Indian Journal of Health, Sexuality & Culture
Vol (5), Issue (2), December 2019
ISSN : 2581-575X

Paraphilia

The tale of forbidden love

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Bhubaneswar

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Editorial.....

Paraphilia: The tale of forbidden love

Since ancient times taboo is associated with sexuality and it is more intense with deviant sexual behaviours, which are currently known as paraphilic disorders. Paraphilia was considered as an immoral act, which impairs the social integrity and defames the social dignity; hence, it was perceived as a crime till recently. On the other hand, there were many popular beliefs (myths) about paraphilia in several societies, which depict the paraphilia as a helpful behaviour. Paraphilia has been considered as a mental illness, if not so, as a phenotype of severe mental illnesses since the past few decades. As a result of which perception and understanding of paraphilia still remain illusive. Paraphilia (Paraphilic disorders) are less discussed and less researched disorders in mental health.

History revealed about the changing dimensions of paraphilia. The acts that were considered as paraphilia once upon a time are now considered as normal variants of sexual behaviour. Centuries ago, masturbation was considered as an unhealthy sexual behaviour, more so a deviant sexual behaviour. However, in the current scenario, it is considered to be a normal variant of sexual behaviour. Similarly, homosexuality and oral sex (cunnilingus and fellatio) were also considered as sexual perversions (paraphilia), years back. They are also now considered as normal variations in sexuality. Incest, though not considered as normal sexual behaviour in many cultures, certain societies allow incestuous relationship by sanctioning consanguineous marriage. Incest has also lost its paraphilic tag. There is broadening of the dimension of normal sexuality as a result of which taboo about sexuality is gradually reducing and the dimension of paraphilia is shrinking.

In this digital world, people have started experiencing sexual gratification online with a virtual partner. Distorted sexual behaviour for gratification is also reported through the online platform. Paraphilia is getting a brand-new wrap in the digital world.

Media reports reveal that among the online viewers of pornography, a significant number of viewers watch paraphilic contents like - zoophilia, voyeurism, sadomasochism, paedophilia, etc. These people may have increased inclination towards paraphilia and they may possibly indulge

in paraphilic behaviour. The exact number of such people is not known, but as per the online viewing data, it seems to be a large number globally. So, it can be claimed with certainty that the prevalence of paraphilia and inclination towards paraphilia are not an unusual phenomenon. The cases of paraphilia reported at the forensic setups or psychiatric clinics are just the tip of the iceberg. Medical curriculum though includes paraphilia, the learning was seldom adopted by the medical professionals during clinical evaluation of patients. As clinicians rarely explore about paraphilia during clinical evaluation, only overt reporting by the patient or their caregivers brings paraphilia to the clinical front.

There is a need for extensive research to understand the different dimensions of paraphilic behaviour. It will help in the prevention of sexual crimes, management of paraphilic disorders as well as possible restoration of social harmony.

S. K. Kar
Editor-in-Chief

ACKNOWLEDGMENT

We sincerely acknowledge the contribution of the reviewers, who carried out the review of various submissions to the Indian Journal of Health, Sexuality and Culture (IJHSC). The reviewers who helped in conducting the review of IJHSC in the year 2019 were :

Dr. Pritha Roy (Ranchi)
Dr. Jai Singh (Patna)
Dr. Sameer Belvi Mangalwedhe (Hubli)
Dr. Bheemsain Tekkalaki (Belgaon)
Dr. Debadatta Mohapatra (Bhubaneswar)
Dr. Praveen Pandey (Lucknow)
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Dr. Jamshed Ahmed (Azamgarh)
Dr. Erika Pahuja (Bengaluru)

Review Article

Portrayal of Paraphilia in History

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Abstract

Normalcy and aberrance in sexual behaviour, is greatly influenced by societal norms and culture of a time and our perception of paraphilia is shaped by them. These conditions have transcended eras from Greek and Roman civilizations to modern medicine, finding mentions in the Bible, the Kamasutra, as well as in the 18th and 19th century works. With the efforts of Krafft Ebing and co-workers, paraphilia and paraphilic disorders now occupy an important niche in medicine. Treatment modalities have also evolved greatly- from radical means to medication and psychotherapy. Therefore our understanding of paraphilia is incomplete without delving into its history.

Keywords: Paraphilia, History, Modern Medicine, Culture

Date Received: 29th October 2019
Date Accepted: 15th December 2019

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Introduction

The term 'paraphilia' (Greek: para- beside, philos- love) has served as a broad term for a range of sexual thoughts and behaviour and as an alternative to derogatory terms like 'deviancy' and 'perversion'. Since the fine line between normal and abnormal sexuality is largely influenced by existent societal perception and culture, the exact idea of what constitutes paraphilia has been a matter of significant debate meriting a brief discussion of the historical aspects.

According to the DSM-5, the term paraphilia denotes *"any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal,*

physically mature, consenting human partner"(American Psychiatric Association, 2013). Because a wide range of sexual behaviour could be considered paraphilic as per the above definition, a clear distinction is made between a paraphilic disorder and a paraphilia indicating that only the former requires attention of a treating professional. Thus, a paraphilic disorder is *"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"* (American Psychiatric Association, 2013). DSM-5 also suggests a 'two-pronged approach' to the diagnosis, outlined in the criterion A, the qualitative aspect and criterion B, the negative impacts of paraphilia.

Eight paraphilic disorders of relative commonness and forensic significance have been described in DSM 5, as mentioned in Table-1. Their classification is depicted in Figure-1. All paraphilic behaviour outside of this classification is described under 'Other Specified Paraphilic Disorder',- a category for which an exhaustive list cannot be drawn owing to patient-based variations.

According to the ICD-11, paraphilic disorders are characterized by *"persistent and intense patterns of atypical sexual arousal...by which the patient is markedly distressed"* (ICD-11-Mortality and Morbidity Statistics, Version : 04 / 2019). The Working Group on the Classification of Sexual Disorders and Sexual Health (WGSDSH) suggested preserving exhibitionism, frotteurism, pedophilia, and voyeurism as mental disorders, renamed them as exhibitionistic, frotteuristic, pedophilic, and voyeuristic disorders respectively (Krueger et al., 2017). They also suggested adding 'Coercive Sexual Sadism Disorder', 'Other Paraphilic Disorder Involving Non-Consenting Individuals', and 'Paraphilic Disorder Involving Solitary Behaviour or Consenting Individuals' (PDISBCI).

