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Diagnostic issues in sexual sadism among sexual offenders

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Abstract *This paper provides an integration of our findings on the diagnosis of sexual sadism among sexual offenders. A summary of our review paper is provided followed by a description of two studies that we conducted where we examined both the application of the diagnosis in clinical settings and the inter-diagnostician agreement of the diagnosis based on detailed case descriptions. On the basis of our findings suggestions are offered regarding the future application of the diagnosis.*

Keywords *Sexual sadism; sexual offenders; diagnosis reliability*

The notion of sexual sadism has a long history dating back at least to the notorious Gilles de Rais, a 15th-century French nobleman who raped, tortured and murdered hundreds of children (Hickey, 1991), although the name was derived from the activities of Donatien Alphonse Francois, or the Comte de Sade as he grandly called himself. It was not, however, until Richard von Krafft-Ebing (1886) published his comprehensive descriptions of sexual deviance that sadism came to be accepted as a diagnosis and subjected to scientific scrutiny. There is now available an extensive literature on sexual sadism which has been subject to various reviews and critical commentaries (Breslow, 1989; Brittain, 1970; Burgess, Hartmen, Ressler, Douglas, & McCormack, 1986; Grubin, 1994; Hickey, 1991; Hucker, 1997; Siomopoulos & Goldsmith, 1976). The present paper summarizes our earlier review of the literature (Marshall & Kennedy, in press) and describes two studies in which we examined the clinical application of the diagnosis of sexual sadism (Marshall, Kennedy, & Yates, in press) and the inter-diagnostician reliability of the diagnosis (Marshall, Kennedy, Yates, & Serran, in press).

Diagnostic issues

The diagnosis, sexual sadism, appears in both the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) and the World Health Organization's International Classification of Mental and Behavioral Disorders (ICD-10, World Health Organization, 1992). In both of

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these manuals, sexual sadism is defined in terms of sexual arousal to actions or fantasies involving the physical or psychological suffering of the victim. Our review of the literature (Marshall & Kennedy, in press) revealed that, while these features were often mentioned as characteristic of sexual sadists, a wide variety of other features were also identified as crucial to the diagnosis. Indeed, we noted that individual authors frequently changed their criteria for the diagnosis across their various studies or even, in one case, within the same report. We concluded that researchers and reviewers had failed to use a commonly agreed upon set of criteria and that, as a consequence, it was difficult to compare results from the various studies or to come to any conclusions regarding the findings.

Despite these problems, we observed that some features (for example, power, control, domination, humiliation, degradation, cruelty, torture, and excessive violence) consistently appeared in most of the definitions offered in the literature. A problem here, however, is that, except for cruelty and torture, the rest are common features of all rapes (see Christie, Marshall, & Lanthier, 1979; Darke, 1990; Marshall, Anderson, & Fernandez, 1999) and of many acts of child sexual molestation (Marshall & Christie, 1981). An additional problem is that all definitions of sexual sadism require that the person be sexually aroused by whatever actions of the offender or consequences for the victim are said to be critical to the diagnosis. Since very few individuals are likely to honestly report the features of sexual acts that are arousing to them and even less likely when the individuals are known sexual offenders, the diagnostician must infer a sexual desire for the presumed defining features of sexual sadism. The accuracy of this inference must always be to some extent in doubt with the degree of confidence being dependent on the quality and extent of the information upon which the inference is based.

In the system within which we work (that is, the Correctional Service of Canada), the diagnosis of sexual sadism has very significant negative implications for the person so diagnosed. When an offender in one of the federal penitentiaries in our region has an offence record that raises some concerns in the mind of the Case Management Officer (CMO) the CMO typically will request an independent psychiatric evaluation. The CMO will make this request to assist in: identifying treatment needs; determining dangerousness; deciding on a transfer to a different level of security; and presenting recommendations to the parole board. The independent psychiatrist will then review the extensive case records, which detail the offender's complete offence history and his salient life history events, document all past psychiatric and psychological evaluations (included test results and phallometric evaluations), and provide treatment reports. The psychiatrist will also interview the man, typically for no more than a single 1-hour evaluation.

