that language again.

²⁶³ The comparison to alcoholism was not merely a metaphor, but formed part of the theory behind his practice. That the clinic’s approach mirrored addiction therapy is discussed later in the chapter. In addition, some patients seemed to take up the connection. One patient, in counseling a younger patient about his anger about having been sexually abused as a child, stated “You’ve got to let the anger go. You’ve got to forgive that guy or you’ll never be able to forgive yourself. It’ll just eat up your whole life (Keith Ablow, “Sex Offenders: Therapy for the People that the Public Despises,” *The Evening Sun*, November 24, 1986). There are only a handful of quotations straight from patients or accounts from group therapy sessions, so I don’t want to make too much of this. Still, it’s notable and can be explained in a few ways. It’s possible that Berlin, in connecting sex crimes to addiction, actually promoted similar techniques. It’s also possible that patients introduced these techniques themselves. Victims of abuse (and the mentally ill more generally) tend to have a higher rate of addiction--drug or alcohol use functions as a coping mechanism. Given that many of the patients were indeed abuse victims, they might also have been attending AA or similar groups. Finally, this may simply be an example of media bias. These statements are the ones authors of news articles chose to quote and not a full representation of what took place in therapy sessions. With public attention to addiction issues rising by this point, perhaps they were simply more striking to journalists. Regarding sexual abuse and substance abuse, see: *Interpersonal Violence and Alcohol Policy Briefing*, World Health Organization, n.d. On substance abuse and mental illness, see both the Substance Abuse and Mental Health Services Administration (samhsa.gov) and “National Survey on Drug Use and Health” (Washington, DC: Department of Health and Mental Services, 2009). Finally, you may notice that Ablow seems to have been given more access to patients than any other journalist. Not only does he quote more patients, but he was also allowed to attend some group therapy sessions and a celebration upon the release of one incarcerated patient from prison. No other journalists discuss attending sessions. Ablow was a student at Johns Hopkins Medical School at the time, which probably explains his access.

can take another group out of chains. I don't believe these people are evil, and I think history will judge our efforts well.²⁶⁴

Another journalist noted that Berlin believed any realistic way to deal with pedophilia “must begin with an understanding of pedophilia as a compulsion similar to alcoholism or drug addiction but more powerful.”²⁶⁵ And, much like addiction was thought of as controllable but incurable, Berlin's approach to treatment was one of controlling behavior and coping with sexual desire, rather than curing the incurable.

While Berlin didn't believe the individuals he treated were witting criminals, he was careful to emphasize that treatment wasn't an alternative to punishment (specifically, prison sentences), but instead an adjunct to it. This was, in some sense, lip service. Berlin was not sanguine about the idea of sentencing sex offenders to jail to begin with. Prison itself did nothing to change the sex offender; according to Berlin, “The problem with prison is that when they release you they kind of shake your hand and wish you well.”²⁶⁶ And, while Berlin agreed that some offenders should be “quarantined,” he thought that “there may be a better place than those prison” for them.²⁶⁷ At any rate, it seemed clear to Berlin that prison was not a sufficient solution; while you could put an offender in prison, “eventually he's going to come out.”²⁶⁸ Without some sort of psychiatric treatment, nothing would be changed and the offender would reoffend. Berlin had some evidence to back this up—the national recidivism rate for sex offenses

²⁶⁴ Ablow, “Therapy for the People That the Public Despises.” While this is the full statement, it was republished in numerous other articles with the references to schizophrenia cut out. This indicates that the comparison to alcoholism resonated particularly well with public interest.

²⁶⁵ Michelle Singletary, “Child Molesters: Like Wolves Disguised as Shepherds They Befriend the Young, Win Their Trust, and Then Prey on Them Sexually. Behavior Rooted in Biology and Childhood Abuse,” *The Evening Sun*, November 12, 1987.

²⁶⁶ Ablow, “Therapy for the People That the Public Despises.”

²⁶⁷ Simon, “Berkson Case.”

²⁶⁸ David Simon, “Outpatient at Sexual-disorders Clinic Is Charged with Molesting 9-year-old,” *The Sun*, June 27, 1987.

was thought to be as high as 70-80%, while Berlin's initial numbers indicated the clinic's rate was around 5%.²⁶⁹ Although this would rise to 20% by the late '80s, it still represented a huge improvement on prison sentences without treatment.²⁷⁰

Moreover, Berlin and his colleagues believed that prison often made the situation worse. Maggie Ryder, the clinic's administrative coordinator, stated that the alternative to psychiatric treatment was "unreasonable even to consider." She explained thusly: sex offenders had an "exorbitant" sex drive that manifested through "constant ruminating and fantasizing about sex." In prison, "as the environment toughens the offender, his sexual thoughts boil in jail's cauldron of boredom." Upon release, he would "come out like a tiger." For the penal system to fail to offer treatment to such men was "unconscionable."²⁷¹ One patient at the clinic confirmed this, stating that prison did little besides "embitter" him and praising the clinic.²⁷² Another argued that without treatment, his return to prison was "inevitable."²⁷³ In all, observers at the time felt that incarceration was not sufficient in dealing with sex crimes. In this sense, Berlin's clinic did indeed represent a step forward.

However, while Berlin publicly promoted the idea of combining incarceration with treatment, this became stickier on the ground as the years wore on. While incarcerated men became an increasingly large percentage of Berlin's client base, a number of judges began sentencing convicted sex offenders to treatment in lieu of jail time. Berlin didn't explicitly

²⁶⁹ Simon, "Berkson Case."

²⁷⁰ Even with this substantial increase, Berlin's numbers remained lower than not just the national rate for sex crimes, but also the recidivism rate of all incarcerated criminals (38%, see Simon, "Berkson Case").

²⁷¹ Joseph Calve, "Corrections Dept. Studies Drug Therapy for Sex Offenders," *Connecticut Law Tribune*, October 5, 1987.

²⁷² Simon, "Berkson Case."

²⁷³ This was part of a legal case in which the man was initially denied access by the prison to Depo-Provera and sued. See Calve.

advocate for this, but some of these judges cited Berlin specifically and Berlin didn't speak out against the practice at any point.²⁷⁴ His passive stance on the issue implies that he had few qualms with sex offenders escaping jail time, so long as they received medical treatment.

In addition to his more generalized ideas about sex offenders, as his work advanced, Berlin would come to believe that adult pedophiles were often abused as children.²⁷⁵ In fact, Berlin would eventually articulate this connection as one of the central underlying causes of pedophilia: "Medical science has identified two causative factors in pedophilic behavior, Berlin says. The first is sexual activity with an adult during one's childhood. The second is biology."²⁷⁶

²⁷⁴ Circuit Judge Robert Borsos cited an article in *Time*, which in turn cited Berlin. Borsos' language mirrored that of clinicians like Berlin: "Recently there have been important scientific studies... that some men are truly oversexed... like a furnace that overheats a house when the thermostat is set too high." See Bill Miller and Bill Nichols, "Upjohn Heir Sentenced: Controversial Drug Therapy Ordered," *USA Today*, January 31, 1984.

²⁷⁵ There was and continue to be a contradiction here that bears mentioning. As far as Berlin was aware, girls are abused at a higher rate than boys. This remains the dominant perception today. Yet abused girls don't become abusers at the nearly the rate that abused boys do. A simple answer would boil down to testosterone and masculinity, as does much of the theory underpinning the use of Depo-Provera. Still, it's interesting to note that Berlin discusses abused girls and notes that he has women patients, but rarely explicitly talks about masculinity (in either biochemical or psychological terms). Rather, that this discussion is fundamentally about men and masculinity remains implicit (excluding Groth's contributions). Despite female patients, nearly every statement made by any of the clinicians discussed here refers to men. Popular coverage of the Sexual Disorders Clinic bears this out—multiple articles even uses the Mars/masculinity symbol to symbolize patients (see: Judy Foreman, "Drugs may help sex offenders," unnamed and undated newspaper article, JHH Sexual Disorders Clinic Collection, The Alan Mason Chesney Medical Archives, Johns Hopkins Medical Institutions [hereafter, JHH Collection]; and Ablow, "Sex Offenders"). No clinicians besides Berlin discuss female patients, and researchers almost certainly did not use any female subjects. In this sense, Berlin is the outlier. Why he never discusses his female patients is a mystery, as they surely represented some contradictions to his theories. It is also worth noting that this developmental model of pedophilia—where the offender's pathology had its roots in his own childhood sexual abuse—mirrored earlier ideas about sexual psychopathy. Stephen Robertson argues that ideas about arrested development (through poor parenting, traumatic events or childhood sexual abuse) were important to the development of the sexual psychopath. See Robertson, "Separating the Men from the Boys: Masculinity, Psychosexual Development, and Sex Crime in the United States, 1930s-1960s," *Journal of the History of Medicine and Allied Sciences* 56, no. 1 (January 2001).

²⁷⁶ Singletary, "Child Molesters."

Not merely a scientific claim, this would also be one of the ways in which Berlin attempted to humanize his patients.²⁷⁷ Berlin stated his case as an appeal to human decency: “I’m not going to apologize for having a sense of compassion and care. In many cases [pedophiles] are formed abused children. Do we write them off when they become children?”²⁷⁸ Berlin would repeat these claims numerous times, but it’s less clear whether or how his treatment regime reflected this idea. While there’s one reference to a group therapy session where a patient’s history of being abused was brought up,²⁷⁹ most of Berlin’s work does not appear to have specifically addressed any prior abuse his patients may have suffered.

Berlin was not alone in asserting that many pedophiles had themselves been abused, and other clinicians very consciously took up this point in their treatment. In particular, a handful of treatment centers for juvenile offenders opened in the 1980s.²⁸⁰ Much like the Johns Hopkins Sex Disorders Clinic, such facilities came into being on an ad hoc basis—as clinicians at larger facilities identified a need, they slowly created a center around those patients.²⁸¹ Most notable here is a clinic for juvenile sex offenders in Escondido, California opened in 1988. Prior to this, clinicians at the Escondido Youth Encounter had been focused primarily on juvenile violence

²⁷⁷ Berlin didn’t always rely on this connection. In one interview, he simply stated, “As we become more and more aware of sexually abused children, we become aware of the adults responsible, and we see not criminals but some pretty decent people” (Ablow, “Therapy for People that the Public Despises”).

²⁷⁸ Singletary, “Child Molesters.” See also Scrivo, “Modern Day Lepers.”

²⁷⁹ See Ablow, “Sex Offenders.”

²⁸⁰ It’s worth noting here that the JHH clinic did treat at least some minors—Ablow’s article makes reference to a sixteen-year-old patient. Berlin seems to have treated these patients in largely the same way as his adult patients, and the Ablow article makes reference to a group therapy session that included the sixteen-year-old patient and adult patients.

²⁸¹ David McWhirter, Ray Murphy, and Laura Colligan, “Treating Juvenile Sex Offenders: A Community Based Treatment Program,” audiotape from the 20th Annual Meeting of the SSS, n.d., Society for the Scientific Study of Sexuality Collection, The Kinsey Institute for Research in Sex, Gender, and Reproduction, University of Indiana at Bloomington (hereafter, Society for the Scientific Study of Sex Collection).

and drug use. One clinician—Ray Murphy—had begun working with abused children and victims of incest in the mid-1980s. Murphy noticed, in the course of his work, that many of the perpetrators of abuse against his patients had themselves been victimized as children. Altogether, the clinicians involved surmised that there was a need for early intervention—if they could treat juveniles who had been abused and were beginning to act out sexually, they could perhaps prevent those juveniles from developing into full-blown sex offenders or pedophiles. Along with David McWhirter, at that time head of the San Diego County Mental Health Department and president of the Society for the Scientific Study of Sexuality, Murphy and his colleagues expanded the Escondido Youth Encounter to include a program specifically for juvenile sex offenders—the Sexual Treatment Education Program and Services (STEPS).²⁸² Treating approximately fifteen to twenty patients at a time, STEPS focused heavily on the emotional development of their juvenile patients. The program offered sex education, family therapy (many of the patients were victims of incest or otherwise detrimental family dynamics), and counseling to increase the patients’ self esteem and ability to recognize and regulate their emotions. In short, like many of the clinicians discussed in this dissertation, STEPS clinicians saw poor socialization as a significant contributor to the problem. Their novel way of dealing with this, however, was to include marathon 24-hour socialization sessions. During these sessions, the patients would stay together in a house and be entirely responsible for running the house. If the concrete responsibilities (cooking, cleaning) were important, so was the mere fact that this forced the patients to live together in close proximity for an extended period of time. While structured therapeutic activities were included in this marathon, the bulk of its therapeutic value was in the

²⁸² Jack Williams, “Dr. David McWhirter, 74; leader in research of human sexuality,” *UT San Diego*, August 5, 2006. It’s worth noting that McWhirter would be accused, in the early 1990s, of sexually abusing at least two patients. See Nora Zamichow, “Sex Therapist Sued by Male Ex-Patient,” *Los Angeles Times*, July 30, 1992.

daily routine of forcing the children to sink or swim and to be accountable to themselves and one another. As these marathon sessions demonstrate, responsibility formed a significant part of STEPS' rationale—alongside the marathon sessions, the boys were required to sign a fifteen-page contract upon entering the program and to routinely write about themselves (their issues, their offenses, their emotional state, their sexual fantasies) and turn in those written assignments to the therapists. This disclosure of fantasies mirrors some of Paul Walker's "covert sensitization" technique—like Walker, the STEPS therapists asked their patients to think through their fantasies to the bitter end, and to imagine themselves in prison as a result.²⁸³ And, as with Walker's "rational-emotive" technique, the boys at STEPS were asked to pore over every emotion and thought that had led up to the offense in order to better avoid such thoughts and feelings in the future. In all, then, STEPS represented an amalgam of approaches. While they didn't employ the concept of PCD, they did use therapies similar to those that PCD-based centers employed. As well, they used a variety of methods particular to juveniles—family therapy and the marathon sessions in particular, as well as their emphasis on responsibility.

A final similarity between these centers is that each one spoke at length about patient demographics—for the juvenile centers, this focused on the ages of both patients and their victims, and for centers with adult patients, on age, occupation, educational history, and so on.²⁸⁴

²⁸³ Judith Levine has been a persistent critic of such approaches to juvenile offenders, and argues that such requests to disclose highly personal information are invasive and detrimental. See: "Drastic Steps," *Mother Jones*, July-August 1996; *Harmful to Minors: The Perils of Protecting Children from Sex* (University of Minnesota Press, 2002).

²⁸⁴ STEPS accepted patients between thirteen and seventeen years of age, with an average age of fourteen. At the time this paper was delivered, there were fourteen patients in the program. Eleven were non-aggressive offenders and three were aggressive. Eight had committed offenses against boys and six against girls; seven had committed incestuous offenses and one had committed against an adult (he exposed himself to a neighbor). The average age of their victims was seven years and eight months. See "Treating Juvenile Sex Offenders," Society for the Scientific Study of Sexuality Collection.

These discussions were, for clinicians, a way to spread knowledge on an understudied issue—despite the proliferation of sex offender treatment centers in the 1980s, the average mental health professional knew little about sex offenders and beginning with demographics made sense in this context. Yet discussions about the demographics of sex offenders took place in the feminist press as well—as discussed in chapter 1, publications like *Off Our Backs* were quick to assert that, “Rape is generally an act of violence perpetrated by ‘normal’ men such as husbands, neighbors, dates, and friendly neighborhood policemen, priests and doctors.”²⁸⁵ The frequency with which such discussions took place indicates that all of those involved were very consciously attempting to reshape public perceptions about sex offenders. If the public thought of sex offenders as visibly creepy (whether this meant the masked stranger in the bushes, the mustachioed child molester in a white van, or merely the perception that someone you knew couldn’t possibly be a threat), then both clinicians and feminists sought to emphasize that sex offenders weren’t readily identifiable. They were as diverse as any other group and could be, in the words of both psychiatrist Gene Abel and feminist magazine *Off Our Backs*, your next door neighbor.²⁸⁶

In terms of Berlin’s patient base, news articles made much of its diversity. Patients’ ages ranged from sixteen well into old age. They ranged from high school dropouts to individuals with doctorates. Professions varied from blue-collar workers to doctors and lawyers. There were prisoners and the self-referred. Some were women.²⁸⁷ Some had come from out-of-state—from surrounding states to farther flung locales like New Orleans and Miami. Still, there are some demographic generalizations we can make: an overwhelming majority were men, and most of

²⁸⁵ “Drugs for Rapists,” *Off Our Backs*, February 1979.

²⁸⁶ Gene Abel’s quotation taken from “Sex Offenders Studies,” *Off Our Backs* 16, no. 8 (August-September 1986). See also chapter 1.

²⁸⁷ Women patients were rarely (possibly never) rapists or pedophiles, and tended to suffer from sexual disorders like masochism, exhibitionism and so on.

them were in their twenties or thirties. It's also clear that, while prisoners initially comprised a small percentage of patients (a dozen in 1985), they would eventually comprise a more significant percentage. This would eventually become an ethical issue, which will be discussed later in the chapter. The number of patients varied too. Berlin had less than one hundred patients in 1983, but this grew to over 150 by the next year. For reasons that are unclear, he claimed a mere seventy patients in late-1985, but this had ballooned back to 150 a year later. According to Berlin, the clinic had evaluated and treated 1,500 patients by 1987. Most of these patients were treated on an outpatient basis, and the clinic maintained around twenty in-patient spots.

The types of sex crimes committed by patients varied as well. The clinic overwhelmingly treated child abusers and pedophiles, and this is the group tended to Berlin concentrate on when talking to the media.²⁸⁸ But there were other sex crimes represented too—from rapists with adult victims to peeping Toms. Along with this, there were individuals who had sexual disorders but hadn't actually committed any crimes. In particular, Berlin presented the case of a gay patient at the Third International AIDS Conference.²⁸⁹ The man was a nymphomaniac who claimed to have had forty sexual partners a week. He felt, like most of Berlin's patients, that he couldn't control his sex drive despite his awareness of putting his partners at risk. Sadists and masochists also received treatment at the clinic; some had committed crimes, some had not.

²⁸⁸ It's worth noting here that the way Berlin described pedophilia didn't quite line up with how the APA typically defined paraphilias. According to the *DSM-III-R*, paraphilias were defined by their overwhelming nature. The paraphiliac was incapable of engaging in 'regular' sex without the presence of the paraphilia. In other words, a masochist must not be able to experience arousal without pain in order to be diagnosed with a paraphilia. Berlin, however, explicitly noted that pedophiles could engage in intercourse with adults (see Singletary, "Child Molesters"). Psychiatric discussions around pedophilia often circled back to this point and there was a general sense that, because pedophilia was inherently harmful if acted upon, it needn't involve exclusive attraction to children to be classified as a disorder. In other words, a pedophile who was also attracted to adults was no less disordered than one who wasn't.

²⁸⁹ "Sex-crazed Gay Was a One-man Plague: Docs," *New York Post*, June 4, 1987.

No matter the patients involved, Berlin relied primarily on group sessions. This was similar to programs for addiction and specifically Alcoholics Anonymous, in a number of ways.²⁹⁰ First, the structure of group therapy (rather than individual therapy sessions) relies on the idea that sufferers of incurable mental illnesses must learn coping skills. This is different from other therapeutic approaches. For instance, a Freudian approach is less about coping skills than finding the absolute root of the problem; by finding the root, one can solve the problem. For Berlin, however, the root of the problem was the sex drive; unless a patient remained on Depo-Provera for life (common for pedophiles, but not other types of offenders), there was no real cure. Instead, the problem was behavioral—by learning coping skills, patients could control, but not cure, the behavior.

Moreover, Berlin and addiction counselors believed that one of the best ways to teach coping skills was to (1) allow patients to learn from each other and (2) create a community. Taking these in turn, the first relies on the belief that those suffering from addiction or compulsive sexual behaviors are themselves best suited to talk about what coping mechanism work and which don't. Again, this was a pragmatic approach and not one that relied overmuch on professional psychiatric guidance (as does psychoanalysis). One patient characterized Berlin's group therapy as "a realistic control system" that "allows you to be where you are, so you can go one step further."²⁹¹ In other words, the coping methods he had learned from his fellow patients allowed him to control his urges and move forward with his life.

²⁹⁰ This comparison was drawn numerous times by the media. Not only did Berlin compare his patients to alcoholics, but he also specifically invoked the comparison between his clinical practices and Alcoholics Anonymous. See, for instance, Scriver's "Drug Treatments."

²⁹¹ Simon, "Berkson Case."

The second rationale was to create both an accepting community to which socially taboo thoughts could be expressed (a community pedophiles in particular lacked) and also a community to which the offender was responsible. One patient stated it thusly:

I mean I never cared about anyone before. I never cared about my victims. In the group I learned to care about people, and that's a whole lot of responsibility. And I've got my responsibility to the group. What happened will never happen again.²⁹²

Offenders not receiving treatment, in contrast, were often cut off and left socially adrift. If they hadn't yet been caught, they might feel a sense of responsibility to their families (and victims), but without being able to speak about their feelings, the sexual compulsion would eventually override that responsibility.²⁹³ For offenders that had been caught, it was arguable worse. In prison, the pedophile might be subject to violence.²⁹⁴ Upon release, he would often find himself cut off from his family and friends, subject to restrictions on where he could live and work, and

²⁹² Ablow, "Therapy for the People That the Public Despises."

²⁹³ Berlin (and most other clinicians) recognized that pathological thoughts and behaviors are exacerbated by stress. Being utterly unable to talk about one's problems—and having to actively hide them—constitutes just such a stressor. By providing a safe space in which to talk without being judged (after all, the person sitting next to you was going through the same thing, though one wonders whether there was tension between pedophiles and other patients) allowed the patients to reduce some of their stress and thus, Berlin hoped, made them less likely to act on their urges.

²⁹⁴ I don't have any studies from the 1980s confirming this, but it was and still is the popular perception that pedophiles are an at-risk population in prisons. For contemporaries of Berlin who believed this, see Calve's article ("Corrections Dept. Studies Drug Therapy for Sex Offenders").

if outed, perhaps fired or run out of town.²⁹⁵ Treatment, however, provided a space where the offender was both accountable and supported.²⁹⁶

Berlin's treatment regime was ostensibly based on combining Depo-Provera with therapies discussed above. But, like other clinics, Johns Hopkins provided Depo-Provera injections to a relatively small number of patients. It is difficult to tell what Berlin's exact numbers were at any given moment, though he did state in 1984 that half of his 146 patients were being treated with Depo-Provera.²⁹⁷ Walker's clinic suffered a similar disconnect—as noted in chapter 1, only thirteen of Walker's forty-three patients were receiving hormone therapy by the mid-1980s. While Berlin certainly treated a great number of patients, the fact that no more than half of patients at a facility touting its work with Depo-Provera actually received Depo-Provera suggests the difficulties of implementing this type of therapy. Moreover, it implies that hormone therapy was still in its infancy, given that these centers represented the absolute cutting edge of such work.

Though Berlin does not emphasize the discrepancy, Walker notes the many difficulties of administering Depo-Provera. His patients refused hormone therapy for a variety of reasons: some

²⁹⁵ One patient stated baldly that he couldn't "always live in fear that somebody's gonna report me to the police" ("Our Say: Stop Shielding Child Molesters," *The Capital*, March 23, 1988.). There's some corroborating evidence for this—and the above idea—in the more hysterical child abuse cases throughout the 1980s, chief among them the McMartin Preschool Case. The falsely accused individuals in that case had their property damaged (spray paint, eggs), were subjected to violence in the streets (one woman reported that she had been physically attacked), and subject to further violence in prison.

²⁹⁶ This general rationale also underlies the group therapy approach used by organizations like Alcoholics Anonymous and Narcotics Anonymous. Such groups additionally use anonymity as a way to create a safe space—anonymity means the addict (who could face the same sorts of social ostracism as did sex criminals) does not have to worry about their life outside the group overlapping with what they talk about inside the group. It's not clear whether Berlin used this approach within his group therapy sessions, though he does have a number of patients who willingly identified themselves to the media.

²⁹⁷ Gerri Kobren, "Sexual Deviancy: Clinic at Hopkins Fills a Need," *The Sun*, February 29, 1984.

did not feel that their desires were so overwhelming that they required medical treatment, some claimed to be innocent, and some worried that their families would find out about their crimes because the hormone injections had to be administered by a physician.²⁹⁸ While Berlin was less explicit on this point, he did believe that therapy for sex offenders required the promise of absolute confidentiality.²⁹⁹ Moreover, many of the men who would have been eligible for this type of treatment were in prison and some argued that this presented a barrier to treatment. Since other prisoners often subjected pedophiles to violence and getting treatment required identifying oneself, requesting Depo-Provera might lead to violence.³⁰⁰ Additionally, federal laws strictly regulating the participation of prisoners in experimental research limited prisoners' access to hormone therapy, as Depo-Provera's use for sexual disorders was not FDA-approved.³⁰¹ Finally, though Walker did not give this explanation, we can assume that hormone therapy would have been threatening to patients in a way that therapy was not. This was a bodily intervention and one that they may have felt struck at their very sense of themselves as men by both lowering their sex-drives and lowering their testosterone levels, both of which were very much connected with masculinity in popular thinking.

As of 1980, these centers were the only significant hormone therapy programs in the United States.³⁰² Money and Walker totaled perhaps thirty patients (and not all of these patients were rapists or pedophiles), and had very limited data on rehabilitation. Moreover, both Walker

²⁹⁸ It's not clear why they wouldn't have the same fear with talk therapy, but nonetheless, Walker lists this as a common reason. One might imagine that coming in for therapy would be more difficult to explain, given that it took a chunk of time, whereas the injections could be administered quickly and didn't always come with an extended evaluation.

²⁹⁹ This would eventually cause serious problems for the clinic when mandatory reporting statutes were introduced. I'll discuss this towards the end of the chapter.

³⁰⁰ Calve, "Corrections Dept. Studies Drug Therapy for Sex Offenders."

³⁰¹ This would become a subject of some debate, to be discussed subsequently.

³⁰² Groth, *Men Who Rape*, 217. Some additional work with Depo-Provera had been done in France, but only the Johns Hopkins Clinic and the center at UTMB were active in America.

and Money specialized in gender (i.e., transsexualism and transvestitism), rather than in sex crimes. Berlin, with his comparatively larger patient base, presented stronger evidence for the successes of Depo-Provera treatment. Still, if we take his numbers at face value, by 1987 he had administered the drug to somewhere between two and five hundred patients.³⁰³ This is a significantly larger number of patients, but still an ultimately small sample size upon which to hang a treatment regime involving drugs.

In all, the general theory behind Depo-Provera's use in treating sex offenders was similar across different clinics and was predicated on the idea that an unusually high sex drive was the major precipitating cause of the behavior. Accordingly, treating the disorder required lowering the sex drive with medication. Yet despite Depo-Provera's stated importance, the major clinics using it did not administer it to all, or even most, of their patients. This implies both the difficulties drug treatment entailed and the need clinicians felt to promote Depo-Provera to the public and potential detractors. In addition, non-hormonal treatment practices differed significantly. While Berlin emphasized a group therapy model (and one predicated particularly on popular understandings of AA-style addiction therapy), others used various forms of individual therapy, aversive therapy, and therapy geared towards re-socializing offenders. These differences reflected the exigent nature of many sex offender treatment programs. Such centers came into

³⁰³ The percentage of drug therapy patients increased from 10% in 1984 to 40% in 1987—a four-year period. I've taken these percentages along with the numbers listed previously, which results in approximately 150 patients. A higher possible number would be somewhere between three and five hundred, if we assume that the average percentage was twenty and compare that to the number of patients evaluated and treated by 1987 (1,500). If his 1984 claim that he was treating 50% of patients with Depo-Provera is true (this was discussed above), then we have an upper limit of 750 (too high both because his use of Depo-Provera increased over the years and wasn't a steady 50% from the beginning, and because that patient count includes individuals who were evaluated but not treated). This all goes to say that, despite how often Berlin gave hard data without any caveats, his statements are not actually clear and some are perhaps even contradictory.

being in response to a concrete need, rather than as the result of intensive research on offenders and what treatments they might most benefit from. Accordingly, treatment centers used a broad range of treatments that were reflective of their particular patient bases and the backgrounds of the clinicians involved.

Ethical Issues

Treating sexual offenders raised wide-ranging ethical concerns. Some of these were focused specifically on Depo-Provera, but others were concerned with sex offenders in general. Most were focused on Berlin's clinic. Despite receiving mostly positive publicity in its early years, the clinic would be subject to at least seven major controversies during the mid- to late-1980s.³⁰⁴ These issues can be generalized into two categories: issues that arose from treatment of sex offenders more generally (Berlin's clinic caught more flak for these due to its public profile, but such issues were not limited to Berlin's clinic) and those that arose due to Berlin's clinic specifically. I will discuss the more general issues first, before moving on to issues specific to Berlin's clinic.

The first complaints resulted from what might be regarded as a semantic issue. Treatment with Depo-Provera swiftly became known as "chemical castration." For many, this aroused grisly thoughts of physical castration. Unfortunately for those working with the drug, it was a

³⁰⁴ These include controversies concerning the criminal justice realm (the Upjohn heir's case and a handful of incarcerated men who sued for access to Depo-Provera), a number of patients who reoffended (Gauthe, Berkson and Hoffman are named; there are additional reoffenders who are not), and the clinic's policies (Berlin deliberately skirted mandatory reporting statutes introduced specifically because of his clinic; additionally, Johns Hopkins refused to cooperate with an investigation in which a psychiatric patient claimed that one of Berlin's patients had raped her on hospital grounds).

complete misnomer. Castration was irreversible and altered the body in a permanent way.³⁰⁵

Depo-Provera, however, only affected the body while it was being administered. Once its use was ceased, the patient's hormone levels returned to normal within about a week.

This is not to say that there weren't serious concerns with Depo-Provera's physical effects. The drug came with a number of side effects, both short- and potentially long-term: weight gain, rashes, bad dreams, and high blood pressure.³⁰⁶ Even worse, the FDA had already rejected the drug's use as a contraceptive (its original purpose) multiple times on the basis of a handful of studies indicating that it might cause cancer.³⁰⁷ All were animal studies and clinicians working with sex offenders vehemently denied that any real danger to humans existed.³⁰⁸ Still, combined with the increasing use of Depo-Provera on incarcerated men (or mandated use in lieu of prison), these potential dangers presented an ethical conundrum. Civil libertarians³⁰⁹ seriously questioned whether or not informed consent could be obtained in these cases: If one was given the choice between going to prison and taking a potentially hazardous drug, could one freely consent?

³⁰⁵ There's an additional argument that physical castration is actually counterproductive. In a feminist-sociological model, where rape is about power rather than sex, the sexual offender doesn't require use of a penis. Instead, forced oral contact, or digital or object penetration may be used. Moreover, these theories are predicated on the idea that sex offenders are asserting their masculinity and anger towards women. By nonconsensually removing the use of a body part deeply associated with masculinity, the sex offender becomes angrier and feels an even greater need to assert his masculinity. Accordingly, sex crimes continue to occur and may even become more frequent or more violent.

³⁰⁶ Calve, "Corrections Dept. Studies Drug Therapy for Sex Offenders."

³⁰⁷ The FDA rejected the drug's use as a contraceptive in 1978 and again in 1984. Ibid.

³⁰⁸ Calve, "Corrections Dept. Studies Drug Therapy for Sex Offenders."

³⁰⁹ They're repeatedly referred to this way in news articles.

As for those already incarcerated, the issue was even stickier. Many argued that prisoners couldn't freely consent to begin with.³¹⁰ There was some general support for this, hence nationwide laws regulating experimental research using prisoners.³¹¹ On the other side of the debate, a handful of prisoners demanded access to the drug. They argued that it was an effective treatment to that they should be given access to rights. To be denied access to treatment constituted, in their opinion, "cruel and unusual punishment." One incarcerated man, according to his lawyer, "demanded that [the prison] provide Depo-Provera [in order to]... avoid what he considered his inevitable return to prison, in view of his repeated imprisonment for sex offenses."³¹² Berlin vehemently supported his own incarcerated patients, issuing an invitation for the ACLU to talk to the prisoners, who (according to Berlin) said, "if they tried to come between them and their treatment, they would sue the ACLU."³¹³ Ironically, civil libertarian used the exact same language, arguing that judges who sentenced sex offenders to receive treatment (whether along with or in lieu of prison time) were likewise imposing cruel and unusual punishment.³¹⁴

³¹⁰ Writes one judge, "It's a difficult choice for a sentenced prisoner to have free choice whether to take the substance. If the only way you get what you need is to allow yourself to be subjected to medication, that's not really informed consent." The judge conceded that prison alone was not a form of treatment and that Depo-Provera might be effective, but ultimately felt that drug therapy in prison was unethical for "civil libertarian" reasons. Though this particular reasoning is unsatisfying, organizations such as the Louisiana chapter of the ACLU argued more successfully that ethical issues existed and should be seriously considered before prisons began administering such treatments (Calve, "Corrections Dept. Studies Drug Therapy for Sex Offenders").

³¹¹ The FDA had banned the use of prisoners in clinical trials in 1980. Regulations regarding the use of experimental drugs for non-trial purposes on prisoners were less clear.

³¹² Calve, "Corrections Dept. Studies Drug Therapy for Sex Offenders."

³¹³ John Pope, "Priest May Lose Sex Drug Treatments," *Times-Picayune*, October 17, 1985.

³¹⁴ For one particularly notable example of this, see the Upjohn case. Upjohn Pharmaceuticals manufactured Depo-Provera. A nephew and the heir to the company was convicted of molesting his stepdaughter from ages 7 to 14 (a similar accusation from his stepson was dropped in a plea bargain). He was first sentenced to probation and donating \$2 million dollars to establish a treatment center for abuse victims. This was swiftly overturned. The second sentence was also to

In addition to health and legal concerns, there were also concerns about public safety. Victims' advocates argued that sex offenders released from the clinic represented a danger to the community. Such concerns were not without cause: while the recidivism rate among Berlin's patients was considerably lower than the national average, there were a number of cases where his patients were arrested for reoffending and these cases received a considerably amount of negative press.³¹⁵ That Berlin was very careful to note that he didn't release those he considered dangerous did little to convince critics, given these circumstances.³¹⁶

Berlin and his clinic became the focus of more of these controversies than any of the other clinicians discussed in this dissertation and, while some were due to no fault of his own, Berlin arguable brought a number on himself.³¹⁷ First, Berlin spent much more time engaging with the media than did others—the UTMB released only a few press releases about Walker's

probation, but mandatory Depo-Provera treatment. The sentence was immediately appealed and rejected a year later as “cruel and unusual.” He was eventually sentenced to 5-to-15 years in prison. The case is one of the first major cases to deal with Depo-Provera sentences. It's also notable in that what exactly the Upjohn nephew expected to get isn't clear. He had been convicted of abusing a child sexually for years; one imagines either of the first two sentences would be preferable to prison time. See: Miller and Nichols, “Upjohn heir.”

³¹⁵ Three patients are named specifically—Berkson, Gauthe and Hoffman. The Gauthe case, regarding Reverend Gilbert Gauthe's crimes against a number of boys attending his church, was one of the first national cases concerning sexual abuse committed by clergy members. The most comprehensive historical coverage was published in a three-part series in *The Times of Acadiana*; see: Jason Berry, “The Tragedy of Gilbert Gauthe,” May 23, 1985. For contemporary coverage of the case, see: Madeleine Baran, “Betrayed by Silence: A Story in Four Chapters,” Minnesota Public Radio, 2014. One article from 1987 states that 4 patients had relapsed, but that none had been charged with rape or attempted rape. On the three patients besides Berkson, the article specifies that, “One patient was arrested for breaking and entering a home, perhaps with the intent of committing rape; another accosted and grabbed a woman but did nothing further; a third wore women's clothes and tied a woman up, but them fled” (Simon, “Berkson Case”).

³¹⁶ Berlin noted many times that he believed certain patients are dangerous and should be either incarcerated or hospitalized, and acknowledged that separating out dangerous sex offenders from those who are acceptably reformed was one of the central issues facing the clinic.

³¹⁷ Not quite true. Money was very controversial in his own right, but those controversies involved his work with intersex children and not sex offenders. Berlin was undoubtedly the most controversial figure working with sex offenders specifically.

work, whereas Berlin received frequent popular coverage over a ten-year period. Groth and Money, while they published widely, didn't engage very often with the media at all and were more focused on engaging with a professional audience, rather than a public one. Berlin's close engagement with the media is further indicated by the fact that, throughout the early and mid-80s, the press could typically verify a controversial patient's status with Berlin's clinic within a day or so. A less open—and more careful—clinic would likely refuse to comment when controversies arose, whereas Berlin's clinic rapidly responded to media questions regarding such situations. And indeed, by the late 1980s, the level of controversy would force Berlin (or at least someone connected to the clinic) to rethink this strategy. In a few of the later cases where former patients committed new crimes, the clinic refused to confirm or deny that the men had been patients at the clinic in the first place, much less comment on them.³¹⁸

Second, Berlin was not particularly careful with his data or his language. While Walker was careful to note that his data on recidivism was tentative, Berlin did not offer any such caveat until he was forced to by the sheer amount of coverage given to patients who had been arrested for reoffending. As early as 1983, when the clinic had been open for a mere three years, Berlin was reporting very low numbers of recidivism without any caveats at all.³¹⁹ Such straightforward

³¹⁸ For this difference, compare these two articles: Pope, "Priest May Lose Sex Drug Treatments," and Simon, "Outpatient at Sexual-disorders Clinic." A comparison of the Berkson and Hoffman cases is instructive here. In April of 1987, Berlin commented extensively on the former patient, and attempted to spin his new sex crimes as less egregious than those he had committed before treatment and thus to spin the clinic's treatment of Berkson as a partial success. Just a few months later, Berlin would refuse to comment at all on Hoffman's new crimes—he would not even confirm whether Hoffman had been a patient at this point.