A person may have more than one paraphilia which may be coincidental or associated with anomalies in psychosexual development, often resulting in other problems and difficulty in maintaining normal social and sexual relationships. Paraphilia tend to become highly idiosyncratic and ritualized.

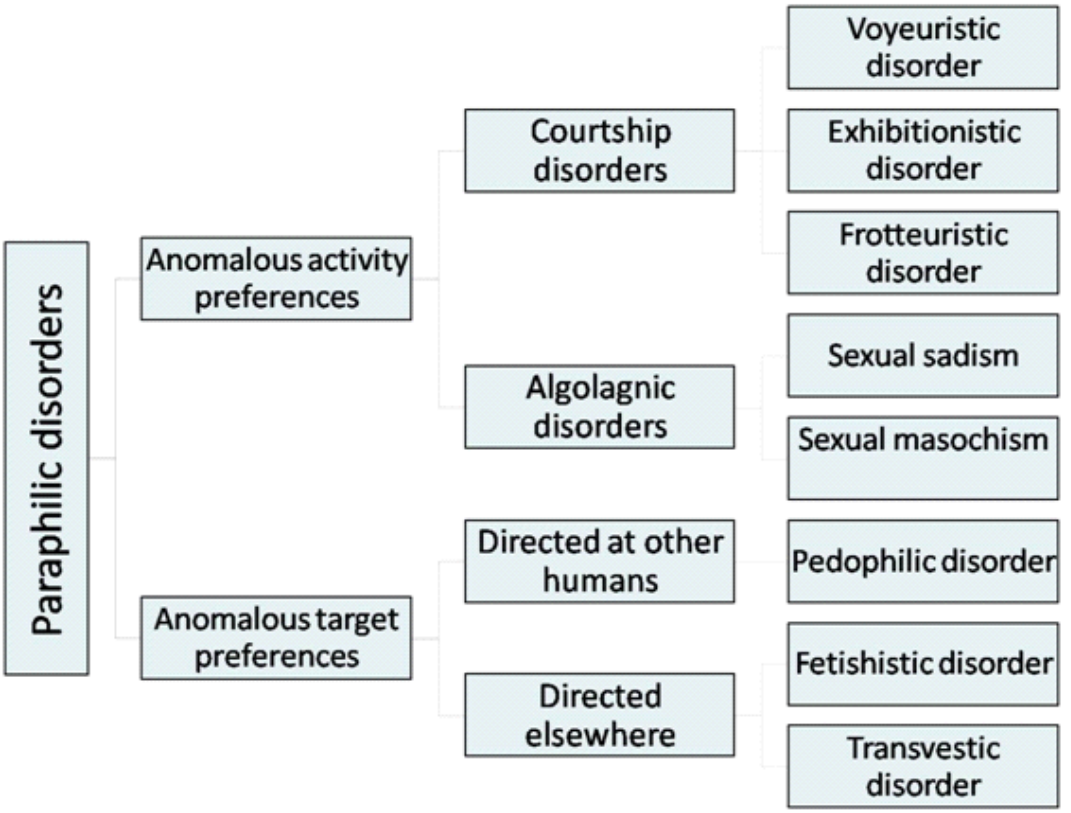

Figure-1: Classification schemes of paraphilic disorders

Paraphilic Disorder	**Cause of sexual arousal (as per DSM-5 Criterion A for diagnosis of each disorder)**
Voyeuristic Disorder	Observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity
Exhibitionistic Disorder	Exposure of one's genitalia to an unsuspecting person
Frotteuristic Disorder	Touching or rubbing against a non-consenting person
Sexual Sadism Disorder	Physical or psychological suffering of another person
Sexual Masochism Disorder	Act of being humiliated, beaten, bound or otherwise made to suffer
Pedophilic Disorder	Prepubescent child or children (usually aged 13 years or less)
Fetishistic Disorder	Use of non -living objects or a highly specific focus on non - genital body part(s)
Transvestic Disorder	Cross-dressing

Table-1: Types of paraphilic disorders (DSM-5)

Epidemiology

Epidemiological data on paraphilia is scant, as they occur rarely and are further less often diagnosed, apart from being inadequately studied. Moreover, their definitions and diagnostic criteria are debatable and constantly changing.

Apart from sexual masochism which is the most common paraphilia in females, paraphilia are found almost exclusively in males.

Different studies have reported as few as 1.7% and as many as 62.4% subjects showing at least some paraphilia related patterns.

The prevalence data given in DSM 5 is represented in Table 2.

Paraphilic Disorder	**Prevalence Data (as per DSM-5)** **(highest possible population prevalence unless specified otherwise)**
Voyeuristic Disorder	Males: 12% Females: 4%, clinically uncommon
Exhibitionistic Disorder	Males: 2% to 4% Females: uncertain but lesser
Frotteuristic Disorder	Males: 30%, clinically 10% -14% Females: lesser
Sexual Masochism Disorder	Males:2% Females: 1.3%
Sexual Sadism Disorder	2% to 30% 37 to 75% in cases of sexually motivated homicide
Pedophilic Disorder	Males:3% to 5% Females: uncertain but lesser
Fetishistic Disorder	Not reported in females
Transvestic Disorder	Males: less than 3% Females: extremely rare

Table-2: Prevalence of paraphilic disorders according to DSM-5

Paraphilia- historic mentions

Some of the oldest mentions of paraphilic behaviour are found in the Bible (Metzl, 2004). Several such acts (voyeurism, bestiality, necrophilia and exhibitionism) are described as socially unacceptable or forbidden. Pedophilia and hebephilia were practiced by ancient Greeks and Romans as part

of preacher-pupil relationships for allegedly wholesome mentoring (Balon, 2016).

The term 'paraphilia' was first used by Austrian ethnologist Friedrich Solomon Krauss in 1903 as 'abnormal erotic instinct', but was popularized in the psychiatric domain by the Vienna-born psychotherapist William Stekel. In his book 'Sexual Aberrations' (1930), Stekel highlighted the difference between 'parapathia' (neurosis), paralogia (psychosis) and paraphilia (perversion), thus separating paraphilia from the other categories of mental disorders (Giami, 2015).

Extensive documentation of these disorders or related behaviour is not found due to the associated stigmatization, however few mentions are found in various texts and legends. The history of the major paraphilic disorders is discussed here.

1. Voyeuristic disorder

The term voyeurism comes from 'voir' (French: to see). The common term 'peeping tom' used for this disorder arises from the English legend of Lady Godiva, (c.1066-86), who rode covering herself only with her long hair, protesting against oppressive taxation by her husband, Earl of Mercia, when a man named Thomas was struck blind (or dead) for privately watching her ride such (Janssen, 2018).

