Sexual Sadism: Avoiding Its Misuse in Sexually Violent Predator Evaluations

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The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), Task Force has recently rejected the proposal to include coercive paraphilia as an official diagnosis, reaffirming that rape is a crime and not a mental disorder. We hope this will discourage what has been the inappropriate practice of giving rapists the made-up diagnosis of paraphilia, NOS, nonconsent, to facilitate their psychiatric commitment under sexually violent predator (SVP) statutes. Losing the paraphilia, NOS, option has tempted some SVP evaluators to overdiagnose sexual sadism, which is an official DSM mental disorder. To prevent this improper application and to clarify those rare instances in which this diagnosis might apply, we present a brief review of the research on sexual sadism; an annotation of its definitions that have been included in the DSM since the Third Edition, published in 1980, and in the International Classification of Diseases, Tenth Edition (ICD-10); and a two-step process for making a diagnostic decision. Rape and sexual sadism have in common violence, cruelty, and a callous indifference on the part of the perpetrator to the suffering of the victim, but they differ markedly in motivation. Rapists use violence to enforce the victim's cooperation, to express aggression, or both. In contrast, in sexual sadism, the violence, domination, and infliction of pain and humiliation are a preferred or necessary precondition for sexual arousal. Only a small proportion of rapists qualify for the diagnosis of sexual sadism.

J Am Acad Psychiatry Law 40:409–16, 2012

Since 1990, many states and the federal government have enacted legislation allowing for the postprison civil commitment of what is assumed to be "a small but extremely dangerous group" of offenders who are referred to as either sexually violent predators (SVPs) or sexually dangerous persons.[1–4] Although the wording of these statutes varies slightly from one jurisdiction to another, "Such laws generally include four elements: (i) a history of sexual offenses, (ii) a mental abnormality, (iii) volitional impairment, and (iv) as a result of mental abnormality, the individual is likely to engage in acts of sexual violence" (Ref. 4, p 31). In this context, a mental abnormality is a legally defined term that refers to a mental illness that makes a person sexually dangerous beyond his control.

Psychiatrists and psychologists are often retained to evaluate whether a respondent to a postprison civil commitment petition may be classified as an SVP because he satisfies all of the foregoing elements that define it. No convincing body of published scientific evidence indicates, however, that mental health professionals can reliably differentiate SVPs from more typical recidivists who may be sexually dangerous but lack a mental abnormality. The terms volitional impairment and sexual dangerousness have also never been adequately operationalized for use by evaluators.[5] Finally, the assumption that volitional impairment causes sexual dangerousness has never been confirmed.

These uncertainties threaten the credibility of experts who testify in SVP trials.[6] As a result, experts invariably claim that their opinions are supported by systems that are only indirectly related to sexual dangerousness but have the advantage of being authoritative in the sense that they are accepted by the scientific community.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is undoubtedly the single source of authority most widely cited in SVP evaluations. Our personal experience attests to this, in that we have read hundreds of such evaluations and have never encountered one that has omitted referencing at least one of the modern DSMs, which thus far include DSM-III,[7] DSM-IIIR,[8] DSM-IV,[9] and DSM-IV-TR.[10]

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Disclosures of financial or other potential conflicts of interest: Dr. Frances was Chair of the DSM-IV Task Force.

Other systems, such as *bona fide* actuarial measures[11] for the estimation of sexual recidivism are certainly authoritative. Even they, however, are not cited universally.

Unfortunately, evaluators in SVP cases have frequently misrepresented the content of the DSM. In previous papers that have discussed the history and rationale of SVP laws, we have been particularly critical of the misuse of two unofficial and makeshift diagnostic labels: paraphilia, not otherwise specified (NOS), nonconsent, and paraphilia, NOS, hebephilia.[12–16] One purpose in writing these papers was to encourage evaluators to refrain from using invented diagnostic labels to shoehorn respondents into a position where they could be incarcerated for life without just cause after having already paid their debt to society. Another was to discourage the Task Force that is currently revising DSM-IV-TR from considering diagnoses that are invalid and will almost certainly damage the reputation of the DSM and the mental health professions by mistakenly turning crimes into mental disorders.