³¹⁹ In the clinic's early years, Berlin also stated that he had been following up with patients treated with Depo-Provera for fifteen years. While it's possible that he had been involved with treatment of sexual offenders for that long (especially given Money's history at Johns Hopkins), this particular claim stretches credulity. He made the initial claim in 1983 (and stuck to it), which would mean that he had been using Depo-Provera since 1968. This is the same year in which Depo-Provera began to be seriously tested in other nations. It's possible that Berlin had obtained

accounts of success flouted typical practices with regard to patient follow-up. Walker insisted that a follow-up period of at least four years after treatment ended was necessary to deem a patient truly cured. Researchers on recidivism rates for sex offenders likewise advocated for a relatively long follow-up period and noted that shorter periods skewed results—any given offender was statistically more likely to have committed additional offenses after four years as after two and therefore measuring only the shorter period meant getting necessarily lower recidivism rates.³²⁰ Berlin, for his part, seemed to count patients as cured a mere year after their release: his treatment regime required a year of intensive therapy, a second year in which the patient was phased out of intensive therapy, and a third year where the patient had biannual checkups. These biannual checkups formed the basis for Berlin’s follow-up period.³²¹ This truncated follow-up period meant both that Berlin was less actively monitoring his patients than many other clinicians and that his reported recidivism rate was likely to be artificially low.

Even worse, Berlin was repeatedly insensitive to victims, and took pains to differentiate between acts of rape and ‘lesser’ acts. This was particularly visible when former patients were caught reoffending. In one case, Berlin argued that a patient who had been caught reoffending represented a partial success.³²² Robert Berkson had previously been arrested for convincing young women that he was a police officer and fondling them; he had also taken one woman to a

the drug at that point, though we’re cutting it awfully close. Certainly, it wasn’t common enough in America to have wound its way to the FDA yet. Moreover, it’s seriously unlikely that he obtained the drug before 1968. Assuming this is the earliest date that he could have acquired it, he had only begun actually *using* the drug 15 years prior. There was, accordingly, an intermediate period in which patients were treated. To conflate the treatment period with long-term follow-up doesn’t provide an accurate recidivism rate.

³²⁰ See chapter 5 on this.

³²¹ Patients on Depo-Provera would additionally have to come in for their weekly injections, but there’s no indication that this involved any therapy, nor even an in-depth evaluation (and patients might receive the injections for a short amount of time or as a lifelong treatment). On Walker, see Bankhead, “News Release,” Blocker Archive.

³²² Simon, “Berkson Case.”

motel and raped her multiple times. The new offense was fondling a woman he had likewise convinced he was a police officer. This was, Berlin was careful to note, a “fourth-degree sexual assault.” As well, Berlin stated, “That’s not to say that the incident wasn’t a serious one. But it was certainly less serious than the earlier offense.” Yet such rhetoric belied the reality of the case. While Berlin concentrated on one charge—the most serious—Berkson had actually gone on a “bizarre sex spree.” Even the single most serious offense could be read in a way directly oppositional to Berlin’s reading. The crime involved a very specific ruse—Berkson pretended, in a premeditated manner, to be an authority figure in order to lure his victim. This was the same ruse he had used in the past. So while his assault in 1987 may have been more minor than his assault in 1984, he had returned to the exact same pattern and had done so not on a whim or in a moment of compulsion, but using a plan that involved some level of forethought and a sustained act. In this context, Berlin’s attempts to spin the Berkson case as anything other than an abject failure come across as remarkably self-serving.

In another case, a suspect had tied up a woman, but fled before assaulting her. Despite the kidnapping and clear intention of rape, Berlin was careful to note to reporters that the man had not been charged with an “actual rape or an attempted rape.” This was likewise true of a pedophile who had been arrested for “fondling” a child and forcing her to “perform a sexual act,” as the arresting officers put it. These were all legally important distinctions, but it’s hard to blame victims or victims’ advocates for feeling that such distinctions were better left to a court of law. And while most of Berlin’s statements are factually correct and even understandable from

his perspective, it's hard to see how he failed to realize that they came across poorly (especially given that he continued to make similar statements despite the public's negative reactions).³²³

Other articles from this period note that, despite such failures, the clinic enjoyed a recidivism rate substantially lower than national rates for convicted sex offenders.³²⁴ Such a statement was fair—even the higher recidivism rate Berlin gave by the late-1980s (10-20%) was indeed lower than the generally accepted state- and national-average. Why Berlin failed to concentrate on this—that a clinic working with sex offenders would likely always experience failures, but that his clinic did more good than harm—rather than concentrating on specific cases and attempting to spin them as success stories is unclear. The press seemed to find such an explanation compelling until at least the mid-1980, and generally agree that failures were certainly newsworthy, but not necessarily an indictment of the clinic as a whole. Had Berlin accepted this and acknowledged the clinic's failures as failures, he might have been able to sway public opinion back to his side to some extent.

As well, there was an additional case where a current patient was accused of committing additional crimes. In 1988, a psychiatric patient at Johns Hopkins claimed that one of Berlin's patients had raped her on hospital grounds.³²⁵ At the time, lawyers for the hospital refused to cooperate with the police, citing concerns over doctor-patient confidentiality. It's not clear how this incident played out—given that the victim in this situation was being treated for depression and that Berlin's patients were being treated for potentially dangerous conditions, it's difficult to

³²³ Berlin also presided over a seminar at Johns Hopkins entitled, "Sex Offenders: Criminals or Patients?" (Singletary, "Child Molesters"). The title reflects his overall philosophy, but also erases the criminal acts perpetrated against the victims of his patients. By presenting this strict binary, Berlin could be accused of failing to be sensitive to those victims who didn't go on to become abusers.

³²⁴ Simon, "Berkson Case."

³²⁵ William F. Zorzi Jr., "Clinic Skirts Laws on Reporting Sex Crime," *The Sun*, March 4, 1990.

imagine why these two groups weren't segregated from one another in a more rigorous way. That Berlin's patients were allowed enough free reign to commit crimes within the hospital itself bears out the concerns of victims advocates—if Berlin couldn't control patients at the hospital, how could he guarantee the safety of the communities such men would eventually be released into? Moreover, patient privacy was one thing when there were no immediately apparent victims, but something else entirely when the concept was used to actively impede a rape investigation. Coverage of this case was comparatively sparse, but it is worth noting that this incident was roughly contemporary with a battle over mandatory reporting laws (to be discussed subsequently).³²⁶ Berlin and Johns Hopkins' reliance on doctor-patient confidentiality in regards to this case may have been an extension of their reaction to the debate over such laws.

In all, Berlin had good intentions, but had two personality traits that served him poorly when combined: publicity seeking and a lack of savvy. Had he not engaged so closely with the media, it's possible that these controversies would have blown over, or at least not been made worse by his poorly worded statements. Similarly, if he were more politically savvy, he could have solved a number of these issues before they started, or at least spun them to his advantage.

This lack of savvy is particularly evident in his reactions to mandatory reporting statutes introduced in the late 1980s. Mandatory reporting statutes, which are common today, require certain groups of professionals to report suspected child abuse to the relevant authorities. The groups bound by these laws typically include teachers and others in the education industry, medical professionals, and mental health professionals—broadly speaking, those who might be expected to interact regularly with children or people in a position to abuse children. Such statutes have been written piecemeal since the 1960s, and their passage was part of a public

³²⁶ This is speculation, but one wonders whether Johns Hopkins' refusal to engage with the media on this case played a role in the relative paucity of publicity.

movement to combat child abuse. While such statutes seem largely uncontroversial today, their passage was fraught with issues.³²⁷ For mental health professionals in particular, doctor-patient confidentiality was a cornerstone of their work. The idea that they would be legally required to report private admissions (on the part of either the abused or the abuser) required a substantial shift in thinking. Many also worried that breaching such confidentiality would inhibit their ability to work with patients, and that patients (particularly those with mental health issues related to criminality, as with sex offenders) would not enter into treatment with the possibility of reporting hanging over their heads.

Given the nature of his work, it is perhaps unsurprising that Berlin found himself in the crosshairs of the battle over mandatory reporting. This particular situation began in 1987, when Berlin managed to persuade state official to exempt clinicians working with pedophiles from a new statute that required professionals who suspected child abuse to report their suspicions to police. The caveat put into place was that Berlin and his colleagues were not required to report abuse that had occurred in the past; ongoing abuse was not included in the exemption. In 1988, a new statute would go into effect and the exemption would run out. Not content merely to reintroduce the same exemption, Berlin wanted specialists to be exempt from mandatory

³²⁷ The first statutes were introduced in the 1960s and applied specifically to medical professionals; moreover, they were designed to combat physical abuse and not child sexual abuse. The push to extend such laws to mental health professionals (and public recognition of the existence of child sexual abuse) came substantially later. On the history of mandatory reporting, see: Leonard G. Brown III, "Mandatory Reporting of Abuse: A Historical Perspective on the Evolution of States' Current Mandatory Reporting Laws with a Review of the Laws in the Commonwealth of Pennsylvania," *ExpressO* (unpublished paper, 2012); John E. B. Meyers, *A History of Child Protection in America* (Xlibris Corp: 2004). On mental health professionals' concerns specifically, see: Seth C. Kalichman, *Mandated Reporting of Suspected Child Abuse: Ethic, Law & Policy* (Washington, DC: American Psychological Association, 1999).

reporting laws even in regards to ongoing abuse.³²⁸ Berlin's chief argument here was that pedophiles wouldn't seek treatment if there were any possibility they would be reported, but Berlin was less than convincing and a new exemption wasn't issued.³²⁹

Berlin, believing strongly in patient confidentiality, began deliberately skirting the new requirements. As soon as the new law took effect, "with the blessing of his supervisors," Berlin released a memorandum to patients and potential patients that not only informed them of the new law, but suggested ways around it.³³⁰ Primarily, Berlin suggested that prospective patients turn first to a lawyer. The lawyer would then issue a referral for evaluation at the clinic. From this, Berlin claimed that any disclosure of ongoing abuse to him would be protected by attorney-client privilege.³³¹ This tactic was not specifically banned in the language of the mandatory reporting statute, but clearly violated the spirit of the law (and logic, more generally). Ultimately, the state's attorney general would issue an opinion clarifying that this was, indeed, not acceptable and against not just the spirit of the law, but now its letter.³³²

³²⁸ Berlin didn't actually introduce this bill, but it swiftly became known as the "Berlin bill." Moreover, a number of officials noted that the original statute had been introduced with Berlin's clinic in mind. See: "Our Say: Stop Shielding Child Molesters," *The Capital*, March 23, 1988.

³²⁹ The exact sequence of events here isn't clear, but by July 1989, the exemption had definitely lapsed.

³³⁰ Zorzi, "Clinic Skirts Laws." As far as the memo is concerned, the former was arguably not a problem, but the latter, ethically and eventually legally, was.

³³¹ This strategy was, simply put, unlikely to work. First, the attorney-client privilege that existed between attorneys and their clients would not have been extended to Berlin or any staff at his clinic. Second, while Maryland did not require attorneys to report suspected child abuse, that profession was involved in the same dispute as were mental health professionals. Accordingly, relying on attorneys as intermediaries wasn't exactly solid ground. In all, Berlin's patients would probably have been poorly served by this strategy had they trusted him enough to follow it.

³³² In Maryland, no civil or criminal penalties for violating the statute existed at that time. While professional penalties—ranging from a state reprimand to suspension or revocation of licenses—were possibly, they didn't occur in Berlin's case. His licensing body required a report of a specific incident in order to investigate. Berlin had provided the means to violate the law, but hadn't actually had the opportunity to follow through. Publicity surrounding the new law

Berlin was likely aware and deliberate in his strategies here, rather than merely misinterpreting the law.³³³ He had acknowledged in two interviews shortly before the attorney general’s opinion that he “understood the legislature’s intent but had deliberately skirted the reporting requirements.”³³⁴ Berlin, of course, spun the story more to his favor; he merely wanted to find a “legal way for people who wanted to seek help to come and get it... without being prosecuted.” Still, it was obvious to those involved with the legal proceedings that Berlin knew what he was doing. One delegate stated, “Doctor Berlin knew the rationale behind the legislation, that legislators were concerned about his clinic. He was not operating in a vacuum. We debated this issue for two years.”³³⁵ Another argued that, “He’s clearly circumventing the reporting statute,” and called for the attorney general to “come down on him.”³³⁶ If Berlin’s goal here was to continue his treatment uninterrupted, the tactic would prove woefully inadequate.

dramatically lowered his incoming patients—only five inquired about treatment and none ever came into the clinic, thus no disclosures were made.

³³³ Berlin’s attitudes here align with the attitudes of other clinicians working at Johns Hopkins. At roughly the same time the sex offender clinic was coming under fire, there was an ongoing debate about Johns Hopkins’ approach to sexual reassignment surgery (SRS). An article from that time notes that Johns Hopkins’ organizations structure was “based on a European model that gives virtual autonomy to each department.” On a colleague embroiled in the controversy over SRS, Money himself noted, “Dr. Jones said that whenever you’re developing something completely new, you’re actually setting a precedent for the law. Therefore you could not go and ask the law what to do. You had to be willing to take the risk and the consequences of the risk” (Kuznik, “Sex Problem”). While the stakes of providing SRS to transgender patients are obviously different from skirting a mandatory reporting law designed to protect children, this general attitude—that clinical practice exists outside the law—is notable.

³³⁴ These are the journalist’s words and not a direct quote from Berlin, but it seems more or less believable given the context (Zorzi, “Clinic Skirts Laws”).

³³⁵ While it’s possible that the Delegate was misremembering (i.e., that Berlin’s clinic had become so deeply connected with the bill due to this controversy that those involved began to imagine they had been worried about him all along), there was clearly bad blood. Since Berlin had been involved with the legislature for years, the Delegate’s statement seems reasonable.

³³⁶ Zorzi, “Clinic Skirts Laws.” The quotations are Delegate Robert L. Ehrlich Jr., R-Baltimore County, and Senator Thomas M. Yeager, D-Howard County, respectively. It’s worth noting that a Republican and a Democrat agreed on the matter, which is often the case in matters involving sexual morality (not just sex crimes against children, but also pornography).

Not only did the laws in question reduce the number of patients requesting evaluations (Berlin's bad legal advice notwithstanding), but his approach to the issue brought more publicity and more controversy upon the clinic.

And while we might imagine that this was ultimately a victimless crime, Berlin's obstinacy produced concrete harm in at least one instance. One of the five inquiries³³⁷ made during the months after the mandate was introduced came from a man who called the clinic after he had "touched his daughter sexually in the bath"³³⁸ The man was less interested in treatment for himself than in having his daughter seen by a psychiatrist. The clinic told him to speak to a lawyer first. The man offered to leave his name and number, but the clinic refused to take it. They also didn't report the incident to the police. This arguable violated the law — while they didn't have much to report, the man had made a disclosure of ongoing abuse (unless your definition of "the past" is awfully recent). The clinic's suggestion to contact a lawyer and their refusal to take down the man's information was logical, given Berlin's approach to reporting requirements. But a clinic like Berlin's should probably have a list of victim's advocates or counselors on hand. By failing to give any advice about the man's daughter, Berlin indicated that it was more important for the caller to protect himself than to get help for his child. Ultimately,

³³⁷ Zorzi, "Clinic Skirts Laws." This 1990 article cites this number—that five men had come in for evaluations since the law had been passed, and that none had entered into treatment. Going strictly off these numbers, the law seems to have introduced a chilling effect on the clinic. Compare this to the lowest numbers in 1988: 150 patients per year, or approximately twelve per month. After the law, this fell to less than one evaluation per month and no new patients. That said, there are a few additional factors: by this point, the clinic has received a great deal of negative publicity (most of it not related to the mandatory reporting law) and that publicity may itself have deterred potential patients. As well, as Berlin's responses to the law demonstrate, he may have played a role in reducing the number of patients (either by actively turning patients away or by suggesting unwieldy legal workarounds that prospective patients were unlikely to engage in).

³³⁸ There's no way of knowing, but that she was in the bath perhaps indicates a very young child—it is common for parents to bathe young children, but most children become independent enough to bathe themselves sometime between ages seven and ten.

while Berlin claimed to be concerned with abused children, it appeared that he cared more about those who had gone on to become sex offenders themselves than those who were still being victimized.

Moreover, this particular event also implied a lack of creative or long-term thinking on Berlin's part. It is conceivable that Berlin could have worked with victim's advocates to find a way to balance the needs of his patients and their victims.³³⁹ Even just having a referral system would have demonstrated a real concern for victims. That a man seeking treatment for his daughter called Berlin's clinic specifically indicates that Berlin was getting a significant amount of publicity—so much so that someone looking for victims' resources contacted him rather than victims organizations directly. Such organizations may have been comparatively underpublicized. Berlin's public profile thus put him in a unique position to work towards helping both offenders and victims, even if only in minor ways such as creating a referral network. Instead, Berlin chose to ignore the issue and even obstruct a child victim from receiving help.

³³⁹ Money did something like this. Since he was a pediatric psychiatrist by training, he sometimes worked with child victims and their families. STEPS also engaged with victims, though in a different way—clinicians at the program believed that patients needed to come into contact with actual victims (though not their own) in order to understand the reality of what they had done rather than seeing their own victims as mere fantasies. In service of this, they invited victims of child sexual abuse to talk at their group therapy sessions. As well they requested that patients in their child victims program write letters and make videos (it's not clear whether this was a one- or two-way exchange with the juvenile offenders), and even suggested that some of these patients go to the marathon sessions with the offenders ("Treating Juvenile Sex Offenders," Society for the Scientific Study of Sexuality Collection). While the methods here are questionable (particularly the idea of leaving victims and perpetrators alone in a house for 24 hours), the mere fact that STEPS clinicians worked with both victims and perpetrators meant that they had some ideas about the unique needs of both groups. Berlin could have easily pursued some institutional connections with programs (whether clinical or community-based) dealing with sexual violence.

Ultimately, Berlin wasn't a callous man. He genuinely cared about his patients and, while he never took any pragmatic actions to show it, he seems to have genuinely cared about sexual violence and its victims. However, despite his good intentions, he was perhaps not the best public face for such a hot-button line of work. Berlin was fond of publicity, but not quite savvy enough to temper his faith in his work, not quite sensitive enough to watch his language or, indeed, his actions. He wasn't a particularly good long-term thinker. Thinking ahead a bit could have alleviated a number of the clinic's issues. Why not think harder about a course of action before the mandatory reporting exemption expired? Why not begin engaging with victims' advocates as soon as the first controversy emerged? As a result of Berlin's choices and the increasingly controversial nature of the clinic, the mandatory reporting debacle would be the nail in Berlin's coffin. Within two years, he and Johns Hopkins would part ways.

Conclusion

Throughout the early to mid-1980s, the Sexual Disorders Clinic received a steady stream of praise for its work with sex offenders and other sexual deviants. By 1990, however, a news article would note, "It's a rare month that the Sexual Disorders Clinic isn't the subject of blistering newspaper headlines or another talk radio rant."³⁴⁰ At that time, the director of Johns Hopkins' psychiatry department would state, in regard to the onslaught of negative publicity, "I think it will force the clinic to close."³⁴¹ He was right and the clinic was shut down shortly thereafter.

These difficulties weren't unique to the Sexual Disorders Clinic or Berlin. In fact, Nicholas Groth had noted, "It comes with the territory... In these kinds of programs your work

³⁴⁰ Kuznik, "Sex Problem."

³⁴¹ Kuznik, "Sex Problem."

has to be not only trying to provide responsible help to the clients but constantly having to deal with public relations issues.”³⁴² For the Sexual Disorders Clinic, the process was written more largely. The number of patients treated meant the number of failures would be larger—if the clinic treated one thousand men over the course of ten years and Berlin’s later recidivism rate of 20% was correct, then we can estimate that two hundred men were released back into the community to commit additional sex crimes. Despite a 20% recidivism rate representing a huge success, such a number of failures was always going to be frightening to the community members Berlin’s ex-patients might offend against. But beyond number crunching, Berlin’s constant interaction with the press made the JHH clinic a public good to be discussed, and whether that discussion was laudatory or critical would ultimately be out of Berlin’s hands.

Subtracting out this question of publicity and its role in the clinic’s downfall, what conclusions can we draw about the state of treatment for sex offenders in the 1980s? First, like most centers, the Johns Hopkins clinic treated a relatively small number of patients. Many of its methods were experimental—the use of Depo Provera in particular—and others were based in preexisting treatment regimes for unrelated disorders—most notably, Berlin’s use of group therapy modeled on Alcoholics Anonymous. While the clinic undoubtedly represented a breakthrough in treatment for sex offenders, Berlin’s presentation of the program as a complete success was an overstatement that would eventually come to haunt him. Second, while the world of research on sex offenders in the 1980s was incredibly small, a comparison of Berlin with other clinicians demonstrates a remarkable diversity in thought and practice. This is particularly visible in the fact that Berlin, Money and Walker had all worked together at Johns Hopkins, but went on to diverge in how they thought about and treated sex offenders. Finally, the Johns Hopkins clinic

³⁴² Kuznik, “Sex Problem.”

raised numerous ethical concerns. Some were overblown (“chemical castration” was an inflammatory misnomer). Others were indeed borne out by the center (mandatory reporting and recidivism rates were a point of well-earned contention). Still, despite these controversies, many observers (both psychiatric and public) continued to advocate for more treatment centers.³⁴³ Ultimately, society seemed to desire a better way to deal with sex offenders, but some serious kinks remained by the end of the 1980s. In the case of the Johns Hopkins clinic, these kinks would outweigh the clinic’s successes.

³⁴³ Calve, “Corrections Dept. Studies Drug Therapy for Sex Offenders.”

Chapter 4

The North American Association for Man/boy Love: Rhetoric and Politics in the 1980s

While the APA was attempting to add rapists to its list of pathological deviants, other groups were trying to get out of the *DSM*. Prior to the 1970s, pathological sexual disorders were regarded as deeply troublesome and bound tightly to criminality. As society became more sexually permissive, however, many of these disorders shed their connection to criminality and became increasingly benign. Indeed, some would cease to be considered pathological at all. This was the period in which homosexuality was gradually reclassified out of the *DSM* entirely. Alongside it, transsexuality, sadomasochism and other paraphilias became regarded with a measure of sympathy, particularly by progressive sexologists. Still, one sexual disorder remained firmly reviled: pedophilia.³⁴⁴³⁴⁵

Yet despite this social stigma, pedophiles began to organize. In 1971, a student of Wilhelm Reich founded the Childhood Sensuality Circle in California. In Britain, the Pedophile Information Exchange (PIE) formed in 1974 and began publishing a journal called *MAGPIE*.

³⁴⁴ While pedophilia—or sexual attraction to prepubescent children—has been firmly reviled, attitudes towards sex with minors more generally have been uneven. During the 1960s and 1970s, attitudes were notably permissive towards sex with pubescent and post-pubescent children. The dominant belief during this era, which Philip Jenkins and other refer to as a the “liberal era,” was that adolescents were inherently sexual, able to consent to sex with adults, and in fact played an active role in any sexual abuse they suffered. On this, see Philip Jenkins, *Moral Panic: Changing Concepts of the Child Molester in Modern America* (Yale University Press, 1998). Jenkins notes, in particular, that New Jersey seriously considered lowering the age of consent to 13 during the early 1970s (102-106).

³⁴⁵ A note on terminology: “pedophilia” is a term that comes out of psychiatric discourse and presumes pedophiles to be mentally ill. Still, a number of pedophile activists identified themselves using that term. I will be using this term in a general sense, and will use more specific terms like ‘pederasty’ or ‘Man/boy love’ where applicable. As well, when feminists discussed the issue, they often used the term “child sexual abuse” (CSA). In order to differentiate between pro-pedophile and anti-pedophile positions, I will be using CSA for the anti-pedophile position. This is not meant to imply that pedophilia isn’t a form of child sexual abuse, but instead a way to quickly and easily separate out these disparate discourses.

Though PIE disbanded in 1984, they would be one of the most significant pedophile groups in Europe for the ten years during which they were active. Around the same time, German group Indianerkommune began promoting children's liberation and pedophilia. In the Netherlands, Vereniging MATIJN formed in 1982.³⁴⁶ But the largest and perhaps best-known group was the North-American Association for Man/boy Love—NAMBLA.

NAMBLA was formed in 1978 in response to a few events.³⁴⁷ First, conservative activist Anita Bryant mounted a campaign against the gay liberation movement called "Save Our Children." Central to this campaign was the idea that gay men "recruited" young men and boys and, through seduction, turned them into homosexuals.³⁴⁸ While pedophiles had enjoyed a relatively uncontroversial, if often unacknowledged, relationship with the gay liberation movement up until this point, Bryant's campaign forced gay liberation leaders to publicly affirm that homosexual men did not sleep with boys in a bid to avoid the increasing controversy.

Two events in December 1977 further underscored the need to organize. First, twenty-four men were arrested in Massachusetts for having sex with boys (mostly teenagers). As a result, a group of pedophiles formed the Boston-Boise Committee to educate the media and public about pedophilia. Second, police raided the *Body Politic*, a Canadian gay liberation newspaper, for publishing an article entitled "Men Loving Boys Loving Men." These three events indicated to pedophiles that they were at risk for political and legal actions. Their

³⁴⁶ There are many more groups than this; this is only a list of groups mentioned by or in connection with NAMBLA.

³⁴⁷ Information on NAMBLA's formation taken from David Thorstad, "Man/boy Love and the American Gay Movement" in *Male Intergenerational Intimacy: Historical, Socio-Psychological and Legal Perspectives*, ed. Theo Sandfort, Edward Brongersma, and Alex van Naerssen (London: Routledge, 1990).

³⁴⁸ On "Save Our Children" and homophobia, see Patrick McCreery, "Miami Vice: Anita Bryant, Gay Rights and Child Protectionism" (Ph.D. diss., New York University, 2009).

preexisting involvement with the gay community and gay political organizations meant that pedophiles' solution was to organize.

One year later, the Boston-Boise Committee's Tom Reeves would organize the first conference on "Man/Boy Love and the Age of Consent" and a small group of conference attendees would go on to form NAMBLA. NAMBLA published its first pamphlet, the *NAMBLA Bulletin*, in 1980. It was a modest beginning—four half-sheet pages typed on plain paper. By 1990, the *Bulletin* had ballooned to a twenty-page glossy magazine replete with photographs, illustrations, and order forms for other publications and materials. By this point, NAMBLA had also begun putting out a Christmas double-issue. And while their membership initially consisted of thirty men and boys, by 1985 they would have four hundred members.³⁴⁹ By the mid-90s, their membership would be twice that.³⁵⁰

This chapter looks first at NAMBLA's strategies for normalizing pedophilia. I use NAMBLA publications—and the publications of other pedophile advocacy groups—to examine how pedophiles framed themselves using rhetoric drawn from both academic and social justice circles. As well, I look at how the arguments NAMBLA put forward were often belied by their actions. This section of my paper is not an endorsement of NAMBLA's position, but rather a discourse analysis that seeks to put NAMBLA in conversation with the women's movement, gay liberation, sexology and social science. I argue that, despite their deeply unpopular sexual desires, NAMBLA felt that it had a rightful place in broader discussions about sexuality, power

³⁴⁹ Membership numbers taken respectively from Thorstad's "Man/boy Love" and Bill Andriette's "Steering Committee Highlights" in *NAMBLA Bulletin* 6, no. 2 (March 1985), Pedophilia Collection, The Kinsey Institute for Research in Sex, Gender, and Reproduction, University of Indiana at Bloomington (hereafter, Pedophilia Collection).

³⁵⁰ Onell R. Soto, "Little-know group promotes 'benevolent' sex," *Union Tribune San Diego*, February 17 2005. The numbers Soto cites are from an undercover police report. By this time, NAMBLA had become much more cautious in regards to its membership and did not release official numbers to the public.

and consent occurring throughout the 1980s. Moreover, NAMBLA's rhetoric evidences a savvy leadership familiar with political activism and academic and scientific discourses.

After this, I turn to NAMBLA's position within the gay community. Initially an accepted (though perhaps begrudgingly) presence in gay community spaces and political organizations, NAMBLA would increasingly be pushed out as gay liberation transitioned into a more narrowly-defined gay right's movement. I trace early conflicts between NAMBLA and the gay organizations to which they attempted to attach themselves. While a number of scholars have written about later conflicts between NAMBLA and the gay rights movement in the 1990s, few have looked at these earlier moments.³⁵¹ I argue that the transition from gay liberation to gay rights was predicated on a narrower definition of what it meant to be gay (where, in this case, NAMBLA members were primarily defined as pedophiles rather than as gay men), and that NAMBLA (along with a number of other observers) saw this as a betrayal of the fundamental ethos of gay liberation.

NAMBLA's Cultural Relativism

From its inception, NAMBLA's central platform was that the organization was part of the gay liberation movement.³⁵² This was both ideological and practical. By the time of NAMBLA's founding, gay liberation had made huge institutional strides. Gay activists had succeeded in

³⁵¹ One conflict in particular, the ejection of NAMBLA from the International Lesbian and Gay Association, has received a substantial amount of scholarly attention. This is, in part, because that ejection was highly public and involved pressure from both national and international political bodies (including the UN). On this, see: Douglas Sanders, "Getting Lesbian and Gay Issues on the International Human Rights Agenda," *Human Rights Quarterly* 18, no. 1 (February 1996) and Joshua Gamson, "Messages of Exclusion: Gender, Movements, and Symbolic Boundaries," *Gender and Society* 11, no. 2 (April 1997).

³⁵² The leadership of NAMBLA had long been involved in the gay community, as I'll discuss later in the chapter.

convincing the APA to remove homosexuality from the *DSM*, leading NAMBLA to take up a similar position and argue that pedophilia was a sexual orientation rather than a sickness.³⁵³ And as the number of laws prohibiting discrimination on the basis of sexual orientation increased, NAMBLA would have another reason to use that language. While neither of these particular strategies would pan out—pedophilia remains in the *DSM*, and NAMBLA’s many suits alleging sexual discrimination were summarily rejected—NAMBLA hoped that an alliance with the gay liberation movement would provide them with some of these cultural and institutional gains.

NAMBLA also relied heavily on historical and anthropological evidence to argue that pedophilia had always existed and was, therefore, a normal expression of human sexuality. In particular, NAMBLA noted the prevalence of pederasty in Ancient Greece. Many NAMBLA members framed their own practices in a similar way; for instance, founding member David Thorstad claimed that NAMBLA members “tend to stress ‘love,’ the nurturing and occasional romantic view of man/boy love.”³⁵⁴ So central were these arguments to NAMBLA that when a debate about whether or not to change the organization’s name to something more euphemistic came up, suggestions included “Society of Spartans” and “Ganymedia.”³⁵⁵ These historical arguments also promoted more recent examples of pedophilia. A recurring *Bulletin* feature entitled “DID YOU KNOW...” listed “famous individuals who were probably boy lovers,”

³⁵³ See the conclusion of this dissertation for a discussion of the fact that, ironically, psychiatrists have increasingly come to agree with this viewpoint since the turn of the century.

³⁵⁴ Interview with David Thorstad in “Loving Boys,” special intervention series, *SEMIOTEXT(E)*, ed. Sylvère Lotringer, NY: Columbia University (summer, 1980).

³⁵⁵ There was a recurring debate within NAMBLA over what to refer to themselves as—pederasty, pedophilia, Man/boy love and other suggestions were put forward. Pederasty, in particular, came with some built-in assumptions about the historicity of pedophilia, as well as the assumption that its nature involved tutelage rather than just sex. For one example, see: *NAMBLA Bulletin* no. 3, March 1980, Pedophilia Collection.

including Harry Stack Sullivan, Oscar Wilde, and Horatio Alger.³⁵⁶ As with their arguments about Ancient Greece, this was “but one more way of acclimating people to the benevolence of sexual variety.” Anthropological arguments served to further emphasize the existence of sexual variation. For instance, philosopher Sylvère Lotringer noted, “In pre-industrial or ‘primitive’ societies the child’s initiation to social roles and responsibilities used to occur between age 9 to 12.”³⁵⁷ As well, “Sex is regarded as an innocent amusement in which the Trobrianders, recalls Malinowski, engage as early as age 4 or 5.” Such factual academic claims were made in the service of NAMBLA’s political arguments.

Other pedophile organizations shared these strategies. In 1985, an Australian group put out the *Eros Juvenilis Index*, an “annotated bibliography concerning eroticism and/or nudity, etc, involving pre-adults (children & adolescents); *& related matters; multi-cultural; impartial.”³⁵⁸ In terms of ‘erotica,’ the *Index* listed nothing that was intentionally produced as child pornography. Given that public debates over child pornography had become heated by this point, this is not particularly surprising. Much of the materials listed are also unremarkable: the *NAMBLA Bulletin*, a variety of nudist publications, and so on. Other materials are more unexpected. These included an “educational toy” from a Special Education Materials catalog. The catalog copy,

³⁵⁶ For examples of the “DID YOU KNOW...” feature, see *NAMBLA Bulletin* no. 4 (May 1980) and no. 5 (June 1980), Pedophilia Collection. See also “Horatio Alger is 150,” *NAMBLA Bulletin* 3, no. 1 (January-February 1982), Pedophilia Collection. As well, these figures served to emphasize NAMBLA’s connections to the gay community, which often invoked the same men as examples of historical homosexuality. Jim Kepner writes, “If we reject the boy-lovers in our midst today, we’d better stop waving the banner of the Ancient Greeks, of Michelangelo, Leonardo de Vinci, Oscar Wilde, Walt Whitman, Horatio Alger, and Shakespeare. We’d better stop claiming them as part of our heritage unless we are broadening our concept of what it means to be gay today” (Thorstad, “Man/boy Love”).

³⁵⁷ Silvered Lotringer, “Editorial: Dirty Old Minds,” in “Loving Boys,” *SEMIOTEXT(E)*

³⁵⁸ “Eros Juvenilis Index” (1985), John Money Collection, The Kinsey Institute for Research in Sex, Gender, and Reproduction, University of Indiana at Bloomington (hereafter, John Money Papers).

reprinted in the *Index*, reads: “Dressing-Undressing Puzzle: Children’s clothes are the puzzle pieces: Assembling the puzzle the child gains a sense of the function of clothing and an increased awareness of the body.”

But the *Index* was not merely concerned with child erotica; rather, most of the document concerns the age of consent, cultural practices, and statistics regarding child rape and prostitution. Some of this information was presented to highlight inconsistencies in laws relating to children. For instance, the *Index* notes that a 14-year-old in Britain could be convicted of rape, but could not consent to marry. For the most part, however, the information was designed to present evidence of both the historical and contemporary existence of pedophilia and thus contribute to its normalization. The *Index* listed a variety of different ideas regarding age of consent: “among Aleuts (Alaska), girl could marry after menarche”; “India: ‘in rural areas, children are still married off at the age of six and seven’”; “‘The Romans... gave their daughters in marriage as early as twelve years old, or even under...’ (-Plutarch, *Lives*.)” While the *Eros Juvenilis Index* referred to itself as “impartial,” these historical and anthropological arguments were not just meant to point out the existence of different sexual mores. Rather, pedophiles used the concept of cultural relativism to suggest that contemporary western sexual mores—those prohibiting homosexuality and pedophilia in particular—were unnatural. Lotringer made this connection explicit: western society “maintain[s] children in a position of dependence which is not altogether ‘natural’ since it has no equivalent in many other cultures.”³⁵⁹

Pedophiles were not the only social groups to invoke these types of arguments. The women’s movement made similar arguments about the historical acceptance of men marrying or having sex with girls. For instance, Florence Rush’s popular study of child sexual abuse began

³⁵⁹ Lotringer, “Editorial,” *SEMIOTEXT(E)*.

with a discussion of the history of child marriage. For Rush, however, this was not evidence of the naturalness of pedophilia. Instead, it was damning: young girls' bodies "are not made for sexual intercourse, pregnancy, and childbirth."³⁶⁰ Moreover, these child marriages were "often paired with physical violence." Rush cites one study that documented "hemorrhaging, ruptured vaginas and uteruses, lacerated and mutilated bodies, peritonitis, venereal disease and even death suffered by child brides."³⁶¹ As well, child marriage did not typically involve a great deal of choice on the part of the child. For Rush and other women, then, child sexual abuse was merely one more manifestation of the historical and contemporary repression of women and girls. This disjuncture between the violence done to girls and the ostensibly consensual and nonviolent relationship between men and boys would be one of NAMBLA's chief defenses, as well as an ongoing point of contention between NAMBLA and women's rights activists.

NAMBLA And Expertise

As well as invoking the language of gay rights, NAMBLA and other pedophile organizations invoked expert authority in their publications. Most notably, Columbia University released a special issue of its philosophy journal, *SEMIOTEXT(E)* on "loving boys" in 1980. The issue included interviews with NAMBLA founder David Thorstad,³⁶² a fifteen-year-old NAMBLA member, and feminist Kate Millet, as well as pieces by Michel Foucault and cultural theorist Sylvère Lotringer. For years afterward, the *Bulletin* advertised the issue as "the hottest

³⁶⁰ Paula J. Caplan, review of *The Best Kept Secret*, *IJWS* 5, no. 1, Paula J. Caplan Papers.

³⁶¹ Florence Rush, *The Best Kept Secret: Sexual Abuse of Children*. Englewood Cliffs, N.J.: Prentiss Hall, 1980.

³⁶² And not just an interview with Thorstad, but also a full-page photo of Thorstad at about one or two years old with the caption "Young Lust." Thorstad is fully-clothed and not sexualized in this photo.

take on man-boy love currently available.”³⁶³ That a respectable university had published the journal—and put two NAMBLA members on par with well-known philosophers—only added to NAMBLA’s legitimacy. As well, reading recommendation lists in the *Bulletin* and *MAGPIE* included books by psychiatrists, sociologists and anthropologists alongside fictional works and advocacy pieces. *MAGPIE* describes psychiatrist John Money’s work in glowing terms: “A little gem of a book. Vital reading for anyone keen to understand how people develop their sexual identity... Forget Freud and all that mumbo jumbo. This is where it’s really at.”³⁶⁴ Another issue reiterated PIE’s relationship to scientific research: “Our aim is to make public scientific, sociological and above all *accurate*, information proving the value of pedophilia.”³⁶⁵ While the advertising of such materials does not necessarily indicate that the average NAMBLA member actually read such works, it does demonstrate that at least NAMBLA’s leadership was familiar with and interested in the ways in which various academic disciplines discussed pedophilia (and sexuality more generally).

Even by the late 1980s, when pedophilia had come under increasing public scrutiny, pedophiles and their advocates managed to maintain a relatively cordial relationship with academics and researchers. Most notably, the Society for the Scientific Study of Sexuality (SSSS), a well-respected organization formed in the 1950s, continued to engage with pedophiles. In 1987, the group published an article by David Sonenschein in their journal.³⁶⁶ Three years earlier, Sonenschein, a Kinsey Institute researcher, had been charged with distributing child pornography. He claimed that the materials pertained to his research and that the particular

³⁶³ “For Sale,” *NAMBLA Bulletin* no. 6, July 1980, Pedophilia Collection.

