Sexual Sadism Disorder: An Introduction for Mental Health Professionals

By Jerrod Brown, Ph.D.

Abstract

Sexual sadism disorder is characterized by the experience of sexual pleasure through causing, witnessing, or fantasizing about a non-consenting individual’s physical or emotional pain. A commonly misunderstood disorder, its prevalence varies widely depending on the study. There is a lack of inter-clinician reliability concerning diagnosis. Recent efforts have been made to reconceptualize sadism as a dimensional rather than dichotomous construct, resulting in the development of several validated instruments to assist professionals in valid and reliable diagnosis of sexual sadism disorder. The aim of this article is to provide mental health professionals with foundational knowledge on sadism and to provide recommendations for how they can improve their understanding of this unique population to provide more effective and efficient care.

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Overview

The diagnosis of sexual sadism remains one of the most controversial and least commonly understood in mental health. Originally conceptualized in the 19th century as the experience of pleasurable sensations of sexual arousal resulting from acts of cruelty (Krafft-Ebing, 1912), sadism has since been incorporated into leading Western diagnostic systems. Sadistic personality disorder was introduced to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in 1987 as part of the organization's third-text revision (DSM-III-R). It was incorporated to promote research into the phenomenon, and it was this research that resulted in the replacement of the syndrome by sexual sadism disorder in the fourth (DSM-IV) and now fifth (DSM-5) editions. Sexual sadism disorder is currently listed as a paraphilia, where it is defined as "recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors" (APA, 2013, pg. 695). The World Health Organization's International Classification of Diseases first included mention of sadism in its ninth edition. Now in its 10th revision (ICD-10), the manual includes a code for sexual sadism disorder, described as, "A disorder characterized by recurrent sexual urges, fantasies, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering of a victim is sexually exciting to the individual" (WHO, 1992). To be diagnosed with sadism, a patient must have experienced these symptoms for at least six months and they must have resulted in significant impairment in their personal, social, or occupational functioning. Common comorbidities include antisocial personality disorder, substance dependence disorders, and other paraphilic disorders (American Psychiatric Association (APA), 2013; Berner & Briken, 2010; Eher et al., 2016; Mokros, Schilling, Weiss, Nitschke, & Eher, 2014; Robertson & Knight, 2013).

Patients diagnosed with sexual sadism disorder are most often males who begin experiencing erotic fantasies involving the infliction of pain on others earlier in life (APA, 2013; McNamara & Morton, 2004). This fantasizing may be supplemented by the viewing of extreme forms of pornography (Kirsch & Becker, 2007). This fantasizing often increases in frequency and intensity into adolescence and adulthood, when fantasies may begin to be acted out, via the infliction of psychological suffering (e.g., manipulation or verbal abuse) and/or physical suffering (e.g., assault or bondage) on a non-consenting individual (APA, 2013; Chan & Heide, 2009; Mokros, Schilling, Eher, & Nitschke, 2012). During adulthood, the degree of violence needed to become sexually excited gradually increases – similarly to tolerance effects in substance abuse – as patients begin to experiment with carrying out their fantasies on non-consenting individuals to achieve the same erotic gratification. As age increases and sex drive diminishes, the urge to engage in sadistic acts often decreases (APA, 2013).

Given the strong negativity associated with the diagnostic label and its influence on decision makers in behavioral health systems (Marshall & Kennedy, 2003), the reliable and accurate diagnosis of sexual sadism is of considerable importance (Nitschke et al., 2013). Lack of agreement as to the etiology of sadistic fantasies, however, has resulted in some of the research literature reporting inconsistent findings. The following is a description of seven important areas concerning sexual sadism disorder:

- The Prevalence of Sadism is Largely Unknown. The DSM-5 estimates the prevalence of sadism as 2 to 30 percent (APA, 2013), with higher rates among committed sexual offenders (about 10 percent) and those who have committed sexually-motivated homicide (37 to 75 percent). This wide range of prevalence speaks to the need for new epidemiological studies both domestically and internationally.
Sadism is Different than Dominance. The key to diagnosing sadism is the motivation behind the act(s). When it is the suffering brought about by the extreme behavior (e.g., infliction of pain, torture, domination, degradation, and pure cruelty) that results in sexual excitement, then a diagnosis of sadism may be appropriate (APA, 2013; Nitschke et al., 2013). When it is the expression of power/control over the victim(s) as manifested by the extreme behavior that results in sexual excitement, then this is a form of dominance rather than a clinical symptom of sadism. However, some authors have stated that domination, control, and power over the victim are key features of the disorder (Marshall & Hucker, 2006). Similarly, sadism is unique to minor forms of aggression (e.g., biting, scratching, spanking, hair-pulling) seen during normal “rough sex” which are usually consensual.