Recently, according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) web site,[17] a proposal to add paraphilic coercive disorder as an official diagnosis was placed on hold. This development is an important one, in that paraphilic coercive disorder is nothing more than a variation of paraphilia, NOS, nonconsent. It may also be a turning point for correcting the misuse of the DSM in SVP evaluations, reversing the previous misguided acceptance of paraphilia, NOS as a qualifying diagnosis for making a mental abnormality determination.

Faced with this development, evaluators who are prone to overclassifying respondents as SVPs may begin to assign the diagnosis of sexual sadism more frequently to rapists.

The problem with the use of sexual sadism in SVP evaluations is different from the problem with the use of paraphilia, NOS, nonconsent, and paraphilia, NOS, hebephilia. Unlike these latter terms, sexual sadism is one of the eight specific paraphilias that are included as official categories in the DSM and a diagnosis that, combined with sufficient impairment and a predisposition to sexual violence, constitutes a mental abnormality. The overdiagnosis of sexual sadism results from insufficient understanding of the DSM requirement that it be used only when the infliction of pain has the goal of sexual arousal and is not merely incidental to the act of rape.

In the next section of this article we briefly discuss the history of the sexual sadism construct and summarize the results of published research on it. Then, we annotate sections of the several editions of the DSM and the 10th revision of the World Health Organization's International Classification of Diseases (ICD-10)[18] that, taken together, define this paraphilia. Finally, we discuss two guidelines that we believe evaluators should follow to prevent the misapplication of the diagnosis of sexual sadism. Overall, we encourage evaluators to differentiate sexual sadists from rapists carefully, to analyze the viability of nonsadistic explanations for sexual violence, and to adhere closely to the diagnostic heritage and framework provided by present and past versions of the DSM and the ICD.

A Brief History of Sexual Sadism and Summary of Research Findings

Various criminal, literary, and political figures over the past 400 years have been characterized as practitioners of sadism, which was named after the Marquis de Sade, an 18th century aristocrat, libertine, author, and revolutionary.[19,20] von Krafft-Ebing[21] and Stekel[22] were the first mental health professionals to describe sexual sadism from a clinical perspective. Most of the efforts of later researchers have focused on examining cases of specific individuals drawn from easily accessible populations,[21–25] groups of sex offenders who have been given the diagnosis of sexual sadism,[26–33] and groups that included sex murderers.[25–27,34–41] Researchers have less frequently collected epidemiological data[1,42,43] or surveyed practitioners.[2,44,45]

Analyses of the sexual sadism construct[25–26,35] have emphasized von Krafft-Ebing's thesis that "mastering and possessing an absolutely defenseless human object . . . is part of sadism" [Ref. 35, p 20]. Complementing this focus, other analyses[19,28,46] have cited his definition of sadism as:

> The experience of sexual, pleasurable sensations (including orgasm) produced by acts of cruelty, bodily punishment afflicted on one's person or when witnessed by others, be they animals or human beings. It may also consist of an innate desire to humiliate, hurt, wound, or even destroy others in order, thereby, to create sexual pleasure in oneself [Ref. 46, p 5].

Published research on sexual sadism that is relevant to SVP evaluations has documented crime scene

behavior, fantasies, and motivations that relate to sadistic behavior and the prevalence and reliability of the diagnosis. The following paragraphs summarize the results of these efforts.

Crime Scene Behavior

The case history references cited in the first paragraph of this section indicate that severe sexual sadists tend to be planful and emotionally detached. They also intentionally torture and humiliate their victims, restrain and abduct them, and subject them to a variety of highly intrusive sexual acts that frequently include anal intercourse and bondage.