³⁶⁴ “PIE TOP 20,” *MAGPIE: Journal of the Paedophile Information Exchange*, October-December 1979, Pedophilia Collection.

³⁶⁵ “an introduction to pie,” n.d., Pedophilia Collection.

³⁶⁶ David Sonenschein, “On Having One’s Research Seized,” *Journal of Sex Research* 23, no. 3 (Aug 1987).

photos in question had been taken from a mainstream magazine. Police had seized all of his research materials as part of the investigation. His article outlines a long history of the censorship of sexological research—he notes that the FBI had monitored Kinsey, that California State University at Long Beach had fired two sexologists in 1982 for “promoting homosexuality,” and even that Magnus Hirschfeld’s sexological institute had been raided by Nazis in 1933. By placing himself in this lineage, Sonenschein simultaneously affirmed his own legitimacy as a researcher and pointed towards attempts at censorship (in this case, laws that banned mere possession of child pornography) as moral hysteria bordering on fascism. While it is not clear whether Sonenschein considered himself a pedophile—nor whether his claims that his research materials had not been pornographic were true—Sonenschein engaged repeatedly with groups like NAMBLA and his presentation of himself as nothing more than a respectable researcher was questionable at best.

Two years later, SSSS’ annual conference would include a panel on pedophilia featuring members of NAMBLA. SSSS had, for many years by that point, included panels and speakers on a variety of feminist concerns, as well as work on psychiatric treatment for sex offenders.³⁶⁷ In fact, SSSS’s leanings were well known enough that the first panelist opened with a statement that “We’re not a politically correct panel. There’s not a woman on the panel. And what we’re about to see is totally not politically correct.”³⁶⁸ In the interest of fairness and objectivity, however, the

³⁶⁷ SSSS’ involvement with psychiatric treatment for sex offenders marks SSSS as an organization that groups like NAMBLA should be rightfully opposed to—as discussed in chapter 1, members of SSSS were involved in court-mandated therapy programs, which NAMBLA deeply opposed. But the chance at legitimacy appealed enough to many NAMBLA members and affiliates to override these concerns.

³⁶⁸ “Pedophilia and Adult-Child Sexual Contacts: Continuities and Discontinuities,” audiotope, 1989, Society for the Scientific Study of Sexuality Collection, The Kinsey Institute for Research in Sex, Gender, and Reproduction, University of Indiana at Bloomington (hereafter, Society for the Scientific Study of Sexuality Collection).

conference allowed for these explicitly pro-pedophile views to be given. Altogether, while not everyone in academic circles supported pedophilia, the general impulse was to support their right to speak.

These attempts at legitimacy, however, would not always serve NAMBLA well. Rather, some would argue that the existence of academic support for pedophilia suggested not that pedophilia was legitimate, but instead that sexology itself was illegitimate. In a 1981 issue of *Time*, John Leo suggests that “a disturbing idea is gaining currency within the sex establishment: very young children should be allowed, and perhaps encouraged, to conduct a full sex life without interference from parents and the law.”³⁶⁹ Leo further argues that typical values among sexologists and other researchers were a mere smokescreen for pedophilia:

Most of the researchers, doctors and counselors... have the wit to keep a low profile and tuck the idea away neatly in a longer, more conventional speech or article. The suggestion comes wrapped in the pieties of feminism (children, like women, have the right to control their bodies) and the children’s rights movement (children have rights versus their parents).

Rather than representing legitimate views, such ideas “fall just short of a manifesto for child molesters’ liberation.” And these views were not so coded as to be invisible; rather, pedophiles had “learned to pick up the rhetoric of sexologists.” Ultimately, “in the world of sexology prestige comes from attacking taboos as repression, not from assessing the psychological damage of the ideas unleashed.” In other words, sexologists had no concern for the ways in which their ideas shored up pedophiles and, as a result, the whole enterprise was morally bankrupt.³⁷⁰

³⁶⁹ John Leo, “Cradle-to-Grave Intimacy,” *TIME*, September 7, 1981, Women Against Pornography Collection, The Arthur and Elizabeth Schlesinger Library on the History of Women in America, Harvard University (hereafter, Women Against Pornography Collection).

³⁷⁰ See Chapters 1 and 2 for a discussion of the APA’s response to arguments that it had a responsibility to deal with the legal repercussions of the *DSM*.

Moreover, NAMBLA's relationship with expertise was not always a positive one. At the 1989 SSSS panel mentioned above, one panelist argued that religious restrictions on pedophilia had merely been replaced with pseudo-scientific ones; in his words, "we've replaced... the black cassock with the white laboratory coat."³⁷¹ A second panelist, NAMBLA member David Tsang, took this point even further: "If the clerical garb has been replaced by the white coat of the scientist, it's being increasingly replaced by the policeman."³⁷² And indeed, this putative relationship between scientific knowledge and police and state power was a significant platform for NAMBLA. Anti-child sexual abuse advocates—including feminists and researchers—were increasingly working with police to develop profiles for law enforcement purposes, and with the state to create new laws against child pornography. This advocacy network would ultimately result in laws in a number of states that allowed for the indefinite civil commitment of sexual predators after they had served their prison sentences.³⁷³ As well, the relationship of NAMBLA and the women's movement to social science—both accepted and rejected it at various times—underscores the increasing politicization of expert knowledge in the 1980s.

Children's Rights to What?

Equally as important as NAMBLA's attempts to frame itself as a gay rights organization was framing its relationship with children as a positive one. NAMBLA had a variety of platforms regarding children, including various anti-child abuse positions, an involvement with children

³⁷¹ "Pedophilia and Adult-Child Sexual Contacts: Continuities and Discontinuities," audiotape, November 11, 1989, Society for the Scientific Study of Sexuality Collection.

³⁷² It's worth noting that Tsang also calls for more "objective" research in the same talk.

³⁷³ For some of the issues posed by these laws, see Jill S. Levenson, "Reliability of Sexually Violent Predator Civil Commitment Criteria in Florida," *Law and Human Behavior* 28, no. 4 (August 2004). Levenson argues that the psychiatric criteria invoked in these statutes are neither rigorous nor reliable enough to support their use in criminal statutes. See also chapter 5 and the conclusion of this dissertation for brief discussions of SVP laws.

and youth liberation groups, arguments about the existence of child sexuality and children's rights, and the role of intergenerational relationships in the lives of gay youths.

Pedophile organizations typically opposed circumcision and corporal punishment.³⁷⁴ These were not merely passing opinions, but came up repeatedly in pedophile publications. For instance, *MAGPIE* devoted an entire issue to corporal punishment, and also included a long-running feature entitled "Children's Rights Report." One of these reports discussed British "Secure Units" where children too young for Detention Centers were placed.³⁷⁵ The article notes that children placed in these units fell into a few categories: not just boys convicted of serious crimes, but also runaways, "unruly" or "disturbed" children, those "requiring special medical supervision" such as epileptics and diabetics, and "boys who show overt homosexual tendencies." Among other details, the piece notes that boys in these facilities still used chamber pots, because bathrooms would increase costs. While the facility's principal officer said he had "come to regard slopping out [the chamber pots] as a useful exercise," the author of the *MAGPIE* piece suggested instead that the office actually saw it as an "exemplary degradation technique." Altogether, the practice underscored Britain's "inhumane," "indecent" treatment of children.³⁷⁶

³⁷⁴ On discussions of these issues, see Valida Davis, "Feedback," *NAMBLA Bulletin* no. 7 (August-September 1980); David Groat, "Circumcision: Infant Rape," *NAMBLA Bulletin* 4, no. 3 (April 1983); page 3 of *NAMBLA Bulletin* 8, no 6 (July-Aug 1987). See also *MAGPIE* 18 (1982) for an issue dedicated to discussing corporal punishment. All sources from the Pedophilia Collection.

³⁷⁵ Tim Gibbon, "Kids in Cages," *MAGPIE* 15 (Spring 1981), Pedophilia Collection.

³⁷⁶ These positions were not limited only to those that would affect boys—one of NAMBLA's official positions was opposition to laws that restricted girls' access to abortion by requiring parental consent. Thorstad's opinions on abortion more generally mirrored feminist concerns. He writes, "Abortion is a complex moral, ethical and social question, above all for women who face the prospect of bearing an unwanted child in a society that provides virtually no social infrastructure for rearing such children in love and dignity." Moreover, right-to-life policies reduced women to "baby-making machines." See David Thorstad, "Feedback," *Bulletin* 6, no. 2 (March 1985), Pedophilia Collection. Less dire issues than abortion and juvenile incarceration also made their way into pedophile publications. For instance *MAGPIE* reprinted Benjamin

This sort of investigative reporting on the abuse of children was not uncommon among pedophile publications.

More often, however, pedophiles spoke about neglect. Pedophiles argued that western society was not only sexually impoverished, but also emotionally neglectful of its children. One NAMBLA member writes, “Children’s growing up is commonly an experience of insufficient love, of rejection, punishment, the nurture of traitorous guilt.”³⁷⁷ Pedophiles, rather than coercing children into unwanted sexual relationships, were merely fulfilling an emotional need.³⁷⁸ More flippantly, Thorstad refers to boy-lovers as “crying towels” for boys and argues that the pedophile “is often the only person, child or adult, with whom a boy can share and discuss his innermost feelings.”³⁷⁹ The image of the pedophile as emotionally available adults in boys’ lives was sometimes reflected in anti-pedophile spaces as well. For instance, the STEPS program discussed in chapter 3 regarded emotionally unavailable fathers as a significant issue for their juvenile patients, and expended significant time in family therapy on this issue. Likewise, a Postal Inspector publication on child pornography notes that “it is not uncommon for a pederast to be more attentive to the wishes of the boy and to devote much more time to him than would be

Spock’s open letter in favor of breastfeeding. See: “An Open Letter from Benjamin Spock md,” *MAGPIE* 14 (October-December 1979), Pedophilia Collection.

³⁷⁷ “One Member’s View,” *MAGPIE* 15 (Spring 1981), Pedophilia Collection. This member also connected childhood emotional neglect and sexual repression to rigidity and authoritarianism and confusion and conformism. Similar ideas were also taken up by the women’s movement in discussing child sexual abuse. See Beryl Satter, “The Sexual Abuse Paradigm in Historical Perspective: Passivity and Emotion in Mid-Century America,” *Journal of the History of Sexuality* 12, no. 3 (July 2003).

³⁷⁸ Sometimes these pronouncements sound especially sinister to our post-child sexual abuse era ears. For instance: “Swedish kids are quite simply starved of sympathetic adult companionship, and this, together with their social independence, makes it delightfully easy to form friendships with them.” Keith Spence, “Report from Sweden,” *PAN*, reprinted in *NAMBLA Bulletin* no. 5 (June 1980), Pedophilia Collection.

³⁷⁹ Interview with Thorstad, *SEMIOTEXT(E)*.

given by a parent.”³⁸⁰ This emotional angle formed part of public opinion, even for those actively opposed to pedophilia.

In many cases, pedophiles emphasized the shortcomings of parents: absent fathers and alcoholism characterized boys’ families quite often, if NAMBLA members were to be believed. This easily lent itself to a negative portrayal of pedophilia, with researchers characterizing the children targeted as “vulnerable” or “needy,” and thus easy prey. NAMBLA, naturally, had a different interpretation: at the 1989 SSSS Conference, one panelist criticized those studies and instead argued that these children were “lonely” and in need of the “attention” that pedophiles offered.³⁸¹ From an objective viewpoint, the panelist and the researchers he criticized were describing the same group of children. For the panelist, however, this kinder gloss reflected a belief that children suffering from emotional neglect could only be helped, not hurt, by the attentions of pedophiles.

NAMBLA also presented itself as “not an organization for pedophiles, but an association for anyone who believes that men and boys have the right to determine for themselves the course of their lives,” including the boys themselves.³⁸² From its founding, NAMBLA had counted a small number of boys among its members and, throughout the 1980s, continued encouraging young people to join.³⁸³ As well, NAMBLA sporadically republished materials from organized youth movements.³⁸⁴ Many of the *Bulletin*’s recurring features reflected this openness to young

³⁸⁰ “The World of Pedophilia and Child Pornography,” Chief Postal Inspector Law Enforcement Report, Women Against Pornography Collection, Women Against Pornography Collection.

³⁸¹ “Pedophilia and Adult-Child Sexual Contacts: Continuities and Discontinuities.”

³⁸² Chris Farrell, “Status Offender,” *NAMBLA Bulletin* 7, no 1 (January-February 1986), Pedophilia Collection.

³⁸³ Thorstad, “Man/boy Love.”

³⁸⁴ See, for instance, Joel Andreas comic, reprinted from *FPS Magazine* in *NAMBLA Bulletin* 7, no. 1 (January-February 1986), Pedophilia Collection.

members. In particular, a featured called “The Unicorn” ran for over a year and purported to be written by an eleven year old.³⁸⁵

Adult members’ writing also reflects an interest in the goings-on of young people’s lives. Notably, Chris Farrell’s “Status Offender” feature was dedicated to discussing youth culture. Among his topics are reviews of movies popular among teenagers (the Sid and Nancy movie offered “ample evidence that the movers and shakers of the punk movement were really young—kids in their teens who issued a challenge to the leisure industry controlled by multi-national corporations”) and curfews and laws against cruising (Farrell writes that aimless driving at late hours was a popular activity among teens; these laws were “a way to control kids’ leisure time...teens are being wrapped in a seamless web of adult supervision, learning that true American pleasure comes only from spending money for goods and services”).³⁸⁶ In another feature, Farrell discusses a fifteen-year-old who was tried as an adult and convicted of shooting a police officer. Farrell writes, “That’s the kind of legal double jeopardy that points up the lengths American society will go to preserve the notion of childhood innocence. The ‘logic’ must go something like this: children are innocent, cop shooters aren’t innocent, so a kid who shoots a cop really isn’t a kid at all.” While it’s true that NAMBLA never counted a large number of boys among their members, these features portray the group as legitimately interested in issues affecting youth, whether positive or negative.

Of course, the primary issue in question was the right of children to consent to sex. NAMBLA’s official position here was a radical one—not to lower the age of consent, but to

³⁸⁵ Segments appeared sporadically throughout the early 1980s. For #11, see *NAMBLA Bulletin* 5, no. 7 (November 1984), Pedophilia Collection. The child turned 12 at some point over the course of the story’s publication, and the subtitle (“written by an eleven year old faggot”) was changed to reflect this.

³⁸⁶ Chris Farrell, “Status Offender,” *NAMBLA Bulletin* 8, no. 1 (January-February 1987), Pedophilia Collection.

abolish it entirely. This was, at least in part, a political move. Thorstad notes, “We did not feel we could afford to compromise on this issue, or in effect to sell out men who may be involved with prepubescent boys. Nevertheless, we’re primarily concerned with relationships involving teenage boys, which are far more common.” Thorstad’s view here reflected the pragmatic reality of belonging to a small and embattled group like NAMBLA: while the majority of members (at least in his view) were interested in teens, every member counted and thus the group could not afford to turn away men interested in younger children. As well, it reflected the ethos of his broader social milieu—Thorstad’s stance was a particularly wide application of the gay liberationist philosophy that drawing lines around acceptable versus unacceptable sexual behavior was a misguided enterprise that was, by its very nature, oppressive.

In supporting their position on the age of consent, NAMBLA put forward two arguments: the first involved again invoking expertise, and the second hinged on children themselves. By the 1980s, a number of researchers had argued for the existence of child sexuality.³⁸⁷ As noted above, John Money wrote on the subject. As well, Thorstad invoked Kinsey, whose research included a chapter on the “pre-adolescent orgasm.”³⁸⁸ He also noted that according to Kinsey’s

³⁸⁷ Alongside these scientific discourses, a feminist discourse on childhood sexuality existed. NAMBLA engaged with this relatively rarely, though Kate Millet’s interview in the *SEMIOTEXT(E)* issue discussed throughout this chapter demonstrates its presence. For examples of feminist discussions of the existence of childhood sexuality, see: Kate Millet, “Beyond Politics? Children and Sexuality,” in Carol S. Vance, ed., *Pleasure and Danger: Exploring Female Sexuality* (Boston, 1984); Shulamith Firestone, *The Dialectic of Sex: The Case for Feminist Revolution* (New York, 1970). Firestone argues that the repression of childhood sexuality “was the basic mechanism by which character structures supported political, ideological, and economic serfdom are produced.” Beryl Satter discusses the connections between these feminist readings of childhood sexuality and the philosophy of Wilhelm Reich. See Satter, “The Sexual Abuse Paradigm in Historical Perspective: Passivity and Emotion in Mid-Twentieth Century America,” *Journal of the History of Sexuality* 12, no. 3 (2003).

³⁸⁸ Thorstad also Kinsey’s use of pedophiles’ accounts in his research in order to position pedophiles as the real experts on boyhood sexuality. To wit, “Did you know that he gave credit to pederasts as his best sources of information on this particular subject? It stands to reason,

research, men's sexual peak occurred in their teens, whereas women's occurred in their late twenties. To Thorstad, this again suggested that boys were naturally and biologically sexual. Moreover, this was not a recent discovery; instead, it went back to Freud's discussions of infantile sexuality and the Oedipal complex. By the 1980s, these discussions were widespread and the existence of child sexuality was generally accepted. Indeed, Lotringer notes, "No one today can deny—at least intellectually—that the child is a sexual being in his own right."³⁸⁹

But none of this was necessarily evidence that the age of consent should be abolished. Many observers—legal, feminist, and otherwise—argued that, in order to account for the reality that young people would engage in sex, the age of consent should be lowered rather than abolished altogether. Most notably, in 1979 a NOW Rape Task Force in New Jersey argued that the state's age of consent should be lowered from sixteen to thirteen.³⁹⁰ They also proposed that criminal charges only be brought in cases where one party was more than four years older than the other—that is, a thirteen year old could sleep with a seventeen year old, but not an adult. This was partly a response to the ways in which age of consent laws were written at the time—most states did not have close-in-age exceptions, and in many states, even consensual sex between minors of the same age was illegal. The New Jersey case ended in a battle between NOW and local parents and state officials that eventually forced NOW to back down and left the state's age of consent at sixteen. By the mid-1980s, the age of consent would become an issue intimately wrapped up with concerns about pedophilia. But in 1979, the women's movement had not yet come to think of the issue in this way.

because boy-lovers were the ones who had observed most closely the transformation of orgasm among boys, from early ages on into later ones, and over a long period of time. No one else, including a boy's parents, has ever been able to do this" (Thorstad interview, *SEMIOTEXT(E)*).

³⁸⁹ Lotringer, "Editorial," *SEMIOTEXT(E)*.

³⁹⁰ Martin Waldron, "Age of Consent in New Jersey Expected to Revert to 16," *New York Times*, May 3, 1979.

For NAMBLA, however, the whole debate was misguided. Thorstad refers to the patchwork nature of age of consent laws and sodomy laws in America as a “legal swamp.”³⁹¹ Moreover, “The very confusion on just when the magical age of consent is proves that nobody knows when a child becomes capable of consenting to sex. This in itself is a compelling argument for getting rid of laws that pretend to do what is patently impossible.” Rather than arguing about where to place an arbitrary line, then, Thorstad and NAMBLA proposed to erase it entirely.

Beyond being arbitrary, NAMBLA saw the age of consent as conceptually problematic. PIE writes, “The whole concept of an ‘age of consent’ is a denial of children’s rights in that, whilst acknowledging their right to say ‘no,’ it denies them the right to say ‘yes.’”³⁹² Moreover, young people weren’t even consulted in regards to the question of consent. Mark Moffatt, a fifteen-year-old member of NAMBLA, notes, “No one seems to believe that before 18 a person is capable of making an intelligent decision. No one under 18 is even valued in his opinion on anything.”³⁹³ Denying children the right to consent was to deny their personhood and intelligence in some fundamental way. Here, again, the ability to consent to sex *with adults* was important: Thorstad opines, “Instead of learning about sex from an experienced adult, if they so desire, young people are told they can only have sex with each other... It’s as though every

³⁹¹ Interview with Thorstad, *SEMIOTEXT(E)*.

³⁹² “an introduction to pie.” NAMBLA was not alone in using the language of “rights.” For the women’s movement, a child’s right to say no, cause a scene, or lie to a potential predator was fundamental. Moreover, the anti-CSA movement did sometimes involve an explicit disavowal of childhood sexuality. For example, psychiatrist Edward Ritva stated, “Childhood sexuality is like playing with a loaded gun” (Leo, “Cradle-to-Grave). NAMBLA’s response to this position was that sex was healthy and not to be feared. Moreover, such denials might produce maladjusted adults (See Satter, “The Sexual Abuse Paradigm”).

³⁹³ Interview with Mark Moffatt, *SEMIOTEXT(E)*.

generation were condemned to reinvent the wheel.”³⁹⁴ Adults, for Thorstad, offered children not only emotional support, but sexual tutelage.

This position on the age of consent led many to question whether or not NAMBLA’s children’s rights platform was merely self-serving. Feminist Kate Millet, for instance, argued in favor of many of NAMBLA’s positions:

Children have virtually no rights guaranteed by law in our society and besides, they have no money which, in a money-economy, is one of the most important sources of oppression. Certainly, one of children’s essential rights is to express themselves sexually... The sexual freedom of children is an important part of sexual revolution.³⁹⁵

Yet Millet also insisted that that NAMBLA was approaching the age of consent issue not as a children’s rights issue, but primarily as an issue of adults’ rights to have sex with children. The reversal was important in that it suggested that NAMBLA’s interest in children’s rights to consent was driven more by adult member’s sexual desires than any sincere interest in the thoughts and wellbeing of children. In support of this point, she notes, “It seems as though the principal spokespeople are older men and not youths.” Yet NAMBLA had young members and the very same issue of *SEMIOTEXT(E)* included an interview with one of them. Moreover, Millet’s interviewer notes that “most gay male youth groups” supported lowering or abolishing age of consent laws. As well, he suggests that “the rhetoric of pedophilia—that of the older men speaking out for the sexual freedom of boys—reflects the underlying powerlessness of children. One could say that it is *symptomatic* of this powerlessness.”

Ultimately, Millet may have been right. While the question posed by Millet’s interviewer on symptom versus cause was compelling within a theoretical framework, the reality on the ground was less favorable to NAMBLA. Despite their publications, it’s not clear how much

³⁹⁴ Interview with Thorstad, *SEMIOTEXT(E)*.

³⁹⁵ Interview with Kate Millet, *SEMIOTEXT(E)*.

actual advocacy work NAMBLA did on behalf of young people. It was also true that the majority of their members were adults. Moreover, a cursory look at Moffat and Thorstad's language reveals some troublesome information. Both Moffat and Thorstad acknowledged that intergenerational relationships were rarely equal in any meaningful sense. Thorstad, throughout his interview, waffles on what precisely intergenerational relationships offer. At one point, he refers to them as "mutually rewarding learning experiences" characterized by "patience and kindness." But at another point, the men in these relationships are "crying towels for boys," in addition to performing "many other social services without either salary or recognition." This odd statement placed pedophiles in yet another hierarchical position over boys while simultaneously opining their supposedly subordinate position. As well, his language comes across as self-pitying, and emphasizes the emotional neediness of boys. Similarly, Thorstad alludes to the relative emotional immaturity of children throughout the piece—they may not be "ready psychologically" for penetrative sex, and can't be discussed "in terms of love in the adult sense." Thorstad was ultimately a romantic, however; boys' emotional immaturity represented, for him, "a healthier attitude" rather than a shortcoming.

Moffatt, for his part, displayed a more pragmatic attitude. He notes that when he realized he was gay, what he "needed emotionally was friends" and that his relationships with men were primarily sexual. And although Moffatt agreed with Thorstad that boys were often the aggressors in intergenerational relationships—that is, boys sought men out for sex more often than the other way around—he seems to be more cognizant of the potential problems here. He notes that boys are "out-powered" and could "of course" be sexually assaulted. He also says that his first relationship involved going home voluntarily with a man who, despite his requests not to, penetrated him. Where Thorstad would dismiss the question of coercion with a pat statement that

“boys know the difference between consent and rape,” Moffat’s reluctance to call what happened to him abuse indicates that questions surrounding consent remained difficult and were perhaps particularly so for young people with little experience.³⁹⁶ As well, Moffatt agreed that age of consent laws should be abolished, but only after “coercion laws” had been strengthened. He states, “As it stands now, a lot of [pre-pubescent] kids would be in danger since they don’t know that much about sex and relationships.” Thorstad’s take? “The younger the boy is, the more responsible the man must be.” In all, while the two agreed on the big points, the details indicate that Thorstad was less concerned with the potential problems in intergenerational relationships than his younger counterpart.

Still, despite perceptively noting the centrality of adults’ sexual desires to NAMBLA’s children’s rights platform, Millet inadvertently underscored NAMBLA’s argument that adults dismissed children’s voices and concerns. In her interview, she not only criticized NAMBLA, but also gay youth organizations. While Millet argues that children should have sexual rights, she also says in regards to gay youth organizations that she “would think that given the conditions under which you’re a young person in this country, many things would be at least as important to you as your sexuality”—in other words, gay youth organizations should be less concerned with sex and more concerned with things that really mattered. Never mind that age of consent laws in many American states at that time placed the age of consent for male-male sex higher than the age for male-female sex,³⁹⁷ if they allowed for male-male sex in the first place.³⁹⁸

³⁹⁶ When the interviewer asks Moffat if he’s ever been “abused,” he says he has. After the anecdote, he says, “I don’t know how you’d call it since it wasn’t me being dragged on to his house.”

³⁹⁷ Interview with Thorstad, *SEMIOTEXT(E)*. As well, the age of consent was a particularly pressing issue for gay youth in the UK, where the legal age of consent for male-male sex was set at 21, but the age of consent for heterosexual sex was set at 16.

This was not the last time that young people’s contributions to debates over sexuality would be dismissed. In fact, a few months after *SEMIOTEXT(E)* was published, Moffat himself would receive a lukewarm reception at a march in New York City. After Moffat defended NAMBLA from activists who tried to force the group to leave the march, he was “booed by a clique from NOW—the only time I have seen presumably straight supporters boo a gay speaker at a gay rally.”³⁹⁹ Preparations for the 1979 March on Washington had been marked by a similar conflict. The National Coordinating Committee had initially adopted a Gay Youth Caucus proposal for revising age of consent laws. But at a National Coordinating Committee meeting, a group of lesbian activists threatened to split from the group unless a substitute for the proposal was adopted. Thorstad notes that the new proposal was “drafted by adults.”⁴⁰⁰ While the new proposal was drafted to “protect” gay youth from discrimination and oppression, it still represented a moment in which the voices of gay youth were eclipsed within the gay community. Moreover, a few months later, lesbian activists in the New York Coalition for Lesbian and Gay Rights succeeded in having the issue labeled “divisive” and stated that “so-called Man/Boy Lovers are attempting to legitimize sex between children and adults by confusing the real needs of Gay Youth with a call to *repeal all* age of consent laws.” This action precluded any further activism by NAMBLA *or* the Gay Youth Caucus, and framed the debate in a way that summarily excised the Gay Youth Caucus’ earlier contributions. While feminist activists may have been

³⁹⁸ For a history of sodomy laws in America, see: William N. Eskridge, *Dishonorable Passions: Sodomy Laws in America* (New York: Viking, 2008). Legal discrepancies between gay and straight sex remained in a number of states into the 2000s—in particular, some “Romeo & Juliet” statutes (those laws that decriminalize sex between close-in-age young people) are written to include only heterosexual sex. This meant, functionally, that homosexual sex remained criminalized in circumstances that involve age gaps. On this, see: Michael J. Higdon, “Queer Teens and Legislative Bullies: The Cruel and Invidious Discrimination Behind Heterosexist Statutory Rape Laws,” *UC Davis Law Review* 42 (2008).

³⁹⁹ Thorstad, “Man/boy Love.”

⁴⁰⁰ Thorstad, “Man/boy Love.”

correct about NAMBLA's motivations, the way they went about things affirmed NAMBLA's arguments that young people had little political capital in the social movements of the 1980s.

The idea that people who denied the existence of child sexuality and children's ability to consent had failed to listen to children and trust them was a popular pedophile platform. At the 1989 SSSS conference discussed earlier, a panelist argued that researchers and feminists who took a hard-line stance against pedophilia were engaging in a discourse of "victimology."⁴⁰¹ There were, he argued, many adults who fondly remembered the intergenerational relationships of their youth, but the "true believers of victimology... would accuse him of being deluded by his positive experience and argue instead that he was really a victim, that he didn't know what he was doing." This criticism was not entirely unfair. Most feminists did see adult-child sexual contact as universally abusive.⁴⁰² Yet feminist advocacy around the issue of rape and domestic violence emphasized the necessity of listening to victims, even those victims whose feelings about their experiences were muddled.⁴⁰³ In fact, throughout the 1970s and 1980s, an extensive feminist discourse on the paradoxical nature of rape and domestic violence flourished, with feminist advocates acknowledging that many victims continued to sympathize with and care about their abusers. Rather than taking any of this as a reason to blame victims of those crimes or

⁴⁰¹ "Pedophilia and Adult-Child Sexual Contacts: Continuities and Discontinuities."

⁴⁰² There were, of course, exceptions. As discussed in this chapter, some radical feminists like Kate Millet, Pat Califia and Shulamith Firestone acknowledged the existence of childhood sexuality and wondered what boundaries ought to be drawn around it.

⁴⁰³ This is most visible in Lenore E. Walker's work on domestic violence. Walker is responsible for the theory of a "cycle of abuse," which had three stages: growing tension, an incident of abuse, and a honeymoon phase. During the honeymoon phase, Walker argues, the abuser attempts to make amends and, once forgiven by the victim, begins the cycle anew. As well, her proposed diagnosis of "battered women's syndrome" included an acknowledgement that victims of domestic violence typically blamed themselves—while this was largely the result of the fear and low self-esteem that abuse fostered, it was also tied to feelings of love for the abuser.

dismiss such mixed feelings out of hand, however, feminists argued that knowledge about these paradoxical effects produced better strategies for intervention.⁴⁰⁴

Despite this discourse, feminists simply did not extend this framework to pedophilia. In fact, feminists sometimes explicitly dismissed people who recalled positive or neutral experiences from their childhoods. Feminist psychologist Paula Caplan writes, about a friend who did not believe that the experience had harmed him that, “He cannot keep his attention on the fact that for most children, in the misogynist, violent and sexually repressive society in which we are living right now, most adult-child sexual contact is disturbing, upsetting, enslaving, and often violent.”⁴⁰⁵ Caplan’s argument here was that the social context in which America found itself in the 1980s did not allow for positive adult-child relationships, because children (and girls in particular) were treated as objects.

While this was partly due to a disconnect between how feminists thought about adult victims versus child victims, it also hinged on a reading of child sexual abuse and child pornography as a form of male power over women and girls.⁴⁰⁶ In some cases, the assumption

⁴⁰⁴ This was, again, particularly important for domestic violence. By the mid-1980s, it was clear to feminist and legal observers that battered women frequently recanted testimony and returned repeatedly to their abusers. Women like Walker sought to explain such behavior in order to provide more realistic treatment and legal strategies. In particular, recognition of the complicated emotions that accompany domestic violence has resulted in the passage of numerous mandatory arrest laws, which require police to arrest at least one partner whenever an incident of domestic violence is reported. On this, see: Elizabeth Pleck, *Domestic Tyranny: The Making of American Social Policy Against Family Violence from Colonial Times to the Present* (University of Illinois Press, 2004).

⁴⁰⁵ Caplan, review of *The Best Kept Secret*.

⁴⁰⁶ Satter discusses both of these disconnects. She attributes feminist anti-CSA advocates’ concentration of girl victims to a more generalized feminist theory that was predicated on a gendered model of violence, as well as to a model which specifically cited sexual abuse of girls as a patriarchal socialization method designed to produce compliant women (see Florence Rush, “The Sexual Abuse of Children: A Feminist Point of View,” in Connell and Wilson, eds., *The First Sourcebook*). Moreover, Satter argues this was a response to earlier social concerns in the 1950s about protecting boys from overbearing mothers; with anti-CSA advocacy in the 1980s,

that victims are girls is made explicit. Janet O'Hare, a member of the New York Women Against Rape, writes that "sexual assault on children functions as a form of social conditioning that is the first step in teaching women their powerless place in society."⁴⁰⁷ Even more notable is a statement from activist organization Women Against Pornography on child pornography laws in New York. The author writes, "These images have the effect of legitimizing and condoning the sexual abuse of children, particularly little girls. We live in a patriarchal culture that allows boys and men to prey upon females."⁴⁰⁸ Not only were victims girls, then, but boys were also more likely to be predators than prey. Even worse, the statement then moves on to quote a letter from a victim of child sexual abuse. The writer of the letter details the sexual abuse that she and her brother suffered at the hands of their father. The abuse began when she was two; her brother was a mere two years older. That a statement eliding boys into adult male perpetrators could coexist with a graphic account of the sexual abuse of a four-year-old boy suggests that feminists had a very rigid and narrow framework for interpreting pedophilia.

For their part, NAMBLA would argue that each of Caplan's three points—misogyny, violence and sexual repression—did not apply to their organization. As for violence, NAMBLA consistently reiterated an anti-violence, anti-coercion position. At their tenth annual conference,

the question became one of protecting girls from fathers. As for the disjunction between attitudes towards adult versus child victims, Satter argues that feminists progressively turned from advocacy for children's rights to advocacy for adult women who had been victimized as children. This would grow into the "recovered memory" movement by the mid-1980s and more concrete advocacy work against child sexual abuse would fall to other groups. Robbie Duchinsky attributes the linkages between child sexual abuse and broader feminist concerns to the concept of sexualization—the sexualization of girls and any sexual abuse that came from it were seen by feminists as reflections of patriarchal attitudes towards women. See Duchinsky, "The Emergence of Sexualization as a Social Problem: 1981-2010," *Social Politics: International Studies in Gender, State and Society* 20, no. 1 (Spring 2013).

⁴⁰⁷ Janet O'Hare, "Letters," *Soho News*, September 15, 1981, Women Against Pornography Collection.

⁴⁰⁸ "Work File on Child Porn Laws," June 1981, Women Against Pornography Collection.

a workshop paper stated, “Forcible penetration is mentally and physically damaging... This should be a principle area of analysis when we consider feminist critiques.”⁴⁰⁹ As well, NAMBLA reprinted an article from *The Other Voice* that stated, “Gay shows that egalitarian relationships are possible and fulfilling. Gay liberation is distinct from sexual revolution in that we reject the notion that the penis is necessarily entitled to whatever he stands up for.”⁴¹⁰ PIE had a similar stance. Their membership form states, “Most paedophiles desire gentle, loving and mutually-pleasurable relationships... PIE is opposed to the rape or physical assault of anyone, regardless of age.”⁴¹¹ In all, then, physical violence was antithetical to the stated positions of pedophile organizations. Moreover, such organizations were willing to consider feminist and gay liberationist discussions of power within sexual relationships.

While the fundamental question about children’s ability to consent versus being coerced remained, public and legal opinions frequently reaffirmed NAMBLA’s stance that men who targeted young boys did so without overt violence. The earlier Postal Inspector’s statement claims, “Rarely does a pederast physically abuse a child.” Ann Wolbert Burgess, a nurse involved with anti-child pornography measures, noted that many pedophiles photographed boys, but did not actually touch them.⁴¹² And among those who did, the touching was not apparently accompanied by physical violence. She notes instead that pedophiles “play on the normal interests of young children who are often in a period of their lives in which sexual

⁴⁰⁹ Power, “1986 Los Angeles Conference Report,” 1986, Pedophilia Collection.

⁴¹⁰ “Gay Liberationism,” *NAMBLA Bulletin* 8, no. 1 (January-February 1987), Pedophilia Collection.

⁴¹¹ “an introduction to pie.”

⁴¹² Tom Reeve, “Trashing the Party of the Nutty Nurse,” *Gay Community News* 13, no. 20 (1980).

experimentation is part of the psychological development.”⁴¹³ Moreover, these men “know what appeals to children of that age—things like having secrets from parents, being part of a special group and the illicit pleasure of grownups; sex, drugs and alcohol.” In all, then, pedophiles might be coercive and dangerous, but they weren’t physically violent in the eyes of most observers.

In some ways, this came down to a question about the extent to which individual relationships are dictated by their social context. For pedophiles, relationships needn’t necessarily reflect preexisting social inequalities. Chris Farrell, NAMBLA’s spokesperson, writes, “Just because classes of people aren’t the same doesn’t mean that relationships between individuals in those classes must reflect the artificial differences society creates between them.”⁴¹⁴ Moreover, to the extent that intergenerational relationships *were* dictated by their social contexts, they were controlled not by men, but by boys. Thorstad put this most boldly:

The boys usually control these relationships... These are probably the most democratic of all relationships, despite the age disparities and the risks for the man. Any boy who is harmed by a man has only to report him. The fact that they rarely do shows not that man/boy sex is rare, but only that it is harmless and fun.⁴¹⁶

In other words, while men might have more power than boys in general, pedophiles were at a substantial enough disadvantage (both legally and socially) to render boys the more powerful partners in any given relationship. Beyond this and in keeping with gay liberationist rhetoric,

⁴¹³ Daniel Goleman, “Complex Coercion Binds Sex Rings Using Children,” *New York Times*, May 8, 1984, Women Against Pornography Collection.

⁴¹⁴ Chris Farrell, “Feedback,” *NAMBLA Bulletin* 7, no. 1 (January-February 1986), Pedophilia Collection.

⁴¹⁵ Ironically, Chris Farrell compares pedophilia to adult heterosexuality, noting that men are bigger than women, wealthier than women, and have more rights than women. He asks “Would [they] campaign against heterosexuality as well as pedophilia? The answer is that some feminists would and moreover that the women’s movement’s anti-CSA stance relied on that very same analogy between pedophilia and heterosexuality.

⁴¹⁶ Interview with Thorstad, *SEMIOTEXT(E)*.

“loving relationships are one way to cross barriers, forge alliances and redistribute power,” and thus intergenerational relationships could be a force for social change.⁴¹⁷

For feminists, however, this vision was a utopian attempt to ignore social prejudice and power differentials. Kate Millet made this explicit in her *SEMIOTEXT(E)* interview. When asked if intergenerational relationships could be equal and loving, she responded, “Of course... [but] what I’m concerned about is the inequitous context within which these relationships must exist.” Attempts to change or abolish the age of consent without first resolving these issues meant that intergenerational relationships would retain an ‘inescapable inequality.’ Caplan had made a similar concession; it might be possible to have a positive experience, but social inequality prevented this in “most” situations.