People were known to pay well to look through peepholes especially in Parisian brothels as early as 1857, but formal recognition to voyeurism appeared in the 1890s (Janssen, 2018).

In 1945, psychoanalyst Otto Fenichel described the case of a 'voyeur', renting a room in a bordello to look through a peephole at another couple having intercourse.

Society has used the term voyeur broadly to describe anyone who views the intimate lives of others, even outside any sexual context. But in terms of psychiatry, voyeurism as a condition is rooted in the abnormal oedipal development, particularly the castration crisis. Sandor Lorand and Henry Schneer wrote in 'The Comprehensive Textbook of Psychiatry' that a voyeur's *"adult sexuality is supplanted by infantile sexuality"*(Voyeurism, 2019). Although considered purely criminal initially, 'voyeurism' appeared in Reader's Guide to Periodical Literature, in 1979, and in The New York Times from 1950 to 1980 and gradually came to be seen more like a mental illness rather than just as an illegal act (Hugh-

Jones, Gough, & Littlewood, 2005). A recent term today is 'digital voyeurism'- the viewing of people's personal lives from the sidelines or recordings for pathological satisfaction (Metzl, 2004).

2. Exhibitionistic disorders

Exhibitionism has existed ever since the mentions of Adam and Eve, because with the development of concepts like 'civility', acts of undressing in public were seen as depraved and often linked to madness (Hugh-Jones et al., 2005). The Bible also mentions a jubilant David engaging in such exhibitionistic behaviour (Aggrawal, 2009).

Exhibitionism was first described as a disorder by Charles Lasègue in 1877. It was understood largely from studies on exhibitionists who were criminally penalized (Dandescu and Wolfe, 2003). In the case of women, the drive for exhibitionistic acts relate to attention-seeking behaviour and low self-esteem, as proposed by Hollander et al (1977). Various theories of biochemical imbalance and cortical disinhibition came up around 1980-1990 (including Fedors et al., 1986, Flor et al., 1988, Zohar et al., 1994) as the pathogenesis of the disorder.

3. Frotteuristic Disorder

This disorder involves a behaviour called 'frottage' (from the French verb 'frotter', meaning 'to rub'), i.e., recurrent touching and rubbing against non-consenting individuals to gain sexual pleasure. Underlying this is the fantasy of a caring, exclusive relationship with the person (Frotteurism, 2019).

In 1887 and later in 1890, in the Study of Three Acts of Frottage by Valentin Magnan, these acts were considered signs of mental disorder. It was Clifford Allen, who in 1969, coined the term 'frotteurism' in his 'Textbook of Sexual Disorders'. Eventually, the word was incorporated in 'Psychopathia Sexualis' and popularized by Richard von Kraft-Ebing.

Until the third edition of DSM (DSM III-R) this condition was called 'frottage', but the name was changed to frotteurism in its 4th edition. Now DSM-5 employs the term 'frotteuristic disorder' (Mc Manus et al., 2013).

4. Sadism

The term 'sadism', though given by Krafft-Ebing, originated in fictional literature, with the 'deviant' sexual behaviour practised and described by Marquis Donatien Alphonse Francois de Sade, a French nobleman. In his work 'Les prospérités du vice', 1797 de Sade wrote:

"How delightful are the pleasures of the imagination! In those delectable moments, the whole world is ours; not a single creature resists us, we devastate the world, we repopulate it with new objects which, in turn, we immolate. The means to every crime is ours, and we employ them all, we multiply the horror a hundredfold" (Balon, 2016).

5. Masochism

Masochism is named after the Austrian baron Leopold von Sacher-Masoch who engaged in paraphilic behaviour and described masochism in his story of 'Venus in Furs'.

-*"Shiny, shiny, shiny boots of leather,*
Whiplash girl child in the dark,
Sever in, your servant comes in bells, please don't forsake him,
Strike, dear mistress, and cure his heart". - Venus in Furs, The Velvet Underground (1967)

Krafft-Ebing again, in Psychopathia Sexualis', is credited for bringing the term into medical parlance (Krafft-Ebing, 1922).

The first theory of masochism was given by the German physician Johann Heinrich Meibom, who in his 'Treatise on the Use of Flogging in Medicine and Venery' (1639) stated that *"flogging a man's back increases sexual arousal by making semen flow down into his testicles"* (Mintz, n.d.). Jean-Jacques Rousseau spoke bravely of the masochistic sexual pleasure he derived from being beaten in childhood in his 'Confessions' (1782).

6. Sadomasochism

Though terms sadism and masochism were coined only in the 19th century, they describe behaviours dating back to the 2nd century. Consensual erotic slapping finds its place in Vatsayana's Kamasutra. Giovanni Pico della Mirandola, a Renaissance philosopher also described a man who required flogging to get aroused.

Krafft-Ebing, credited with introduction of the terms as disorders, considered sadism and masochism as arising from different sexual and erotic logics. But in 1905, Sigmund Freud in his 'Three Papers on Sexual Theory' rendered the observation that both often occur together, therefore combined the terms as Sado-masochism (The Psychology of Sadomasochism, 2014). Referring to them as the most common and important of all perversions, Freud also theorized that *"sadism is a distortion of the aggressive component of the male sexual instinct, and masochism is a form of*

sadism against the self-and a graver aberration than simple sadism".

In 'Studies in the Psychology of Sex' (1900), British physician Havelock Ellis considers both as being differentiated finely from each other and relates sadomasochism to eroticism rather than cruelty. The French philosopher Gilles Deleuze, in the essay 'Coldness and Cruelty' (1967), also contended that sadomasochism is an artificial term, and sadism and masochism are separate phenomena.

7. BDSM- A different perspective

Here, however, BDSM needs special mention. It includes a variety of erotic practices and role-playing involving B-Bondage and Discipline, D-Domination and Submission, S-Sadism and M-Masochism (DEFINITIONS OF BDSM TERMS, 2019).

Though, the term was first recorded in a Usenet post from 1991, however, these practices have survived from antiquity. They were associated with the worship of Goddess Inanna in ancient cuneiform writings describing cross-dressing, transformation and beating practices (Nomis, 2013). In the 9th century BC, Spartans practiced the whipping of young men and priests. Kamasutra describes four different kinds of hitting during love-making (Mallanaga, 2002).

In Indian culture, apart from mentions in Kamasutra and mural paintings, no significant data is available. Indian law takes no clear stand with consensual practices being otherwise legal except in cases of complaints under section 377.

