SECOND EDITION

Sexual Deviance

Theory, Assessment, and Treatment

edited by
D. Richard Laws
William T. O'Donohue

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CONTENTS

CHAPTER 1

INTRODUCTION

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WILLIAM T. O'DONOHUE

The professional approach to sexual deviance involves the scientific study of the paraphilias and related sexual misbehaviors (e.g., rape), as well as the clinical assessment and treatment of these domains. In this chapter we briefly overview the major issues involved in the scientific study and clinical treatment of sexual deviance.

DEFINITIONAL ISSUES

Problems with Defining Sexual Deviance as Mental Disorder

There are continuing controversies about what constitutes "sexual deviance." The present book generally follows the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR; American Psychiatric Association, 2000), although admittedly this is ultimately an institutional rather than a scientific resolution to the definitional problem. That is, the American Psychiatric Association—by working committee, and ultimately by a vote of its membership—decides both what kinds of sexual behaviors are considered mental disorders, and the specific criteria to be used in attempting to define these demarcations. This is in stark distinction to the chemists' periodic table of elements, which is a taxonomy that carves nature at its joints. There are no votes by the American Chemical Association to determine whether oxygen or hydrogen is inside or outside this taxonomy. Committees, of course, are not carving nature at its joints. They instead are subject to political, personal, and other extrascientific considerations. Various editions of the DSM have included as paraphilias different entities (such as homosexuality), and have used different diagnostic criteria. In addition, controversies continue. For example, there is no explicit paraphilia that directly covers rape; some who commit rape may meet the current diagnostic criteria for sexual sadism, but many do not. Whether this is a gap is debatable.

The DSM-IV-TR offers a general definition of "mental disorder," which presumably all paraphilic diagnoses must meet:

> A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one of more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, *or sexual*) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above. (American Psychiatric Association, 2000, p. xxxi; emphasis added)

This definition raises the question of whether deviant sexual behavior "is a symptom of a dysfunction in the individual, as described above." Apparently, the American Psychiatric Association thinks so, as it includes in the DSM-IV-TR a number of paraphilias. However, nowhere does it explicitly state exactly how the included categories meet this standard, or why some categories such as rape or homosexuality do not. Thus the principles used to make decisions regarding what should be included and what should be excluded are unclear. This is unfortunate, because if they were explicated not only would the taxonomy seem more open and reasoned, but it could be criticized and thus potentially improved.

Value Judgments and Sexual Liberation Movements

We also need to recognize that a somewhat complex issue involves value judgments that a type of sexual behavior is disordered or deviant. Certain value judgments have at times flown and continue to fly in the face of various "sexual liberation" movements that have been prominent in the past century. To some extent, these have probably been inspired by what happened with the diagnostic category of homosexuality. In some earlier editions of the DSM, homosexuality was regarded as sexual deviance, but after some effective political campaigning (and some rather weak scientific study) it was removed. In the first edition of this book, the authors of one chapter took issue with the view of sexual masochism as deviant (Baumeister & Butler, 1997).

One of the best-known current sexual liberation movements is the pedophilic one. It has previously received endorsements from such prominent sex researchers as Alfred Kinsey and John Money. For example, Kinsey, Pomeroy, Martin, and Gebhard (1953) stated:

> When children are constantly warned by parents and teachers against contacts with adults, and when they receive no explanation of the exact nature of the contacts, they are ready to become hysterical as soon as any older person approaches, or stops and speaks to them in the street, or fondles them, or proposes to do something for them, even though the adult may have had no sexual objective in mind. Some of the more experienced students of juvenile problems have come to believe that the emotional reactions of the parents, police officers, and other adults who discover that the child has had such a contact, may disturb the child more seriously than the sexual contacts themselves. The current hysteria over sex offenders may very well have serious effects on the ability of many of these children to work out sexual adjustments some years later. . . . (p. 122)

John Money (1991), the prominent Johns Hopkins sex therapist (although see Colapinto, 2000), said:

> If I were to see the case of a boy aged ten or eleven who's intensely erotically attracted toward a man in his twenties or thirties, if the relationship is totally mutual, and the bonding is genuinely totally mutual . . . then I would not call it pathological in any way. (p. 3)

Groups such as the North American Man/Boy Love Association (NAMBLA) and the René Guyon Society describe themselves as representing the most recent wave of sexual liberation. Typically they assert that the first wave of sexual liberation was women's sexual liberation, that the second was liberation associated with the acceptance of premarital sex, and that the third was gay liberation. For example, a speech posted first on the NAMBLA website and then elsewhere on the Internet asserts the following regarding "cross-generational love":

> The issue of love between men and boys has intersected the gay movement since the late nineteenth century, with the rise of the first gay rights movement in Germany. In the United States, as the gay movement has retreated from its vision of sexual liberation, in favor of integration and assimilation into existing social and political structures, it has increasingly sought to marginalize even demonize cross-generational love. Pederasty—that is, love between a man and a youth of 12 to 18 years of age—say middle-class homosexuals, lesbians, and feminists, has nothing to do with gay liberation. Some go so far as to claim, absurdly, that it is a heterosexual phenomenon, or even "sexual abuse." What a travesty! (Thorstad, 1998)

Mary DeYoung (1989) has analyzed the literature produced by pedophile organizations, and has found the use of the following persuasion strategies:

1. Adoption of value-neutral terminology.
2. Redefining the term "child sexual abuse" (to terms such as "adult–child sex" or even "intergenerational intimacy").
3. Promoting the idea that children can consent to sex with adults.
4. Questioning the assumption of harm.
5. Promoting "objective" research (as opposed to the research produced by "biased" researchers).
6. Declassification of pedophilia as mental illness.