Beyond this discussion of what to privilege (the individual relationship or its social context), there was still that disjuncture between which children were being discussed. For feminists, victims were implicitly girls. And while NAMBLA would periodically encourage men interested in girls to join, their ideas about pedophilia were firmly centered on boys. That NAMBLA thought of itself primarily as a gay organization would fundamentally shape its ideas on children, and lend itself to a very different interpretation than Caplan’s or Millet’s. Where Caplan would argue that sexual repression was something that happened to women and girls *within* relationships, NAMBLA would argue that sexual oppression of boys occurred as the result of a homophobic society that cut off gay youth from the gay community. Intergenerational relationships, for NAMBLA, were liberatory rather than oppressive.

⁴¹⁷ Pat Califia, *The Advocate*, October 30, 1980. Reprinted as “Women Against the New Puritans,” *MAGPIE* 15 (Spring 1981), Pedophilia Collection. Califia was not a member of NAMBLA, as far as I can tell, but did attend a NAMBLA conference in 1985.

Tom Reeves affirmed these ideas at a conference on “Controversial Sexuality,” where he argued that the backlash against the radicalism of the 1960s had played out in two ways: “to control sexuality and to control young people.”⁴¹⁸ The “segregation and professionalized handling of children,” combined with “the cutting off of gays into a ghetto thereby strictly limiting their liberating influence in the society at large,” left young gay people stranded in a sexually-repressive heterosexual world. When feminists, law enforcement, and politicians tried to protect children from sex, they contributed to the oppression of young gay people. Moreover, Reeves connected this repression back to social unrest (and the anthropological arguments discussed earlier): “Those societies which bury [childhood sexuality] do so to foster socially controlled violence. There is a link between the peacefulness of society and man/boy love.”

Feminist Pat Califia offered a similar, though less capacious, argument that “young lesbians and gay men don’t need to be protected from ‘corruption’ —they need protection from their repressive families, nonjudgmental information about human sexuality and gay lifestyles, and the economic freedom to make their own choices.”⁴¹⁹ While these issues were larger than pedophilia, pedophilia might play a significant role in alleviating the problems young gay people faced. Indeed, Califia argued that advocacy against NAMBLA was the same as “abandoning boy-lovers to the police and gay kids to their homophobic families.” For Califia, gay rights necessarily included the rights of young gay people, and those rights in turn included the right to consent to sex with people of any age. NAMBLA, which stood as one of the few organizations to explicitly advocate for these rights, could not be abandoned.

⁴¹⁸ Bill Bliss, “Sexuality in Society,” *NAMBLA Bulletin* 6, no. 2 (March 1985), Pedophilia Collection.

⁴¹⁹ Califia, “Women Against the New Puritans.”

In some cases, this was drawn from personal experience. Scott O’Hara, an adult film star, wrote to the *Gay Community News* in the wake of some controversy over NAMBLA. He writes, “Were none of these people ever teenaged, gay, and alone? Am I the only gay person to have learned a sense of identity from a 50-year-old gay man—who just happened to be great sex as well?”⁴²⁰ Likewise, Califia notes, “Many of us—both men and women—had our first homosexual experience with partners who were older than ourselves.”⁴²¹ For these individuals, NAMBLA represented a valued part of the gay community and intergenerational relationships a valued part of their own childhoods. As the gay community came under increasing fire from groups like Save Our Children, NAMBLA’s presence would become even more important. After NAMBLA’s ejection from the International Lesbian and Gay Association in 1994, O’Hara would state that not only would he have joined NAMBLA as a teen, but also that “Most of our supposed gay leaders are afraid to do anything with [gay youth]... That mean’s we’re leaving the sex education of our youth to angry heterosexuals who don’t understand... [NAMBLA] are the only ones willing to acknowledge that adolescents actually do have sex lives.”⁴²² For these individuals, anti-child sexual abuse advocacy groups had made membership in NAMBLA more dangerous for adults, and had also further separated gay youth from the broader gay community.

Some gay organizations shared the opinion that the gay community was not inclusive enough to young people. In 1979, the Mattachine Society released a statement that it had been trying to rectify this by encouraging gay youth to go on speaking engagements, having a young person on its Board of Directors, and lending its office space to young gay activists. Bob Burdick

⁴²⁰ Scott O’Hara, “CSW vs NAM/BLA: The Rage of Consent,” *NAMBLA Bulletin* 7, no. 7 (September 1986), Pedophilia Collection.

⁴²¹ Califia, “Women against the new puritans”

⁴²² “Scott O’Hara,” North American Association of Man/boy Love. Accessed February 1, 2015. <http://nambla.org/ohara.html>.

writes, “All of this, I hope, is a good sign that the ‘generation gap’ is a fantasy of the past.”⁴²³

Here, again, was a statement that suggested gay youths were a special group to which the gay rights movement had paid insufficient attention. But Burdick’s statement went further; he writes also that he hopes “that more and more liberation leaders will understand and accept the pedophile as another true exponent of the love between males of all ages.” There was no explicit connection here to work NAMBLA was doing on behalf of children; rather, Burdick simply associated the two on the basis of his belief in young people’s rights and NAMBLA’s public platforms regarding children’s rights.

In the early 1980s, then, there was a sense within certain segments of the gay community that it was more important to support gay youth than to vehemently oppose pedophilia or endorse measures that might inadvertently oppress young gay people. Few believed that targeting NAMBLA would solve the problem of rape or children’s abuse and oppression; rather, such movements were more likely to increase public homophobia. Moreover, campaigns against child sexual abuse were about “‘protection’ of the young and ignoring the *rights* of the young,” and “undoubtedly set back the aspirations of youth liberation.”⁴²⁴ In this context, pedophilia was “a secret not to be told” rather than a point against which to rally.⁴²⁵

Official Rhetoric and Contradictions

If the foregoing discussion of NAMBLA’s rhetoric presents the most positive image of NAMBLA possible, it should come as no surprise that an uglier side lurked behind it. For all that

⁴²³ “Mattachine V.P. on Pedophilia,” *Better Life Monthly* 2, no. 7 (July 1975), Pedophilia Collection.

⁴²⁴ Gayle Rubin, “Sexual Politics: The New Right & the Sexual Fringe,” reprinted in *MAGPIE* 16 (Autumn 1981), Pedophilia Collection.

⁴²⁵ Thorstad, “Man/boy Love.”

NAMBLA tried to present a particular face to the public, cracks showed through. In particular, as scrutiny of NAMBLA heated up throughout the mid- and late-1980s, the organization's rhetoric became more cautious and NAMBLA's leadership began making explicit statements that the organization did not condone sex with minors. Notably, Peter Melzer recounts NAMBLA's response to an instance of police infiltration in a 1987 issue of the *Bulletin*. Kevin Healy, an undercover NYPD agent, had joined NAMBLA in January 1983. Less than a month earlier, the NYPD had falsely accused NAMBLA of being involved with the disappearance of a local boy, and many NAMBLA members were on high alert.⁴²⁶ A member of the Steering Committee recalled Healy "asking me where the action was. He was looking for boys. I told him that he should act as if the Steering Committee were infiltrated by police, and that he should not break any laws."⁴²⁷ Another member recalled Healy asking for "pointers on making his 'boyfriend' more sexually pliable." That member was "a firm believer in consent" and advised Healy to "find another boyfriend." After a year of "apparently feckless behavior," Healy managed to enlist or coerce NAMBLA member Pat Ciricillo into his infiltration efforts. The ultimate result was the arrest of another member, Richard Bagarozzy, for having had sexual contact with three boys.

From this account, it seems that NAMBLA's newfound caution extended only to the behavior of the organization's leadership. Small details in this story indicate that NAMBLA exercised relatively little control over its membership. Healy engaged in "feckless" activity for nearly a year. The man he enlisted into his infiltration operation was, at that time, on probation

⁴²⁶ The missing boy was Etan Patz. His disappearance helped spark the missing children's movement. After his father began distributing photos of the boy, Patz became the first child to appear on the side of a milk carton. As of January 2015, the investigation into his disappearance has been reopened.

⁴²⁷ Peter Melzer, "Police Infiltrator: Part II," *NAMBLA Bulletin* 8, no. 1 (January-February 1987), Pedophilia Collection.

for “alleged sexual misconduct with a minor.” That neither of these men were kicked out of the organization is, perhaps, unsurprising given NAMBLA’s policy of accepting all people interested in pedophilia. But Melzer’s insistence on referring to Ciricillo’s crimes as “alleged,” even after he had been convicted, suggests that NAMBLA’s official position against coercion and rape was easier said than lived by. Despite numerous statements against abuse, NAMBLA apparently regarded all accusations to be false and thus implied that its members were incapable of abuse or rape. This is especially notable in Ciricillo’s case. Melzer refers to him throughout the piece as “larcenous” and talks about how Ciricillo manipulated an “emotionally-unstable” member and repeatedly played “games” where he tried to out members in order to get them fired. If Melzer could not imagine that a man who he clearly thought very little of was legitimately a child molester, then it’s hard to imagine what would change his mind.

Moreover, while Melzer argues that Bagarozzy was falsely accused, he also states, “the man/boy love movement cannot afford to discourage the vital contribution of people like Richard by taking the fatalistic view that mixing love and activism is always doomed.” Melzer was referring here to Bagarozzy’s purportedly non-sexual friendships with young men, but combined with the continued acceptance of a convicted Ciricillo and the clearly problematic Healy, it suggests that NAMBLA was more concerned with maintaining membership numbers and defending men accused of sex crimes than with taking a concrete stand against potential child abuse by its members.

As well, despite NAMBLA’s official position on the age of consent, the *Bulletin* was generally cautious in what it published. Members sometimes wrote openly about relationships with children, but rarely specified if they were younger than ten—a member might specify that he was involved with a fourteen-year-old, for instance, but generally the vague descriptor “boy”

was used. Moreover, the *Bulletin* rarely included any explicit discussions of sexual contact with children, though it did occasionally publish pieces eroticizing children.⁴²⁸ For the most part, then, NAMBLA and the *Bulletin* evidence a belief that all children should have sexual rights and that all pedophiles were welcome in NAMBLA, but that it was in NAMBLA's best interest not to acknowledge this too loudly.

Yet NAMBLA also published work by individuals whose positions on pedophilia were extremely and explicitly radical. Most notably, NAMBLA continued to publish articles by Valida Davila, founder of the Childhood Sensuality Circle, throughout the 1980s. On their face, Davila's articles are inoffensive and line up with NAMBLA's platforms regarding the rights of children to control their own sexuality. And, like NAMBLA, she opposed circumcision, corporal punishment, and emotional neglect. Yet while NAMBLA was careful to avoid the subject of younger children, the CSC "believe children should begin sex at birth. It causes a lot of problems not to practice incest."⁴²⁹ Likewise, when an article in the *Bulletin* declared sex with a four year old to be "just hypothetical," a reader responded with a letter describing a sexual act with a child of that age.⁴³⁰

⁴²⁸ One issue of NAMBLA included a poem, "the eroticism of banal architecture," by Hakim Bey. In the poem, a narrator sees "a skinny ten-year-old with mop of brown hair & cut-off jeans heading for the mens room" and follows him. The narrator then offers a florid description of the boy's penis and leaves "horny as a toad." See *NAMBLA Bulletin* 8, no. 1 (January-February 1987), Pedophilia Collection. This is one of the more graphic pieces in the *Bulletin*. More often, children are described in terms of their "fleeting beauty," as in Thorstad's *SEMIOTEXT(E)* interview.

⁴²⁹ Leo, "Cradle-to-Grave Intimacy."

⁴³⁰ The incident involved a 3 and a 5 year old at a nudist camp. The author writes that, "During a cuddling and tickling session (sensual and non-genital), the 3 year old playfully grabbed the adult's penis and placed it in his mouth for a few seconds before removing it. The adult was pleasantly surprised, but deliberately 'ignored' the token fellatio." Perhaps an ultimately harmless event, but made all the more sinister by the author's statement that the children's ages were "considerably above their calendar years." See "Feedback," *NAMBLA Bulletin* 6, no. 2 (March 1985), Pedophilia Collection.

As well, NAMBLA's position on children's rights and abilities would eventually be belied by their readership's response to the increasing barrage of CSA accusations. Officially, pedophile publications took pains to differentiate between consensual relationships and sexual abuse. In *Better Life*, an author writes that "if the child really has been shocked by the behavior of the adult or has been attacked or raped, then of course parents should take its side and show their love and sympathy."⁴³¹ Thorstad made similar claims—not only could boys "tell the difference" between consensual sex and rape, but they could also report abuse to the police.⁴³² Taken together with their criticism of victims' advocates disbelief in the positive experiences recounted by boys and adult men, NAMBLA took the position of trusting boys to make good decisions for themselves.

In arguing against allegations, pedophiles would typically position police as the wrongdoers—they sought out boys, and coerced or forced them into making accusations. This was not merely an attack on pedophiles, but on gay men in general. After one of California's first gay foster parents was accused of molestation, the *Bulletin* published an article stating that the allegations were patently false and would not have been taken seriously had the man in question been heterosexual. The story continues, "All Gay men should remember this important information: police do not care whether or not they can find a boy who has had sex with you. What they are looking for is a boy who can be coerced into saying he has had sex with you."⁴³³ And in the Bagarozzy case discussed above, NAMBLA published excerpts from various affidavits to demonstrate the kinds of tactics police used. One of the alleged victims stated, "At the station they told us we were sexually molested by Rich, and that if we did not tell them that Rich made

⁴³¹ "Pedophilia: The Act," *Better Life Monthly* 2, no. 6 (June 1975), Pedophilia Collection.

⁴³² Thorstad, *SEMIOTEXT(E)*.

⁴³³ John Fish, "For Those Who Think Love is Legal," *New York Daily News* (Dec 21, 1984), reprinted in *NAMBLA Bulletin* 6, no. 2 (March 1985), Pedophilia Collection.

us have sex with them, that they would beat us until we did, and said they would put us in Spoffard [a notorious Bronx jail for youth] and make sure we got fucked up the ass, and they called us queers and fags.”⁴³⁴ Another said that a detective “took out his gun and put it on the table in front of me while threatening me. I thought he was going to shoot me and say it was an accident.” Even in some cases where men admitted to sexual contact with boys, sympathy for the boy and contempt for the police remained. One reader writes, “Being in a police department to a 14 year old is scary. I do not hold Ryan’s statement against him but in fact I respect him for not telling a lie.” Altogether, whether accusations were true or false, many pedophiles allied themselves with boys, and positioned police as the interlopers.

Yet by the mid-1980s, the *Bulletin* increasingly took the stance that boys who accused men of sexual abuse were liars—that is, they refused to believe accounts of negative experiences. One reader’s letter illustrates this cognitive dissonance. He discusses a television special that emphasized a child’s right to say no to sexual contact. According to the letter-writer, a boy in the audience asked about a child’s right to say yes. The question was brushed off; the author suspects it “wasn’t in the script.”⁴³⁵ Presumably the point here is to note the ways in which anti-child sexual abuse advocates only listened to one experience, while ignoring others. But immediately following this anecdote, the author writes “You may also notice that a lot of these so claimed sexually abused children you see on TV giving their ‘I am damaged for life’ testimonies seem to be a lot more into the money afterwards—part of the payoff I guess!” Like those he criticized, the author was only willing to accept one version of the story. Another reader wrote in saying that he and his partner would “like nothing more” than to take in homeless boys but wondered “how much time would pass until he turned us in to the authorities, with some

⁴³⁴ Melzer, “Police Infiltrator.”

⁴³⁵ Feedback, *NAMBLA Bulletin* 6, no. 2 (March 1985), Pedophilia Collection.

contrived story, blown out of proportion?”⁴³⁶ Here, there was no suggestion that police had coerced the hypothetical boy; rather, the letter’s author worried that any boy, by his own volition, might betray him.

In the same *Bulletin* issue, another reader wrote in to discuss a case in which a 40-year-old male therapist was accused of repeatedly molesting two teenaged boys. The boys had waited two years before reporting the incidents and the reader took this as a sign of bad faith. He writes, “These males 13 and 17 years old allow their bodies to be fondled sexually and enjoy it for a long period of time; then as the tide of age and fear of exposure to their friends on their part comes about, they blow the whistle! What in the HELL are you young males trying to prove?”⁴³⁷ The rest of the letter engages in standard rape apologia: thirteen- and seventeen-year-olds were “worldly” and because the boys continued their therapy sessions “something must be holding your interest!” This second part is particularly telling when juxtaposed with NAMBLA’s positions on children’s rights—members were quick to argue that children didn’t have much choice in how they spent their time, citing mandatory school attendance, religious services forced on them by their families and so on. That the reader assumed that these boys had the option to simply stop going to therapy suggests that his anger at the boys had overridden any other concerns.

Others took this even farther. Richard Geis writes that “malcontent children... watch TV and learn what to say in order to punish people they don’t like,” and wonders “how many child abuse cases exist because a child seeks revenge on a restrictive, disciplinary parent.”⁴³⁸ So manipulative are children in Geis’ world that he suspects parents are being “blackmailed” by

⁴³⁶ Feedback, *NAMBLA Bulletin* 6, no. 2 (March 1985), Pedophilia Collection.

⁴³⁷ Feedback, *NAMBLA Bulletin* 6, no. 2 (March 1985), Pedophilia Collection.

⁴³⁸ Richard Geis, “The Real Child Molesters,” *NAMBLA Bulletin* 7, no. 1 (January-February 1986), Pedophilia Collection.

children who threaten to report their parents for sexual abuse should they receive so much as a spanking. In fact, “in more families than we may realize, a wariness and/or actual fear may have developed as parents come to dread retaliation by their child or children.” Not only are children not always honest or innocent, but also “by the age of five or six, kids can be as cunning liars, cheaters and thieves as any adult. And they can be as heartless and amoral as any adult psychopath.” In the face of accusations of abuse, then, NAMBLA’s romanticization of boyhood and intergenerational relationships flew out the window, only to be replaced by the image of the boy as a conniving, mean-spirited liar.

In some ways, this rhetoric flowed naturally from NAMBLA’s position on the maturity of children. If children are mature enough to consent to sex, then they are also mature enough to lie. But these statements were not merely an acknowledgement that children are sometimes dishonest—or manipulated into making false statements by police, as NAMBLA would have it. Instead, they represent a paranoid fantasy in which boys were manipulative liars out to get pedophiles. This, in turn, lent itself to self-pity that the objects of their affections were so withholding. The author from above who wished to take in homeless boys ends his letter with a passive-aggressive statement that, “It is sad, for there are many young gay males who wish for the emotional and loving relationship of an adult male and cannot get it; for that person that could make your life whole and worth living RISKS ALL IN TRYING TO FIND YOU!”

While not all NAMBLA members thought this way, there was a marked shift in how members responded to allegations of abuse by the mid-1980s.⁴³⁹ As the number of accusations grew, NAMBLA could no longer maintain the position that police coercion formed the basis for most accusations, but neither could they admit that pedophiles *did* take advantage of boys in

⁴³⁹ These three letters appeared alongside the letter that acknowledged “a police department to a 14 year old is scary.”

many cases. This left only one party to blame: the boys themselves. Alongside this growing mistrust came an increasingly negative portrayal of boys as manipulative and withholding. Altogether, while NAMBLA attempted to portray itself as a caring organization invested in the wellbeing of boys, responses to accusations of abuse demonstrate that such caring attitudes were ultimately self-centered and rarely extended to boys who had been abused or had made accusations of abuse. As NAMBLA became more embattled—both in the political and activist arena and in courts of law as the numbers of abuse accusations increased—their empathy shifted away from boys and back onto themselves.

NAMBLA & the Gay Community

As noted earlier, NAMBLA's central platform since its inception had been that the organization was properly considered a gay rights organization. But this was not merely a rhetorical strategy. Rather, NAMBLA members had been heavily involved with the gay community. While it is impossible to tell the affiliations of their average member, or even of many of the authors who published in the *Bulletin* (where works were often anonymous, or listed only a first name), a look at the organization's leadership demonstrates deep personal ties to the gay community and long histories of activism. Founder David Thorstad was president of the New York's Gay Activists Alliance (GAA). The Boston-Boise Committee had spawned not only NAMBLA, but also the Gay and Lesbian Advocates and Defenders (GLAD). As well, Boston-Boise Committee member Tom Reeves would become active not only in NAMBLA, but also ACT UP, a gay group concerned with AIDS. He had also been a writer for *Fag Rag*, a Boston radical gay paper. John Mitzel, whose work on public panics over pedophilia would be frequently excerpted in NAMBLA, was also a writer at *Fag Rag*, founded *Gay Community*

News, and helped plan Boston's first pride parade in 1971. NAMBLA also participated in more formal political ways. The group was a member of the NYC Community Council of Lesbian and Gay Organizations and the International Lesbian and Gay Association (ILGA). In fact, for two years, NAMBLA was the sole American member of ILGA.⁴⁴⁰

But it's not merely that pedophiles belonged to gay organizations. Rather, those organizations often engaged with NAMBLA's platforms. In 1976, the Gay Activist Alliance sponsored a public forum on "man/boy love."⁴⁴¹ The GAA also believed that age of consent laws should be modified, though this never formed a particularly important issue for the group. As well, NAMBLA members were invited to speak at a number of academic venues by gay groups, including the UCLA Gay Academic Union, the Lesbian and Gay Seminararians at the Harvard Divinity School, and the Rutgers Gay Alliance.⁴⁴² These relationships went both ways, with a number of high-profile gay rights activists attending NAMBLA conferences. Among them were Harry Hay, Mattachine Society founder, and Jim Kepner, founder of the International Gay and Lesbian Archives and a member of Christopher Street West.

While it's certainly true that not all members of the gay community supported NAMBLA, resistance to their presence there in the early 1980s was sporadic and often symbolic. In 1980, the *Bulletin* attests to just three instances: first, the *Village Voice* refused to publish an ad containing the words "boy love." An editorial in the *NAMBLA Bulletin* sneered that "some people still think of the *Village Voice* as a 'liberal' publication," but nothing else on the matter

⁴⁴⁰ While NAMBLA's presence in ILGA remained largely unremarkable in the 1980s, it would become deeply controversial in the 1990s. See Joshua Gamson, "Messages of Exclusion," *Gender and Sexuality* 11, no. 2 (April 1997).

⁴⁴¹ Thorstad, "Man/boy Love."

⁴⁴² "NAMBLA Dues," *NAMBLA Bulletin* no. 4 (May 1980), Pedophilia Collection.

was said.⁴⁴³ As well, *Gay Community News* published a “very prejudiced, almost vicious” letter from a straight woman “equating man-boy love with rape.”⁴⁴⁴ But not only did this letter come from someone outside the gay community, *Gay Community News* also published responses from three NAMBLA members.⁴⁴⁵

A third incident points towards the symbolic, cautionary nature of responses to NAMBLA. In its announcement of the fourth annual NAMBLA conference, NAMBLA included a flyer for a public meeting on “Homosexual Relationships: Between Youths and Adults.”⁴⁴⁶ Sponsors of the forum included NAMBLA, the East Village Lesbian and Gay Neighbors, the Gay Activists Alliance, the Gay Media Alliance, Gay Youth, Gay Atheists League of America, New York Gay Anarchists, and the Revolutionary Socialist League. In effect, these groups represented a cross-section of the gay community, with various political affiliations, ages, and genders. The flyer refers to intergenerational relationships as “an important and controversial topic” that “sponsors of this forum believe... needs to be discussed and on which consciousness needs to be raised.” It also included a disclaimer in large print that “sponsorship of the forum does not necessarily mean agreement with the positions of NAMBLA.” Given that NAMBLA’s conference—and thus this forum—was to be held during Gay Pride Week in New York City, this disclaimer indicates that sponsors believed that enough members of the gay community would object to NAMBLA to necessitate the disclaimer’s inclusion. Yet, despite the disclaimer, no real dissent appeared. A month after the event took place, the *Bulletin* referred to the forum as a

⁴⁴³ “Odds and Ends,” *NAMBLA Bulletin* no. 4 (May 1980), Pedophilia Collection.

⁴⁴⁴ *NAMBLA Bulletin*, no. 3 (March 1980), Pedophilia Collection.

⁴⁴⁵ *Gay Community News* counted among its founding members at least two NAMBLA members. The publication maintained a fairly pro-NAMBLA stance throughout the 1980s.

⁴⁴⁶ Flyer, Pedophilia Collection.

“total success.”⁴⁴⁷ The event’s open mic portion resulted in speeches ranging “from rah-rah man-boy love to man-boy love as a road to socialism to ‘they have a right to speak.’ During the open mike portion, except for outright vilification, most possible viewpoints were presented.” At the very least, then, NAMBLA was not so controversial as to draw in vehement opposition in 1980.

David Thorstad cites a number of more successful moves against NAMBLA throughout the late 1970s and early 1980s.⁴⁴⁸ He notes that in April 1980, the NY Coalition for Lesbian and Gay Rights called for his removal as keynote speaker at a gay rights rally in Albany. When these efforts failed, a number of lesbian groups chose to boycott the rally and a half dozen of the most active groups in the coalition resigned. That same year, feminists objected to his giving a keynote at the May Gay Festival in 1981; while the group that invited him initially voted to reaffirm his invitation, they eventually withdrew it when feminist groups threatened to picket or boycott the festival. The next year, a group of lesbian activists attempted to prevent NAMBLA from renting space at the Philadelphia Lesbian and Gay Community Center, but were ultimately unsuccessful. These incidents reveal that NAMBLA’s presence in gay rights groups provoked genuine debates in the early 1980s, but that those debates were driven largely by lesbian and feminist activists rather than by gay male activist. Moreover, the larger gay community was just as likely to continue accepting NAMBLA as reject them.

By the mid-1980s, this would change and NAMBLA’s participation in gay spaces would become increasingly controversial. The first major incident concerned the Christopher Street West (CSW) parade in Los Angeles, in the summer of 1986. Christopher Street West had formed in 1970, and held its first parade in that year. Along with the Christopher Street parade in New York City, CSW was one of the first gay pride parades held to commemorate the anniversary of

⁴⁴⁷ “Gay Pride Week,” *NAMBLA Bulletin* no. 6 (July 1980), Pedophilia Collection.

⁴⁴⁸ Thorstad, “Man/boy Love.”

the Stonewall Riots. From the beginning, CSW was plagued by issues from within and without the gay community. In planning the first parade, CSW ran into issues obtaining insurance for the parade that were only resolved when CSW prevailed upon an ACLU attorney to intervene.⁴⁴⁹ The issue of insurance would be a recurring one for CSW, as city officials demanded they take out increasingly expensive policies. CSW connected this to homophobia—organizers stated that members of the LAPD had referred to them as “child molesters and criminals” in 1970, and complained about the “unsavory” content of the parade in 1972.⁴⁵⁰ In 1986, two insurers turned down the group due to fears of AIDS.

Complaints about the parade also came from groups within the gay community. In 1972, the CSW Planning Committee drafted a statement that the parade was “for ALL gay people,” noting, “our community is quite diversified when it comes to politics, religion, lifestyle, etc.”⁴⁵¹ But over the years, a number of groups would push the boundaries of these statements. In 1973, a coalition of gay bathhouse owners complained that the parade was too vulgar, and lent itself to negative media portrayals of the homosexual community.⁴⁵² This sparked a protracted debate among members of the planning committee that ultimately resulted in the parade being cancelled that year. Four years later, in 1977, the parade would bar the members of the National Socialist League (a neo-Nazi organization restricting its membership to gay men) from marching. This

⁴⁴⁹ Stephen Braun, “Gay parade sponsors sue, seeks insurance cut,” *LA Times*, June 8 1986.

⁴⁵⁰ Respectively, Don Kilfhefner, “Edging Out,” *Frontiers* 27, no. 3 (June 2008); and Mary Ann Cherry, *The Kight Affect: the Authorized Biography of a Gay Liberationist*, accessed February 1, 2015, <http://morriskight.blogspot.com/2012/10/gay-pride-1973.html>.

⁴⁵¹ Cherry, *The Kight Affect*

⁴⁵² Cherry, *The Kight Affect*. Among other things, the parade included “a float made out of wire and paper-mâché, shaped to look like a long Chinese dragon with a penis head. Called “The Cockapillar,” it ejaculated white fluid as it weaved down Hollywood Boulevard.”

move, unlike the debate over the presence of sexually explicit materials at the 1973 parade, engendered little protest.⁴⁵³

These various run-ins set the stage for CSW to bar NAMBLA from the parade in 1985. The following year, CSW began exercising more control over the contents of the parade and now required all signs carried by participants to be approved by a committee prior to the parade. In protest of NAMBLA's ejection from the parade, Harry Hay wore a sign that read, "NAMBLA walks with me." Hay refused to remove the sign at the request of a CSW monitor and then found himself surrounded by mounted sheriff's deputies. The deputies threatened to arrest Hay, and CSW moreover said that his entire organization (the Radical Faeries) would be forced to leave the march if he refused to remove the sign. Eventually, a member of his organization removed the sign and tore it up. CSW officials would later state that they had only intended to detain, not arrest, Hay, and that they would issue a letter of reprimand to Hay for "engaging in political activity during a gay pride parade."⁴⁵⁴ That CSW now thought politics could be separated out from a gay pride parade indicates that CSW had come a long way from its 1972 statement.

At the heart of this were questions about respectability and public image, and politics versus identity. CSW insisted that NAMBLA was a political organization for pedophiles rather than a gay organization. Accordingly, they had no place in a gay pride parade. However, this separating out of politics and gay identity struck NAMBLA as unstable. Only two years earlier, they had been allowed to march in coalition with groups advocating peace and civil liberties in El Salvador. Not only had NAMBLA not been objectionable in that context, but the coalition was also undoubtedly using the parade to make a political statement. Rather than being a move

⁴⁵³ Don Slater, "Solidarity vs. Liabilities," *NAMBLA Bulletin* 7, no. 6 (July-August 1986), Pedophilia Collection.

⁴⁵⁴ John Fish, "The Trouble with Harry." See also, O'Hara, "The Rage of Consent." Both in *NAMBLA Bulletin* 7, no. 7 (September 1986), Pedophilia Collection.

against the presence of politics in the parade, CSW had made a move towards a politics of respectability. NAMBLA and the National Socialist League both represented distasteful politics with bad public images; despite their members being gay men, both groups could easily be construed as not just political, but the bad kind of political that might threaten the good standing of CSW. Don Slater, founder of the Homosexual Information Center (HIC), wrote to NAMBLA, “What took you so long to notice the tyranny in CSW?”⁴⁵⁵ Slater noted that his organization was the only group to protest the expulsion of the National Socialist League from CSW in 1977, with nary a peep from NAMBLA. Ultimately, Slater framed CSW’s respectability politics as an economic issue, writing, “CSW has been a profit-making enterprise for a number of years now... [NAMBLA] represents a liability on the commercial market. In the business world, CSW has every right to limit its liabilities.” These liabilities were, of course, intimately connected to public appearances. Slater writes, “HIC has never been denied entry to the parade. On the contrary, as a bunch of old, white-haired, respectable looking men and women, we represent an ideal attraction. However, we voluntarily absent ourselves in dissent, lest anyone regard our presence as a submissive endorsement of CSW’s discriminatory policy.” As with the National Socialist League, HIC would find itself mostly alone in its stance on NAMBLA.

That same year, this combination of respectability politics and local and economic pressures would come to haunt the New York chapter of NAMBLA. In April of 1986, NAMBLA had requested to rent meeting space at the Lesbian and Gay Community Services Center. The Center initially refused to respond directly to NAMBLA and instead published an open letter in the gay press denying the request. NAMBLA continued requesting meeting space

⁴⁵⁵ Slater, “Solidarity vs. Liabilities.” These anti-commercialism, anti-capitalist statements were common among NAMBLA members and those who supported them. Note Farrell’s anti-capitalist screed in “Status Offender” and Thorstad’s involvement with socialist groups.

and, in June, the Center relented to a meeting.⁴⁵⁶ At the time of the meeting, Irving Cooperberg, the president of the Center's board of directors, was "evasive," citing "the existence of external constraints on the Center's ability to rent space to NAMBLA." A month later, NAMBLA heard through unofficial channels that its application had again been rejected. After NAMBLA demanded official notification, the Center finally sent a letter on July 29. Cooperberg writes,

We received a definite indication that our fundraising efforts would be severely compromised should NAMBLA be permitted to meet at the Center... It should also be obvious by now that the Center has become a vital mainstay of the lesbian and gay community of New York City. We have the responsibility to our community to ensure the wellbeing and vitality of this institution. We must not, and will not, jeopardize the Center by honoring your request. We hope you understand that we really had no choice but to deny your application.⁴⁵⁷

Though the letter did not specify, NAMBLA cited rumors that city officials had threatened to withhold funding from the Center if NAMBLA's request was approved. Taken all together, the Center's response implicitly excised NAMBLA from the gay community—its responsibility was not to NAMBLA, which was not a part of the community but was instead a threat to it. Moreover, the Center's choice to direct the initial response not to NAMBLA itself, but to the gay community more broadly further implies that the Center did not see NAMBLA as part of its intended audience.

NAMBLA, as always, doggedly insisted that it was a rightful part of the gay community. They note, "NAMBLA has been a recognized part of the lesbian and gay movement for more

⁴⁵⁶ A NAMBLA press release implies this was due, in part, to protests from various gay and lesbian groups, among them the Revolutionary Socialist League. See "NY Chapter Files Discrimination Suit against Gay Center," *NAMBLA Bulletin* 8, no. 1 (January-February 1987). Pedophilia Collection.

⁴⁵⁷ Letter reproduced in *NAMBLA Bulletin* 8, no. 1 (January-February 1987). Thorstad writes that the center had applied for large grants from the city and state at the time of this debate. The increased scrutiny that came along with such applications likely influenced the center's alacrity in disavowing NAMBLA. See Thorstad, "Man/boy Love."

than five years now. It has participated in annual gay pride marches. It is a member of the New York City Lesbian and Gay Community Council and of the International Lesbian and Gay Association.”⁴⁵⁸ NAMBLA’s rejection or inclusion in events like the CSW parade or the NYC Community Center was not disconnected, then. Rather, each one represented a little step towards legitimacy and added up to a place in the gay community.⁴⁵⁹ One by one, throughout the mid-1980s and 1990s, NAMBLA lost these individual claims, whether in the face of feminist advocacy against child sexual abuse or political opposition from local, federal and sometimes even international groups.

In 1980, an article in *The Advocate* had stated, “Our movement cannot survive the man-boy issue. It’s not a question of who’s right, it’s a matter of political naïveté.”⁴⁶⁰ In response, Pat Califia wrote that advocates for this “politics of expediency are dead wrong. Gay rights is a question of right and wrong.” While abandoning NAMBLA “may hasten the day when adult lesbians and gay men have full civil rights... Will we ever be able to forgive ourselves? Can we honestly say we have freedom if gay minors do not? Our movement cannot survive the loss of its conscience.” A decade later, this “politics of expediency” had come to pass. NAMBLA’s membership continued to dwindle and would eventually become small enough that NAMBLA stopped holding public meetings. Thirty years ago, NAMBLA had a large political presence within the gay rights movement, divisive though it was. Today, the majority of NAMBLA activity takes place online, amongst only a few and far away from the gay rights movement.

⁴⁵⁸ Chris Farrell, “An open letter to the lesbian and gay community,” *NAMBLA Bulletin* 8, no. 1 (January-February 1987), Pedophilia Collection.

⁴⁵⁹ It’s ironic that they cited ILGA here, since they would be ejected in 1994. Again, see Gamson, “Messages of Exclusion.”

⁴⁶⁰ Quoted in Califia, “Women Against the New Puritans.”

Conclusions

While NAMBLA's attempt to latch onto the gay community was partially utilitarian, it also reflected deeply held beliefs by the leaders about themselves (as both gay men and gay activists) and influenced their beliefs about pedophilia and children's rights in very important ways. In addition to its more crass attempts to argue that homosexuality and pedophilia were equivalent sexual orientations, NAMBLA put forward sincere arguments about the place of gay children in American society. While society has dealt with this issue in a radically different way today (through the encouragement of gay youth organizations in schools, for instance), NAMBLA identified a very real problem in the 1980s. And while we might agree that NAMBLA advocacy around pedophilia was distasteful and harmful to the children it involved, taking seriously NAMBLA's position within various social circles sheds light on lesser-known aspects of social activism in the 1980s. While much has been written about the history of the gay rights movement and the women's movement, less has been said about the place of children within either of those movements. One of the ways that NAMBLA gained acceptance in its early years was by pointing to this elision in its own time and claiming to speak for children when no one else would. Though this rhetoric ultimately rang false—as demonstrated by NAMBLA's turn in the mid-1980s as the number of abuse accusations increased—it proved to be persuasive to many within the gay community in the early 1980s.

As well, looking at NAMBLA's rhetoric and publications indicates both a certain savviness, and a persistent engagement with academic, scientific and activist discourses. By levying these various discourses, NAMBLA sought to make a place for itself and to become a contributor to broader social discussions surrounding sexuality—not just on homosexuality and pedophilia, but also on the nature of consent and coercion. In a moment when so many other

groups—psychiatrists, lawmakers, feminists, and the general public—were discussing the nature of sex, gender and sexual violence, it’s perhaps unsurprising that a group like NAMBLA could think of itself as having a space in those discussions. Yet for all their familiarity with the discourses that sought to define them, NAMBLA and other pedophile activists ultimately had little success in reshaping how outsiders thought about pedophilia. While they enjoyed a brief moment of acceptance—begrudging or otherwise—from the gay community, they would be pushed out over the course of the 1980s and 1990s.