Fantasies and Motivational State

Sexual sadists have told various interviewers that they fantasized about how they would offend before their crimes and often tried out, or rehearsed, their behavior.[34,39,40] Frequently depressed or angry before offending, they elicit fearful reactions from victims and often engage in self-provocation that stimulates an escalation in their aggressive behavior.

Prevalence Rates

Estimates of cases of sexual sadism, in general, vary as a function of the setting where data are collected and the practices and preferences of diagnosticians in those settings. Rates are low, however. No visits for sexual sadism were reported, for example, in an analysis of close to a half billion visits to U.S. outpatient medical clinics.[20] Somewhere between two and six percent of those who were seen at outpatient clinics that treat paraphilic disorders reported problems with sadism; this was the least frequent complaint of those for all paraphilias.[1,32,42,47] The estimated rate was only slightly higher (6.4%) for about 2,000 sex offenders detained under the SVP civil commitment laws in seven states.[43] It has been reported to be substantially higher (from 10% to 81%) in offenders who have been hospitalized or incarcerated after murdering or severely assaulting a victim.[29–31,33,35,48] Members of this small group are unlikely to be the subject of SVP petitions, however, because of the long-term nature of their confinements. DSM-IIIR states that less than 10 percent of all rapists engage in sexual sadism (Ref. 8, p 288).

Diagnostic Reliability

Diagnostic certainty is a function of a disorder's prevalence rate and the accuracy of the criteria used for its identification.[5,15,49–51] The reliability of sexual sadism in everyday forensic practice is likely to be open to question because of the disorder's low prevalence, documented in the previous section. A few investigators who have reported favorable diagnostic reliability coefficients presented evaluators with sets of case history vignettes for sex offenders and asked that they be identified as either sadists or nonsadists.[31,52] Their vignettes included an unrealistically high percentage of sadists, however, and evaluators had to choose from only two diagnostic options. Such procedures generate inflated reliability coefficients.[16] Other investigators, using the same inflationary methods, found poor diagnostic agreement.[19,30,44] They concluded that agreement is unlikely because both nonsadistic and sadistic rapists control, humiliate, assault, and hurt their victims, and the DSM criteria require inferences about abstract states (e.g., offender motivation, arousal, and gratification) that are subjective and unreliable. Taken together, the prevalence and reliability research on sexual sadism indicates that diagnosticians who do not use very stringent diagnostic criteria to identify this disorder will be subject to error (Ref. 5, p 198).

An Annotation of the DSM and ICD-10 Diagnostic Criteria

Table 1 shows the criteria sets for sexual sadism included in DSM-III, DSM-IIIR, DSM-IV, DSM-IV-TR, and ICD-10. Changes have been made to this framework over the years, but von Krafft-Ebing's conception is evident, in that the defining characteristics of sexual sadism are recurrent and intense sadistic fantasies, urges, and behaviors that require the infliction of psychological or physical suffering as a preferred or obligatory pattern of sexual arousal. The following phrases from the DSM-IV-TR text that precede the criteria also refer to the urges for "mastering and possessing an absolutely defenseless human" emphasized by Kraff-Ebbing:

> . . . [T] he sadistic fantasies usually involve having complete control over the victim, who is terrified by anticipation of the impending sadistic act . . . . Sadistic fantasies or acts may involve activities that indicate the dominance of the person over the victims (e.g., forcing the victim to crawl or keeping the victim in a cage). They may also involve restraint, blindfolding, paddling, spanking, whipping, pinching, beating, burning, electrical shocks, rapes, cutting, stabbing, strangulation, torture, mutilation, or killing [Ref. 10, p 573].

Table 1 Criteria Sets for Sexual Sadism From the DSM and ICD-10

Criteria from DSM-III[7]

(1) On a nonconsenting partner, the individual has repeatedly and intentionally inflicted psychological or physical suffering in order to achieve sexual excitement.