This sort of thinking has also received some agreement from a few current researchers, such as Theo Sandfort of the Netherlands. Sandfort was one of the editors of the Dutch journal *Paidika: The Journal of Paedophilia*, which advocated adult–child sexual contact. Sandfort (1982) has stated that when he gave a screening questionnaire to a small group of boys who reported sexual contact with adults, "the question was whether a sexual contact with an adult could be a positive experience for a child. To the extent to which this research material can give a definite answer, the question must be answered in the affirmative" (p. 84). O'Donohue (1992) has criticized Sandfort's research and conclusions, on the grounds that both the psychometrics of the clinical screening scales he used and his reasoning are problematic. Sandfort's research is based on utilitarian ethics: One has to

show harm to render a negative moral evaluation. Sandfort seems oblivious to duty-based ethics or voluntariness-based ethics. O'Donohue has argued that (1) Sandfort's methodology is insufficient to detect all possible harm; (2) children do not by definition have the cognitive capacity to enter into negotiations with adults regarding sexual contact; and (3) adults have the duty to protect and not to harm children, and sexual contact can be harmful to children in a variety of ways. Based on these three considerations, O'Donohue has argued that there is no "sexual liberation" associated with pedophilia, but rather just a problematic argument that has the potential to do much harm. Nevertheless, in 2003 Sandfort was elected president of the International Academy of Sex Research.

In conclusion, professionals in this field need to be aware of these "liberation" movements and these debates, as their arguments and evidence at first blush can seem to have some merit. There is certainly no consensus regarding such definitional issues. However, much is at stake concerning these issues, and open consideration and clarity are important.

Problems with the Current Diagnostic Criteria

O'Donohue, Regev, and Hagstrom (2000) criticized the 1994 DSM-IV diagnostic criteria for pedophilia—and, by extension, the criteria for all the paraphilias, because of their similar structure—on a number of grounds. In DSM-IV, Criterion B for all paraphilias was "The behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 1994, p. 523). O'Donohue and colleagues suggested that this would allow the contented pedophile who has not acted on his urges[1] to avoid the diagnoses. Although the DSM-IV-TR was supposed to make no changes in diagnostic criteria, the editors *have* changed the diagnostic criteria for pedophilia and all the other paraphilias that involve a nonconsenting person, so that acting on the urges alone currently meets Criterion B. Although this change is a significant improvement, many problems still remain:

1. The interdiagnostician reliability of all the paraphilic diagnoses is still unknown.
2. There is still much vagueness in the criteria (e.g., what is meant by "recurrent" and "intense" in Criterion A for these diagnoses?).
3. There is significant arbitrariness in the Criterion A specification that the person must experience a paraphilia for 6 months before a diagnosis is made. What is the argument or evidence that this time frame is reasonable?

MEASUREMENT ISSUES

Measurement is a fundamental process and skill in both research and clinical endeavors. The task of accurate measurement is not easily achieved in any domain, but it may be particularly difficult with regard to sexual deviance.

Sensitivity and Specificity

Scientists rely on measurement for several basic goals. First, scientists want to be able to accurately detect the presence or absence of something (e.g., does this person experience

violent fantasies?). An accurate instrument is characterized by both "sensitivity" and "specificity." Sensitivity is a quality metric that addresses the question "If *X* is present, to what extent will the measurement operation detect *X*?" Another way to look at sensitivity is that it is an index of false negatives. Specificity is the converse; it addresses the question "If *X* is *not* present, to what extent will the measurement process indicate that it is not present?" Specificity is a measure of false positives. We want our measurements to detect as accurately as possible—that is, with no false negatives and no false positives. Often, although not always, there is a tradeoff between these two attributes. When we make our measure more sensitive, we also "buy" more false positives.

Detection of phenomena related to sexual deviance may be difficult because the target may be covert (e.g., fantasies), and/or because a person may have an interest in providing distorted information (as is usually the case when a person has been arrested for a sexual offense). In our field, we need to know through careful scientific psychometric studies the specificity and sensitivity of our measures, as much can ride on false positives or false negatives. In too many cases, this information is missing; despite this important gap, such instruments are often still used.

Quantification

In addition to presence or absence, some phenomena allow for quantification. Height is not simply present in people; it can be quantified. Thus another measurement task is to accurately measure quantity. Sometimes, though, it can be difficult to discern what the underlying scale would be. Sex drive seems to be not simply present or absent; it seems to have magnitude. But what scale is to be used? This is a complex question (e.g., would men and women use the same scale, or are their sex drives so different in some basic way as to require separate scales?). Quantification is important because many of the questions we are interested in depend on it. Clinically, we are often interested in reducing (or eliminating) some phenomena and thus are interested in quantity.

Evidence-Based Assessment

It is axiomatic in psychometrics that all measures contain error. The keys are to try to estimate or understand the size of the error term, and to consider this in all inferences and decisions based on the assessment. These are among the aims of a recent movement called "evidence-based assessment." Hunsley and Mash (2005) define this movement as follows:

> First, research findings and scientifically viable theories on both psychopathology and normal human development should be used to guide the selection of constructs to be assessed and the assessment process.
>
> Second, as much as possible, psychometrically strong measures should be used to assess the constructs targeted in the assessment. Specifically, these measures should have replicated evidence of reliability, validity, and, ideally, clinical utility. Given the range of purposes for which assessment instruments can be used (e.g., screening, diagnosis, treatment monitoring) and the fact that psychometric evidence is always conditional (based on sample characteristics and assessment purpose), supporting psychometric evidence must be available for each purpose for which an instrument or assessment strategy is used. Psychometrically strong measures must also possess appropriate norms for norm-referenced interpretation and/or replicated supporting evidence for the accuracy (i.e.,