Instruments Are Available to Help Diagnosis Sexual Sadism Disorder. Despite diagnostic criteria for sexual sadism disorder having been published in both the DSM-5 as well as the ICD-10, academic reviews have established a lack of inter-clinician reliability for this diagnosis (Longpré, Proulx, & Brouillette-Alarie, 2016; Nitschke et al., 2013). Thankfully, several evidence-based instruments have been published which assist professionals increasing the reliability and, hence, the accuracy of their diagnoses. These instruments include the Severe Sexual Sadism Scale (SSSS; Nitschke, Osterheider, & Mokros, 2009) and the Short Sadistic Impulse Scale (SSIS; O’Meara, Davies, & Hammond, 2011), and their psychometric validity has been established.

Collect Corroborating Diagnostic Evidence for Sexual Sadism Disorder. Although interviewing a patient suspected of sadism may be a useful source of information for diagnostic purposes, self-report is notoriously unreliable, and corroborating evidence from collateral sources such as friends and family as well as file records is recommended. Of particular diagnostic importance are statements made by the victim(s) of the offense(s) as well as detailed law enforcement reports which may point to a corresponding disposition in the patient which he or she may not readily disclose. In the absence of such information, a diagnosis of sadism is more difficult to establish, as the motive behind the potentially sadistic behavior may be unclear (Eher et al., 2016; Marshall & Kennedy, 2003).

Sadism is a Risk Factor for Recidivism. Sadism is considered a risk factor for recidivism (Berner, Berger, & Hill, 2003; DeLisi et al., 2017; Eher et al., 2016). Certain comorbidities have also been found to increase the likelihood of certain individuals acting out their sexually sadistic thoughts and urges (Alghffar & Said, 2017).

Sadism Can Be Thought of as a Spectrum: Although both the DSM-5 and ICD-10 conceptualize sexual sadism disorder as a dichotomous construct (i.e., you have it or you do not), some scholars have advocated the adoption of a dimensional perspective (Marshall & Kennedy, 2003). The principal benefit of adopting a dimensional perspective is reduced reliance on clinical inference or patient self-report about sexually sadistic fantasies (Marshall & Hucker, 2006). The SSSS and SSIS instruments described above are derived from this perspective.

Sadism Can Be Treated. Most patients with sexual sadism disorder do not willingly seek help, either due to shame or fear of being reported to law enforcement, instead being forced to enter treatment after court mandate. That said, evidence-based interventions to address sadism exist using both psychotherapeutic and pharmacological approaches. Psychotherapeutic approaches to treatment include both cognitive-behavioral (e.g., cognitive restructuring and empathy training) and behavioral techniques (e.g., aversion therapy and systematic
desensitization), whereas pharmacological approaches to treatment include the use of antidepressants to reduce impulsivity and anti-androgens to reduce sex drive (APA, 2013). It should be noted that patients diagnosed with sadism may be more resistant to both psychotherapeutic and pharmacological treatment compared to those without the disorder (Hamilton & Rosen, 2016).

Conclusion

Persons diagnosed with sexual sadism disorder experience sexual excitement when causing, witnessing, or fantasizing about a non-consenting individual undergoing physical and/or emotional pain, suffering, and humiliation (Jozifkova, 2013). The accurate and reliable diagnosis of the disorder is of paramount importance due to both its implications for both community safety as well as individual liberty. Misdiagnosing a patient as having the disorder (a false positive) may result in unwarranted stigmatization and unnecessarily long-term detention or intervention, whereas misdiagnosing a patient as not having the disorder when they do have it (a false negative) may result in acts of serious violent recidivism. Due to the high cost of misdiagnosis, the following recommendations are presented:

1. Using an evidence-based screening instrument during the diagnostic process for sadism
2. Reviewing key journals in the field of sexuality and criminal justice on a quarterly basis to stay abreast of the latest peer-reviewed research on sadism
3. Obtaining additional training for the assessment of and treatment techniques for patients diagnosed with sadism as part of ongoing Continuing Education

By following this guidance and by encouraging researchers to continue to disentangle the biological and environmental precursors to sadism, it is hoped that mental health professionals will be able to more effectively and efficiently work with this unique population.

Bibliography

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References