If a diagnosis of sexual sadism is made, the offender may be moved to a higher security level, he may be required to do extra treatment or even repeat a programme that he has already completed, and he will be very unlikely to get early parole; indeed, he may be kept until the expiry of his full sentence. While these implications are significantly negative for all offenders diagnosed as sexual sadists, they are even more gloomy for offenders with long sentences who constitute the bulk of those referred for such evaluations. An offender serving a life sentence, for example, who is diagnosed as a sexual sadist, is likely to be held in maximum security for far longer than would otherwise be expected, and he is almost certain to have to repeat (perhaps several times) treatment of various kinds (for example, programmes such as those for sexual offenders or violence, cognitive skills and substance abuse). In addition, he will characteristically spend more time in prison than offenders who are not so diagnosed. In other words, this diagnosis has severe and significant direct effects on the offender.

Diagnosis in clinical practice

In our experience over the past 30 years, it has often been difficult to discern any obvious differences between those offenders diagnosed as sexual sadists and those who were similarly referred for a psychiatric evaluation but who did not receive the diagnosis of sexual sadism. Accordingly, we decided to examine the reports from these independent psychiatrists to determine what differences, if any, were apparent between those who were diagnosed as sexual sadists and those who were not (see Marshall, Kennedy, & Yates, in press, for a complete description of this study). To do this, we extracted all the reports from two institutions where the requests for a psychiatric evaluation were most frequent. One of these institutions is a maximum security treatment centre where the most dangerous sexual offenders are treated, the other institution is a so-called "soft" medium security institution to which many of the most dangerous sexual offenders cascade after treatment at higher security levels as they finalize treatment and await possible parole.

We identified the complete set of psychiatric assessments for each year in the period 1989–1998. This produced 59 psychiatric evaluations of incarcerated sexual offenders, all done by 14 experienced and well-respected forensic specialists. From the same files that the psychiatrists had consulted, we extracted extensive details of each offender's current offence(s), his offence history, his life history, his self-reported sexual and violent history and interest, and all psychological assessments including phallometric appraisals. For those readers unfamiliar with phallometric evaluations, they essentially monitor the man's erectile responses to a variety of sexual stimuli, some of which depict consenting relations, some depict rapes varying in violence, and some depict sex between an adult male and a child (both male and female children are depicted in different sets of stimuli). Greater arousal to rape or child stimuli, compared to responses to adult consenting sex, is taken to mean that the man has a sexual preference for these deviant acts. However, for the diagnosis of sexual sadism, arousal to nonsexual violent stimuli might be more relevant, but not all phallometric laboratories assess arousal to such scenes.

While deviant sexual arousal, as revealed by phallometric assessments, has been shown to contribute to an actuarial prediction of risk to re-offend (Quinsey, Rice, & Harris, 1995), we could find no studies that clearly linked the diagnosis of sexual sadism to an increased risk of subsequent re-offending. Nevertheless, most decision makers appear to respond as if being labelled as a sexual sadist does in fact indicate that the person so diagnosed is at greater risk for recidivism.

We then compared those offenders diagnosed as sexual sadists with those who were given some other diagnosis (in all cases this was one or another of the personality disorders, or paedophilia). Although the psychiatrists could have refrained from making any diagnosis, this in fact never occurred. Table I indicates the features we included in our comparisons. Although we evaluated differences on various psychological tests and on self-reported features of their life histories, we found no differences on any of these and we will not discuss them further here.

Four of the remaining specific features did differ statistically significantly, and each of the differences was contrary to expectations. For example, the non-sadists were significantly more likely than the sadists to have beaten their victim(s) and they were more likely to have tortured the victim. In addition, the non-sadists displayed significantly greater sexual arousal to scenes of a man non-sexually assaulting a woman than did the sadists, whereas the sadists showed greater arousal to consenting sex than did the non-sadists (Marshall, Kennedy, & Yates, in press). On a composite score of sadism derived from the offence features (that is, acts inflicted on the victim including cruelty and torture, humiliation, bondage, and mutilation,