8. Pedophilia

Incidences defined today under pedophilia are believed to have occurred throughout history, but formal recognition was deferred until the 19th century.

The ancient Greeks are often depicted enshrining pedophilia, in attempts to establish a quasi-mentoring relationship with young students (Pedophilia, 2019). The society was naturally displeased and Solon passed strict laws against children being taken as lovers. Plato pleaded ban on pedophilia in 'The Laws' (4th century BC).

Elite European households in the 15th and 16th centuries sometimes treated young children as sexual playthings, a striking example involving the future King of France, Louis XIII, being the subject (Kinsey, Pomeroy, Martin, &

Gebhard, 1998).Krafft-Ebing elucidated this formally by coining the term 'Pedophilia erotica' in an article in 1886 but inclusion in 'Psychopathia Sexualis' was done in its 10th German edition (Krafft-Ebing, 1922).

Freud in his 1905 work 'Three Essays…' described the same in a section titled 'The Sexually Immature and Animals as Sexual Objects '(Pedophilia, 2019).

In 1908, Swiss psychiatrist Auguste Forel described the behaviour as 'Pederosis', the 'Sexual Appetite for Children'.

In his landmark study of female sexual behaviour, published in 1953, Alfred Kinsey reported rampant sexual abuse of under-14 children (Pedophilia, 2019).

The term pedophilia saw wide spread adoption medically in the 20th century, appearing in the 5th Edition of Stedman's Medical Dictionary in 1918. Pedophilia was included in the DSM I and later in the DSM II, placed under 'Sexual Deviation', but diagnostic criteria were missing. These criteria were provided by DSM III in 1980 and further expanded in DSM III R in 1987 (Pedophilia, 2019).

9. Fetishism

The term 'fetishism' originates from the Portuguese 'feitico' meaning 'obsessive fascination'. Non genital body parts may also be arousing for some without it being a cause for concern. A fetish is considered abnormal only when social and sexual function is impaired by it, or when it becomes an absolute necessity for sexual arousal (Fetishistic Disorder, 2019).

Fétichisme (fetishism) as a term was brought to erotic considerations by Alfred Binet in 1887. He put forward a theory of pathological result of associations, where residual attachment remains after a possibly emotionally rousing experience linked with the fetish object in childhood. Krafft-Ebing and Havelock Ellis also agreed to this theory of associations, but without specifications.

In 1920, Magnus Hirschfeld pointed out that everyone can have a healthy level of fetishism. But how much is too much?

In 1951, Donald Winnicott presented another theory of transitional objects and phenomena, where an object closely associated with the growing up child eventually becomes sexualized (Sexual fetishism, 2019).

10. Transvestism

Transvestism, known in common parlance as cross-dressing, refers

to dressing that in general agreement of society is in close consonance with the opposite gender. Cross-dressing is seen in varying degrees in paraphilias like dual role transvestism, fetishism and trans-sexualism.

Transvestism was prohibited in the Bible; Deuteronomy, the Fifth Book of Moses says: *"The woman shall not wear that which pertaineth unto a man, neither shall a man put on a woman's garment"*(Aggrawal, 2009).

Later in the 20th century, transvestism was distinguished from cross-dressing, the former done for sexual excitement, which became known as transvestic disorder, a recognized mental condition.

Paraphilia- inclusion in medical literature

The inclusion of paraphilic disorders in recognized texts, the ICD and DSM reflects the prevalent social concepts of the normal sexuality and serves to categorise its pathologic variants.

Paraphilia first appeared in the ICD-6 in 1948, which included for the first time a large section for mental disorders, not as they are defined today, but as disorders and problems related to sexuality called 'sexual deviation', under the sub-category of 'pathogenic personality', closely influenced by the works of Kraft-Ebing and Ellis. It regrouped a number of non-reproductive sexual behaviours including exhibitionism, fetishism, homosexuality, pathologic sexuality, and sadism, and differentiated them from 'disorders of sexual function' which were categorized as 'psychogenic reactions affecting the genitourinary system'.

This was carried forward in the ICD-7 (1955) and in ICD-8 (1965). ICD-9 (1990) introduced the terms 'disorders of sexual preferences' and 'paraphilia', following similar perspectives developed in the DSM-III in 1980.

Theorists of the 20th century deemed it necessary to include personal distress and the desire to hate or harm oneself or a criminal dimension to help understand the 'deviant sexual behaviours'.

DSM III introduced 'paraphilia' under the heading 'psychosexual disorders', while in DSM III-R (1987) the term was renewed and now comprised exhibitionism, fetishism, frotteurism, pedophilia, sexual sadism, sexual masochism, and atypical paraphilia.

In ICD-10, paraphilia is featured in

F60-F69, 'Disorders of Adult Personality and Behaviour' and excluded homosexuality.

The term 'paraphilic disorders' was coined during DSM-5 task force in 2009 and 2010.

In ICD-11, it was proposed to change 'Disorders of Sexual Preference' to 'Paraphilic Disorders'. They also advocated for the removal of fetishism, fetishistic transvestism, and sadomasochism categories *"as inconsistent with human rights principles endorsed by the UN and WHO"* (Drew et al., 2011).

In ICD-11, Krueger proposed that paraphilic disorders be classified by the absence of consent, distress felt by an individual and the hurt or the harm caused to the partner or oneself.

Significance of the history of paraphilia

History forms the basis of understanding paraphilia and its conceptual evolution, helping in understanding how it could be managed more effectively. It is clear that paraphilias have transcended centuries and is directly or indirectly described in the scriptures, mythologies, manuscripts, inscriptions and murals, prehistoric caves and monuments.

History of management

Being heinous and unforgivable in public view, paraphilic behaviour was often penalised with death in many cultures and faiths including the Islamic and Sharia laws, Christian tenets and Hindu scriptures.

Surgical castration was thought of as the only management till the 20th century for such 'perverts'.

Initially, when medical therapy commenced, due to the psychological belief of improving such patients and reducing the chances of their recidivism, the mainstay of treatment was psychotherapy wherein, pharmacotherapy was later added. An ideal treatment having components for reducing the distress of the patient, abolishing repeated thoughts and fantasies, having no/minimal side effects and preventing them from acting out and victimizing others, is currently unavailable.

Individual paraphilic disorders may receive different therapies based on individual symptoms, therapeutic goals and patient's response.

Conclusion

It is essential to realize and appreciate that what is moral

regarding normal sexuality heavily depends on and is as transient as the culture and public opinion of that time (Giami, 2015).