Finally, taking NAMBLA’s place in history seriously points towards a different dimension of the respectability politics that are so often discussed in regard to the gay rights movement. While most contemporary scholars (and many historical observers) have been critical of the shift from gay liberation to a narrower and more respectable gay rights framework, they’ve typically framed such criticism around the pushing out of very different groups than NAMBLA—transgender individuals and, as with the ultimately-cancelled CSW parade in 1973, those gay men and women who were deemed too overtly sexual. Adding NAMBLA to this history (and even the gay fascist groups who were likewise pushed out of the gay rights movement) provides a very different view of the stakes of respectability politics. Even if we agree that such politics had many negative results, it would be hard to argue that NAMBLA belonged in the gay community—not only have our ideas about what constitutes the gay community changed substantially since the 1980s, but it’s also likely that the presence of such deeply unsavory groups as NAMBLA would truly have interrupted the forward momentum gay rights groups managed to gain during that period. In this light, taking NAMBLA seriously suggests a less sinister and more complicated side to the politics of respectability: pushing out NAMBLA was both a politically-expedient move and part of a broader redefining of gay identity

as being solely about sexual attraction between adults rather than about intergenerational attraction, and solely about orientation rather than about politics.

Chapter 5

“The purpose of confinement is treatment and not punishment”⁴⁶¹: Mentally Disordered Sex Offenders in the Courts

American courts have been concerned with the role of mental illness in sex offenses since the 1930s. At that time, the idea of a “sexual psychopath”—a sexual deviant who could not control his pathological desires and thus represented a danger to the public—took hold in public discussions and resulted in the passage of numerous laws. These laws allowed for so-called sexual psychopaths to be placed in psychiatric care rather than prison. Since the 1930s, the idea of the mentally ill sex offender has remained part of both the public imagination and American legislative culture, but had undergone numerous transformations. First, the idea of a singular disorder (sexual psychopathy) lost its appeal, and was replaced by multiple disorders. Alongside this, legal language shifted and increasingly referred to the “sexually dangerous person” or to the “mentally disordered sex offender” (MDSO). Second, attitudes towards the possibility of rehabilitation have changed over the course of the twentieth century. During the 1930s, there was little belief that the sexual psychopath could be cured—though he might belong in a psychiatric facility rather than prison, his underlying disorder was would persist. By the 1950s, however, psychiatrists had begun to believe that sex offenders might be treated and, if not fully cured, substantially rehabilitated.

Historians have argued that this treatment era lasted for a brief thirty years until 1980. At that time, courts shifted rapidly towards punishing rather than treating sex offenders.⁴⁶² By the

⁴⁶¹ “Procedures determined for treating sex offenders and drug-addicted defendants,” *Mental Disability Law Reporter* 5, no. 4 (July-August 1981).

⁴⁶² For examples of this argument, see: Chrysanthi S. Leon, *Sex Fiends, Perverts and Pedophiles: Understanding Sex Crime Policy in America* (New York University Press, 2011); Simon A. Cole, “From the Sexual Psychopath Statute to ‘Megan’s Law’: Psychiatric Knowledge in the

1990s, this transition would result in the passage of laws against “sexually violent predators” (SVPs). These laws allowed for the imprisonment of sex offenders and their subsequent commitment to psychiatric facilities after their release. The basis for such laws was that some sex offenders were so pathologically dangerous that they simply could not be released back into the public. The mechanism for their continued containment occurred was involuntary psychiatric commitment. Like earlier sexual psychopath laws, however, there was little belief that SVPs could be cured and little interest in sincere treatment.

Broadly speaking, the shift that historians have identified—from the sexual psychopath era to the rehabilitation and treatment era to the containment era—is correct. There has been a marked (and arguably cyclical⁴⁶³) shift in how American courts have thought about mentally ill sex offenders across the twentieth century. However, arguments that this shift occurred rapidly and attempts to divide the twentieth century into clear eras misses a crucial moment of upheaval. During the late 1970s and 1980s, a hybrid system emerged in which courts began to rethink what it meant to treat an offender and what it meant to punish one. Despite continued interest on the part of psychiatrists in treating sex offenders—and new approaches to rapists in particular—courts were beginning to question whether mentally ill sex offenders were best dealt with as patients or as prisoners. Alongside this, there emerged questions about what rights such offenders were entitled to and what the nature and efficacy of psychiatric treatment for such offenders was. In practical terms, these questions meant that courts continued to cite the use of

Diagnosis, Treatment, and Adjudication of Sex Criminals in New Jersey, 1949-1999,” *Journal of the History of Medicine and Allied Sciences* 55, no. 3 (July 2000).

⁴⁶³ Ewing refers to SVP laws as a “reinvention” of the sexual psychopath. See: Charles Patrick Ewing, *Justice Perverted: Sex Offender Law, Psychology, and Public Policy* (Oxford University Press, 2011).

involuntary commitment under MDSO statutes as a treatment measure, while caring less and less whether such treatment truly existed or was actually effective.

Moreover, historians have generally taken this moment as the end of an era for more concrete reasons: by the 1970s, a number of states were repealing their MDSO statutes altogether and, as Chrysanthi Leon notes, the number of sex offenders committed to psychiatric facilities during this period was significantly lower than those committed at the peak of the MDSO era (the mid-1960s).⁴⁶⁴ But despite these downturns, state and federal courts continued to churn out legislation and case law on the subject. Throughout the 1980s, state supreme courts heard at least a dozen cases related to MDSO statutes, with dozens more filtering through various circuit and appellate courts. While retrospectively it may seem that this period was an end point, at the time and to observers it seemed an extraordinarily fertile moment full of upheaval.

Finally, the stark division between a rehabilitation era (1950-1980) and a containment era (1980-present) raises questions about how the SVP laws of the 1990s came about. For many historians, these laws are representative of an ethos of containment. However, placing these three eras—sexual psychopathy, rehabilitation and containment—into a continuous timeline suggests that SVP laws actually had their roots in the hybrid system that helped shift rehabilitation to containment. The questions raised about SVP laws in the 1990s—whether they represented double jeopardy and cruel and unusual punishment, whether they misused the involuntary commitment system, whether diagnosing someone as an SVP and predicting their future dangerousness was possible—were all raised repeatedly in reference to the MDSO statutes of the 1980s. While MDSO statutes may have been increasingly modified and repealed throughout the

⁴⁶⁴ Leon, 84.

1980s, the ways in which legislators and courts worked through such questions laid the groundwork for the SVP laws that followed.

This chapter is divided into four sections. First, I offer a brief discussion of involuntary commitment in the 1970s and 1980s, and then I turn to MDSO statutes and the procedural issues therein. After this, I discuss the concept of treatment within the context of MDSO statutes. Finally, I discuss the issue of psychiatric knowledge in MDSO proceedings, and its limitations. Cases discussed here are drawn from the *Mental Disability Law Reporter*—a publication first published in 1976 by the American Bar Association. Some of these cases produced wide-ranging changes in the law and many were tried in the Supreme Court. Others, however, dealt with small procedural issues at the state level. All cases discussed, however, struck observers at the time as important. Historians of this subject have typically looked at individual jurisdictions and traced changes over time within those jurisdictions.⁴⁶⁵ By looking across state lines, it becomes apparent that small procedural issues (while they may have affected only the sex offender whose case it applied to in an immediate sense) added up to a broader cultural change in how courts approached MDSOs.

I argue that MDSO statutes followed some broad trends in involuntary commitment legislation, but also constituted their own system that was markedly different from either civil or criminal systems. This came with some unique disadvantages for those classified as MDSOs. Most notably, such individuals were denied a variety of procedural rights. These rights were revoked on a few different bases: public safety, the idea that such proceedings were designed to treat rather than punish, and the idea that the ability of courts to pursue MDSO proceedings in the first place depended on less stringent procedural rights for defendants. Alongside this, I argue

⁴⁶⁵ The authors noted above—Leon and Cole—concentrate on California and New Jersey, respectively, though Leon gestures to broader national trends.

that treatment was more complicated in practice than in rhetoric. Courts rarely examined the distinction between treatment and punishment directly, and the implementation of treatment for MDSOs presented numerous, persistent problems. Questions about who was entitled to evaluation as an MDSO and to treatment arose, as did the question of whether effective treatment existed. On top of this, patients were not always willing to cooperate with treatment. This left both the courts and the treatment facilities involved with a problem: How would they determine whether any given offender could benefit from treatment, and what would they do with those patients whose lack of cooperation made treatment unbeneficial? I contend that courts frequently claimed the right to answer such questions for themselves, which left treatment centers in a bind. Finally, I argue that MDSO proceedings presented a number of problems for psychiatrists. In particular, most statutes required that a defendant be determined to be an ongoing or future danger in order that the offender remain committed. Psychiatrists argued consistently that they could not determine whether any given patient would be a danger in the future. More generally, statutory language was vague and, despite being predicated on psychiatric knowledge, psychiatrists had little guidance in interpreting such statutes.

Altogether, what emerged was a messy system that was simultaneously civil and criminal, and simultaneously legal and psychiatric. This hybrid system would prove problematic for the courts, the treatment centers involved, and the MDSOs themselves. Ultimately, by the mid-1980s, these problems would become overwhelming enough that many MDSO statutes would be heavily amended or repealed altogether. But while it may appear that the late-1970s and early-1980s represented the last gasp of a longer sexual psychopath-MDSO era (as a number of historians have posited), this moment instead set the ground for the later SVP era.

Involuntary Commitment in the 1970s and 1980s

In many ways, laws regarding mentally disordered sex offenders reflected broader changes in involuntary commitment standards. Accordingly, it is useful to give a brief overview of commitment in the 1970s and 1980s. Prior to the 1960s, psychiatric patients had virtually no legal rights. The prevailing presumption was that three-fold: that mentally ill individuals could not make decisions for themselves, that the state had a *parens patriae* duty to care for such individuals, and that inpatient care was the most beneficial approach to mental illness.

Accordingly, all that was needed to commit an individual was proof that the individual suffered from a mental illness of some sort.⁴⁶⁶ During the 1960s, however, the American mental health care system changed rapidly. In a process known as deinstitutionalization, inpatient facilities across the country shut down.⁴⁶⁷ In the wake of this, US lawmakers began to shift standards for involuntary commitment away from a need-for-treatment model and toward a model based on the dangerousness of a patient.⁴⁶⁸ The first such statute was written in 1964 in Washington, DC. This statute required that, in order to be involuntarily committed, a person had to be determined not just to be suffering from a mental illness, but also that a person be determined to pose an

⁴⁶⁶ For a brief overview of civil commitment prior to 1960, see: Megan Testa and Sara G. West, “Civil Commitment in the United States,” *Psychiatry* 7, no. 10 (2010).

⁴⁶⁷ For a discussion of deinstitutionalization, see: Gerald Grob, *The Mad Among Us: A History of the Care of America’s Mentally Ill* (1994). Grob, and other authors, argue that deinstitutionalization had a few major factors: first, advances in psychopharmacology meant more effective medications for a number of mental illnesses which, in turn, meant many patients could be released. Second, a number of political and economic concerns were at play—mental health care funding shifted from the state to the federal level and would be progressively defunded federally. Third, numerous factions raised concerns about patients’ rights and involuntary commitment; alongside this, there was a cultural shift towards community mental health care.

⁴⁶⁸ Many authors have written about the ways in which a shift away from need-for-treatment as a justification for civil commitment has left many mentally ill individuals without proper care. See, for example: Sarah Gordon, “The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness,” *Case Western Law Review* 66, no. 3 (2016).

imminent threat either to him or herself or to others. Five years later, California would adopt a similar statute. Over the course of the 1980s, nearly all American states would follow suit.⁴⁶⁹

When these statutes were written, “imminent danger” was interpreted narrowly—that is, a person could be committed if deemed likely to commit suicide or cause serious bodily injury to someone else in the near future. Sex offender statutes, as this chapter will demonstrate, stretched the meaning of both words. “Imminent” would come to encompass vague notions of any given offender’s potential to reoffend at any point in the future and “danger” would encompass not just physical harm, but also the psychological harm caused by rape or molestation; in other words, an offender need not use violence or force in his attacks to be considered dangerous, even in states where MDSO statutes included language regarding bodily harm. Even with civil commitment statutes, however, the meaning of these two words was much disputed. Studies throughout the 1970s and 1980s found that psychiatrists and other mental health professionals had a multitude of understandings of what was meant by such statutory language—whatever courts and legislatures had intended with such language, psychiatrists were apt to interpret it in highly individualized and under-informed ways. One study from 1978 found that, while the psychiatrists polled were apt to know that dangerousness was a legal justification for civil commitment, they generally had little idea what this term meant.⁴⁷⁰ In the absence of clear legal definitions, psychiatrists might interpret “danger” narrowly (to mean suicidal or homicidal urges) or broadly (to mean any self-destructive tendencies). Temporally, they might interpret it to mean

⁴⁶⁹ A few states do not rely on dangerousness in their civil commitment statutes. Testa and West note that Delaware and Iowa use different standards. In Delaware, an individual need only be demonstrated to be unable to make “responsible choices” about their mental health. In Iowa, the person must be found likely to cause “severe emotional injury” to people unable to avoid them (e.g., family, coworkers).

⁴⁷⁰ Glenn G. Afleck, et al., “Psychiatrists’ Familiarity with Legal Statutes Governing Emergency Involuntary Hospitalization,” *American Journal of Psychiatry* 135, no. 2 (1978).

a clear and present danger, or one that was merely probable or possible at some future moment. And, in general, legal statutes offered little specific guidance on these issues. For instance, the statutes of the two jurisdictions involved in the 1978 study (Washington, DC and Connecticut) stated simply that commitment required that a patient be “likely to injure himself or others” or “must present a danger to himself or others.” No more specific details on what constituted such a danger were offered within the statutes themselves.

Alongside changing justifications for involuntary commitment, there were procedural changes regarding the burden of proof required to commit an individual. In criminal courts, evidence is generally required to prove beyond a reasonable doubt that an individual is guilty in order for that individual to be convicted. However, there exist two additional standards of proof that may apply in civil cases. The lowest standard of proof is a “preponderance of evidence.” Under this standard, the court must believe a decision is more likely to be correct than incorrect. Between these two standards—proof beyond a reasonable doubt and a preponderance of evidence—is “clear and convincing evidence.” Under this standard, evidence must be substantially more likely to tilt toward one conclusion than the other. It is helpful to think here of percentages: if a preponderance of evidence of guilt means it’s more than 50% chance of guilt and proof beyond a reasonable doubt means the proposition of guilt approaches 100%, then clear and convincing evidence indicates that the likelihood of guilt falls somewhere between these two numbers.⁴⁷¹

⁴⁷¹ I say here that guilt “beyond a reasonable doubt” approaches 100%—rather than is 100%—because courts did not suggest that any given verdict was a definite and incontrovertible reflection of the truth. Moreover, some doubt could remain (rendering the prospect of guilt less than 100%), so long as it was not to a level that a “reasonable person” (which is, in itself, a legal construct) would question the guilty of the defendant.

In *Addington v. Texas*, a landmark 1978 case, the Supreme Court ruled that civil commitment must meet the middle standard.⁴⁷² In that case, the Supreme Court determined that imposing the highest standard on civil commitment procedures would ultimately disadvantage patients—because psychiatry could not accurately predict whether patients would harm themselves or someone else, requiring proof beyond a reasonable doubt of their dangerousness would prevent many individuals from getting the help they needed.⁴⁷³ In other words, a lesser burden of proof was justifiable in the interest of protecting patients (and, in states where the dangerousness criteria existed, in the interest of protecting anyone those patients might harm).

As this chapter will demonstrate, similar arguments were put forward for lesser standards of proof regarding the commitment of sex offenders. However, because committed sex offenders occupied a hybrid criminal-civil system, these standards would meet with consistent legal challenges. Even within the context of non-MDSO civil commitments, however, the question of whether and how psychiatrists could accurately assess dangerousness would be an ongoing dilemma. Many psychiatrists argued that there were few ways to accurately assess the dangerousness of potential patients and that statutes presumed they had predictive powers that were simply nonexistent.⁴⁷⁴ Part of the shift away from inpatient treatment to community mental health care would be based on such questions and on criticism that patients' civil rights were violated based on such nebulous predictions of danger.

⁴⁷² *Addington v. Texas*, 441 U.S. 418 (1979).

⁴⁷³ Christyne E. Ferris, "The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards," *Vanderbilt Law Review* 61 (2008). This question of whether or not psychiatrists could feasibly offer a higher standard of proof is also taken up later in the chapter.

⁴⁷⁴ See, for example: B. J. Ennis and T. R. Litwack, "Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom," *California Law Review* 62 (1974); H. J. Steadman, "Some Evidence of the Inadequacy of the Concept of Determinism of Dangerousness in Law and Psychiatry," *Journal of Psychiatry and the Law* 1 (1973).

MDSO Statutes

MDSO statutes, within this context, were a very particular form of civil commitment statute. Like more general civil commitment statutes, they generally required that an individual present some form of danger (in this case, a specifically sexual danger) in order to be committed. As well, they required that the offensive sexual behavior an individual exhibited be linked to a diagnosable mental illness. With earlier sexual psychopath statutes, that mental illness was contained in the name: sexual psychopathy. As discussed earlier, psychiatrists increasingly argued throughout the mid-twentieth century that such a disorder (understood as a singular condition, rather than a multitude of sexual disorders) did not exist.⁴⁷⁵ By the 1970s, MDSO statutes allowed for a wide (and undefined) range of mental disorders to count towards MDSO status. This might include any of the paraphilias listed within the *DSM* (e.g., pedophilia, sexual sadism), a Paraphilia-NOS disorder (thus allowing disorders like Paraphilic Coercive Disorder or hebephilia⁴⁷⁶ to be used),⁴⁷⁷ or in some cases, non-sexual disorders (for instance, sex crimes

⁴⁷⁵ On shifting psychiatric attitudes towards the sexual psychopath, see: Estelle Freedman, “‘Uncontrolled Desires’: The Response to the Sexual Psychopath, 1920-1960,” in Kathy Peiss and Christina Simmons, eds., *Passion and Power: Sexuality in History* (Temple University Press, 1989).

⁴⁷⁶ Hebephilia is a putative mental illness that consists of sexual attraction to pubescent minors (generally, ages 11 to 14). The existence of such a disorder has been intensely controversial. For a review of the controversy and potential evidence of hebephilia’s existence, see: Bruce Rind and Richard Yuill, “Hebephilia as Mental Disorder? A Historical, Cross-Cultural, Sociological, Cross-Species, Non-Clinical Empirical, and Evolutionary Review,” *Archives of Sexual Behavior* 41, no. 4 (2012);

⁴⁷⁷ The use of NOS diagnoses would become a significant issue in the 1990s and 2000s, after SVP laws were introduced. See the conclusion of this dissertation for a brief discussion. As well, disorders not included in the *DSM* were used in a number of court cases, with varying levels of success –Premenstrual Dysphoric Disorder (or PMS, its popular equivalent), in particular, was introduced as a defense in a number of criminal cases. For a review of such cases, see: Patricia Esteal, “Premenstrual Syndrome (PMS) in the Courtroom” (conference paper, *Australian Institute of Criminology: Women and the Law Conference*, Canberra, Australia, September 24-

might be attributed to a personality disorder).⁴⁷⁸ Here, the salient point was that a psychiatric evaluation and subsequent expert testimony linked sexual behavior to a mental disorder *and* that expert testimony argued that the defendant would continue to present some form of danger to others in the future. Together, these two pieces justified the civil commitment of a specific class of sexual offenders.

Despite these two general commonalities, MDSO statutes varied from state to state. Most significantly, they existed along a spectrum from purely civil to mostly (in procedure, if not result) criminal. In some states, MDSO statutes were almost entirely civil, in both procedure and result. In these states, the accused MDSO would be tried in a civil court and taken to a mental health facility without any criminal proceedings at all—this process involved neither criminal conviction nor any formal and thus time-limited sentence. In these cases, MDSOs could be civilly committed indefinitely. By 1983, four states—Washington, DC, Illinois, Massachusetts and Washington—had this type of MDSO statute. Four other states—Florida, Maryland, South Dakota and Tennessee—approached MDSO hearings through a primarily criminal lens. In these states, a defendant would be tried for a sex crime, convicted, and sentenced in a criminal court. After the conviction and sentencing, the sex offender would be assessed by mental health professionals for status as an MDSO and then remanded to a psychiatric facility if it was deemed appropriate. Under these statutes, the commitment could last no longer than the original prison sentence—in other words, if a sex offender was sentenced to five years imprisonment and then found to be an MDSO, whatever psychiatric facility he was remanded to would be obliged to

26, 1991); Rosanna Langer, “‘That Time of Month’: Premenstrual Dysphoric Disorder in Criminal Law-Another Look,” *International Journal of Criminology and Sociology* 1 (2012).

⁴⁷⁸ For an example of this, see *Delaware v. Tarbutton*, 407 A.2d 538 (1979). Tarbutton had molested and subsequently murdered a young boy. The court determined that both actions were the result of an underlying personality disorder and on that basis, the court designated him as an MDSO.

release him after five years, regardless of whether it felt the treatment had been effective. The remaining states with MDSO statutes used a hybrid system. Here, an offender would be tried and convicted in a criminal court, but the MDSO assessment would be made before sentencing. Offenders found to be MDSOs could be committed indefinitely. In all, then, the majority of states allowed for indefinite commitment by the mid-1980s.

Most of these statutes afforded accused sex offenders few rights. As with more general civil commitment statutes, they did not require proof beyond a reasonable doubt that a defendant had committed the crime of which they were accused in order to be civilly committed. The reasoning behind this was that the highest standard of proof was unique to criminal matters and not, as the Supreme Court had ruled in *Addington v. Texas*, required for civil commitment. Yet this put the courts in an odd position—accused sex offenders came to the attentions of the courts not just because they were putatively sexually dangerous, but also because they were accused of specific crimes. In that case, shouldn't their criminal guilt be established? Ultimately, state legislatures sidestepped this issue in two ways. First, MDSO statutes as written were generally civil and not criminal—in other words, despite a criminal act being the precipitating factor for a trial, the purpose and outcome was a civil matter and therefore not subject to criminal standards of proof. Moreover, courts insisted that, because the purpose of civil commitment for MDSOs was for treatment rather than punishment, a lesser standard was acceptable. In other words, although the sex offender was equally as confined in prison or a mental facility, confinement to a mental facility was not a punishment and therefore did not require any extraordinary proof in order to be legitimately imposed. I will return to this argument later in the chapter.

While this lower burden of proof generally aligned with federal standards for civil commitment as established in *Addington v. Texas*, MDSO statutes left sex offenders uniquely

disadvantaged in some ways. MDSOs were denied a variety of procedural rights — from periodic judicial reviews of their commitment or jury trials to determine whether they were mentally ill to the privilege against self-incrimination and the right to doctor-patient privilege during psychiatric evaluation and treatment. These rights (and how they were or weren't extended to MDSOs) varied from state to state, but were generally justified on the same bases: public safety, the treatment-based purpose of MDSO statutes, and the necessity of limiting such rights in order for the courts to pursue MDSO proceedings. The following section will discuss a handful of cases that demonstrate these procedural issues.

Wisconsin, in particular, would fight a lengthy battle over whether MDSOs ought to be accorded the same rights as other individuals who were involuntarily committed. The Wisconsin Sex Crimes Act, passed in 1958 and still in effect throughout the 1970s, allowed for convicted sex offenders to be committed to the Department of Health and Social Services for evaluation and, from there, to a treatment facility in lieu of prison for the maximum length of the prison sentence for the crime for which they had been convicted (e.g., if a child molester would have been sentenced to five years in prison, he would be sentenced to five years in a treatment program). This was in keeping with more criminally-oriented MDSO statutes. At the end of that sentence, however, the Department of Health and Social Services could petition for a renewal of the commitment for an additional five years, for however many times they thought necessary. These petitions would be determined by a judge and granted if an offender was assessed as “dangerous to the public because of his mental or physical deficiency, disorder or abnormality.”⁴⁷⁹

⁴⁷⁹ Wis. Stat. Ann. 959.15 (1958), amended to Wis. Stat. Ann., c. 975 (1971). It is worth noting here that the Sex Crimes Act actually required an even lower than typical standard of proof: courts needed only to have a preponderance of evidence to adjudicate an individual as an MDSO.

In 1970, a defendant (Humphrey) was convicted of contributing to the delinquency of a minor (a misdemeanor in Wisconsin) and sentenced to one year in prison. At that time, he was assessed as an MDSO and sent to a mental health facility. At the end of his one-year sentence, the Department of Health and Social Services petitioned for a five-year renewal and, in response Humphrey brought a lawsuit. Humphrey's primary argument had to do with the procedural differences between the state's MDSO statute and its civil commitment statute. At that time, the state's Mental Health Act allowed for jury determinations in civil commitment proceedings.⁴⁸⁰ In contrast, the state's MDSO statute left the determination to a judge. Humphrey argued that his initial commitment was equivalent to any other civil commitment, and that denying him procedural rights granted to other civil committees by virtue of his status as a sex offender represented a violation of due process. Moreover, he was denied the right to be present and to rebut witnesses for the State at his renewal hearing. Finally, Humphrey argued that the renewal hearing constituted double jeopardy. Given that he was initially sentenced to one year's imprisonment and had served that year in a mental health facility, a renewal of his commitment represented a retrial and additional incarceration for the same crime.⁴⁸¹

⁴⁸⁰ Interestingly, Wisconsin relied on juries to help deal with the question of dangerousness. The Supreme Court case noted the following: "Wisconsin conditions such confinement not solely on the medical judgment that the defendant is mentally ill and treatable, but also on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty. In making this determination, the jury serves the critical function of introducing into the process a lay judgment, reflecting the values generally held in the community, concerning the kinds of potential harm that justify the State in confining a person for compulsory treatment." See *Humphrey v. Cady*, 405 U.S. 504 (1972).

⁴⁸¹ Humphrey put forward an additional argument regarding the nature of the treatment he received. According to Humphrey, the Sex Deviate Facility (a prison unit) he was remanded to offered basically no treatment for his purported psychiatric issues. When the Supreme Court heard his case, they declined to rule factually on this issue—Humphrey had already been paroled and, by that time, Wisconsin had established a new treatment facility at the state mental hospital for future MDSOs, so the issue was moot. Still, however, this issue of whether statutes relying on

The case wound its way through district and appeals courts and eventually found its way to the United States Supreme Court in 1971. For the state's part, it argued that the Sex Crimes Act was substantially different from other types of commitment. Rather than representing civil commitment at all, in fact, commitment as an MDSO was "merely an alternative to penal sentencing," and therefore didn't require the same procedural safeguards as provided for under the Mental Health Act. Yet the argument that Humphrey's commitment as an MDSO was merely criminal held little water: had he been considered merely criminal, he would have been released at the end of his one-year sentence. Instead, he inhabited a hybrid civil-criminal system that allowed for an unlimited series of five-year renewals not based on his original crime and not reflective of his original sentence. The Supreme Court agreed with this assessment and noted that the argument put forward by the state "can carry little weight." The Supreme Court sided with Humphrey, ruling that Wisconsin's Mental Health Act and its Sex Crimes Act were not mutually exclusive and, therefore, that Humphrey and other MDSOs must be given the same rights allowed for by the Mental Health Act (in this case, jury determination prior to civil commitment). Moreover, they ruled that Humphrey's confinement in a mental facility was a "massive curtailment of liberty," and thus one that necessitated greater procedural protections. Altogether, then, the Supreme Court addressed a number of issues that critics raised regarding MDSO statutes. It agreed that such statutes required a relatively high level of scrutiny and that, in states where such proceedings were both civil and criminal in nature, procedural protections from both realms must be followed. The justification here was that, while such statutes might be geared towards treatment, they still put serious limitations on the freedom of MDSOs; for this reason, procedural rights should be guaranteed.

the concept of treatment (in contrast to punishment) actually offered treatment would be a recurring issue, as I'll discuss later in the chapter.

Yet while this case would be referenced frequently in subsequent decisions, it seemed to have little affect on state-level legislation regarding sex offenders. As late as 1985, Colorado was still denying committed sex offenders the same rights accorded to other committed individuals. In a case decided that year, the Colorado Supreme Court ruled that this did not violate the constitutional rights of sex offenders.⁴⁸² The case concerned periodic judicial review for individuals who were involuntarily committed. While non-sex offenders were afforded this right, sex offenders were not. Instead, once committed, staff at the treatment facility made their own determinations about whether an offender should be released. In this case, Colorado argued that sex offenders were guilty of crimes “regarded by society as particularly heinous,” and therefore the state “has a greater interest in protecting the public from sex offenders than from other categories of committed persons, and the less stringent procedural protections afforded sex offenders are rationally related to this interest.” Yet by 1985, Colorado’s civil commitment standards for other sorts of cases were based upon the concept of dangerousness. In other words, even with those mentally ill persons determined to present a danger to the public, Colorado still required periodic judicial review. Moreover, periodic judicial review was also afforded to other mentally disordered criminals—those found not guilty by reason of insanity and those found incompetent to stand trial. Of all the groups that Colorado committed (either forensically or

⁴⁸² *People v. Kibel*, 701 P.2d 37 (Colo. 1985). It is worth noting that Steven Kibel’s crimes were more serious than those of Humphrey. Kibel had pled guilty to first-degree sexual assault and second degree kidnapping. Moreover, two psychiatrists assessed him to be an ongoing danger due to violations of the hospital work-pass rules and Kibel’s reports of violent fantasies. In all, it may have been in the best interest of the state (and the public) to continue Kibel’s commitment. While the procedural issues discussed here are important, courts did not face an easy choice and many of the offenders they dealt with were genuinely dangerous and had committed genuinely heinous crimes.

civily), only sex offenders were denied the right to period judicial review. The justification for this was that their crimes were “particularly heinous” by virtue of being sexually motivated.⁴⁸³

The difference between the two cases is instructive. In *Humphrey v. Cady*, the courts ruled that sex offenders were entitled to the same protections as other individuals who were involuntarily committed, in accordance with Wisconsin’s Mental Health Act. In *People v. Kibel*, however, Colorado relied on the concept of public safety in order to argue that individuals involuntarily committed were only entitled to the protections afforded by the state’s civil commitment statutes if they were *not* sex offenders. Curiously, the courts did not argue that MDSOs were not civil committees—in other words, there was no argument put forward that they had been committed as a criminal matter.⁴⁸⁴ Moreover, sex offenders were also not entitled to the same rights as other individuals who were criminally committed, as with those found not guilty by reason of insanity. Implicitly, then, there was an acknowledgement that MDSOs were subject to civil procedures, but a simultaneous assumption that they occupied a unique place in the hierarchy between criminal prisoners and civil committees. In the eyes of the Colorado courts, the sexual aspects of their crimes made those crimes particularly heinous, in comparison to all other dangerous persons.

Alongside these procedural issues, interactions with psychiatrists and psychologists emerged as a secondary arena in which accused sex offenders were uniquely disadvantaged. In both civil and criminal proceedings, a defendant generally had a right to doctor-patient privilege.

⁴⁸³ This had its roots in the earlier “sexual psychopath” era. During that time, sexual offenses were regarded as particularly offensive, because they targeted ostensibly vulnerable citizens (women and children) and targeted public morality more broadly. On this, see Freedman. While the sex offender himself wasn’t conceived in the same way during the 1980s, his crimes were often still thought of as uniquely offensive.

⁴⁸⁴ Colorado had a hybrid system: defendants were tried and convicted in criminal courts and then assessed under the state’s Sex Offenders Act. The dual nature of this system did not form the basis of the state’s defense in this case, however.

In other words, statements made to a psychotherapist or psychiatrists could not be used in legal proceedings. In cases where this privilege was expected to be waived, mental health professionals generally issued what might be called a Miranda warning—before beginning a psychiatric examination, they would tell the defendant that any statements made to them could potentially be used in court.⁴⁸⁵ Yet when it came to MDSOs, such rights might be summarily revoked.

Illinois is instructive here. In the early 1980s, Terry Allen was charged with unlawful restraint and deviate sexual assault.⁴⁸⁶ The state filed to have Allen declared a sexually dangerous person under the Illinois Sexually Dangerous Persons Act. As part of these proceedings, Allen was ordered to submit to two psychiatric examinations. His statements in these examinations (rather than merely the results of the examinations) were then used as state’s evidence. Yet, prior to beginning the examinations, neither psychiatrist had informed Allen that his statements might be used in court (though one did inform him the results of the examination itself might be reported to the court). Allen alleged that this violated his privilege against self-incrimination.

When Allen first appealed, an appellate court found that Allen’s arguments had merit. They ruled that, though the state’s MDSO proceedings were civil in nature,⁴⁸⁷ defendants retained a privilege against self-incrimination (and other criminal safeguards) because status as

⁴⁸⁵ One author from the *Mental Disability Law Reporter* refers to this warning as a Miranda warning, though that’s not what’s technically meant by that term. There does not seem to have been a formal name for this warning, as it was more an ethical question for psychiatrists and mental health professionals than a legal issue for the courts.

⁴⁸⁶ Case history taken from the subsequent U.S. Supreme Court proceedings. See: *Allen v. Illinois*, 478 U.S. 364 (1986).

⁴⁸⁷ Not everyone involved in the case would agree that Illinois’ MDSO statute was civil in nature. While it certainly fell on that end of the spectrum (a defendant was assessed as an MDSO before being tried, convicted or sentenced), the dissenting opinion from the Illinois Supreme Court would argue that the state’s Act had a “heavy reliance on the criminal justice system” and therefore “must be considered ‘criminal’” when determining what rights a defendant was entitled to.

an MDSO could “result in a substantial deprivation of the defendant’s liberty.” In other words, despite being procedurally civil, the result for the defendant was serious enough to require certain protections accorded during criminal proceedings. That the result of such hearings was treatment in a mental facility did not outweigh the fact that a defendant would still be incarcerated in some sense. Moreover, they noted that the case had “made its entire case from the defendant’s unwarned statements”—this was not a small procedural issue, then, but a situation in which the entire edifice of the case rested on the question of whether or not Allen had been entitled to a warning regarding his psychiatric testimony.

The state appealed and took the case to the Illinois Supreme Court, which reversed the appellate court’s verdict. Here, the court argued that Illinois’ Sexually Dangerous Persons Act was designed to provide treatment, rather than punishment. Because the Act was “essentially civil in nature,” a lesser number of procedural rights was necessary.⁴⁸⁸ Ultimately, the United States Supreme Court would rule with the Illinois Supreme Court in 1986 that MDSO proceedings were not criminal, and therefore did not guarantee a right against self-incrimination. Yet at the same time, the Court acknowledged that the proceedings here were hybridized: Illinois had to file criminal charges before it could attempt to apply for MDSO status, yet this fact “does not transform a civil proceeding into a criminal one.” Here, as in other cases, the justification for this division came down to treatment: Illinois’ MDSO statute aimed “to provide treatment, not punishment, for persons adjudged sexually dangerous.”

⁴⁸⁸ Part of this argument relied on a continued separation between the civil and criminal proceedings as well: here, courts argued that a defendant’s statements would not be used in any subsequent criminal proceedings and were therefore admissible during the civil proceedings. That is, if a defendant was found to not meet the criteria for an MDSO and was remanded back to a criminal court, statements made during the earlier psychiatric examination would become inadmissible.

In addition to the above, the Illinois Supreme Court had argued (and the US Supreme Court affirmed) that giving accused MDSOs such rights would hamstring state courts. Citing an earlier case, they argued that a “strict application of the self-incrimination privilege” in MDSO proceedings would “almost totally thwart” the state’s ability to engage in such proceedings in the first place.⁴⁸⁹ While other classes of defendants (both criminal and civil) had the right to remain silent during psychiatric examinations, the Illinois Supreme Court ruled that no such privilege existed for accused MDSOs for purely practical reasons: “If MDSO defendants refused to answer questions during psychiatric interviews it would be nearly impossible for the state to prove sexual dangerousness.” The idea here was that little in the way of concrete evidence could exist that a defendant met MDSO criteria—even if a psychiatrist could establish that a defendant was mentally ill, connecting that mental illness in a concrete way to their sexual behavior and determining whether the offender was an ongoing danger required the defendant to disclose a great deal to the examining psychiatrist. This was not merely an argument over whether a psychiatrist needed to warn a defendant about their rights prior to embarking upon an examination, then, but a broader argument that defendants in such hearings could be compelled to undergo an examination in the first place. In Illinois at least, by the mid-1980s, MDSOs would have no right to refuse a psychiatric examination because the state’s interests in successfully pursuing such charges could not coexist with this right. Alongside this, the court determined that advising MDSOs that statements made to psychiatrists could be used in courts hamstrung the process in basically the same way: a defendant, if informed that his statements might be used in court, would not give such statements. Here was the double-bind of a partly-criminal, partly-civil

⁴⁸⁹ Robert M. Wettstein, “No Miranda Warnings for Alleged Sexually Dangerous Persons,” *Mental Disability Law Reporter* 10, no. 4 (July-August 1986). Here, the courts cited *Matthews v Eldridge*, 96 S. Ct. 893 (1976).

system: because MDSO commitments relied as much on the accused's mental state as on their actual crimes, proving their dangerousness became an internal task predicated on examining the mind of the offender rather than one based upon the crime itself and that could be assessed through more objective evidence.

In Illinois' case, this represented a particularly pointed irony: the state's civil commitment statute expressly protected a defendant's privilege against self-incrimination, and expressly required that such a warning must be provided by any examining psychiatrists.⁴⁹⁰ Failure to issue such a warning resulted in that psychiatrists' testimony being barred from court.⁴⁹¹ Thus when the Illinois Supreme Court argued that it was the civil nature of MDSO hearings that allowed such a privilege to be waived, it ignored the nature of civil commitment hearings in the state. Here, again, MDSOs were placed in a unique position. Stranded between the civil and criminal systems, they received the full rights accorded within neither system. Observers at the time noted this explicitly: "Thus, as noted by Justice Stevens and by the amicus brief filed by the American Psychiatric Association, in order to deny the justification for Miranda warnings in this case, the Illinois Attorney General had to argue that pre-conviction sexually dangerous persons' proceedings were neither wholly criminal nor wholly civil in nature."⁴⁹²

For their part, psychiatrists chafed at these restrictions. Doctor-patient privilege was an important part of psychiatric work, particularly for forensic psychiatrists.⁴⁹³ According to guidelines written by the American Academy of Psychiatry and the Law, psychiatrists ought to

⁴⁹⁰ The right to such warnings in civil commitment cases had been established in a case in 1972—*Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972). The Lessard case is considered a landmark case in the history of civil commitment and patients' rights. Courts across the country adopted numerous pieces from the case, but few adopted the 'Miranda warning' piece.

⁴⁹¹ Wettstein, "No Miranda Warnings."

⁴⁹² Wettstein, "No Miranda Warnings."