Table I. *Features on which sadists and nonsadists were compared.*

Offence features	*Life history features*
Use of a weapon	Relationships (children, teens, adults)
Use of threats	with parents/siblings
Abduction/Confinement	with peers
Humiliation	intimate/romantic
Bondage	Juvenile behaviour problems
Torture	School problems
Mutilation	Cruelty/torture
sexual	animals
nonsexual	other persons
post mortem	Use of intoxicants
Beating	Psychiatric problems
Strangle/Suffocate	Cross dressing
Murder	Work history
Sexual acts	Sexual history
anal	
use of object	
bizarre acts	
Offender intoxicated	
Offender self-reports	*Psychological assessments*
Admits to	Phallometric
sadistic fantasies/acts	MMPI
violent sexual fantasies/acts	PCL-R
rape fantasies/acts	Actuarial risk measures
other paraphilic fantasies/acts	Multiphasic Sex Inventory
Murder fantasies/acts	Buss-Durkee Hostility Inventory
control fantasies/acts	Millon Clinical Inventory
Denies any deviant fantasies/acts	

and the perpetration of bizarre sexual acts), we again found the non-sadists to score significantly higher than the sadists (Marshall, Kennedy, & Yates, in press). These findings do not encourage confidence in the diagnosis of sexual sadism as it was applied by these psychiatrists.

Diagnosis by experts

Given that our review of the literature indicated that psychiatrists in different settings seem to employ their own somewhat idiosyncratic criteria for sexual sadism, the results from our initial study may have simply reflected these idiosyncratic tendencies. Since none of the psychiatrists in our first study saw the same individuals it was neither possible for us to compare their diagnoses nor to discern just what criteria they were using to arrive at a diagnosis of sexual sadism. We therefore embarked on a second study, which would allow us to evaluate diagnostic agreement across several psychiatrists and to determine their agreement on the criteria necessary for the diagnosis.

In this second study (Marshall, Kennedy, Yates, & Serran, in press), we randomly extracted six cases identified in the first study as sexual sadists and six cases identified as non-sadists. From the extensive file information available on these 12 cases, we extracted detailed descriptions of each sexual offender's offences, life histories, self-reported

sexual interests and activities, phallometric evaluations, and responses to psychological tests. These details were written as case descriptions and provided to 24 internationally known forensic psychiatrists. Each of these psychiatrists has extensive experience working with dangerous sexual offenders and has published papers concerning these men. These experts were asked to make a diagnosis of sexual sadism or not for each of the 12 cases, and to rate their confidence in these decisions. They were also asked to rate the relevance of 26 features of the offences and offenders concerning their importance for the diagnosis of sexual sadism. Fifteen (62.5%) of the contacted psychiatrists returned their completed forms.

Results from this study indicated inter-diagnostician agreement on the diagnoses to be below acceptable standards (75% overall agreement). It is generally accepted that when a decision has important implications for the client (as is certainly the case with the diagnostic decision of sexual sadism), the reliability of the decision must be higher than would otherwise be acceptable. Nunnally (1978) indicates that agreement near 90% or above is the minimal acceptable standard for such important decisions. Clearly, diagnostic agreement in our study was well below this level.

Our expert psychiatrists did, however, agree on the diagnostic importance of some of the features of the offences and the offenders. They rated the following features of the offences as important, very important, or crucial to the diagnosis of sexual sadism: control/domination/power displayed by the offender; attempts at humiliation and degradation of the victim; and subjecting the victim to cruelty or torture. In addition, with a single psychiatrist as an exception, evidence of deviant sexual interests in sadism and the sexual mutilation of the victim were both rated as either very important or crucial.

While this evidence of agreement is comforting, there are problems with defining sadism in terms of the exercise of power, control and domination, and the humiliation or degradation of the victim. For example, there is such extensive evidence of the exercise of power over the victims of rape that several theorists (for example, Brownmiller, 1975; Clark & Lewis, 1977; Groth, 1979) construe the sexual assault of women as a pseudo-sexual act meant to serve the offender's need for control and dominance over the victim. Similarly, the age and size discrepancy between adult offenders and child victims indicates a necessary power difference in child sexual abuse and again, as a result, some theorists see power as the primary motivator in these offences (Frosh, 1993; Groth, Hobson, & Gary, 1982; Howells, 1981). With respect to the relevance of humiliation and degradation of the victim in the diagnosis of sexual sadism, our experts agree with DSM-IV (American Psychiatric Association, 1994). Again, however, there is evidence that most rapes involve these features. Darke (1990), for example, reports that 60% of rapists said that their primary motive in sexually assaulting women was to humiliate their victims. Not surprisingly, women victims of rape view all such attacks as extremely humiliating (Kilpatrick, Veronen, & Resick, 1982).