Intimately intertwined, sexuality and culture influence each other profoundly. Kinsey, Pomeroy and Martin remarked quite aptly, *"the ancient religious codes are still the prime sources of the attitudes, the ideas, the ideals, and the rationalizations by which most individuals pattern their sexual lives"* (Kinsey et al., 1998).

Therefore, to understand sexual perversions, their roots in history need careful examination.

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Review Article

Paraphilia and other Sexual Variations in the 'Game of Thrones'

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Abstract

'Game of Thrones' (GOT) is an award-winning Drama Series of this decade and one of the most-watched series on television. The TV series includes not only fantasy animals and epic battle scenes but has garnered praise for cinematography, design, breathtaking landscapes, lifelike costumes, and makeup, a captivating storyline, and performances by the cast. There was a significant portrayal of sexuality in various dimensions by the characters in this story. Apart from normal sexuality, love, and honorable relationships, the characters also presented a platter of 'paraphilic behaviors' like exhibitionism and sadomasochism. Also, there is the depiction of sexual variations like incest, homosexuality, bisexuality. The accurate depiction of these behaviors, in the series, helps one understand the nature and extent of these behaviors and personalities associated with these conditions.

Keywords: Paraphilia, Game of Thrones, Drama.

Date Received: 22nd October 2019

Date Accepted: 31st December 2019

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Introduction

Game of Thrones (GOT), is based on a book titled 'The Song of Ice and Fire' by George RR Martin. This story was adapted by HBO, a leading American television channel, as a television series. It gained immense popularity throughout the world (Stedman, 2019). It belongs to the historical fiction genre and is divided into 8 seasons (comprising of 73 episodes

in all). More than 500 characters belonging to different houses have played significant roles in the development of the story. The show is based on the pre-medieval and medieval era in the fictitious continents of Westeros, Essos, and Sothoryous. It shows the socio-political power struggles among some major Noble houses in the continent namely- House Targaryen of Dragonstone, House Stark of Winterfell, House Lannister of Casterly Rock, House Baratheon of Stormlands, House Arryn of the Vale, House Greyjoy of Iron Islands, House Martell of Dorne, etc.

The series has been awarded multiple Emmy Awards in various categories (Stedman, 2019). Apart from the amazing storyline and computer graphics, extravagant scenery, fantasy animals (dire-wolves, giants, dragons), epic fights and strategic war scenes, there was a significant portrayal of sexuality (Cogman, 2014). There is a wide range of variations and deviations in sexuality depicted in the show (Anders C J, 2012; Cogman, 2014).

Paraphilic behaviors have been a topic of discussion time and again. There have been arguments regarding their nosological status in the diagnostic system of psychiatry. The criteria for various diversions from culturally acceptable sexual relationships change with time. This article focuses on the sexual orientations and relationships of different characters in the show. It discusses different paraphilias and sexual variations other than heterosexual interest.

Definitions

Paraphilias

Defining paraphilia has posed a problem in psychiatry. There have been a lot of debates and discussions regarding what needs to be included and what not. Though ICD-10 does not give a definition, DSM-5 definition for paraphilia remains widely accepted - *"Any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physiologically mature, consenting human partners"*. Paraphilias, however, may not necessarily classify as *'intense and persistent' but rather preferential sexual interests or sexual interests that are greater than non-paraphilic sexual interests. A paraphilic disorder is 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* (American Psychiatric Association, 2013).

In DSM 5, paraphilic disorders

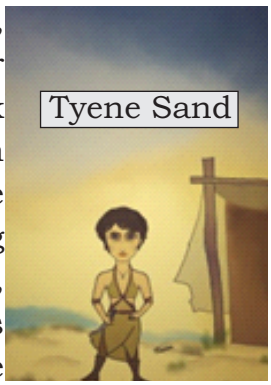
have been divided into many types (Table1), which are described below along with their depiction in the GOT.

Exhibitionism

Exhibitionism is a type of paraphilic behavior in which, the person displays their genitals to gain sexual gratification. DSM-5 defines exhibitionism as *"recurrent and intense sexual arousal from the exposure of one's genitals to an unsuspecting person, as manifested by fantasies, urges, or behaviors".*

As per the American Psychiatric Association, the individual should have acted on these sexual urges with a non consenting person. These sexual urges or fantasies cause clinically significant distress or impairment in social occupational, or other important areas of functioning (American Psychiatric Association, 2013).

There were not many instances that could be classified as exhibitionism in the Game of Thrones.



In season 5, Episode 7, Ser Bronn of Blackwater was held in the cells of Dorne for attacking Prince Trystane, when he was assisting Jaime Lannister in sneaking into Dorne secretly for shipping away princess-Myrcella from Dorne to King's Landing. During his imprisonment, Oberyn Martell's daughter Tyene Sand and Bronn had a conversation regarding who is the most beautiful woman in the world and to prove her point, Tyene seductively displayed her private parts (David Benihoff & Weiss, 2013). The behavior of Tyene is compatible with the phenomenon of exhibitionism. However, the important feature of exhibitionism is to derive sexual gratification from the act, which is not clearly depicted in the show.

Frotteurism

Frotteurism can be identified as *"a recurrent and intense sexual arousal from touching or rubbing against a non-consenting person, as manifested by fantasies, urges, or behaviors. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning"* (American Psychiatric Association, 2013).

These type of paraphilic behaviors have been observed in association with threatening and often proceeded into rape in the storylines of GOT (D Benihoff & Wiess, 2014).

Voyeurism

Voyeurism means to engage in the behavior of observing un-suspecting and non-consenting people in a compromised situation and deriving sexual gratification. This type of behavior is different from watching pornography.

This can be described as the behavior of observing non-suspecting people. Although there have been incidents of observing the characters in their intimate times, however, according to the show none of them could be classified as Voyeurism, one precise occasion which matches closely with voyeurism is the time when Petyr Baelish watches his prostitutes in his establishments (David Benihoff & Weiss, 2012).

Paedophilia

It can be defined as a disorder of sexual preference, among the adults where they get pleasure by engaging in sexual activity with prepubescent children, both male and female. Often the perpetrator lures them with candies, toys, and chocolates to get their way with the children (World Health Organization, 2004). Paedophiliacs often experience recurrent and intense sexual fantasies, urges or behaviours mostly related to younger children(American Psychiatric Association, 2013).