⁴⁹³ See chapter 3 on mandatory reporting statutes for one example of this.

explain “what could result from such disclosure of the information” provided during a court-ordered psychiatric examination.⁴⁹⁴ The APA’s own ethical guide reiterated this: “The psychiatrist must fully describe the nature and purpose and lack of confidentiality of the examination to the examinee at the beginning of the examination.”⁴⁹⁵ There was no clear reason to mental health professionals why such ethical guidelines should be waived simply because the proceedings in question concerned sexually-motivated crimes. And in response to the Illinois case, the APA filed an amicus brief arguing that the right against self-incrimination (and, along with it, the preemptory warnings given by psychiatrists and other mental health professionals) should be retained during MDSO hearings.⁴⁹⁶ Such psychiatric objections, however, produced little in the way of legal changes.

Altogether, the debate over the rights of MDSOs demonstrates that courts weren’t quite sure what to do with sex offenders. Treating mentally ill sex offenders as merely criminal was problematic for two reasons: first, criminal penalties for sex crimes included relatively short sentences and thus would see MDSOs back on the streets more quickly than observers would have liked, and second, incarceration did little to treat the underlying mental illness, thus rendering the released offender just as dangerous as he had been before imprisonment.⁴⁹⁷ At the

⁴⁹⁴ American Academy of Psychiatry and the Law, “Ethical Guidelines for Forensic Psychiatry” (draft version, 1985), as cited in Wettstein, “No Miranda Warnings.”

⁴⁹⁵ American Psychiatric Association, *Principles of Medical Ethics with Annotations, Especially Applicable to Psychiatry* (Washington, DC: American Psychiatric Association, 1985).

⁴⁹⁶ Brief for the American Psychiatric Association as Amicus Curiae, “Whether 5th amendment privilege against self incrimination applies to proceedings under the Illinois sexually dangerous persons act,” *Allen v. Illinois*, U.S. Supreme Court, No. i85-5404.

⁴⁹⁷ Perhaps a more obvious solution would have been to lengthen prison sentences for sex crimes. Attempts to do so occurred, but were uneven. The chief mechanism by which states increased penalties against sex offenders (and other classes of criminals) was imposing mandatory minimum sentences (rather than lengthening maximum sentences). Conversely, there were arguments from both legal observers and feminists that longer sentences for sexual offenses would be counterproductive—here, such individuals argued that juries were more likely to

same time, courts couldn't pursue MDSO proceedings while observing existing procedural rights in either the criminal or the civil system. Accordingly, what emerged was a legal morass where courts attempted to deal on the ground with a group of offenders whose crimes they felt were particularly heinous and who were, in many cases, legitimately dangerous. Throughout this period, cases ping-ponged from state courts to the Supreme Court and back down again. Statutes were rewritten and reinterpreted. Sentences were given, renewed and vacated. Little in the way of a solution to the larger problem—how to adequately deal with mentally disordered sex offenders—emerged.

“For the Purposes of Treatment”

As noted above, as legal challenges to MDSO statutes mounted, courts would return again and again to the same justification: the purposes of such statutes were for treatment, rather than punishment. But what was meant by this distinction? In some cases, it spoke to a confused amalgam of the two systems—for instance, in Illinois, where alleged MDSOs were denied the right against self-incrimination by virtue of being involved in civil proceedings, yet where civil committees enjoyed that very right. In most cases, such assertions seemed merely to reflect the way statutes were written and were given by courts as pat assurances—in other words, MDSO

convict sex offenders if penalties were relatively low and that increasing sentences meant lowering conviction rates. On this, see: Noreen Connell and Cassandra Wilson, *Rape: The First Sourcebook for Women* (New York: New American Library, 1974); “Revolt against rape,” *Time*, July 22, 1974. For a summation of feminist attitudes towards sentencing and other legal questions in this period, see: McNickle Rose, Vicki, “Rape as a Social Problem: A Byproduct of the Feminist Movement,” *Social Problems* 25, no. 1 (October 1977). For a more general history of sentencing—and mandatory minimums in particular—see: Nancy Gertner, “A Short History of American Sentencing: Too Little Law, Too Much Law, or Just Right,” *Journal of Criminal Law and Criminology* 100, no. 3 (Summer 2010); Judith Greene, “Getting Tough on Crime: The History and Political Context of Sentencing Reform Developments Leading to the Passage of the 1994 Crime Act,” in Cyrus Tata and Neil Hutton, eds., *Sentencing and Society: International Perspectives* (Hampshire: Ashgate Publishing Limited, 2002).

proceedings took place in civil courts and were therefore civil, ergo there was no need to question what constituted a civil system versus a criminal one.

Occasionally, however, courts would directly broach this underlying question. In *Illinois v. Allen*, for instance, the Supreme Court would state that Illinois' MDSO statute "does not appear to promote either of the traditional aims of punishment—retribution or deterrence." The dissent from that case would argue, conversely, "With respect to a conventional statute, if a State declared that its goal was 'treatment' and 'rehabilitation,' it is obvious that the fifth amendment would still apply." Here, we have an operational set of definitions: punishment meant retribution and deterrence, and treatment meant rehabilitation. Yet it is not clear how such definitions applied on the ground. While the American prison system was not geared towards rehabilitation in the 1980s in any practical sense, such a goal could be argued to be part of that system.⁴⁹⁸ Moreover, what did the Supreme Court mean by "deterrence" here and why didn't commitment to a mental health facility—expressly done to protect the public from further danger—fit with that goal? Alongside the above definitions, courts frequently brought in an additional aspect: the loss of liberty. Courts didn't generally assign this to either side—treatment or punishment—but noted that it applied to both. While the distinction between treatment and punishment may have made sense from the standpoint of the justice system, such a distinction made little difference to defendants.

Alongside the question of treatment versus punishment, there was also a recurrent question about treatment itself. If the prospect of treatment was the justification for a variety of

⁴⁹⁸ The criminal justice system's interest in rehabilitation has waxed and waned over the twentieth century. Rehabilitation was a significant motivation in the early twentieth century, but played a significantly smaller role in criminal justice discussions by the mid-1980s. The relative balance of retribution and rehabilitation (and other concerns, such as deterrence and public safety) has been hotly debated throughout American history. On the shift away from rehabilitation, see Gertner, "A Short History."

things (lesser standards of proof, fewer procedural rights, indeterminate sentences), then treatment must truly exist. In an Oregon case, *Ohlinger v. Watson*, a court asserted that sex offenders had a constitutional right to realistic individual treatment and noted, “the *quid pro quo* for their longer confinement was rehabilitation.”⁴⁹⁹ Moreover, such treatment must be given regardless of budgetary concerns or time constraints on the part of the prison or treatment facility. In its ruling, the court argued that treatment might reflect budgetary concerns or time constraints and still be constitutionally adequate if the prisoner had a determinate sentence. The imposition of indeterminate sentences on MDSOs, however, necessitated a higher standard of care. While such care did not have to be “the best possible treatment or a guarantee that they would be cured,” it did have to be individualized, address each offender’s particular needs, and have the “reasonable objective of rehabilitation.” If treatment could not meet these needs, then it rendered the indeterminate sentence problematic, in that the sentence no longer bore a “reasonable relation to the purpose for which the individual is committed.”⁵⁰⁰ Another case from the early 1980s (*Balla v. Idaho*) further affirmed that the trade-off for the indeterminate sentences that generally came with MDSO statutes was appropriate treatment.⁵⁰¹ In all, courts in the early 1980s generally agreed that MDSO statutes were not merely a way to indefinitely remove offenders from the public; instead, they were sincerely intended to help treat mentally ill sex offenders.

How treatment was implemented was a different question entirely. First, there was a question of whether or not accused and convicted sex offenders were entitled to evaluations to

⁴⁹⁹ “Realistic Right to Treatment,” *Mental Disability Law Reporter* 5, no. 1 (January-February 1981). The case in question here was *Ohlinger v. Watson*, No. 78-3037 (9th Cir. Nov. 12, 1980).

⁵⁰⁰ Here, the court cited an earlier case: *Jackson v. Indiana*, 406 U.S. 715 (1971).

⁵⁰¹ *Balla v. Idaho State Bd. Of Corrections*, 595 F. Supp. 1558 (D. Idaho 1984). For a discussion of the case, see: “Psychiatric care for federal inmates,” *Mental Disability Law Reporter* 9, no. 2 (March-April 1985).

determine whether they were MDSOs and thus entitled to treatment. States ruled differently on this issue. In Florida, courts repeatedly found that judicial discretion did not necessarily include denying such evaluations.⁵⁰² More specifically, any accused or convicted sex offender with a demonstrable history of mental illness was entitled to an evaluation if he sought it out.

Massachusetts took the opposite approach and allowed judges to deny evaluations due to other concerns, such as “punishment and deterrence.”⁵⁰³ In other words, Massachusetts could decide that a particular crime warranted punishment regardless of whether or not the offender might be mentally ill.

As well, the realities of implementing treatment regimes for sex offenders were more uneven than such language suggested. As demonstrated by the *Ohlinger* case, many prisons simply didn’t have the resources to offer individualized treatment—in these cases, offenders were given indeterminate sentences justified by the idea of treatment and then left to languish without it. And while an increasing number of treatment centers existed, spaces in such facilities were highly limited. The Johns Hopkins Sex Disorders Clinic, for instance, had about a dozen in-

⁵⁰² “Stages of Proceedings: Initial Determination,” *Mental Disability Law Reporter* 5, no. 1 (January-February 1981). Two cases are discussed here: *Gerardo v. Florida*, 383 So. 2d 1122 (Fla. Dist. Ct. App. 1980); *Durbin v. Florida*, 385 So. 2d 172 (Fla. Dist. Ct. App. 1980). A third case—*Dudley v. Florida*, 397 So. 2d 1048 (Fla. Dist. Ct. App. 1981)—is discussed in “Two mentally disordered sex offenders were improperly treated, Fla. Courts declare,” *Mental Disability Law Reporter* 5, no. 5 (September-October 1981). In the first case, the offender had a history of institutionalization and a court-appointed psychiatrist testified that he needed treatment in order to not be dangerous upon release. In the second case, part of the issue was the Durbin had been previously found to be an MDSO. After being released and reoffending, a judge denied him a second evaluation as an MDSO, arguing that further treatment would be futile. An appellate court ruled that, “Once adjudicated as a mentally disordered sex offender the court is without authority to sentence such an offender to prison before he receives treatment.” In the third, an appeals court ruled that the judge had erred in refusing to allow an MDSO evaluation for a defendant.

⁵⁰³ “Blind rape victim uses voice identification; defendant denied psychiatric exam,” *Mental Disability Law Reporter* 5, no. 5 (September-October 1981). The case discussed here is *Massachusetts v. Pacheco*, 421 N.E.2d 1239 (Mass. App. Ct. 1981).

patient spots. Though the clinic treated a much higher number of individuals on an outpatient basis, outpatient treatment might not be acceptable for any given MDSO. Likewise, New Jersey's premier forensic treatment center for sex offenders would become more overcrowded proportionally than any prison in the state by the mid-1980s.⁵⁰⁴ Opened in 1976, it initially housed 155 sex offenders and was rated for 228. By 1985, there would be 362 patients and a 92-person waiting list.⁵⁰⁵ By 1988, the facility would implement double-bunking to accommodate its 466 patients, more than twice as many as it was intended to hold. Courts weren't entirely unaware of this issue. In fact, the Illinois Supreme Court had noted in 1976 that the justification of treatment was "archaic" and that, "The promise of treatment has served only to bring an illusion of benevolence to what is essentially a warehousing operation for social misfits."⁵⁰⁶ Taken with the above rulings that treatment must be adequate in order to justify indeterminate sentences, the issue of overcrowding (and the less adequate treatment such overcrowding resulted in) was significant.

Finally, the way procedural issues were resolved in the courts could have negative effects on treatment programs. For instance, while indeterminate sentences remained a persistent legal issue, determinate sentences could be equally as problematic. Cole notes that a shift between these two systems caused significant issues for the Adult Diagnostic and Treatment Center, New Jersey's largest sex offender treatment facility. Prior to 1979, the state had imposed indeterminate sentences on MDSOs. That year, it revised its statute and began imposing longer determinate sentences. The result was that officials at the facility had little control over when an inmate was released. Cole argues that this took away a major incentive for offenders to cooperate

⁵⁰⁴ And, in many cases, had been a problem for some time. Cole ("From the Sexual Psychopath") notes overcrowding at Avenel during the 1950s too.

⁵⁰⁵ Cole, "From the Sexual Psychopath."

⁵⁰⁶ *Stachulak v. Coughlin*, 424 U.S. 947 (1976).

with treatment—if they were going to serve a twenty-year minimum sentence regardless of how they behaved while committed, there was less reason to cooperate in good faith with treatment. The legislature had made this change in an attempt to appear tough on crime and, by erring on the side of punishment, the legislature detracted from the idea of treatment in both abstract and concrete ways.

Conversely, one ironic case indicates that indeterminate prison sentences could conflict with entry into treatment programs. *Utah v. Bishop* (1986) was a minor case that produced no major changes in case law, but was symbolic of the shift away from the treatment-based legal approaches of the 1970s and early 1980s. Douglas Bishop had been accused of three counts of sodomy committed against a child (three separate children, in fact) and two psychiatrists testified that his crime was related to mental illness (“chronic pedophilia,” which they stated was a “psychosexual behavioral disorder”).⁵⁰⁷ Because of this, he was found guilty and mentally ill. In keeping with the state’s criminal statutes, Bishop was sentenced to an indeterminate prison sentence.⁵⁰⁸ Altogether, this should have made Bishop an ideal candidate for one of the state’s treatment programs for MDSOs—he had a diagnosable mental illness to which his sexual crimes could be attributed and, given the chronic nature of his disorder, would most likely represent a danger to the public upon his release. However, the treatment program for which he was best suited only accepted convicts as they neared the end of their sentences—the program ran for

⁵⁰⁷ *Utah v. Bishop*, 717 P.2d 261 (1986).

⁵⁰⁸ Most crimes in Utah could receive an indeterminate sentence. Few had mandatory minimums. For instance, as Bishop noted in his suit, a second-degree murderer might be sentenced to a term of five years to life. That meant the murderer could be paroled before that five years was up. Conversely, a child molester like Bishop would be sentenced to a mandatory minimum of five years to life, meaning he would not be eligible for parole until he had served at least five years. The Utah Supreme Court justified this discrepancy on two bases: first, they didn’t parole many second-degree murderers before five years, so Bishop’s point was moot. Second, second-degree murderers had a lower recidivism rate than did child molesters, so it was just to remove child molesters from society for a longer period of time.

three years and accepted men three years out from parole. Bishop's mandatory minimum sentence of five years prevented him from entering the program immediately; his indeterminate sentence effectively barred him from it indefinitely. As a result, Bishop brought a suit claiming that his sentence was cruel and unusual for, among other things, preventing him from accessing treatment for a mental disorder that the court agreed he suffered from.⁵⁰⁹ The court, however, rejected the suit and claimed that effectively barring him from the state's sex offender program was not a violation of his rights because he could seek treatment for any psychiatric problem requiring "immediate" attention. In other words, while his pedophilia was a mental illness, it wasn't a pressing one and therefore the state was not required to offer him treatment for it. Just a few years earlier, courts across the country had ruled that the existence of treatment programs entitled offenders like Bishop to their use. By the mid-1980s, however, punishment was increasingly considered more important than treatment, even when such treatments could easily be made available to an offender. The reliance on "tough on crime" policies (such as mandatory minimum sentences) and a judicial philosophy that increasingly privileged retribution over rehabilitation meant that men like Bishop, despite their potential treatability, would be caught up

⁵⁰⁹ Bishop's suit was capacious. He argued that the state's indeterminate sentencing structure, having been imposed by the legislature, interfered with the constitutional rights of the state's judges and the Board of Parole. He argued that the indeterminate sentence was unique to sex offenders, which wasn't true and which the court dismissed out of hand. He argued that his mandatory minimum sentence was cruel and unusual because it was disproportionate to his crime—the court disagreed, given that he had committed three acts of sodomy against two children. He argued that the state's statute meant that any time spent in a mental health facility wouldn't count towards his mandatory minimum sentence—the court said that this was nothing more than a misinterpretation and that Bishop was required to serve five years in total, but three years spent in a treatment facility would count towards this. In all, Bishop seems to have thrown everything at the wall in the hope that something would stick. Most of his arguments were specious and based on misinterpretations of the state's laws.

in a more general shift towards punishment taking place in the criminal justice sphere by the mid-1980s.⁵¹⁰

For its part, the Utah Supreme Court argued openly that punishment ought to supersede treatment in Bishop's case. It gave three reasons:

First, a minimum mandatory sentence is likely to have a substantially greater deterrent effect than an indeterminate sentence subject to early termination by the Board of Pardons. Second, a minimum mandatory sentence is likely to provide child molesters, both those who have been convicted and those who have not been prosecuted, a greater incentive to reform. Finally, because therapy and other rehabilitation efforts have not proved very successful with molesters, it is reasonable to isolate offenders from society for a longer period of time to reduce the potential for future offenses.⁵¹¹

In other words, punishment itself was an incentive to reform. It's not clear how the court thought this would work—they agreed that Bishop was suffering from a chronic mental disorder that had resulted in his sexually victimizing three children, yet simultaneously argued that therapy had proven largely ineffective for offenders like him. What was left was an unsupported assertion that punishment helped—through both deterrence and reform—because lawmakers were left with few alternate solutions.

It also stands to reason that Utah, by having criminal statutes that allowed for indeterminate prison sentences, had circumvented the initial need for civil commitment of sex offenders (with prison sentences lacking, legislators had been in search of a way to more permanently remove sex offenders from the public or otherwise make them not dangerous).

⁵¹⁰ See Gertner, "A Short History;" Greene, "Getting Touch on Crime."

⁵¹¹ The court also argued that a mandatory minimum sentence was justified for sexual offenses against children in particular because such crimes resulted in long-term harm in two senses. First, even crimes that did not involve physical violence produced long-lasting psychological harm to the victims. Second, molested children might themselves become molesters. In other words, men like Bishop harmed not just their immediate victims, but passed down their predilections like an illness and were thus, at some level, responsible for any victims their own victims might produce. Here, the court cited the following article: Irving Prager, "'Sexual Psychopathy' and Child Molesters: The Experiment Fails," *Journal of Juvenile Law* 49, no. 6 (1982).

Since Utah could keep Bishop in prison for as long as it liked, the possibility that he would constitute a public danger was not quite as pressing an issue and, therefore, neither was offering him treatment for his pedophilia.

In addition to the question of whether or not offenders were entitled to treatment or whether adequate treatment existed within increasingly overcrowded facilities, there was the issue of determining whether any given offender was suited for treatment. The Utah Supreme Court had addressed this issue by arguing that treatment wasn't particularly effective for men like Bishop. But alongside this broader question—could treatment be effective for particular types of sex offenders, and for child molesters in Bishop's case—was a more individualized question. Here, courts had to determine whether a particular offender could be helped—and helped to what extent—by a treatment program. Courts approached this issue in a few different ways. Some determined that an MDSO was entitled to treatment if there was a reasonable chance he could be helped by such treatment. Others determined that MDSOs were entitled to treatment regardless of whether such a treatment was likely to help; the mere existence of a sex offender program entitled the MDSO to its use. Other courts, however, took a less permissive stance. Nebraska, in particular, tended to rule that sex offenders were only entitled to treatment if the treatment was likely to cure them of their disorder.⁵¹² The result here was that an MDSO deemed untreatable was entitled to nothing beyond a standard jail sentence, despite having been found to suffer from a mental illness. Nebraska seems to have been unique in this regard and for good reason: few psychiatrists would testify that something like pedophilia could be, strictly speaking, cured.

⁵¹² “Untreatable Sex Offender,” *Mental Disability Law Reporter* 10, no. 2 (March-April 1986). The case in question was *Nebraska v. Reddick*, 376 N.W.2d 797 (Neb. Sup. Ct. 1985). An earlier case—*Nebraska v. Sell*, 277 N.W.2d 256 (Neb. Sup. Ct. 1979)—had similarly affirmed that such offenders were not entitled to treatment.

As part of the treatability question, courts needed to determine whether any given offender was amenable to treatment. Initially, there was a commonsensical assumption that an individual must be willing to cooperate with therapy in order to benefit from it.⁵¹³ In the early 1980s, however, courts gradually moved away from this idea and eventually argued that cooperation did not define amenability at all. Alongside this, there was an argument that whether an offender agreed to cooperate with treatment had little bearing on whether they belonged in a treatment facility. This was partly a pragmatic assessment: many mentally ill offenders did not recognize that they had a problem, but this lack of recognition shouldn't form a bar to treatment. Moreover, courts would argue that mentally ill sex offenders shouldn't be given the right to absent themselves from treatment. It was in the interest of everyone involved for such offenders to get treatment, no matter how much the offender might not want it. In this sense, the shift away from amenability was convenient for courts and allowed them to commit uncooperative MDSOs who they believed to be unsuited to prison. Behind this, in many states, was the choice between an indeterminate psychiatric sentence and a determinate and often short prison sentence. Any given offender, in this context, raised two questions for the courts: Could he be treated and would his premature release from prison pose a danger to the public? The answers to these questions did not always match up and, in such cases, courts erred on the side of public safety. Arguing for a wider definition of amenability justified such practices without getting rid of the treatment ethos entirely.

This shift is most visible through a 1980 case in California. In 1973, Lee Donald Lakey had been convicted of involuntary manslaughter. After the conviction, a court and jury

⁵¹³ As discussed in chapter 1, this had been one of the chief impediments to treating sex offenders. Groth, among others, had argued that sex offenders did not typically have the sorts of self-awareness and ability to change that made therapy useful.

determined that he was an MDSO and he was committed to Atascadero State Hospital, California's largest facility for sex offenders. Over the next few years, Lakey would prove largely uncooperative—though staff at Atascadero said he occasionally accepted treatment, he generally refused to participate in therapy and his resistance grew more pronounced over time. In 1975, his behavior had become so counterproductive that staff at Atascadero began recommending he be removed from the facility and returned to the courts for criminal sentencing. This was arguably in keeping with the state's legal procedures at that time. The state's statute provided that once a person "has been treated to such an extent that in the opinion of the medical director of the state hospital or other facility... the person will not benefit by further care and treatment and is not a danger to the health and safety of others," the medical director should file with the court a recommendation "concerning the person's future care, supervision, or treatment." In the event that such an individual wasn't eligible for parole, they would be returned to a criminal court "to await further action" regarding criminal sentencing.⁵¹⁴ Clearly, then, the statute allowed for treatment to end, with the result that the offender would be either released or incarcerated in a prison. Yet there remained a question: could Atascadero be done with Lakey if he only met one half of the statute ("the person will not benefit by further care and treatment") but not the other ("is not a danger to the health and safety of others")? The part of the statute that allowed for continued incarceration in a criminal facility brought up the same issue—it specified that this might happen "upon the entry of a finding that the person is no longer a mentally disordered sex offender." But Atascadero wasn't arguing that Lakey was no longer an MDSO nor that he was no longer dangerous; they were merely arguing that his specific issues and personality made him unable or unwilling to benefit from treatment.

⁵¹⁴ California Welfare and Institutions Code Section 6325.

After Atascadero's report in 1975, a series of legal events resulted in Lakey remaining at the hospital for the next two years.⁵¹⁵ By 1977, however, California's relevant statute had been amended. It now read that commitment as an MDSO "places an affirmative obligation on the department to provide treatment for the underlying causes of the person's mental disorder."⁵¹⁶ In other words, Lakey's initial commitment as an MDSO meant Atascadero was required to offer him treatment. On the question of patient cooperation, the statute read:

Amenability to treatment is not required for a finding that any person is a person as described in subdivision (a), nor is it required for treatment of such person. Treatment programs need only be made available to such person. Treatment does not mean that the treatment be successful or potentially successful, nor does it mean that the person must recognize his or her problem and willingly participate in the treatment program.

In other words, the statute dictated that a patient need not be cooperative in order to be rightfully kept in a treatment facility. They needn't even benefit from such treatment. The mere existence of such treatment meant both that the offender was entitled to treatment and might be forced to remain in treatment, and also that the facility was obligated to provide such treatment.

For Atascadero, the immediate result of this change in statutory language was that the hospital's medical director would drop his attempt to remand Lakey to the courts and instead pursue an extension of Lakey's commitment. In the subsequent recommitment hearing in 1977, part of the issue would be whether or not Lakey was able to cooperate—in other words, had he made a choice of his own volition, or was his lack of cooperation been due to an underlying mental disorder—and whether cooperation would have resulted in him benefiting from treatment. The two psychiatrists who testified at the hearing disagreed on the former point, but

⁵¹⁵ In 1980, the court would note that the reason for this wasn't entirely apparent. It seems that Lakey filed and then abandoned some sort of lawsuit, and the result of this wrangling was that Atascadero's attempt to hand him off to the courts was forestalled. See the appeals court case for coverage of the case's history: *California v. Lakey*, 102 Cal.App.3d 962 (Cal. Ct. App. 1980).

⁵¹⁶ California Welfare and Institutions Code Section 6316.2.

both agreed that Lakey would have benefited from treatment had he cooperated with it. In other words, Lakey's ability to benefit was contingent on his cooperation with and amenability to treatment (though one of the psychiatrists stated that they might be able to design a treatment program that took Lakey's refusal to cooperate into consideration). Regardless of Lakey's reasons, however, the psychiatrists agreed that the prospect of Lakey cooperating was grim—while one gave a 40% chance that he might begin cooperating, and the other stated the prospect was “almost nil” and that further treatment would be “a waste of time and energy on the part of medical personnel.” Altogether, then, while Atascadero's staff might be able to work around Lakey's lack of cooperation, the likelihood that he would substantially benefit from treatment was low.

Yet when the question of Lakey's recommitment went to the jury, they were instructed to consider only two things: whether Lakey suffered from a mental disorder and whether that mental disorder made Lakey likely to commit further sex crimes and thus a danger to the public.⁵¹⁷ Because of the new statute, the question of whether Lakey was amenable to treatment or likely to benefit was largely irrelevant in determining whether Lakey should be in a treatment facility. The result was, unsurprisingly, that the jury agreed with Atascadero's petition to extend Lakey's commitment.

Shortly after this verdict, Lakey appealed. Much of his appeal centered on the question of amenability—he argued that an extension of his commitment as an MDSO required that he be

⁵¹⁷ The court defined the phrase “mental disorder” as “any abnormal condition of the mind causing and/or permitting conduct of the type not acceptable to society as expressed in its criminal statutes *and of a nature changeable with or by treatment.*” However, there was no indication that this second part need narrowly apply to Lakey—if he, for personal reasons, chose not to cooperate with treatment but his condition was treatable in more cooperative patients, then Lakey met this barrier.

shown to be amenable to treatment and that the courts had failed to prove that he was.⁵¹⁸ The appeals court that heard the case noted that the statute, as written, did not require a finding of amenability to treatment. They disagreed, however, that this was acceptable. Citing a number of court cases, the appeals court concluded that, “Not only is medical treatment the *raison d’etre* of the mentally disordered sex offender law, it is its sole constitutional justification.”⁵¹⁹

Accordingly, because treatment was the overriding justification for such a law, an individual must be demonstrated to be able to benefit from treatment in order to be adjudicated under such a law. As with the Oregon case discussed previously, treatment must realistically exist and realistically benefit a particular offender; the abstract existence of treatment was not sufficient to justify MDSO statutes. The new statute’s attempt to estrange amenability from benefit, then, was constitutionally dubious. Moreover, failure to provide treatment from which an offender might realistically benefit troubled the line between treatment and punishment: “Absent treatment, the hospital is transformed ‘into a penitentiary where one could be held indefinitely for no convicted offense.’ The purpose of involuntary hospitalization for treatment purposes is *treatment* and not mere custodial care or punishment.” Without *real* treatment (and not merely the abstract or technical availability of such treatment), then, a treatment facility was functionally no different from a prison.

⁵¹⁸ Lakey cited a few other issues. First, that the statute he had been adjudicated under was constitutionally void for vagueness (it didn’t sufficiently define terms like “mental disorder” or “danger,” in Lakey’s opinion). Second, that the court should not have admitted statements he had made to hospital staff during therapy sessions, as those statements were privileged.

⁵¹⁹ Here, the courts cited two cases: *California v. Compelleebee*, 160 Cal. Rptr. 233 (Cal. Cr. App. 1979), and *California v. Feagley*, 535 P.2d 373 (Cal. Sup. Ct. 1975). The Feagley case had determined that a patient must reasonably benefit from treatment in order to be committed in the first place; thus in the Lakey case, the appeals court held that such standards should be equally applied to a recommitment hearing.

Despite these findings, however, the appeals court ultimately argued that Lakey's lack of cooperation in treatment did not render him unamenable to treatment. They stated,

We believe it patently unwise to give a person committed to treatment what is in essence a veto power. If a patient can render himself unamenable to treatment by simply refusing to cooperate in therapy programs set up for his benefit, the state's fundamental interest in treating and, hopefully, curing those persons with dangerous mental health disorders would be frustrated.

It is not clear how the appeals court was defining amenability here. A commonsensical understanding of that term had been based largely on patient cooperation. While cooperation wasn't the only thing that made an offender able to benefit from treatment, it played a significant role in the eyes of psychiatrists.⁵²⁰ Here, it seems that California had chosen to redefine its objectives (to provide treatment whether or not an offender wanted it) while couching them in familiar language. The court had concluded that the ability of a patient to benefit from treatment was an important justification for MDSO status, and likewise that relying on MDSOs to cooperate was unworkable. To resolve this difficulty, they relied on a revised definition of amenability that no longer required cooperation but hinged on other unspoken aspects of the patient's psyche and the treatment regime.

The disconnect here was in how these two spheres—psychiatric and legal—were defining amenability. For treatment facilities, amenability was a question of whether a particular offender would benefit from treatment and one answered on the ground. In an earlier case, Atascadero's former medical director had framed it thusly:

A person determined to be a mentally disordered sex offender is considered to be amenable to treatment... if he recognizes that he has a problem, indicates a desire for help, and cooperates in treatment programs offered at Atascadero...
Conversely, someone who does not think that he has a problem, or who does not want help, or who cannot participate in or benefit from our treatment program

⁵²⁰ Note, again, Utah's contention that child molesters were generally unable to benefit from treatment due to the nature of their crimes and mental disorder.

because his predisposition towards violence renders him primarily a custodial problem, is not considered amenable.⁵²¹

How someone behaved within the treatment facility was a significant part of what determined, for psychiatrists, whether that person was amenable to treatment. For the courts and legislature, however, amenability was a question of where an offender belonged in the first place. The presence of a mental disorder might make a person amenable to treatment and thus entitled to it, regardless of pragmatic questions about whether any given offender was likely to benefit.

Alongside this, the question of “benefit” might take place at a higher level—could an offender theoretically benefit? Then their behavior within a treatment center mattered less. In all, it was a question of whether prison versus treatment was more appropriate, whereas treatment facilities were more predisposed to worry about whether the facility itself was an appropriate environment once an offender was there. Amenability became, for the courts, a word that “further[ed] the conceptual distinction between treatment and incarceration,” rather than a word that conveyed specific expectations about an offender’s behavior.

This was a significant symbolic difference between treatment-based and punitive systems. While statutes still relied on the concept of treatment, by dropping the idea of patient cooperation and arguing that amenability did not rely on it, courts implicitly acknowledged that whether or not a treatment was likely to be effective was less important than removing an MDSO from the public. From this, it’s clear that treatment had ceased to be the overriding goal of such statutes in practice, even if treatment remained the overriding rhetorical justification for those statutes.

This created practical issues for treatment programs, in that a number of individuals were committed to their care who refused to participate in the program and who, in many cases,

⁵²¹ Leon, 94.

caused trouble. Lakey was one such man. Atascadero's treatment program was predicated on group therapy and creating a community amongst its patients. Lakey's refusal to cooperate in that community could make the community itself less effective. Other, similar cases cropped up across the country. In Massachusetts, one MDSO (Albert Gagne) committed to Bridgewater State Hospital was found so unmanageable that the state's Commissioners of Mental Health and Corrections brought a suit to be rid of him. They stated that Gagne had been "threatening, assaultive, and generally dangerous and unmanageable" and that he was unable to benefit from treatment.⁵²² Moreover, they argued that Gagne's problems were not primarily rooted in a sexual disorder nor did his problems manifest in primarily sexual ways (though he had been convicted of sexual crimes committed against a number of children and had initially been deemed to be a sexually dangerous person by consultants at Bridgewater).⁵²³ While the first court that tried Gagne's case agreed with Bridgewater's suit, an appeals court reversed that decision. The issue here came down to the standing of the plaintiffs—the appeals court argued that the Commissioners of Mental Health lacked standing to bring a suit regarding Gagne's status as an MDSO "because they lacked a cognizable interest in the subject matter of the dispute." While this might make sense from the court's point of view—after all, legal standing is a byzantine question—it demonstrates the relative lack of power that many treatment facilities had in this process. In many states, they could neither determine which patients were suitable nor get rid of

⁵²² *Commissioner of Mental Health v. Gagne*, 475 N.E.2d 1243 (Mass. App. Ct. 1985).

⁵²³ Gagne's case underscores the ways in which psychiatric knowledge was imprecise. It's not clear what led to the change in his diagnosis between his initial evaluation and the subsequent lawsuit, though there are a number of possibilities. The initial evaluation relied on a relatively brief interaction and his longer stay at Bridgewater may have provided better insight into his condition. The shift may have been purely instrumental on the part of Bridgewater staff to be rid of a troublesome patient. It may have been reflective of changing practices or theories at Bridgewater. In any case, the *Gagne* case made it clear that psychiatric experts could disagree quite fundamentally on patients' diagnoses and that this disagreement would present problems for courts attempting to ascertain an objective picture of the situation.

unsuitable patients once they had them. In MDSO proceedings, courts were concerned with aligning a defendant with a domain—treatment versus punishment. Conversely, a treatment center’s ability to function was predicated on aligning a given patient with a given treatment. When confronted with men like Gagne, then, the courts’ interests superseded and thus challenged the psychiatric domain.

In the Gagne case, there was also an issue of what to do with Gagne in an immediate sense. Gagne wasn’t eligible for parole and had been criminally sentenced to a treatment facility. There was no provision within the state’s statute for the treatment center to send him back to court to a criminal facility, thus the Commissioners’ request was a legal non-starter. The alternative—what the statute actually allowed for, as written—was to parole Gagne. Given that both the courts and the staff at Bridgewater agreed that Gagne was still dangerous, this didn’t strike the court as a good option. Accordingly, from a legal standpoint, it was in the best interest of the public for Gagne to remain at Bridgewater.

While the Commissioners argued that Gagne’s continued presence at Bridgewater represented “a waste of the valuable and limited resources of the treatment center,” the appeals court argued that administrators at Bridgewater were selfishly looking towards their own needs rather than the needs of the public:

The plaintiffs, on the other hand, are officials who have responsibility for operating the treatment center, and their concerns are primarily administrative in nature. They cannot be expected to have the incentive to advocate the interests of public safety. In fact, their administrative concerns, while understandable and compelling, might often be expected to run counter to the public protection objectives of [the statute].

If the Lakey case demonstrated the different ways in which psychiatric and legal observers defined concepts like amenability, the courts statements here demonstrate the ways in which the courts wielded the concept of public safety against treatment centers. At the end of the day, the

appeals court argued, their concern was for the broader public and any issues that happened at Bridgewater were simply “not within the area of concern of the statutory scheme.” Finally, the appeals court alluded to the possible existence of “remedies” for Bridgewater in dealing with unmanageable patients like Gagne that wouldn’t possibly present a threat to the public. They did not, however, specify what such remedies might be, nor seem overly concerned with the question. Those remedies were, again, Bridgewater’s responsibility to find and not the court’s.

What emerges is an extraordinarily complicated picture not simply of the treatment versus punishment question for mentally ill sex offenders, but also of the relationship between the legal and psychiatric domains. Courts insisted, again and again, that MDSO statutes were designed to treat rather than punish. Yet on the ground, this distinction was not so simple. Despite relying on this rhetorical distinction, few courts provided a clear definition of the differences between those two things. While it may have been clear to the courts what the distinction between civil and criminal matters were (in that the two used different courts and different procedures), it was less clear from the standpoint of offenders who were going to be confined regardless of which courts their trials took place in. Moreover, providing treatment raised complicated questions: Did such treatment exist in any particular jurisdiction? Who was entitled to it? Who would determine which offenders were suitable for treatment? What would happen when a patient proved unsuitable? Ultimately, despite treatment being the justification and psychiatric knowledge the mechanism behind such statutes, courts would claim the power to answer such questions for themselves.

Psychiatric Knowledge and Its Limits

The language used in MDSO statutes indicates that psychiatrists and psychiatric knowledge played a pivotal role in their creation. And, indeed, most courts relied heavily on

expert witnesses in determining whether an offender was an MDSO. Yet throughout the 1980s, psychiatrists and other observers took issue with the courts' use and understanding of psychiatric expertise. As we have seen, this was a key issue in disagreements over treatment. Even more persistently, psychiatrists questioned the courts' insistence that psychiatrists determine whether or not an offender would present a danger to the public if released. This determination was central to most MDSO statutes—offenders must be treated and could only be released if they were determined to be no longer dangerous. In essence, this required psychiatrists to testify whether or not an offender would reoffend in the future.

Psychiatrists began expressing serious reservations about this question in the 1970s. By 1977, psychiatrists were skeptical enough that the Group for the Advancement of Psychiatry listed MSDO statutes—and the concomitant demand that psychiatrists determine the potential dangerousness of MDSOs—as “approaches that have failed.”⁵²⁴ Contemporary observers argued that such predictions were unreliable and that research on the subject demonstrated that psychiatrists had little ability to make the predictions courts requested.

In support of this, psychiatrists undertook an ever-increasing number of research studies on the question of predicting dangerousness. The conclusions of such studies were generally bleak. By 1981, psychologist and lawyer John Monahan argued, in a much-celebrated book on the topic, that research had not successfully demonstrated that psychiatrists could accurately predict future violence.⁵²⁵ While Monahan was hopeful that a more rigorous research methodology would provide a way forward, the state of the field was not promising. A 1982 study likewise found that there was “essentially no relationship between clinical predictions of

⁵²⁴ Group for the Advancement of Psychiatry, *Psychiatry and Sex Psychopath Legislation: The 30s to the 80s* (New York, 1977).