(2) With a consenting partner, a repeatedly or exclusive mode of achieving sexual excitement combines humiliation with simulated or mildly injurious bodily suffering.

(3) On a consenting partner, bodily injury that is extensive, permanent, or possibly mortal is inflicted in order to achieve sexual excitement.

Criteria from DSM-IIIR[8]

A. Over a period of at least six months, recurrent intense sexual urges and sexually arousing fantasies involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The person has acted on these urges, or is markedly distressed by them.

Criteria from DSM-IV[9]

A. Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criteria from DSM-IV-TR[10]

A. Over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The person has acted on these urges with a nonconsenting person, or the sexual urges, or behaviors cause marked distress or interpersonal difficulty.

Criteria from ICD-10[18]

A preference for sexual activity which involves the infliction of pain or humiliation. If the subject prefers to be the recipient of such stimulation this is called masochism. If the provider, sadism.

It is useful to assess an SVP respondent against the content of previous DSMs and the ICD-10, not just the current version of the DSM. Unfortunately, the Sexual Disorders section of DSM-IV-TR is the most incomplete and poorly written in the entire manual. A particularly egregious oversight is that valuable wording was omitted for differentiating rapists from sexual sadists that was included in previous DSMs. The relevant text from DSM-IIIR, which elaborates on points introduced in DSM-III, stated that:

> *Rape or other sexual assault* may be committed by people with this disorder. In such instances the suffering inflicted on the victim is far in excess of that necessary to gain compliance, and the visible pain of the victim is sexually arousing. In most cases of rape, however, the rapist is not motivated by the prospect of inflicting suffering, and he may even lose sexual desire while observing the victim's suffering. Studies of rapists indicate that fewer than 10 percent have sexual sadism. Some rapists are apparently sexually aroused by coercing or forcing a nonconsenting person to engage in intercourse and are able to maintain sexual arousal even while observing the victim's suffering. However, unlike the person with sexual sadism, such people do not find the victim's suffering sexually arousing [Ref. 8, pp 287–8; emphasis in the original].

Rather than including the foregoing passage, DSM-IV and DSM-IV-TR contained identical passages that emphasized the importance of differentiating paraphilias from sexual interests of a nonclinical nature and from nonparaphilic disorders. Regarding this differentiation, DSM-IV-TR pointed out that:

> A Paraphilia must be distinguished *from nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement in individuals without a Paraphilia.* Fantasies, behaviors, or objects are paraphiliac only when they lead to clinically significant distress or impairment (e.g., are obligatory, result in sexual dysfunction, require participation of nonconsenting individuals, lead to legal complications, interfere with social relationships).
>
> In *Mental Retardation, Dementia, Personality Change Due to a General Medical Condition, Substance Intoxication,* a *Manic Episode* or *Schizophrenia*, there may be a decrease in judgment, social skills, or impulse control that, in rare instances, lead to unusual sexual behavior. This can be distinguished from a Paraphilia by the fact that the unusual sexual behavior is not the individual's preferred or obligatory pattern, the sexual symptoms occur exclusively during the course of these mental disorders, and the unusual sexual acts tend to be isolated rather than recurrent and usually have a later age onset [Ref. 10, p 568; emphasis in the original].

The introduction to Chapter V of the ICD-10 describes the block of disorders that includes sadomasochism, which combines the concept of sadism with that of masochism, as "a variety of conditions and behavior patterns of clinical significance which tend to be persistent and appear to be the expression of the individual's characteristic lifestyle and mode of relating to himself and others." This theme, taken together with the view that sadomasochism consists

of a "preference for sexual activity which involves the infliction of pain or humiliation" (Ref. 18, § F65.5), supports the views articulated in DSM-III and -IV-TR that sexual sadism involves urges that are very strong in the sense of being "necessary" (Ref. 7, p 266) and "preferred or obligatory" (Ref. 10, p 568). As Table 1 indicates, however, the ICD criteria do not clearly differentiate between sadomasochism as a paraphilia and the enactment of sexual scripts that seem to fit its definition but are harmless and carefully orchestrated simulations among the large number of consenting and unimpaired adults who find these pursuits to be sexually gratifying.[20,46,53] The ICD criteria for sadomasochism and a number of other disorders of sexual preference have consequently been cited as:

> . . . pathologizing, stigmatizing, and discriminating, against individuals who engage in alternative sexual practices. . . . Indeed, Sweden recently took the step of removing transvestism, fetishism, and sadomasochism from its official list of diseases and mental disorders [Ref. 20, p 325].

Guidelines for SVP Evaluation

Great care is necessary in evaluations performed as part of SVP civil commitment proceedings if they are to reach the high level of confidence necessary to justify a recommendation of likely lifetime incarceration. To reduce diagnostic errors, we recommend that evaluators document that they have carefully completed a two-step assessment.

Step 1: Provide Affirmative Evidence for the Diagnosis

The evaluator must first document that the offender has the required features of sexual sadism as these are defined by the content of the current DSM and its predecessors. For those cases in which a rapist admits to being sexually aroused preferentially by the suffering of his victim, the diagnosis of sexual sadism is relatively straightforward. Unfortunately, knowing the implications of such an admission, most sadists are likely to deny having any kind of paraphilic arousal pattern. The evaluator may rely on other evidence to infer the presence of sexual sadism, but should always be cautious, given the possible fallibility and unreliability of inference. Evidence may include preoccupation with pornography having vivid themes of sadistic violence, possession of sadistic devices, routinely forcing sadistic behavior on his partner during intercourse, and frequent inability to become aroused in sexual relations that do not include the infliction of pain. These behaviors should be persistent and characteristic of the individual's sex life rather than occasionally present or present only under the influence of alcohol or other substances.

Step 2: Differential Diagnosis

An evaluator who claims that a respondent to an SVP petition meets the criteria for sexual sadism must testify to being reasonably certain that this diagnosis is present. Such certainty requires considering and ruling out all the many other much more common motivations for rape. Evaluators occasionally make the mistake of assuming that all violence and infliction of pain associated with a sexual offense are diagnosable as sexual sadism. In doing so, they fail to appreciate that sexual sadism is a very specific disorder that is almost never seen in clinical practice and is extremely rare, even in forensic settings, except among sexual and serial murderers. They may also overlook that violence, humiliation, and the infliction of pain are inherent aspects of the crime of rape.[19] Rapists are routinely violent and callous, but very few are sadists. The more common contexts of rape are an antisocial personality pattern of criminality, the use of disinhibiting substances, the use of poor judgment and social skills, or the presence of psychoses or other mental disorders; an attempt to establish status in a relationship; or an expression of anger, cruelty, or revenge against women. Other rapes are committed under the guise of a date, by a gang of perpetrators, by an opportunist, or primarily for monetary gain.

Further, per our foregoing DSM annotation, paraphilias like sexual sadism "must be distinguished from the *nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement* in individuals without a Paraphilia" (Ref. 10, p 568, emphasis in the original). Sadomasochistic foreplay among consenting adults therefore does not count as sexual sadism.

We also indicated in our annotation that DSM-IV-TR requires evaluators to consider and rule out the possibility that violent or cruel behavior might better be explained as the result of more common disorders. These disorders include "Mental Retardation, Dementia, Personality Change Due to a General Medical Condition, Substance Intoxication, a Manic Episode, or Schizophrenia" (Ref. 10, p 568).

Discussion and Conclusions

Unlike rape, sexual sadism is an official DSM-IV diagnosis that, if applied properly, is a legitimate qualifying mental disorder in SVP cases. Unfortunately, it is easy to confuse the rare, preferred, and specialized violence of sadism with the common, occasional, and nonspecific violence of rape. Failing to make this crucial distinction is likely to lead to considerable confusion and inaccurate diagnostic practices.