GOT shows a scenario, where very young girls are being sold into prostitution because people showed interest in getting young girls in brothels in that era (eg. Doreah - Daenerys' hand maiden was sold into prostitution, in the Free City of Lys by her mother, at 9 years of age).

Ser Meryn Trant, a Knight of the Kings Guard, had showcased sexual preference towards young girls who were probably prepubescent. In season 5, Episode 10, we observe Meryn Trant beating very young girls as a process of selecting a girl for sexual pleasure in a pleasure house of Bravos (free city). He chose the girl who tolerated his beating without any reaction. To his misfortune, the girl he chose turned out to be Arya Stark, who by then had become a faceless assassin. This is followed by Ser Meryn Trant's assassination. The scene not only depicts paedophilia but also sadomasochism.

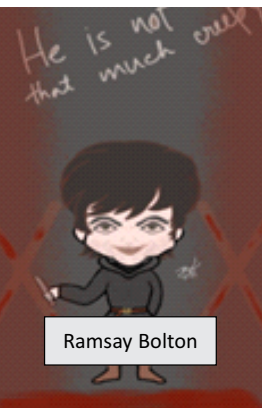
Kitty Frey was the 9th wife of Walder Frey. She was younger than his 8th wife, Joyeuse Erenford, who was 13 years old. Walder Frey who was around 95 years of age, married Kitty after the death of

Joyeuse at the red wedding in hands of Catalyn Stark. Also, Daenerys was married to Khal Drogo, when she was 13 years old. Though early marriage cannot be considered as pedophilia, because back then early marriage might have been a norm, but is not very acceptable in present social scenario (Egner & Weinberg, 2016).

Sexual Sadism

It can be defined as, a condition when inflicting pain upon a person gives pleasure to the person inflicting the pain and humiliation (World Health Organization, 2004).

One of the major characters of the show 'Joffrey Baratheon' the First Born Prince of the Seven Kingdoms, through the seasons 1-2 can be seen to inflict pain and suffering to Sansa Stark - in the courtroom by humiliating her for what her brother did in battlefield, executing her father in suspicion of treason and then making her look at his head on pike. Joffrey Baratheon was a sadist and enjoyed brutalizing people physically and emotionally. The show depicts that he injured the prostitutes sent to him by Tyrion, for pleasure. On one occasion, he forces Ros to beat Daisy (the two prostitutes Tyrion Lannister arranges for him), with increasingly brutal instruments. He seemed to enjoy their pain. In a later part of the series, he murders a naked Ros (sent by Little Finger as her punishment of giving information to Varys) by shooting her multiple times with a crossbow, apparently finding sexual pleasure in it. This can be categorized as Erotophonophilia which is an extreme form of Sadism. However, to qualify for sexual sadism there should be sexual arousal by doing the brutal activity which is not confirmed in the show.



Ramsay Bolton is a character that notoriously gained the title of the most brutal character in GOT (Egner & Weinberg, 2016) in 2016. He has been depicted to have sadistic sexuality. Ramsey Bolton along with his love interest Myranda were both very similar. They had a sadomasochistic relationship in which, Myranda used to enjoy the brutality inflicted upon her from her lover Ramsey. Ramsay was a bastard born in the north and later legitimized by the King to become the Warden of North and heir of Bolton House. He used

various tactics to gain over the enemy. The first appearance (David Benihoff & Weiss, 2013) showcased him as a person, trying to help the Theon Greyjoy escape captivity, after the attack of Bolton's on Winterfell. In the due course of the series, we observe Ramsay brutalize Theon - inflicting pain, mutilating and even castrating him. However, to qualify as sadism there should be sexual gratification by inflicting pain to the sexual partner which is not the case between Ramsay and Theon. Later in the series, Sansa Stark was sold to the 'Boltons' for marriage and on her wedding day she was brutally raped by Ramsay Bolton. Theon Greyjoy was forced to be a mute spectator of this brutality. Verbal threatening and physical assault of both Theon and Sansa was an everyday affair. Sansa was sexually assaulted many times in sadistic ways and even mutilated or 'cut' as we can infer from her conversation with Little Finger (regarding Ramsay) afterward in the 5th episode of Season 6. The sociopathic, apathetic nature of the character and the sexual sadism portrayed in the series made Ramsay Bolton the most dreaded and hated character in the series (Egner & Weinberg, 2016). He was later defeated by John Snow in 'The Battle of Bastards', and ultimately killed by his beloved dogs whom he used to inflicting brutality upon others. Ramsey Bolton became the worst character on the small screen in 2015 (Spella, 2015). Ramsey Bolton's character has been critically analyzed by the media, which also gives an impression that paraphilia is more commonly associated with people who are sociopathic and engage in violence (Greitemeyer, Weiß, & Heuberger, 2019; Egner & Weinberg, 2016; Robertson & Knight, 2014).

Sexual Masochism

Masochism can be defined as a tendency to put oneself in great agony or pain, and deriving sexual pleasure from it (McManus, Hargreaves, Rainbow, & Alison, 2013). The definition according to DSM 5 is recurrent and intense sexual arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors (American Psychiatric Association, 2013) The most notable character who portrayed this type of behavior in the series of GOT is Myranda, the companion of Ramsay Bolton, she was the daughter of the Kennel Master at Bolton's. She and Ramsey grew up together. They developed affection towards each other. She became a partner in tormenting victims of Ramsay. The character was in a romantic relationship with Ramsay

Bolton and she becomes jealous of Sansa when she is forcefully married to Ramsay. During season 4 we get to see a glimpse of her sadist nature when she along with Ramsay, killed another pleasure woman called Tansy as she was pregnant and Ramsay grew 'bored' with her. Myranda did love Ramsay but for him, she was merely a toy of pleasure and completely disposable, as he threatened her with consequences of getting him 'bored' by her jealousy towards Sansa (Egner & Weinberg, 2016).

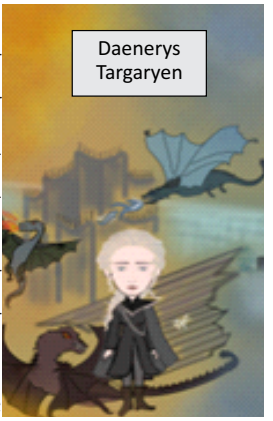
Fetishstic disorder, Transvestic disorder are also included in the DSM 5 but no character in GOT has been shown to depict these paraphilias.

Other variations in sexuality portrayed in GOT

There are other sexual behaviors depicted in GOT, which were shown to be socially unacceptable, but are not included in DSM 5 classification including incest, bisexuality, homosexual behaviors, etc.