⁵²⁵ John Monahan, *Predicting Violent Behavior: An Assessment of Clinical Techniques* (Beverly Hills: Sage, 1981).

dangerousness and outcome at four years”—in other words, psychiatric predictions on whether an offender would commit additional crimes had basically no relationship to whether that offender would actually commit such crimes.⁵²⁶

After 1981, a significant number of researchers took up Monahan’s suggestions for a more rigorous methodology. The basic structure of such research was to have a group of psychiatrists (or other mental health professionals) rate a group of offenders on their potential dangerousness.⁵²⁷ After a set period, the study would follow up with the offenders to see which ones had committed additional crimes. Comparing the ratings to the actual incidence of recidivism allowed researchers to determine the accuracy of the initial predictions. Such studies divided predictions into four categories: true negative (an offender was predicted non-dangerous and did not commit subsequent crimes), false negative (predicted non-dangerous, did commit subsequent crimes), false positive (predicted dangerous, did not commit crimes) and true positive (predicted dangerous, committed crimes).

One of the most hopeful studies at this time argued that predictions were “reasonably effective (though with many false positives)” based on a two-year follow-up.⁵²⁸ Even here, though, the mechanisms by which such predictions were made are opaque—the study notes that while previous offense patterns played a role, no other demographic variables (they list age, sex, and previous psychiatric history) could be linked to the likelihood to reoffend.

⁵²⁶ Quotation is from: Christopher D. Webster, et al., “The Reliability and Validity of Dangerous Behavior Predictions,” *Bulletin of the American Academy of Psychiatry and the Law* 12, no. 1 (1984). The authors are referring here to the following study: J. M. Mullen and R. C. Reinehr, “Predicting Dangerousness of Maximum Security Forensic Mental Patients,” *Journal of Psychiatric Law* (Summer 1982).

⁵²⁷ This structure is generally attributed to Monahan and is described in his book. Its use was still pervasive enough by 2000 to be described in manuals from that time. See, for example: Clive R. Hollin, ed., *The Essential Handbook of Offender Assessment and Treatment* (Wiley, 2003).

⁵²⁸ Webster, “Reliability.”

In regards to the results of the study, the authors argue that their reliability rating of +0.20 was be “fairly good”⁵²⁹ within this particular context. Because a fair assessment of MDSOs required that the MDSO disclose personal information and because MDSOs had a variety of reasons to avoid such disclosures, a higher rating shouldn’t be expected. Much can be said about this conclusion. First, the argument that a lower rating should be *expected* does not necessarily mean that the lower rating should be *accepted*. A number of courts had pointed towards the “loss of liberty” that came along with commitment as an MDSO as a justification for guaranteeing certain procedural rights; the same rationale could apply here—the high stakes involved were a reason to demand higher standards, rather than lower.

Moreover, the number that the authors put forward (+0.20) was reflective of the *average* of the psychiatric raters involved. Their individual scores, however, varied immensely—their reliability ratings were +0.33, -0.01, +0.10 and +0.49.⁵³⁰ Only two of the psychiatrists—half of the test group—exceeded this bar. If we take these numbers on an individual level, then, only 50% of the psychiatrists involved managed a “moderately good” performance. The other half failed to meet the rather low bar set by the study in the first place. Alongside this, the study also included two external coders. The coders considered two-thirds of the offenders to be highly dangerous, but follow-up indicated that only about one-quarter met the criterion for dangerousness. In all, then, while the authors of the study were optimistic about the abilities of

⁵²⁹ An earlier study by the same authors had used the terminology “moderately good.” In a footnote in the 1984 study, they note that they had been “taken to task” for such language and that the current study was, in part, a justification for it.

⁵³⁰ Saleem Shah, one of the earlier critics of the concept of predicting dangerousness, had found similar variability among clinicians’ predictions. See Shah, “Dangerousness: Conceptual, Prediction, and Public Policy Issues,” in J. R. Hays et al., eds., *Violence and the Violent Individual* (New York: SP Medical and Scientific Books, 1981).

psychiatrists to assess future dangerousness, the results of the study could be interpreted as another mark against psychiatric predictions.

As well, the typical set of questions applied: How could recidivism rates be accurately assessed, when what psychiatrists and courts measured were simply offenses for which an offender had been caught? How could such studies account for offenses for which the offender wasn't caught? The studies' authors note this and argued that the short follow-up period was partially responsible for the discrepancy in their numbers. Had they had a longer follow-up, surely a larger number of the offenders deemed dangerous by the study participants would have re-offended. This is a fair point, but also one that dismissed the false positives out of hand. As the authors of the study noted, false positives had "very different effects" than false negatives. This put a certain amount of pressure on raters to err on the side of caution and rate patients as dangerous—and indeed, the study's authors note that other research had found evidence of this effect. Because psychiatrists were ultimately responsible for making recommendations to the courts, they were the ones who suffered "professional consequences" if their opinions turned out to be incorrect.⁵³¹ The consequences for allowing someone to be released to went on to reoffend were different, and often more damaging, than the consequences for committing someone who didn't truly need to be committed. Along these lines, the authors cite Vernon Quinsey, who had found that "psychiatrists are more prone than members of other disciplines to impute such dangerousness."⁵³²

⁵³¹ On this, see: Nigel Walker, "Dangerous Mistakes," *British Journal of Psychiatry* 158, no. 6 (June 1991).

⁵³² Here, the authors cite: Vernon Quinsey, "The Long-Term Management of the Mentally Abnormal Offender," in S. J. Hucker et al., eds., *Mental Disorder and Criminal Responsibility* (Toronto: Butterworths, 1981). Quinsey, as discussed in chapter 1, was a member of the APA's Work Group on Paraphilias.

At that same time, there was an ongoing discussion about what was meant by the term “dangerousness.” Many observers asserted that courts failed to rationally define this criterion and instead adjudicated habitual sex offenders who were committing relatively nonviolent crimes.⁵³³ Psychologist Vladimir Konečni wrote that statutes reflected a view that, “punishment should fit the offender, not the crime.”⁵³⁴ From the viewpoint of mental health professionals, however, MDSO statutes predicated on dangerousness should be assessing the crime itself. The offender, even a habitual offender, wasn’t necessarily dangerous if his crimes were nonviolent. It is not clear, however, whether Konečni was correct in his interpretation. Rather than ignoring the “dangerousness” criterion, it seems that courts found sexual crimes, by virtue of the fact that they

⁵³³ A 1974 study of Atascadero State Hospital found that habitual child molesters had formed a majority of MDSO patients throughout the hospitals’ history. The numbers varied substantially—they formed 52% of patients in 1952, 80% in 1967, and 66% in 1974. As well, the study found that the majority of these patients had not used force or threats in the commission of their crimes. See: G. E. Dix, “Differential Processing of Abnormal Sex Offenders: Utilization of California’s Mentally Disordered Sex Offender Program,” *Journal of Criminal Law and Criminology* 67, no. 2 (June 1976); and Leon, 86, for a discussion of the study. While it’s true that such men were not, strictly speaking, violent, whether they should be regarded as less dangerous because of it was an open question. There was an ongoing discussion at this time about the nature of child sexual abuse and what damages it might cause to children. Increasingly, observers argued that the presence or absence of physical force was immaterial and that the emotional harm was equally as important as any physical harm (that this mirrored feminist approaches to rape was not coincidental; much of the anti-child sexual abuse activism at this time came from within feminist circles). On the shifting perceptions of child sexual abuse, see: Philip Jenkins, *Moral Panic: Changing Concepts of the Child Molester in Modern America* (Yale University Press, 1998); Beryl Satter, “The Sexual Abuse Paradigm in Historical Perspective: Passivity and Emotion in Mid-Twentieth Century America,” *Journal of the History of Sexuality* 12, no. 3 (2003).

⁵³⁴ Vladimir J. Konečni et al., “Prison or Mental Hospital: Factors Affecting the Processing of Persons Suspected of Being ‘Mentally Disordered Sex Offenders,’” in Paul D. Lipsitt and Bruce Dennis Sales, eds., *New Directions in Psycholegal Research* (New York: Litton Educational Publishing, 1980). Konečni’s research had found a trend related to the one described by Dix. At California’s Patton State Hospital, adjudication as an MDSO was strongly linked to a history of prior sexual offenses—the absence of a such a history tended to disqualify a defendant from status as an MDSO, even if he had committed a sexual offense recently. This meant that, in practice, habitual sex offenders were more likely to be deemed MDSOs than those who had only been caught for one offense, even if the singular offense was egregious.

were sexual, to be inherently more dangerous than other types of crimes. Whether a particular sex crime involved physical force was less important than that the crime itself having involved a sexual motivation.

This divergence of opinion can be seen particularly in Nebraska's MDSO statute. The state's statute allowed for commitment for crimes that weren't quite sex crimes: "The commission of any felony as defined by law in which the sexual excitement of the person committing the crime is a substantial motivating factor." In other words, a crime needn't involve an actual sexual assault on a person in order to qualify the aggressor as an MDSO. This fit with the ethos of the time—psychiatrists were increasingly attributing sexual motivations to non-sexual crimes. One striking instance is a discussion of sexually motivated burglaries. Eugene Revitch writes, "Overt or covert sexual motivation was found in several repetitive, compulsive burglars."⁵³⁵ Such compulsive, sexually-motivated burglars also tended to suffer from some combination of "voyeuristic impulses, transvestism, confused sexual identity, and hatred of mother transferred to women." Konečni's criticism suggests that such crimes were not particularly notable or indicative of dangerousness; the underlying sexual motivation did little to change the facts of the crime—in this case, simple burglary. For Nebraska courts (or other states whose MDSO statutes didn't strongly connect MDSO status to actual sex crimes), however, the fact that a burglary might be sexually motivated made the offender uniquely dangerous and pathological, regardless of the crime. Revitch bears this out, albeit in a more cautious manner—while he notes that not all sexually motivated burglars would go on to kill or assault women, he suggests that police should investigate compulsive burglars "with a history of minor attacks on women" whenever cases of "bizarre murders of females" arose. Here, both Revitch and the

⁵³⁵ Eugene Revitch, "Sexually Motivated Burglaries," *Bulletin of the AAPL* 6, no. 3 (1978).

courts relied on a theory of escalation—minor sex offenses (or, indeed, nonsexual offenses motivated by sexual urges) were liable to escalate into increasingly serious sex crimes.⁵³⁶ There was no real end to what sorts of evidence might be taken into account as part of the escalation theory. Revitch suggests that mistreatment of animals and, in particular, cats could be a warning sign that an offender would go on to commit more serious assaults against women—he writes, “The cat appears to symbolize a woman, so mistreatment of cats in combination with sexually motivated burglaries should be considered an important prognostic sign.” Revitch suggested only that police be aware of the connection between more and less serious crimes. Many state legislatures, however, took the position that the possibility of escalation made the minor crimes inherently serious and worthy of MDSO status in the interest of preventing the more serious assaults from occurring in the first place.

This question of crime versus offender was an ongoing issue in the research literature. Researchers consistently found that assessing the patient’s personality was a poor way to predict dangerousness. Dangerousness “has never been demonstrated to be an identifiable personality dimension,” but was instead a nebulous concept that none of the involved observers (courts, psychiatrists) agreed upon.⁵³⁷ In addition, clinicians who attempted to make such assessments on the basis of stable personality traits (the authors here list “honesty, conscientiousness, friendliness and, by extension, dangerousness”) hit a “sound barrier” of +0.40—in other words,

⁵³⁶ For a historical discussion of the escalation theory of sexual offenses, see Jenkins, *Moral Panic*, and Freedman, “Sexual Psychopath.” Freedman argues that this theory was reflected in the psychiatric literature and legal approaches of the 1930s and 1940s. Both Freedman and Jenkins argue that the theory was being debunked and dismissed by the 1950s. However, remnants of the theory remained in both psychiatric work and legal culture, as demonstrated here.

⁵³⁷ Mullen, “Predicting Dangerousness of Maximum Security Forensic Mental Patients.”

basing predictions on personality traits was accurate less than half the time.⁵³⁸ The authors argue instead that predictions should be based on situational factors—the circumstances of the crime itself, the support network the offender could be expected to have once released, and so on.⁵³⁹ Yet it was difficult for this sort of assessment to take place for a variety of reasons—the offender, along with his personality, was sitting in front of the psychiatrists during the evaluation. This interpersonal exchange made it difficult for psychiatrists to avoid making personal judgments about the offender, which in turn colored their evaluations. Police reports and other documents might “induce clinicians to establish theories about individuals” rather than entering into the evaluation unbiased. Moreover, the presence of the clinician biased the subject—offenders did not behave normally nor disclose fully or accurately during evaluations.

In all, then, psychiatrists were presented with a number of problems. First, they had no reliable system by which to determine dangerousness. Second, they weren't entirely clear on what that term meant in the first place, and often disagreed with the courts' apparent definitions. Third, the high stakes involved in such predictions created a certain amount of bias among psychiatrists that resulted in a high number of false positive assessments. In response to these numerous methodological and theoretical difficulties, Webster and his coauthors argued that, “As researchers we may have to devise ‘idiographic’ predictive methods that have at their center

⁵³⁸ R. J. Menzies et al., “Hitting the Forensic Sound Barrier: Predictions of Dangerousness in a Pre-Trial Clinic,” in C. D. Webster et al., eds., *Dangerousness: Probability and Prediction, Psychiatry and Public Policy* (New York: Cambridge University Press, 1985).

⁵³⁹ A number of authors had discussed the differences between personality and situational factors by this time. Webster cites the following: W. Mischel, *Personality and Assessment* (New York: Wiley, 1968); D. Bem and A. Allen, “On Predicting Some of the People Some of the Time: The Search for Cross-Situational Consistencies in Behaviors,” *Psychology Review* 81 (1974); W. Mischel and P. K. Peake, “Beyond Déjà vu in the Search for Cross-Situational Consistency,” *Psychology Review* 89 (1982); R. B. Felson and H. J. Steadman, “Situational Factors in Disputes Leading to Criminal Violence,” *Criminology* 21 (1983).

the particular patient's constructs and not the rather rigid and uniformly applied parameters of research.”

While perhaps reasonable in an abstract sense, this flew in the face of forensic attempts to standardize such questions. Courts—and the psychiatrists who testified on their behalf—were searching for standardized methods, rather than the highly individualized methods Webster and his coauthors were suggesting here. Even responses to earlier studies by this set of authors underscored this. The previous year, they had published an article that stressed the “limited validity” of the tools discussed. The result was that they were “deluged with requests for the manual on which the scale was based.” Although they argue in this article for “idiographic” predictive methods, the prior article had demonstrated that “there would potentially be acceptance of an instrument that was reasonably succinct and acceptably grounded in clinical and research practice.” Despite their optimism, it wasn't clear how the authors of the study intended to bridge the gap between complex and individualized assessments and the search for “succinct” and standardized assessment tools.

By 1980, psychiatric skepticism of forensic predictions was pervasive enough that one defendant, Ray Eugene Henderson, submitted into evidence eight articles written by psychiatrists questioning the accuracy of psychiatric assessments of future dangerousness. Henderson objected to the extension of his commitment on the basis that “the state of the art for predicting dangerousness is too unreliable.” Henderson's invocation of these materials indicates that a wide variety of actors had become aware both of psychiatric discourse and the role such discourse played in the courts. For Henderson (and his lawyers), if the court was going to use psychiatric knowledge to label Henderson, then Henderson was equally entitled to use psychiatric knowledge to question the court. In the end, the court took a middle route and ruled that while

such predictions were “statistically unreliable,” they still constituted “valuable pieces of evidence.”⁵⁴⁰ That same year, the American Psychiatric Association filed an amicus curiae brief in support of Henderson “opposing the use of psychiatric testimony for sentencing in the context of determining whether the defendant will commit further acts of violence and thus continue to be a threat to society. Such predictions of future dangerousness, the APA says, are unreliable.”⁵⁴¹ The *Mental Disability Law Reporter*, for its part, referred to Henderson case as one of the most “interesting” that year, yet objections from both defendants and psychiatrists produced no substantive legal changes. By the mid-1980s, courts were increasingly likely to acknowledge that psychiatric prognostications about the future were unreliable, but were no less likely to rely on them. The Minnesota Supreme Court, for instance, noted the “fallibility of psychiatric diagnoses and the inherent lack of certainty in psychiatric prognoses,” but still required a prediction of future dangerousness for its MDSO statute.⁵⁴² In all, this left defendants at a disadvantage—their indeterminate commitments to psychiatric facilities were based on information that psychiatrists, and increasingly courts, acknowledged as fallible.⁵⁴³ At the same time, it indicates the bind courts had placed themselves in. The rationale for MDSO statutes hinged on psychiatric testimony. The

⁵⁴⁰ “The Criminal Justice System and the Mentally Disabled,” *Mental Disability Law Reporter* 4, no. 4 (July-August 1980). See also, “Sex offender cases rule on statutes, evidence and predictions of dangerousness,” from the same issue. The case in question is *California v. Henderson*, 162 Cal. Rptr. 886 (Cal. Ct. App. 1980).

⁵⁴¹ “The Criminal Justice System and the Mentally Disabled.”

⁵⁴² “Dangerousness explored in four cases,” *Mental Disability Law Reporter* 9, no. 5 (September-October 1985). The case in question is *Minnesota v. Ward*, 369 N.W.2d 293 (Minn. Sup. Ct. 1985).

⁵⁴³ As will be discussed later in this chapter, psychiatrists also increasingly noted that they were likely to err on the side of public safety when making such predictions—in other words, psychiatrists were more likely to deem ultimately un-dangerous offenders dangerous than deem ultimately dangerous offenders un-dangerous. It is helpful here to think of the criminal justice system’s general proposition that it was better for one hundred guilty men to go free than one innocent man be wrongfully imprisoned. Psychiatrists, in offering testimony about future dangerousness, tended to reverse this proposition.

unreliability of such testimony must either be used to undercut such statutes or be reasoned away in the interest of continued commitment of ostensibly dangerous sex offenders. In cases like those discussed above, courts chose the latter course and argued that some level of unreliability was not enough to justify the repeal of MDSO statutes.

In addition to theoretical questions about the reliability of these assessments, psychiatrists encountered practical difficulties. As noted earlier, it wasn't necessarily clear to psychiatrists what legal statutes meant when they specified that an offender present an ongoing danger. On top of this, what evidence mattered in determining the answer to such a question was ambiguous. This became a particular problem for recommitment hearings. While it might be clear that someone who had recently committed an act of sexual violence was likely to commit another, similar act in the near future, what about when an offender had been in a treatment facility for an extended period of time and hadn't had the opportunity to commit additional crimes? How were psychiatrists to judge the types of behavior such an offender would engage in if released when the patient had been heavily monitored and controlled for so long?

One early case demonstrated the difficulty. In 1974, Theodore Blythman was convicted of molesting a girl under the age of 16.⁵⁴⁴ It was found, at that time, that he was a sexual sociopath but that he would not benefit from treatment.⁵⁴⁵ In accordance with the state's sexual

⁵⁴⁴ *Nebraska v. Blythman*, 302 N.W.2d 666 (Neb. Sup. Ct. 1981). Blythman had a long history of mental illness and criminal behavior—he had been convicted on a juvenile charge for stabbing a girl in 1963 and kept in custody (first at a Boys Training School and subsequently at the Lincoln Regional Center) until 1972. He spent an additional 6 months the following year at the Hastings Regional Center for undisclosed reasons. A year after that, he was charged with the incident discussed here.

⁵⁴⁵ The examining psychiatrists disagreed on what, precisely, was wrong with Blythman. One psychiatrist reported that Blythman suffered from “a complex case of mental retardation, emotional deprivation, psychosis, and a mixture of sexually and aggressively deviant impulses.” While that psychiatrist thought Blythman might qualify as a sexual psychopath (the statutory language used by the Nebraska courts at this time), he felt the case was too complex to take a

sociopath legislation, he was sentenced to an indefinite prison term until such a time as the courts could determine he was no longer a sexual sociopath. Five years later, after a series of annual evaluations that offered the same confused opinions as Blythman's initial evaluation, the court found that he was suitable for treatment and sentenced him to the Lincoln Regional Center.⁵⁴⁶ Following this, Blythman brought a suit that the court had not sufficiently demonstrated that he met the criteria for MDSO status—more specifically, he argued that there was insufficient evidence that he was dangerous at that time and that the court had erred in using acts committed five years prior to determine his current and future status as dangerous.⁵⁴⁷ Blythman's argument here relied on the specific language supplied in Nebraska state law that “a mentally ill dangerous person” must present “a substantial risk of serious harm to another person or persons within the near future, as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm.” Blythman's counsel argued that acts committed five years earlier did not meet any reasonable definition of “recent.”

Despite acknowledging the language of the statute, the court chose to define dangerousness in its own idiosyncratic way: “The finding that he is dangerous, i.e., that absent confinement, he is likely to engage in particular acts which will result in substantial harm to

stand on that question for legal purposes. A second psychiatrist was initially unsure whether Blythman qualified as a sexual psychopath, but later amended his opinion and agreed that Blythman was; as well, that psychiatrist agreed that he required continued supervision. After the testimony from these two psychiatrists proved inconclusive, Blythman was sent to Lincoln Regional Center for observation and evaluation. The two examining psychiatrists at the center agreed: Blythman *was* a sexual psychopath, but would not benefit from treatment.

⁵⁴⁶ In 1977, a prison psychiatrist would state that Blythman was mentally ill, but not a sexual sociopath. At the same time, he was amenable to treatment, but wouldn't benefit from continued in commitment at the center. This left the question of whether he belonged at Lincoln Regional Center largely unanswered.

⁵⁴⁷ The statute in question (Neb Rev Stat § 82-1037) reads: “A substantial risk of serious harm to another person or persons within the near future, as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm.”

himself or others.” Moreover, the court referenced a previous ruling from 1979. In *Hill v. Country Board of Mental Health*, the Nebraska Supreme Court had held that “there is no way to establish a definite time-oriented period to determine whether an act is recent.”⁵⁴⁸ That case further held,

The term recent should be given a reasonable construction. We hold that an act or threat is ‘recent’ within the meaning of [the act] if the time interval between it and the hearing of the mental health board is not greater than that which would indicate processing of the complaint was carried on with reasonable diligence under the circumstances existing.

In other words, the definition of the term “recent” relied on the concept of a speedy trial. Given that Blythman had already been indicted and imprisoned for five years, re-evaluated for MDSO status multiple times and moved to a treatment facility, the case would seem to far exceed the definition laid out in the *Hill* case. Moreover, according to Blythman’s counsel, applying the *Hill* standard to this case “would permit involuntary civil commitment regardless of how remote in times the acts or threats of violence are.”

Ultimately, the court sidestepped the question of strictly defining the term “recent,” and instead chose to justify Blythman’s commitment by arguing that there was no proof that Blythman *wasn’t* dangerous. That is, the court could not rely on the metric of recent acts of violence because Blythman’s incarceration meant he had not had the opportunity to engage in his particular sex crimes. More specifically, Blythman had committed offenses against young girls and, since there were no young girls present in the treatment facility, he had no possibility of committing further crimes against them. The court laid out its reasoning thusly:

We cannot believe that the Legislature intended that by requiring a recent act or threat, a mentally ill person should be given the opportunity to commit a more recent act once a sufficient amount of time has passed since the last act. Judicial

⁵⁴⁸ *Hill v. County Board of Mental Health*, 279 N.W.2d 838 (Neb. Sup. Ct. 1979).

action need not be forestalled until another young girl is sexually assaulted, or some other harm takes place.

This made sense from a public safety standpoint: Blythman had committed multiple acts of violence against young girls over the course of his lifetime, and all of his examining psychiatrists believed him to be a continued danger. There was no particular evidence that Blythman had been cured of his predilections. And yet the language used by the courts here was Orwellian in its insistence that Blythman was somehow exempt from a commonsensical understanding of the term “recent” (which would have been accorded to any other class of civil committee) and that his inability to commit offenses while in prison somehow made his actions five years prior stand as “recent.”

Throughout all this, however, courts insisted that MDSO statutes were straightforward. In California, for instance, an appeals court argued that all the terms in its statute had a meaning “commonly understood” by people of reasonable intelligence.”⁵⁴⁹ And yet courts across the country persistently demonstrated that the terms employed in such cases weren’t commonly understood. A patient who refused to cooperate with treatment might still be “amenable,” a crime committed five years prior might be considered “recent,” “danger” might mean anything from serious bodily harm to psychological damage, and “future dangerousness” might mean anything from crimes committed tomorrow to crimes committed decades down the line. And all this without opening up the diagnostic can of worms, and asking whether designations like “sexual psychopath,” “sexual sociopath” or “sexually dangerous person” were meaningful in any psychiatric sense.

If psychiatrists were confused by the language of MDSO statutes, so were defendants. Throughout the 1970s and 1980s, a number of suits were brought to challenge the vagueness of

⁵⁴⁹ *California v. Martin*, 165 Cal. Rptr. 773 (Cal. Ct. App. 1980).

such statutes. In 1975, Frank Stachulak, an MDSO, argued that the Illinois Sexually Dangerous Persons Act was “unconstitutionally void for vagueness,” because the phrase ‘sexually dangerous person’ was too indefinite.⁵⁵⁰ Moreover, this vagueness meant that there were not “meaningful standards” for who could be committed under the act. The court, however, argued that there was “sufficient objective criteria” contained within the act. Yet the “objective criteria” of the act are quite vague. In fact, the act defined a “sexually dangerous person” as follows:

All persons suffering from a mental disorder, which mental disorder has existed for a period of not less than one year, immediately prior to the filing of the petition hereinafter provided for, coupled with criminal propensities to the commission of sex offenses, and who have demonstrated propensities toward acts of sexual assault or acts of sexual molestation of children, are hereby declared sexually dangerous persons.

Illinois’ act, then, didn’t even explicitly link mental disorders to sexual offenses. The presence of both, even in the absence of evidence that the sexual offenses were products of the underlying disorder, was enough to designate an individual as a sexually dangerous person. This type of statutory language would have been a boon in cases like Blythman’s—whether his underlying disorder was a mental illness or mental retardation, and whether his sex crimes were linked with either of those issues, would have been irrelevant under Illinois’ statute. Yet for psychiatrists working in treatment facilities, the specificity of the patient’s disorders formed a crucial part of whether they were suitable patients who might benefit from treatment, versus whether they were warehoused and took up valuable resources and limited space.

The debate at the heart of *Stachulak v. Coughlin* demonstrates the difficulties of writing a legal statute to cover a disparate group of offenders while incorporating psychiatric knowledge and terminology. Such statutes were always going to meet with legal challenges, particularly as

⁵⁵⁰ *Stachulak v. Coughlin*, 424 U.S. 947 (1976). This case also dealt with issues regarding burden of proof. The courts had initially relied on a preponderance of evidence. A district court ruled that this was inappropriate and asserted that proof beyond a reasonable doubt was required.

psychiatric theories regarding sex offenses evolved. At the same time, the courts' insistence that such language was straightforward implied an unwillingness to acknowledge such difficulties.

Altogether, the cases that came before courts and juries in the 1970s and 1980s exemplify the ways in which courts failed to consider psychiatric expertise in a meaningful way even as they depended on it. While MDSO statutes generally required psychiatric testimony, such testimony could be disregarded (particularly if it pertained to difficult patients) or could prove faulty (as the bulk of research on psychiatric predictions demonstrated). Moreover, psychiatrists themselves were increasingly concerned that the questions being asked of them were impossible to answer.

Conclusions

While MDSO statutes would increasingly be repealed under sustained scrutiny during the 1970s and 1980s, a strikingly similar set of laws (SVP laws) would be enacted during the 1990s. These laws raised all the same issues—they required psychiatric testimony to determine whether an offender remained dangerous, they brought up questions of legal double jeopardy, and they (at least according to psychiatric observers) threatened to misuse the involuntary commitment system. The most significant difference was that they were more overt in their aims. While they used the civil commitment system, they did not justify themselves on the basis of treatment, but simply on the basis of public safety. When psychiatric groups had opined during the tail-end of the MDSO era that courts misused their knowledge and their institutions, they were moderately successful in the short term. Throughout the 1980s, MDSO statutes were heavily amended and even repealed in response to the persistent psychiatric criticism and legal challenges discussed here. Historians have taken this as the end of an era, where the repeal of such laws indicated a

rejection of the idea that mentally disordered sex offenders could be rehabilitated. While it is true that observers moved away from treatment-based approaches to sex offenders, a more thorough examination of the upheaval of the 1980s indicates that discussions around MDSO statutes opened as many questions as they closed. While it would be easy to read the repeal of MDSO statutes as a straightforward victory—for psychiatric and legal critics, as well as for MDSOs who challenged their status—the 1980s instead emerge as a moment bridging the gap between earlier rehabilitation efforts and the SVP laws that followed in the 1990s. Those laws would reveal the same tangle of legal and psychiatric issues that had plagued MDSO statutes and would indicate that, despite the volume of changes taking place in the 1980s, the debates that occurred had solved little in the long run.

Conclusion

Taken altogether, the 1980s emerge as a peculiarly unsettled moment. The debate over sexual violence involved a wide-ranging set of actors and suggested that collaboration across professional and political divides was necessary. Yet such collaboration eluded many, and psychiatrists in particular had persistent issues engaging with feminists and with those within the legal sphere. Such engagement suggested that psychiatrists needed to seriously rethink their professional duties and consider how psychiatric work affected society more broadly. To the APA, this line of thought also suggested that psychiatry was liable to become increasingly politicized (whereas external actors, and feminists in particular, would suggest that the politicization was an inherent part of psychiatry). In an attempt to maintain clear professional lines, the APA and many psychiatrists would continually attempt to withdraw from these public debates and deal with sex offenders in as insular a manner as possible.

As this dissertation has documented, sexual violence became a subject of many different domains in this era, and those domains were themselves changing rapidly. The APA was shifting towards a standard of empiricism that it simply couldn't live up to, particularly in regard to sexual disorders. The legal system was treading a middle ground between treating sex offenders as psychiatric patients versus treating them as criminals, and was using these two goals in service of one another in a hybridized system that would lean increasingly towards punishment as the decade wore on. The women's movement was engaged in a very public debate over the nature of sexual violence and gender more broadly. Women's advocates are still involved in such campaigns, but have rarely looked to organizations like the APA as sites of change since the 1980s. Ironically, then, the 1980s was a moment when Americans increasingly recognized the power of psychiatry to shape public and legal opinions, but in which psychiatrists attempted to

withdraw from the limelight. Their success in doing so suggests that feminists no longer look to psychiatry as a particularly important shaper of society. Finally, groups like NAMBLA identified a shifting cultural discourse about the limits of acceptable sexuality and sought to make a place for themselves within not just the gay liberation movement, but also psychiatric and other scientific and academic discourses. Since the 1980s, the participation of fringe groups like NAMBLA in public discourse has become basically impossible. While the articles discussed in this conclusion demonstrate that a handful of pedophiles have sought a public platform and that there is increasing public sympathy towards such individuals, there has been no widespread movement on the part of pedophiles to push for social acceptance or legal rights like the one NAMBLA orchestrated. This is partially related to the way that American social movements have developed since the 1980s. When gay liberation was a fringe movement, it had more room to define itself loosely. As gay liberation transitioned into the gay rights movement and gained greater political clout, the boundaries around what could be contained within the movement tightened. Altogether, what emerged was a wide-ranging discourse about sexual violence involving very dissimilar participants: psychiatrists, women's advocates, legal scholars, concerned citizens and even those considered sex offenders themselves. Together, these groups argued over concepts of sexual violence, consent, gender, politics, the nature of scientific objectivity, and what psychiatry as a discipline ought to look like.

While various activist groups have been drawn back to looking at the APA periodically since the 1980s, nothing so sustained as the discourse surrounding sexual violence has emerged. Reform efforts surrounding sexual violence have been more fragmented. This is probably partially the result of the increased secrecy (or, more accurately, a return to an earlier isolationist stance) of the APA in recent years, as seen particularly with discussions of the *DSM-5* revisions.

It is probably also related to contemporary developments in the women's movement. Campaigns against sexual violence have continued to focus on the legal sphere (as discussed in chapter 2, and in the historical literature), and on cultural reform. The question of PCD or psychiatric diagnosis hasn't entered into this. Despite its continued proposal for inclusion in subsequent additions of the DSM, it seems unlikely to ever become a formal diagnosis and is thus not a pressing concern for women's advocates.

Some of these changes have been inarguably good for the women's movement. The increasing accessibility and public presence of feminism is a positive, even if the movement's fragmentation has made it less effective in some respects. Moreover, most would agree that NAMBLA's lack of public presence—and its reflection of society's increasing awareness of child sexual abuse—is a good thing too. Changes within the APA are more mixed. The secrecy surrounding the *DSM-5* serves no positive purpose for anyone outside the organization. On the other hand, if we take seriously the changes in opinion surrounding PCD, the APA seems to be moving towards a more nuanced understanding of the role of politics in science and science in politics.⁵⁵¹ Granted, as discussed in this conclusion, such questions are far from settled and remain significant points of contention within the APA.

However, despite sustained public discourse on the nature of sexual violence and how to best deal with it, it is difficult to say what concrete gains have been made in regard to the problem of sexual violence. The Justice Department states that the incidence of sexual violence

⁵⁵¹ As discussed in chapter 1, many of the members on the Paraphilias Work Group cited social concerns when they eventually came to agree with the Board's decision to delete PCD from the *DSM-III-R*. And, as will be discussed subsequently, such social concerns have continued to play a role in discussions about PCD. Allen Frances, Bob Spitzer, Vernon Quinsey and Raymond Knight (all prominent members of the APA during the 1980s and 1990s) have changed their position on PCD. While Quinsey's change of heart is due more to the theoretical lenses he employs to assess PCD's fitness as a disorder, Frances, Spitzer and Knight cite social concerns.

dropped 64% between 1995 and 2010, mirroring a 65% drop in violent crime over that same time span. A deeper look at these numbers reveals more mixed results: the drop in sexual violence took place between 1995 and 2005 but stalled for the last five years measured, while the drop in violent crime continued throughout the entire period. Moreover, reporting rates have varied—the Justice Department estimates that 29% of sexual assaults were reported in 1995, 56% were reported in 2003 and 35% were reported in 2010. In other words, more than half of all sexual assaults remain unreported, and only 12% result in an arrest. While conviction rates have increased since the 1980s, the passage of SVP laws indicates that criminal penalties remain too low.

Given the difficulties of determining accurate recidivism numbers, any comment on the subject would be speculative. That said, these rates do appear to have dropped precipitously.⁵⁵² In the 1980s, researchers generally agreed that more than 70% of convicted sex offenders would commit additional sex crimes.⁵⁵³ There is no strong consensus on recidivism rates for sex

⁵⁵² Recidivism rates are notoriously hard to measure, particularly for sex crimes. First, such rates only capture whether or not a convicted sex offender has been caught committing subsequent crimes. Given that so many sex crimes go unreported, recidivism rates will naturally not reflect the real rate of sex crimes. Moreover, such rates are measured at different moments (the rate for recidivism within 5 years of release from prison is going to be quite different from the rate within 20 years of release from prison). As well, different sex crimes come with different post-release conditions. Child molesters, in particular, are subjected to a variety of legal interventions that control how often they report to a parole officer, where they live, and who they interact with. Recidivism rates while such stringent measures are in place may be lower than recidivism rates once these measures are removed, but may also be less likely to be captured in statistics (to put it more simply, these legal measures may work to prevent recidivism and may also be more likely to catch recidivism when it happens due to the incessant monitoring of the sex offenders; accordingly, it is hard to say with any certainty what post-conviction and post-monitoring recidivism rates look like). Finally, it is worth noting that numbers regarding sex crimes are paradoxical—just as greater awareness of sexual violence and concomitant legal reforms resulted in increasing reporting and thus an apparent increase in the number of sex crimes in the 1980s, similar changes may have an influence on the reported recidivism rate that doesn't necessarily reflect any change over time.

⁵⁵³ See chapter 3 on this.

offenders today, though experts generally agree that the rates are lower for sex offenders than most other classes of criminals.⁵⁵⁴ One study, cited by the U.S. Department of Justice, puts the recidivism rates in this decade at 10-25%, depending on length after release and type of sex crime.⁵⁵⁵ More specifically, 14% of rapists commit another sex crime within 5 years of release, 21% commit another crime within 10 years of release, and 24% within 15 years of release. For child molesters, the numbers are noticeably lower but still not promising: 9% at 5 years, 13% at 10 years, and 16% at 15 years.

From all this, it seems likely that activism surrounding sexual violence has made many gains, but that such gains are uneven and unfinished: the social epidemic of sexual violence that the women's movement identified in the 1980s remains a contemporary problem. What I wish to suggest here is that we can learn something from the struggles over and even missteps of debates over sexual violence in the 1980s. While the attempts to diagnose, treat and think about sex offenders in the 1980s were preliminary and some of them may have been deeply problematic, looking at these past attempts may offer a way forward.

In service of looking to the past to reimagine the present, what follows is a brief overview of how psychiatric (and, in relation, popular and legal) attitudes regarding sexual violence have evolved since the 1980s.

⁵⁵⁴ On this, see: Patrick A Langan and David J Levin, "Recidivism of Prisoners Released in 1994," Bureau of Justice Statistics: Special Report, June 2002.

⁵⁵⁵ A.J.R. Harris and R.K. Hanson, "Sex Offender Recidivism: A Simple Question," Public Safety and Emergency Preparedness, Ottawa, Canada (2004). This study is cited in Roger Przybylski, "Recidivism of Adult Sexual Offenders," SOMAPI Research Brief (US Dept of Justice, Office of Justice Programs, July 2015).

The Afterlife of PCD

The attempts to treat, diagnose and debate sex offenses in the mid-1980s indicate a number of things about psychiatry at that time. The APA, as a professional organization, was isolationist in its attitude not just towards society and the law, but also towards other mental health professionals. As a scientific organization, it was grappling with a shift towards empiricism that, in particular, didn't match up with how paraphilias were conceived and researched at that time. A brief discussion of where the APA has gone since the mid-1980s indicates that these issues continue to exist today.