Some evaluators may be tempted to switch from paraphilia, NOS, nonconsent to sexual sadism, now that it is becoming widely known and accepted that the former has no standing within the diagnostic system. To prevent this from happening, evaluators must rely on the information from DSM, Third Edition through DSM, Fourth Edition, to understand the steps that are involved in making an accurate diagnosis, to stringently apply all relevant qualifiers and criteria, and to avoid steps that might result in misuse of the DSM. Otherwise, well-intentioned but misguided evaluators may wind up misclassifying many nonsadistic rapists with an incorrect diagnosis of sexual sadism.

Unless the great differences between rape and sexual sadism are kept in mind, sexual sadism may become the next misunderstood and misleading fad diagnosis used to misclassify rapists to facilitate SVP commitment. Sexual sadism applies only to a very small minority of rapists. Rapists and sadists are superficially similar, but fundamentally different. Both rapists and sadists are often violent toward their victims but with different motivations. The goal of the rapist's violence is to rapidly and thoroughly control the victim to insure sexual compliance. For the majority of rapists, violence and control are primarily tools to force a nonconsenting person to have sex. By definition, rape is nonconsensual sex that would occur only under conditions of overt or threatened violence.

In contrast, the sadist has a more specific motivation. His stereotyped and often diabolical violence and his demeaning control are the main event of the sex act that fulfill deeply held and sexually arousing fantasies and sexual urges that are recurrent and intense rather than infrequent and isolated. For the sadist, sex would not be nearly so exciting and might not be possible at all if it were not accompanied by violence that elicits pain, humiliation, and suffering in the victim.

Rapists and sadists are both routinely cruel and nonempathic. Both also show a lack of concern regarding the impact of their attack on the victim. Here again, they have different motivations. For the sadist, the sexual excitement is enhanced by, or may exclusively reside in, being dominating and cruel in a way that elicits pain. For the rapist the pain inflicted is more incidental, seen perhaps indifferently as necessary collateral damage, not as the goal of the sex act. The rapist and the sadist both lack a conscience to inhibit hurting others, but only the sadist requires pain as a sexual stimulant. Rape is always a heinous, ugly, violent, and cruel crime. But the violence and cruelty that are part of all rapes should not be confused with the internally motivated violence and cruelty of sexual sadism that requires causing the victim pain to generate excitement.

This distinction must be clearly appreciated, and a positive diagnosis must be supported with strong confirmatory evidence. Otherwise, virtually all rapists could receive a mental disorder diagnosis of sexual sadism and be subjected to SVP commitment on the basis of a faulty diagnosis. This prospect runs counter to specific research results indicating that older rapists are unlikely to recidivate.[54] It also flies in the face of Supreme Court rulings[55,56] that accepted the constitutionality of SVP statutes only on the condition that rape and other forms of sexual violence that qualify for civil commitment must result from a predisposing mental disorder that can be reliably distinguished from common criminality: sexual sadism does not explain most coercive sex and most rapes should not be mislabeled as sexual sadism.

Psychiatric diagnoses have the unfortunate tendency to run in fads.[57] A hundred years ago the most common diagnoses were conversion disorder and neurasthenia. Fifty years ago pseudoneurotic schizophrenia was particularly popular. Twenty years ago, there was an outbreak of multiple personality disorder amid public hysteria about alien abductions. The fad of diagnosing rape as a mental disorder under the rubric paraphilia, NOS, nonconsent, is about 15 years old and seems finally and mercifully to have run its course. It is in the nature of fads to seem compelling at the moment and then to fade into history. Some SVP evaluators, feeling the loss of paraphilia NOS, nonconsent, may be tempted to substitute the DSM-IV-TR-authorized diagnosis of sexual sadism in its place. A clear understanding of DSM criteria and the many subtle considerations necessary to

make a differential diagnosis will nip this potential fad in the bud.

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