Incest

Incest can be defined as a behavior of human sexuality, in which the sexual relationships take place among close relatives of members of a family by adoption, clan or blood lineage. It is mostly considered as a taboo in the societies in modern as well as ancient ones (Wolf & Durham, 2004).

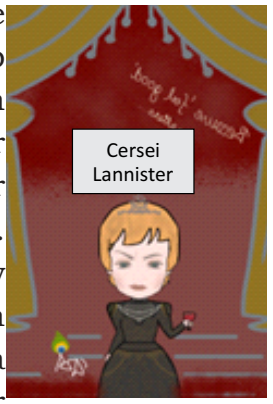


Incest is probably the most vividly pictured and discussed topic in the GOT universe. The previously ruling royal family of the Westeros were 'The Targaryens', who originated from the 'Old Valyria', which was then a very developed civilization. They had magical creatures like fire breathing dragons. These dragons were responsible for giving them a great advantage in war and aerial attacks. They also believed in prophecies, this led them to believe that marrying within the family will help them to preserve their pure bloodline, which they thought, was superior to other houses. This led to the generational incest among the Targaryens. This was also a reason for many familial diseases prevalent among them. Viserys Targaryen was supposed to marry Daenerys as per their family tradition and has been shown to be sexually attracted to her in the first episode of the season, but because he wanted the support of Dothraki's for winning back the iron throne he traded Daenerys.

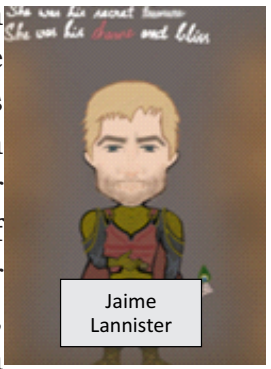
The Incest was looked down upon by the people of Westeros who were mainly the believers of Seven (seven Gods). For this reason, Cersei

Lannister was punished with the walk of atonement by High Sparrow, in the 10th episode of season 5 (Nutter, 2015).

The most significant depiction of incest from the beginning of the show is the relationship between Queen Cersei and her twin brother Jaime Lannister. The show presents us with the picture of a king who over spends and wastes the countries resources for luxury and pleasure, not being bothered about other aspects of the ruling. He does not give enough attention to the queen or her children. Thus, there is an incestuous relationship between the queen and her brother. The children she had were from her brother and not from the king.



The first big turn of events occurs when Brandon Stark, sees the Lannister twins together in a high tower at Winter fell. Out of fear of disclosure of their relationship, Jaime threw him down the tower window expecting him to die from the fall. However, Brandon survived and became crippled, also he became amnestic about that incident.



There was social disapproval of incest in the 'Andal' culture (culture of the Westeros people) and the faith of Seven. The social prestige of the family was at stake which created a sense of discomfort and a potential threat to the reigning monarch family, leading to the drama in the series.

During the clash of the five kings when Jaime gets captured by House Stark, Cersei enters into a sexual relationship with their first cousin Lancel Lannister. Another important depiction of incest can be observed in the 'Craster's Keep' where Craster lives with his daughter wives, every male child born to Craster, was given away to the white walkers (Snow Zombie Demons). Craster would keep the daughters to procreate more and more children in order to be left safe by the White walkers.

Homosexuality

Homosexuality although currently recognized as a normal variant of sexuality, was not considered an acceptable form of sexuality in the past (Roy, 2019).

Homosexuality has been depicted by the characters Renly Baratheon, the youngest prince of Storms Land and young lord Loras Tyrell of High

Garden. The show has depicted them as homosexual lovers, in times when homosexuality was considered in a very negative way. The show portrayed Renly and Loras in a very intimate relationship. To cover up their story, Loras's sister Margery Tyrell was betrothed to Renly and also was wed to him. But their marriage was never consummated as Renly only wanted to be with Loras. This also created an issue with Margery which lead to her dissatisfaction (David Benihoff & Wiess, 2011). After Renly was killed by the 'Shadow Demon', Margery and her house supported the Lannisters in the King's Landing.

Later, Loras Tyrell is shown to get sexually involved with Olyvar who was a spy and a male prostitute employed by Petyr Baelish. Olyvar initially poses as Loras Tyrell's squire during a sparring match and develops romantic relations with Loras, which was known to Margery. Later in the series when Olyvar is called to give evidence at the 'Holy Inquest' against Loras and Margaery. Olyvar provides the High Sparrow with testimony against Loras and Margaery, leading to their arrest. This event depicts the social disapproval of homosexuality in the said culture.

Bisexuality

Bisexuality has been depicted by few characters in GOT like Margery Tyrell, Yara Greyjoy, Oberyn Martell and Ellaria Sand. The characters will be individually discussed with their styles of revealing their sexuality.

Margery Tyrell- She was the daughter of the Tyrell family, and was very ambitious. She desired to be the queen of Westeros. She was wed to Renly Baratheon, youngest prince of the Stormlands. But him being gay, the marriage could not be consummated. In season 2 episode 3 (David Benihoff, Weiss, & Shakharov, 2012) she expressed to Renly that she would not mind having Loras Tyrell (her brother and Renly's love interest), in their intimate moments. This showed her liberal attitude towards sexuality. Before her wedding with King Joffrey, she had a conversation with another main character of the show Sansa Stark, who had been previously betrothed to King Joffrey, to know about him as a person. There, with subtlety, she disclosed her bisexuality to Sansa in season 3 episode 2 (David Benihoff & Weiss, 2013). This shows that bisexuality, was something to be frowned upon and a taboo in their society, so it was practiced in secrecy.

Yara Greyjoy- She is the daughter of Balon Greyjoy and elder sister of Theon Greyjoy, of the Iron Islands. She has been shown to have a sexual inclination towards both sexes. She openly embraces her bisexuality and utilizes it for strategic advantages as well. The entry of Yara's character in the series starts with an awkward encounter with her brother Theon, who not knowing her true identity tries to sexually please her (David Benihoff & Weiss, 2013). She despite knowing that Theon is her brother, seems to be enjoying this encounter. This can also be taken as an example of incest. Yara and Theon after escaping Iron island (with a big part of the iron fleet), due to Euron Greyjoy's fear, take the Iron Fleet to Essos and stop over the Free City of Volantis for rest and relaxation. There Yara is seen to be sexually involved with a female prostitute. Later, we again see her with Ellaria Sand, where she takes a masculine approach towards her sexuality and engages in her affection and attraction toward Ellaria Sand (Weiss & Benihoff, 2017). The character of Yara accepts her bisexuality openly and does not hide it under the curtains like Margery Tyrell.