When the APA began revising in order to publish the DSM-IV, the organization made an honest attempt to address the professional issues it had been criticized for during the *DSM-III-R* revisions process. Allen Frances, appointed as head of the revisions process, worked towards inclusion of non-psychiatrists in the process and towards increased transparency. Yet, according to Frances himself, all of these gains were stripped away when the APA began to revise for the *DSM-5*. Whereas it had been common practice for members of revisions workgroups to discuss their process far and wide, the *DSM-5* revisions were “inexplicably closed and secretive.”⁵⁵⁶ The

⁵⁵⁶ Frances, A Warning Sign On The Road To DSM-V: Beware Its Unintended Consequences.” *Psychiatric Times*, August 2009. Frances offered two additional warnings. First, the *DSM-5* revisions proposed to classify subthreshold and premorbid disorders (for example, low-level depression that didn't meet the current diagnostic standards but might develop into something that did). Frances warned that including such diagnoses might have “the potentially disastrous unintended consequence that DSM-V may flood the world with tens of millions of newly labeled false-positive ‘patients.’ ...The result would be a wholesale imperial medicalization of normality.” Such rhetoric harkens back to Paula Caplan's concerns about the *DSM-III-R*. It's not clear whether Caplan's involvement with the DSM-IV revisions is responsible, in any significant or direct way, for Frances' outlook here. However, the similarities are worth noting here. Second, Frances notes that the majority of psychiatrists involved with the revisions process were involved with “the atypical setting of university psychiatry” and that their clinical experiences thus couldn't be generalized to the general population. As discussed in chapter 4, NAMBLA made similar comments about pedophilia—that psychiatrists worked with practicing pedophiles (i.e., child molesters) and, moreover, those who had been caught by the justice system. Such men

most telling feature was the fact that work group members for the *DSM-5* were required to sign confidentiality agreements that were only dissolved after a series of “embarrassing” articles were published in the popular press.⁵⁵⁷

In addition to his criticisms of the *DSM* itself, Frances has been an outspoken critic of the concept of PCD. PCD has been suggested for inclusion in every version of the *DSM* since it was first proposed in the 1976. It has likewise been rejected from every version of the *DSM*. Its rejection from the *DSM-III* and *III-R* are discussed at length in chapters 1 and 2. One direction for further research is to return to the APA archives (which have recently obtained records for the *DSM-IV* revisions) to discuss its rejection from the *DSM-IV*. I offer here a brief overview of the debate over PCD’s potential inclusion in the *DSM-5*. While the APA’s leadership appears to agree that the disorder isn’t suitable for the *DSM*, its continued proposal indicates that many psychiatrists continue to stand behind the disorder. Moreover, this cycle of proposal-rejection-proposal points to unresolved issues within the APA. In fact, a brief look at the debate surrounding PCD’s potential inclusion in the *DSM-5* indicates that nearly every issue brought forward in regards to the *DSM III-R* remained unresolved at that time.

Like the debate in the mid-1980s, much of the debate over PCD in the *DSM-5* centered on potential legal uses of PCD. However, unlike in the mid-1980s, this struck the APA as a very

were not, NAMBLA insisted, representative of pedophiles in general. This is not to suggest that NAMBLA was prescient—such criticisms of psychiatry existed and circulated widely far before NAMBLA was formed (and, as will be discussed later in this conclusion, continue to be discussed by clinicians working with sex offenders today). But it is another indication that NAMBLA, or at least its leadership, was comprised of savvy, educated men who understood the psychiatric discourse that circulated about them and attempted to intervene into it.

⁵⁵⁷ Frances cites the following here: Benedict Carey, “Psychiatrists revise the book of human troubles,” *New York Times*, December 18, 2008; Ron Grossman, “Psychiatric manual’s update needs openness, not secrecy, critics say,” *Chicago Tribune*, December 29, 2008. The *Chicago Tribune* article notes that Bob Spitzer, head of the *DSM-III* and *III-R* revisions, was a vocal critic of the secrecy surrounding the *DSM-5* revisions.

pressing question for the *DSM-5* due to changes in the legal treatment of sex offenders. Since the 1990s, a number of states have passed Sexually Violent Predator (SVP) Laws. SVP laws are statutes that allow for the civil commitment of individuals deemed to be at high risk for recidivism. These individuals are sentenced to prison terms and, once they serve those prison terms, may be subjected to civil commitment proceedings. If they are found to be “sexually violent predators” (that is, if they are likely to reoffend and have a diagnosable mental illness that their sexual offenses can be attributed to), then they may be committed indefinitely. Designation as an SVP relies, in every state with such a statute, on examination by mental health professionals and a concrete psychiatric diagnosis to which their sexual crimes can be attributed. In most cases, this means a diagnosis contained within the *DSM*. Such laws have been challenged repeatedly, and the Supreme Court has heard three cases on the constitutionality of SVP statutes.⁵⁵⁸ In each case, the Supreme Court has allowed them to stand. Still, they remain controversial, with many critics arguing that they represent a type of legal double jeopardy.

The APA, despite their attempts to ignore the legal questions raised by PCD in the mid-1980s, has repeatedly joined in challenging SVP statutes. This is partly the culmination of years of professional challenges levied against the MDSO statutes discussed in chapter 5. As well, the attitudes of psychiatrists on this issue have changed in response to the laws themselves—while earlier MDSO statutes were at least theoretically geared towards treatment (and thus could be rationally supported by psychiatrists), SVP laws basically lack this interest. They are expressly

⁵⁵⁸ *Kansas v. Hendricks*, 521 U.S. 346 (1997) is the best-known case of this type. As with the laws discussed in chapter 5, the Supreme Court ruled in this case that Kansas’ SVP law did not represent a form of double jeopardy because the civil commitment procedures were not a form of punishment. However, they also decided that it needn’t be a form of treatment—the ruling stated that indefinite civil commitment wasn’t a considered punitive if it failed to offer treatment for an untreatable condition. In short, the purpose of civil commitment under Kansas’ SVP law was to confine people unable to control their dangerous sexual urges; this was neither a form of punishment nor necessarily a form of treatment, but merely a way to protect the public.

designed to remove sex offenders from the public, and use involuntary commitment to do so without any particular interest in whether the offenders in question receive treatment. For many psychiatrists, this misuse of the involuntary commitment system is much more obvious and more egregious than any misuses that occurred under MDSO statutes.

In two of the Supreme Court cases, the APA submitted amicus curiae briefs. Their arguments here were twofold: first, that the civil commitment of SVPs fulfilled an essentially legal purpose and thus represented double jeopardy.⁵⁵⁹ Second, the APA argued that such a use of the civil commitment system was an abuse of the system and thus lessened the “moral authority” and “societal confidence” in the civil commitment system.⁵⁶⁰ In addition to the briefs submitted to the Supreme Court, a debate within the profession has taken place and Frances has been one of the most visible participants. Frances’ objections to the inclusion of PCD in the *DSM-5* likewise center around its potential use in SVP proceedings. While including the disorder in an appendix (Frances argues that there is not enough research to warrant full inclusion in the main text of the manual) “might facilitate research and provide guidance to clinicians,” its potential for “misuse” in SVP hearings outweighs these potential benefits.

Frances’ argument here relies on his perception of the NOS designation—a term used for disorders “not otherwise specified” in the *DSM*. As discussed in chapter 1, the “NOS” designation was introduced in the *DSM-III* for pragmatic reasons. The *DSM* was growing apace and its authors realized that not every unique mental disorder could be catalogued within its pages. A designation—and a diagnostic code—for disorders that largely resembled those classified within the *DSM* but that were significantly different enough to warrant a diagnosis of

⁵⁵⁹ American Psychiatric Association, *Amicus Curiae Brief of the APA in support of Leroy Hendricks, Kansas v. Hendricks*, 95-1649, 95-9075.

⁵⁶⁰ American Psychiatric Association, *Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association* (Washington, DC: American Psychiatric Publishing, 1999).

their own seemed necessary. Hence the NOS diagnosis: now each of the exceedingly rare paraphilias clinicians like John Money saw in their practices could be labeled as paraphilias “not otherwise specified.”⁵⁶¹ Frances refers to the NOS designations as “residual wastebasket categories provided for clinical convenience” and further notes that an NOS diagnosis is “inherently idiosyncratic, imprecise, and unreliable.” While such imprecision may be dangerous, it is also fundamentally what makes such a category useful: clinical convenience to diagnose. In an era where an insurance company may demand a formal diagnosis to cover treatment, uncategorized disorders are a necessary evil. Yet with the introduction of SVP laws in the 1990s, the NOS category has become a catchall for otherwise un-diagnosable sex offenders. Frances is vehement that this use of the NOS designation is a complete misuse of the diagnosis, and he refers to it as an “unintended consequence” of the introduction of the NOS category. There is a sense in which the APA’s earlier feminist critics had been prescient. Many suggested that including PCD, even in an appendix, would represent a grave mistake—no matter how many disclaimers the APA put on an appendix, the disorder would still be in the *DSM* and could still be used. While feminists didn’t criticize the NOS designation specifically, they were correct that the APA couldn’t control the use of any particular disorder once they put it out into the world.

While many psychiatrists have argued against the concept of PCD in recent years,⁵⁶² the disorder continues to have some support. Lawyer Paul Stern has put forward a series of arguments in favor of the diagnosis that are illustrative of the pro-PCD side. Ironically, it is Stern

⁵⁶¹ The NOS category was not unique to the paraphilias section, but is included as a diagnostic option for every type of disorder listed in the *DSM*.

⁵⁶² Not just Frances, but Bob Spitzer and at least two of paraphilias work group members (Vernon Quinsey and Raymond Knight) offered arguments against PCD’s inclusion in the *DSM-5*. For their dissent, see: Vernon Quinsey, “Coercive Paraphilic Disorder,” *Archives of Sexual Behavior* 39 (2010); Raymond Knight, “Is a Diagnostic Category for Paraphilic Coercive Disorder Defensible?” *Archives of Sexual Behavior* 39 (2010).

who takes up the APA's old position that "ideological and political views may be properly used to influence public policy, [but] should not be used to influence science" (in other words, that psychiatry was an objective science best kept separated from other disciplines, even if those disciplines later took up psychiatry's objective and disinterested claims). while psychiatric critics of PCD increasingly acknowledge that all three—ideology, public policy, and science—are inextricably linked. More specifically, Stern argues that there is enough hard science to prove that PCD exists.⁵⁶³ By denying this science, the APA implicitly asserts that ideology and legal ramifications are more important than empirical research. In Frances' case, this implication is made explicit: as discussed above, he argues that the persistent misuse of the NOS category in SVP proceedings indicates that PCD is too dangerous to include in the *DSM-5*, despite potential benefits to clinicians.

This piece of the debate suggests that the APA faces ongoing difficulties in weighing these two things—science and politics—particularly in the context of SVP laws. SVP laws require a psychiatric diagnosis and thus directly implicate the APA in the use of such laws. Accordingly, many APA members (and the APA as an organization, given its participation in legal challenges to SVP laws) see the legal questions raised by SVP laws as inextricable from the 'science' questions represented in the paraphilias section of the *DSM*. Stern's statement that the APA chooses to weigh political factors in this context is correct, but it's not clear whether this is a bad thing. The APA's near-total avoidance of such questions in the mid-1980s was, I argue

⁵⁶³ The majority of Stern's citations are works from the 1980s (Abel, Marshall, and Freund among them). He includes only one recent article advocating for PCD: David Thornton's "Evidence Regarding the Need for a Diagnostic Category for a Coercive Paraphilia," *Archives of Sexual Behavior* 39 (2010). The four men discussed here—Knight, Quinsey, Stern and Thornton—were all members of the Advisory Group on Paraphilias for the *DSM-5*. While the advisory group for the *DSM-III-R* was in universal agreement regarding PCD, the group for the *DSM-5* was very much split.

throughout this dissertation, detrimental. It is likewise clear that the APA is still grappling with how to weigh science versus law and society. It is possible that, as Stern argues, the organization has gone too far in opposing SVP laws and has erred on the side of ideology rather than empiricism. However, Stern's suggestion that ideology has no place in science—in effect, that the APA should return to its earlier isolationist stance—is a retrograde one. If nothing else, the battle over PCD in the mid-1980s demonstrated that the APA could not afford to remain detached. No matter how much the APA's leadership insisted that psychiatry was its own field that had little to do with feminism, the law, or American culture at large, outside observers were going to continue to look to psychiatrists for answers and lobby psychiatric organizations when the answers were ones they didn't like. Since the 1980s, psychiatrists have increasingly realized that this interchange is unavoidable. To return to an earlier stance, as Stern suggests, would be impossible.

Given that so much of this debate has centered on SVP laws, it is perhaps unsurprising that support for the diagnosis points towards these laws as well. Stern argues that the inclusion of PCD in the *DSM-5* would be a boon for prosecutors by allowing them a more specific diagnosis rather than forcing them to rely on the NOS designation. Thus, Stern argues, fewer men would be subject to SVP proceedings in general. Conversely, Frances argues that the introduction of PCD would lead more men to be civilly committed as SVPs. Both predictions seem unlikely. Whatever pool of prisoners might be diagnosed as suffering from PCD are already liable to be diagnosed as suffering from a paraphilia NOS—in other words, PCD-sufferers (if we assume for a moment that such individuals exist) are already included in the NOS pool. If the APA were to include PCD as a diagnosis, this group of men would be shifted out of the NOS category and into the PCD category. However, all the other NOS-diagnosed men remain in the NOS category.

While Stern is correct that fewer men would be diagnosed as suffering from PCD than a paraphilia NOS (due to the specificity of the PCD diagnosis), this doesn't seem likely to change how many men are diagnosed as suffering from a paraphilia NOS. There have been no serious suggestions to do away with the NOS category, despite the problems it has presented in the legal sphere. Unless Stern has some reason to believe that prosecutors will discontinue using the NOS category entirely (which is itself an unlikely prospect, given that it is not just rapists who are designated as SVPs, but a wide variety of sex offenders), it's unclear why PCD would change the number of men designated as SVPs.⁵⁶⁴ Frances' position seems likewise unlikely: whatever men might be diagnosed with PCD are, again, already being diagnosed with paraphilias not otherwise specified. Creating a formal diagnosis to cover an informal one doesn't threaten to allow more individuals to be diagnosed. All of the criteria that might be listed under a PCD diagnosis are already part of any NOS diagnosis, given that such diagnoses have no specific criteria of their own. Accordingly, this debate over the whether the inclusion of PCD in the *DSM-5* would influence the actual number of diagnosable SVPs seems misguided from both ends.

The ongoing debate over PCD, and the *DSM-5* more broadly, demonstrates that the problems that plagued the APA in the mid-1980s were never fully resolved. Although Frances made attempts to mitigate the isolationism and lack of transparency surrounding the *DSM* during his tenure as head of the revisions process, these moves ultimately fell away after his tenure ended. Likewise, the APA's failure to ever really deal with its linkages to the legal sphere in the 1980s have put them in an ever-increasing bind today, with the introduction of SVP laws.

⁵⁶⁴ Stern, a lawyer commenting on psychiatry, argues further that psychiatrists should not comment on the law because they are prone to misinterpret it. Given his many misinterpretations of psychiatry, he may be correct on this, though in a particularly ironic way.

Though the APA now voices strong opposition to such laws, that opposition may have come too late.

Pedophilia in the 21st Century

Psychiatric discourse around PCD has remained largely static. Individuals have changed sides, but the debate has continued to circle the same questions of empiricism, ideology and legal consequences. But psychiatric opinions of pedophilia have changed immensely since the 1980s. In a particularly ironic turn, psychiatrists have increasingly wondered whether pedophilia might, as NAMBLA suggested, be analogous to a sexual orientation. But while NAMBLA argued that this meant that pedophilia was merely another normal variation on human sexuality, psychiatrists see this as an indication for the kind of treatment needed rather than any indication that pedophilia should be socially (or legally) accepted.

The sexual orientation analogy relies on a few components: primarily whether or not the attraction appears to be inborn (versus caused by external, environmental factors), and whether the attraction is stable over time (versus whether it can be changed). Contemporary scientific research indicates that homosexuality is inborn (and, increasingly, that it may be influenced by genetic and prenatal factors) and that attempts to change a homosexual orientation (through “reparative therapy,” as it’s most commonly known) have overwhelmingly failed. While such therapy might change the behavior of the patient, it fails to change the underlying sexual orientation.

Researchers in favor of a pedophilia-as-orientation model argue that these statements are likewise true of pedophilia. In contradistinction to the earlier idea that pedophilia was the result of some external factor (for instance, a trauma during childhood that resulted in emotional and

sexual arrested development), these researchers argue that many pedophiles suffer no such event and instead experience a lifelong attraction to children (and one which they, much like gay men and women, often come to recognize during puberty). And while therapeutic attempts to treat pedophiles have been somewhat successful in preventing patients from offending against children, these therapies have not been demonstrated to be successful in altering the pedophiles' underlying attraction toward children.

This latter point—that pedophilia is a stable orientation rather than a curable disorder—has been essentially accepted by the APA.⁵⁶⁵ In the *DSM-5*, they write, “Pedophilia per se appears to be a lifelong condition.”⁵⁶⁶ In other words, while its manifestation may wax and wane over time, depending on treatment and life events, the underlying condition (sexual attraction to children) remains basically stable.⁵⁶⁷ The implication here is that treatments may exist which help a pedophile manage their condition (by making them less likely to offend against children), but that no true cure exists. As further evidence of this, the *DSM-5* omits a qualification for Pedophilic Disorder that appears for every other listed paraphilic disorder: the “in full remission”

⁵⁶⁵ Even critics of the orientation model of pedophilia note that the idea that pedophilia is a choice is an unpopular one. Briken writes, “Individuals do not voluntarily decide to have a sexual interest in children. Sex researchers hold this view almost universally and only about 30% of the general population thinks that individuals choose to become pedophiles” (Briken, *Why Can't Pedophilic Disorder Remit?*)

⁵⁶⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (Arlington, VA: American Psychiatric Publishing, 2013), 699.

⁵⁶⁷ There is an additional wrinkle here: the *DSM-5* differentiates between paraphilias (“any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners”) and paraphilic disorders (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”). Paraphilic Disorders are classified within the *DSM-5* as disorders, but paraphilias are not. Under these definitions, many non-normative sexual interests exist without being inherently disordered—sexual sadism, for instance, can be fulfilled in a consensual manner. Pedophilia, conversely, is inherently disordered—the sexual desires of the pedophile cannot be fulfilled without involving a partner who is by definition unable to consent.

qualifier.⁵⁶⁸ By omitting this qualifier, the APA implies that pedophilia cannot be in remission—again, because the APA’s official position is that it cannot be cured.

This is not to say that the debate around the nature of pedophilia is closed. In fact, the sexual orientation model has been subjected to much dissent. This is most visible in responses to the *DSM-5*. Dissent can be grouped into two major categories (with most researchers against the orientation model expressing both types of dissent): scientific and social. In terms of scientific dissent, many researchers claim that the APA’s definition of pedophilia as incurable is without strong evidence.⁵⁶⁹ That such disagreements on the nature of pedophilia continue to exist is not

⁵⁶⁸ A paraphilia “in full remission” is defined, within the DSM, as one that has not been acted upon or experienced as subjectively distressing for a period of 5 or more years. It’s worth noting here that the wording of the qualification introduces some theoretical instability: it’s entirely possible that a pedophile might not act on their urges and also might not experience them as distressing (in other words, that someone might find their attraction to children completely normal and unproblematic, but might simultaneously not act on their attraction due to any number of factors). This, in itself, wouldn’t mean that the disorder was in remission—the pedophile in this hypothetical is still attracted to children. It’s not clear whether this instability is due to poor wording within the *DSM-5*—elsewhere, the paraphilia section is careful to define a paraphilic disorder as one that is repeatedly acted upon, one that causes subjective distress to the sufferer, or one whose fulfillment causes nonconsensual harm to others. It’s plausible that the APA merely neglected to include this latter part in its definition of remission. However, given how persistently controversial the paraphilia section of the *DSM* is and given how careful the APA is in its wording elsewhere in the manual, this seems somewhat unlikely. More likely, the APA still hasn’t fully grappled with how to define mental illnesses that are so closely tied to criminality [yes, excellent point, clearly stated]. When its fundamental model for mental illnesses is whether an emotional state causes subjective distress, but when they also believe pedophilia to be incurable, the idea of “remission” becomes complicated.

⁵⁶⁹ A second type of scientific dissent relies on different definitions of both pedophilia and the concept of sexual orientation. Some researchers have argued that homosexuality is not a purely sexual attraction to the same-sex, but also a romantic attraction. These researchers construct pedophilia as primarily sexual, in order to contrast it with homosexuality. Such definitions of pedophilia are incomplete, however. Groups like NAMBLA and PIE spoke at length about the romantic and emotional components of pedophilia. To define pedophilia as purely sexual seems to miss the different ways in which pedophilia manifests. It’s unclear whether such constructions of pedophilia are purposeful (in that they conveniently lend themselves to an anti-sexual orientation model) or due to historical and practical factors (few pedophiles openly speak about their romantic attachment to children these days; as well, much of the research on pedophiles is done on men who have been convicted of child sexual abuse, which creates a sampling bias. It’s

surprising. Despite decades worth of research, knowledge in this area remains tentative for pragmatic reasons. Pedophiles rarely volunteer for treatment or for research studies, given the linkages between their condition and criminality, and given the social stigma against pedophilia. While many such men did volunteer for treatment at the centers discussed in this dissertation, most research on pedophilia has been done on convicted child molesters. This presents a sampling bias—it is likely that significant differences exist between practicing child molesters and nonoffending pedophiles. Moreover, it is plausible that significant differences exist between convicted child molesters and unconvicted child molesters—those who are caught may be less savvy than those who aren't, and those who are convicted may be engaged in more heinous or more frequent crimes than those who aren't. All of these factors have implications for the study and treatment of pedophilia as a more general condition, as has been noted since the 1980s.⁵⁷⁰ To say, in this context, that the APA's designation of pedophilia as incurable is tentative is a reasonable statement.

On the other hand, some researchers' assertions reach beyond this. Peer Briken, for instance, claims that designating pedophilia as incurable communicates to prospective patients that they cannot get better, "regardless of treatment." This is a peculiar criticism for a number of

possible that pedophiles with a greater deal of romantic and emotional attraction to children are less likely to offend, or that those convicted are more likely to see their attraction to children in primarily sexual terms). At any rate, while there are likely a number of pedophiles whose attraction to children is solely sexual, there is likely an equally large number for whom the attraction is more complex. To define pedophilia on the basis of one component or one subgroup seems misleading.

⁵⁷⁰ David Finkelhor, a leading authority on child sexual abuse in the 1980s, noted of research subjects, "[They are] a small fraction of all offenders, the most flagrant and repetitive in offending, most socially disadvantaged, and least able to persuade criminal justice authorities to let them off" (David Finkelhor et al., *A Sourcebook on Child Sexual Abuse* (Thousand Oaks, CA: Sage, 1986), 138). NAMBLA made similar observations, as discussed in chapter 4. See also Richard Green, "Is pedophilia a mental disorder?" *Archives of Sexual Behavior* 31, no. 6 (December 2002).

reasons. First, there is a perception that many mental conditions are manageable, despite being incurable—schizophrenia and depression among them, to name just two. There also exists a popular discourse that alcohol and drug addiction are fundamentally incurable—the AA model, far and away the most popular treatment method, designates addicts as people who will always be addicts, but who manage their conditions and control their behaviors. It’s not at all clear that pedophilia should be considered different in order to appeal to prospective patients.

Moreover, contemporary treatment efforts that endorse the orientation model seem to be enjoying some success. The Prevention Project Dunkelfeld in Germany, for instance, advertises its services with this statement: “In therapy I learned no one is to blame for their sexual preferences, but everyone is responsible for their own behavior.”⁵⁷¹ The project, launched in Berlin in 2005, offers confidential⁵⁷² and free treatment to pedophiles and had, by 2013, treated approximately 500 individuals.⁵⁷³ While the project doesn’t publicly offer numbers on recidivism rates, the project’s continuation⁵⁷⁴ suggests that their official stance that pedophilia is incurable

⁵⁷¹ Prevention Project Dunkelfeld. Accessed May 29, 2016. <https://www.dont-offend.org>.

⁵⁷² Germany has no mandatory reporting laws—unlike American therapists, German therapists are not required to report child sexual abuse to any legal authorities. PPD therapists attribute their ability to reach out to patients and offer treatment to this fact, and consider absolute medical confidentiality to be central to the success of the project. On this, see their FAQ video on the PDD website, and also “How Germany Treats Pedophiles Before They Offend” (Kate Connolly, *The Guardian*, October 16, 2015). American observers have made similar observations. Elizabeth Letourneau, director of the Moore Center for the Prevention of Child Sexual Abuse at Johns Hopkins University, stated of mandatory reporting laws that, “Self-referrals for help really dried up. And people watched helplines go silent, because folks are too afraid to reach out for help. The consequences are too high” (Tarrad and Feathered, *This American Life*, National Public Radio: WNYC, New York, April 1, 2014). See also Fred Berlin’s reaction to mandatory reporting laws in chapter 3.

⁵⁷³ Dorit Grundman, et al., “Stability of Self-Reported Arousal to Sexual Fantasies Involving Children in a Clinical Sample of Pedophiles and Hebephiles,” *Archives of Sexual Behavior* 54, no. 5 (July 2016).

⁵⁷⁴ Not just continuation, but expansion: the project began as one treatment center in Berlin in 2005. It now spans 10 treatment centers across Germany and is looking to continue opening more.

hasn't led any significant number of patients away from their doors. In addition, leading researchers on pedophilia tend to agree that the best approach to treatment is cognitive behavioral therapies designed to help pedophiles control their urges and to prevent them from acting on such urges.⁵⁷⁵ Few clinicians working with pedophiles today are in search of a cure, strictly speaking.

Interestingly, some of the researchers in favor of an orientation model of pedophilia directly comment its potential social and legal implications. Michael Seto, one of the biggest proponents of this model, concludes his 2012 article with a brief discussion on this topic. He argues that the legal implications are minimal—while pedophilia may have many commonalities with sexual orientation, it is highly unlikely that this will result in the extension of any particular civil rights to pedophiles. In terms of social implications, Seto doesn't take up one of the more obvious questions (that is, “Given the history of gay men being analogized to pedophiles, does analogizing pedophilia to homosexuality threaten the gains made by the gay rights movement?”). However, Seto argues that such an analogy would potentially allow enough social acceptance to make treatment more easily available. Like most others in his field, Seto believes that the intense social stigma against non-offending pedophiles (to the extent that popular opinion sometimes doesn't differentiate between “pedophile” and “child molester”) prevents such individuals from seeking or accessing treatment.⁵⁷⁶ A “more compassionate and less discriminatory” attitude

⁵⁷⁵ CBT forms the basis of Prevention Project Dunkelfeld's treatment regime, though they use other techniques as well (including medications such as hormone therapy and SSRIs with select patients). James Cantor, regarded as a leading expert on paraphilias, endorses CBT as the most effective treatment for pedophilia. On the former, see project's website. On the latter, see: James Cantor, “'Gold-Star' Pedophiles in General Sex Therapy Practice,” in Yitzchak Binik and Kathryn Hall, eds., *Principles and Practice of Sex Therapy* (New York City, NY: Guilford Press, 2014).

⁵⁷⁶ I include the second part of this statement because a number of pedophiles report attempting to access treatment and being turned away. Among the men being treated at Prevention Project

towards pedophiles, argues Seto, would allow for more treatment and services for non-offending pedophiles. In turn, this would allow interventions to happen before pedophiles offend against children and thus help reduce the number of sex crimes against children.

Given that the APA has spent decades insisting that these social and legal implications were not within their purview, such statements are especially notable. They do not represent the leadership of the APA, nor have they had much influence on official documents like the *DSM*. However, that psychiatrists are beginning to ask such questions indicates that APA members are increasingly recognizing the ways in which psychiatry is intertwined with society, the law, and other spheres.

Moreover, this debate indicates that superficially scientific questions (“Can pedophilia be cured?”) involve a complex political and social calculus: “What does the answer to that question communicate to patients and potential patients?”; “What are the potential legal and social ramifications?” As this dissertation demonstrates, such questions were omnipresent in the debates over PCD. What’s changed since the 1980s is that APA members are more likely now to ask these questions themselves, whereas in the mid-1980s, such questions were asked almost exclusively by external observers (women’s advocates, legal scholars, concerned citizens). The APA is no closer to fully answering such questions, or even to developing a systematic way to approach such questions. However, merely acknowledging that these questions exist and are within the purview of the APA is a step forward.

Finally, it’s worth noting that popular media are increasingly receptive to the idea that pedophilia is a mental disorder that should be treated, rather than a moral failing that should be roundly and vehemently condemned. Over the past five years, the following headlines have

Dunkelfeld, for instance, approximately 50% report previous attempts to access treatment which were denied.

appeared in popular online publications: “Treating Pedophiles: Therapy Can Work, But It’s a Challenge,” “Born This Way: Sympathy and Science for Those Who Want to Have Sex with Children,” “How Can We Stop Pedophiles? Stop treating them like monsters,” “Reducing harm done by and to paedophiles.”⁵⁷⁷ In 2014, UK Channel 4 commissioned “The Paedophile Next Door,” a documentary on non-offending pedophiles. That same year, popular podcast *This American Life* released a well-received segment discussing an online support group for young pedophiles.⁵⁷⁸ Other, similar support groups have cropped up and received modest (and positive) publicity.⁵⁷⁹ While it is clear that U.S. society isn’t willing to accept pedophilia as a normal sexual variant, it is apparent that the science on pedophilia is increasingly making inroads into the popular perception of the pedophile and that, just as researchers are increasingly regarding pedophiles with a modicum of sympathy, so too is the public.⁵⁸⁰

⁵⁷⁷ Lauren Cox, “Treating Pedophiles: Therapy Can Work, But It’s a Challenge,” *Live Science*, December 16, 2011; Cord Jefferson, “Born This Way: Sympathy and Science for Those Who Want to Have Sex with Children,” *Gawker*, September 7, 2012; Jennifer Bleyer, “How Can We Stop Pedophiles? Stop treating them like monsters,” *Slate*, September 24, 2012; “Reducing harm done by and to paedophiles.” *The Guardian*, October 21, 2015.

⁵⁷⁸ Tarrred and Feathered. A longform article discussing this group appeared later that year: Luke Malone, “You’re 16. You’re a Pedophile. You Don’t Want to Hurt Anyone. What Do You Do Now?” *Medium*, August 10, 2014. Both the podcast and the subsequent article have been widely reposted and discussed online.

⁵⁷⁹ Among the better known and more publicized support groups for pedophiles are Virtuous Pedophiles (with over 1200 registered users), and Schicksal and Herausforderung (*Fate and Challenge*, run by a former Prevention Project Dunkelfeld patient). Both of these groups—along with the unnamed support group for young pedophiles discussed in *This American Life*—condemn the consumption of child pornography and require their members to abstain from it. It seems likely that without doing so, such groups would not receive nearly as much public sympathy as they do. For one example of public coverage of such groups, see: Tracy Clark-Flory, “Meet pedophiles who mean well: The men behind VirtuousPedophiles.com are attracted to children but devoted to denying their desires,” *Salon*, July 1, 2012.

⁵⁸⁰ All of the articles listed here discuss research on pedophiles and make reference to some of the researchers discussed here. In addition, James Cantor was invited to write an article on pedophilia for CNN in 2012: “Do pedophiles deserve sympathy?” *CNN*, June 22, 2012.

Psychiatry and Fourth-Wave Feminism

In terms of psychiatry, the women's movement (such as it is today) no longer appears to regard the APA as a significant site of change for gender relations. While transgender advocates continue to watch psychiatric debates over Gender Identity Disorder, the women's movement has apparently moved on.⁵⁸¹ This is most visible in the near-total lack of response to the inclusion of PMDD in the *DSM-5*, versus the extended protest campaign levied against it and the two other proposals in 1986. Feminists have likewise not weighed in on the continued proposal of PCD in any significant numbers.

This fact is quite lucky for some researchers. Vernon Quinsey, in particular, has committed some egregiously sexist statements to paper in discussing PCD's potential addition to the *DSM-5*. He writes, in opposition to PCD, that rape cannot be considered a mental illness because such behavior represents an evolutionary tactic to increase a man's number of sexual partners and thus his Darwinian fitness. Had Quinsey written such a statement in 1986, the feminist and public response would have been immediate and brutal. Quinsey's argument here also centers on his assumption that rapists overwhelmingly engage in vaginal penetration. He writes:

It could be argued that rapists who engage in oral or anal intercourse do suffer from a pathology because their behaviors are manifestly reproductively irrelevant... At present, it is unknown what proportion of rapists engage exclusively in oral or anal intercourse or whether *any* actually prefer these activities.⁵⁸²

By the time Quinsey wrote this article (in 2010), women had been sharing their experiences with sexual assault for decades. It's abundantly apparent that many rapists engage in sexual violence

⁵⁸¹ Gay rights groups continued to lobby professional organizations to take a stand against reparative therapy into the 2010s. Most organizations—the APA among them—have done so at this point.

⁵⁸² Quinsey, "Coercive Paraphilic Disorder."

that does not involve vaginal penetration, that many engage only in oral or anal intercourse, or only in digital penetration, or object penetration. It's likewise apparent that many rapists attack individuals who are overwhelmingly unlikely to become pregnant (men, post-menopausal women, girls too young to reproduce). Women in 1986 argued that the APA had failed to listen to their experiences or concerns. Here, Quinsey makes the same error by assuming that a lack of data on rapists means a lack of data on rape.

In all, then, the debate about PCD (and other disorders like Premenstrual Dysphoric Disorder) has continued on within the psychiatric sphere. The above discussion demonstrates that feminists' turn away from psychiatry is perhaps a failure. Despite the success of the protest movement in 1986, feminist input into diagnostic categories remains lacking. For the women's movement, however, there's no longer a serious investment in the idea that rapists could be thought pathological. The trends discussed throughout this dissertation—a shift away from treatment in the legal realm, the closure of a number of treatment facilities due to these legal shifts and to public controversies, and the deletion of PCD from the *DSM*—have meant that there is little public investment in the idea that rapists be thought of as mentally ill today. Accordingly, feminist advocacy around the issue of sexual violence has moved on to arenas more likely to produce significant changes—advocacy around the law and law enforcement continues, as does advocacy to change cultural perceptions of sexual violence. Without the looming threat that rapists could be diagnosed as mentally ill or sentenced to treatment facilities in any large numbers (SVP laws notwithstanding⁵⁸³), psychiatric theories about sex offenders have become

⁵⁸³ SVP laws do not present the same challenges to feminist theories of sexual violence in that they require an offender to be incarcerated before being committed—in other words, such laws do not threaten conviction rates and do not suggest that offenders should be treated *rather than* being punished. They both punish and treat (or, in the argument of many psychiatrists, use commitment simply to extend punishment), and thus offer no implication that a psychiatric

less pressing to feminist observers. As well, today the women's movement has succeeded in claiming a great deal of ownership over the question of sexual violence—feminist theories permeate popular culture and, in many ways, the law.⁵⁸⁴ The mid-1980s, however, were a moment where the women's movement was marginal but increasingly powerful—ensuring that oppositional theories of sexual violence like PCD did not gain traction was exceedingly important. Now that feminist theories of sexual violence are culturally entrenched, such oppositional psychiatric theories are less threatening. In this sense, the APA (as an organization that had long been targeted by activist groups and which had a great deal of cultural capital) had been a convenient staging ground for feminist activism and theory in the 1980s.

disorder makes someone less culpable for their crimes. Feminists have generally not offered objections to SVP laws, though Rose Corrigan does argue that related community registration laws are antithetical to feminist aims. Corrigan argues that such laws distract from more mundane and typical types of rape (intra-familial rape, or rape committed by individuals known to the victim) in favor of more dramatic forms of sexual violence (stranger rape). While Corrigan does argue that community notification laws reinforce a view of rapists as pathological and that this framework is problematic for feminist aims, she doesn't particularly emphasize this point. It's not so much the existence of a pathological framework that is the problem, but its overemphasis and the ways in which that overemphasis erases other types of sexual violence. On top of this, Corrigan offers many familiar criticisms of SVP laws: the alliance between prison and therapy relies on "uniquely coercive conditions," and the requirement that sex offenders disclose personal information in service of being indefinitely committed places them in a "catch-22." See Rose Corrigan, "Making Meaning of Megan's Law," *Law and Social Inquiry* 31, no. 2 (June 2006).

⁵⁸⁴ This is not to say that the women's movement has succeeded in meeting all its goals, nor that resistance to feminist theory does not remain in both public and legal culture. However, the passage of legislation like the Violence Against Women Act of 1994, the many changes feminist activism has produced in federal and state definitions of rape, and the prevalence of feminist-led initiatives regarding domestic violence all indicate that the women's movement has a much stronger foothold in American culture today than it did in the 1980s. On domestic violence and the law, see Elizabeth Pleck, *Domestic Tyranny: The Making of American Social Policy against Family Violence from Colonial Times to the Present* (University of Illinois Press, 2004), and Elizabeth M. Schneider, *Battered Women and Feminist Lawmaking* (New Haven: Yale University Press, 2000). On feminist theories of sexual violence in the law, see Maria Bevacqua, *Rape on the Public Agenda: Feminism and the Politics of Sexual Assault* (Lebanon, NH: Northeastern University Press, 2000), and Kristen Bumiller, *In an Abusive State: How Neoliberalism Appropriated the Feminist Movement Against Sexual Violence* (Duke University Press, 2008).

A comparison of the discourse surrounding sexual violence in the 1980s versus what has taken place since demonstrates the difficulties psychiatrists and feminists had in implementing deep and long-standing changes. For all that PCD became a flashpoint for debates over gender, sexual violence, and the nature of psychiatry, its deletion from the *DSM-III-R* forms a sort of superficial endpoint. After the protests ended in 1986 and the *DSM-III-R* revisions process wound to a close, the larger questions brought up by protesters remained unresolved. Altogether, while the actors discussed here argued at length and sometimes quite forcefully, this is a story of limited engagement. The APA, once prying eyes closed, returned to its earlier isolationist stance. Despite its dissatisfaction with SVP laws, it still hasn't rigorously theorized how to approach the places where legal questions overlap with psychiatric ones. Likewise, while radical reformers like Caplan (and professionals like Bernandez) remained involved in with the APA after the protest movement's "success," most of those involved (both individual protesters and national groups like NOW) faded away and failed to notice when the APA continued to propose all three disorders, or even to notice when they successfully included PMDD in the *DSM-5*. In all, this dissertation demonstrates that sustained change happens slowly. While moments of controversy can encapsulate larger questions—as did PCD—those moments rarely answer such questions in full.

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