A number of the features described in the literature as important to the diagnosis of sexual sadism (see Marshall & Kennedy, in press, for a list of these features) did not emerge as important according to our experts, despite the fact that many of them had contributed to this literature. The expert psychiatrists in this section of our study were asked to identify those features they considered must be present to diagnose a client as a sexual sadist. Features of the offence that were not rated as important included: ritualism; gratuitous violence; abducts or confines the victim; anal sex; and evidence of the offender keeping trophies or records of the offence. Similarly, features of the offender's life history that were not deemed important by our experts included: bondage or choking their consenting sexual partners; and cruelty to other people or to animals.

Conclusions

The only features on which our experts agreed were important to the diagnosis of sexual sadism, and that are not common features of all sexual assaults, were: cruelty and torture of the victim; the sexual mutilation of the victim; and sexual interests in sadistic acts as shown by either self-reports or phallometric assessments. Since these features appear to distinguish only a small percentage of sexual offenders, and may, therefore, serve as differential diagnostic features, we suggest that they be identified as the critical features for the diagnosis of sexual sadism.

However, the question remains concerning the real value of the diagnosis so long as it requires the distinguishing features to generate "recurrent, intense sexually arousing fantasies, sexual urges, or behaviours" (American Psychiatric Association, 1994, p. 530). This requirement forces clinicians to make an inference about the sexually arousing properties of the diagnostic features, except in those rare cases where the client admits such propensities. The more a diagnosis relies on the inferences of the clinician the more likely it is that reliability will be low (Garfield, 1993). In fact, the authors of DSM are aware of this and these concerns led to the radical changes from DSM-II to DSM-III, which moved toward more behavioural descriptors except, unfortunately, among the paraphilias. It is not at all clear why there is this insistence that the diagnostic features of the paraphilias must be sexually arousing unless it is a need to see them as sexual disorders. Clearly they have sexual features, but these may be instrumentally related to meeting other needs such as the need for control, or the humiliation of the victim, or the desire to act cruelly.

One point of concern about the diagnosis of sexual sadism that gets little attention in the literature, but is in fact very important, concerns the distinction between a "sadistic sexual offence" and the more problematic issue of a persistent "sadistic sexual interest". The question here concerns how much a diagnostician can infer from a single sexual assault with clear sadistic elements. All too often only a single offence is known, perhaps in part because a sadistic attack is likely to mobilize investigatory resources in a way that a less brutal sexual assault might not. For whatever reason, diagnosticians need to be cautious in over-interpreting information from a single offence.

It seems that there is a possible solution to the dilemma that the current data and the more general literature present. The various features of sexual assault (for example, power/control/domination, humiliation/degradation, violence) and the features that appear to distinguish those offenders who might be labelled "sadistic" (that is, cruelty/torture, sexual mutilation) could all be seen as lying along a continuum, which, indeed, they appear to do. Clinicians could then simply rate sexual offenders on each of these dimensions and if the offender scored sufficiently high on most of the dimensions, particularly those that seem critical to the notion of sadism (that is, cruelty/torture, sexual mutilation), then the diagnosis of sexual sadism could be applied. Construing diagnoses in dimensional terms has been advocated by researchers working with personality disorders (Livesley, Schroeder, Jackson, & Jang 1994; Widiger & Costa, 1994) as a way of both overcoming diagnostician unreliability and providing more meaningful information. Describing sexual offenders in these terms should increase reliability (since they are all observable features) and, perhaps more importantly, such descriptions will provide information to treatment providers that should be far more helpful than a simple diagnosis. Such information should also be far more helpful than a diagnosis to those who have responsibility for making important decisions (for example, release from incarceration, applying sexually violent predator status) about these offenders. These are among the most important purposes that a diagnosis is supposed to serve but which do not seem to be accurately served by present diagnostic practices.

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