Oberyn Martell and Ellaria Sand

Oberyn Martell was the prince of Dorne, his paramour (spouse, but not married) was Ellaria Sand. They were both openly bisexual. The first depiction of their sexuality is portrayed when they arrive at the establishment by Petyr Baelish in the King's Landing in season 4 Episode 1 (David Benihoff & Weiss, 2014). This establishment was taken care of by Olyvar at that time. Olyver was approached sexually by Oberyn Martell. Olyvar later takes part in a small orgy involving Oberyn and Ellaria along with two other prostitutes, which was suddenly interrupted by the entry of Tywin Lannister. Both Oberyn Martell and Ellaria Sand characters are fierce, independent and notorious. They also depicted the part of the culture where children born out of wedlock were not looked down upon, and variations of sexuality were accepted until anyone was harmed.

Others- Another depiction of sexual variation can be observed in the 1st episode of GOT when the Dothraki wedding of Khal Drogo and Danaerys takes place, it can be observed that many of the Dothrakis engaged in violent sexual activities in front of other tribe members creating a scene and there were open killing and brutality along with sexual exploitation at the wedding scene (D Benihoff & Weiss, 2011).

Sl. No.	Paraphilic Behaviour as per DSM 5	Characters portraying those behaviors
1	Exhibitionism	Dothraki Tribesmen, Prostitutes in Petyr Baelish's establishments and Tyene Sand
2	Voyeurism	Petyr Baelish
3	Paedophilia	Ser Meryn Trant
4	Sexual masochism	Myranda
5	Sexual sadism	King Joffrey Baratheon, Ramsay Bolton.
6	Fettishistic disorders	Not depicted in GOT
7	Transvestic disorders	
8	Other specified paraphilic disorders	
9	Other non-specified paraphilic disorders	

Table1- The paraphilic behaviours shown by the characters of GOT

Conclusion

This article requires cautious interpretation of sexual behavior in the context of European culture as depicted in the fantasy series. These events in this web-series have been depicted to occur in the pre-medieval and medieval eras. There is doubt that many of the behaviors may not be considered abnormal in the previous era or other cultures. The sociocultural understanding changes with time, like consensual homosexuality has come a long way from being a punishable offense in almost all of the countries to gaining sexual liberation and becoming a normal variation in the 21st century. This topic remains an interest provoking and debatable topic.

It can also be observed that except for consenting incest relationship all the other paraphilic relationships consist of victimization. The common relationship between the paraphilic partners is of a perpetrator and of a victim as depicted in the TV series. The portrayal of the sexual relationships in the Fantasy of Game of Thrones is varied. This article evaluated the

sexual relationships among the characters of the television series according to the current socio-cultural understandings.

The deviations in sexuality in 'GOT' helped in refining the characters and bring about important aspects of their personality. The interplay of the sexuality of the characters has been a topic of discussion throughout the 8 seasons in the general GOT viewers. There can be a few conclusions drawn from the whole discussion. The sexuality in this web-series has been shown as a method of obtaining power, political benefits, and revenge as well as for showing strength, power, and dominance apart from obtaining sexual gratification. It is so deeply rooted in the society that fiction also does not remain away from it.

There are a lot of differences in the book - ' The Songs of Ice and Fire' and the television series of GOT, this article is based on the show, and thus, may have differences with the books. Further criticism and appraisal of this timeless classic story of the Game of Thrones will continue to entertain the curious. The massive viewership of Game of Thrones not only was enjoyed by the adults but many juvenile and vulnerable people also got exposed to the sexual and violent content of the series. This can imprint the minds of vulnerable young people. Detailed analysis of such characters can help academicians understand various aspects of human personality and their psychodynamics. Paraphilia will continue to shift shapes and intrigue humans along with the evolution of human society and culture.

Illustrations

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Review Article

Management of Paraphilias: Guidelines, Challenges and Options

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Abstract

Paraphilias are important psychiatric disorders that have an important impact on society due to their relationship with sexual offences. Management strategies for paraphilias range from surgical to pharmacological to psychotherapeutic strategies. The studies have many methodological issues. This review aims at identifying the various management strategies that are available for paraphilias and the evidence for use of these strategies.

Keywords: Paraphilia, Paraphilia Treatment, Paraphilia Pharmacotherapy, Paraphilia Psychotherapy, Guidelines

Date Received: 18th October 2019
Date Accepted: 15th December 2019

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Introduction

During the late nineteenth century, clinical psychiatry had started recognizing the biological basis for sexual deviance, prior to which, Freud's psychoanalysis was being utilized for assessment as well as treatment for paraphilias for almost a century (Rosen, 1997). The first therapeutic use of 'Surgical castration' was done to treat hypersexuality in an imbecile patient in 1892 (Sturup, 1972). The United States & certain European countries had continued this treatment for some sex offenders leading to marked reduction in recidivism rates (Bremer, 1959; Cornu, 1973; Heim and Hursch, 1979; Ortmann, 1980; Heim, 1981; Wille and Beier, 1989). Surgical castration has been used for sex offenders in some states in the USA (Weinberger et al., 2005). The treatment of paraphilias aims not only to reduce the personal distress of the paraphilic patient but also to prevent sexual offences in paraphilias such as pedophilia.

Along with the biological modalities of treatment, psychological therapies are equally necessary for holistic management. This review provides an overview of pharmacological as well as psychological strategies for treatment of a paraphilic patient, challenges in management and evaluation of paraphilia as well as guidelines for its management.

Methodological limitations & ethical concerns

Literature regarding the treatment of paraphilias consists mainly of case reports or series & controlled treatment efficacy studies are sparse as paraphilic sex offenders are most often referred by the court or under societal pressure and rarely seek treatment voluntarily. Also, ethical considerations restrict double-blind placebo-controlled studies in paraphilic subjects. In addition, statistical analyses remain difficult in most studies due to small sample size, cross over designs & short duration of follow up. The outcome measures also continue to be subjective and unreliable as paraphilic sexual activity is mostly self-reported. It is often difficult to compare the existing studies due to methodological differences like the type of paraphilias included; outpatients or prisoners; retrospective or prospective designs; variations in follow up durations and different operational criteria.

Evaluation of paraphlias

A detailed evaluation of the subjects with paraphilia is crucial for deciding- whom to treat and what modality of treatment is to be used according to the severity of symptoms. Not all sex offenders suffer from paraphilia, and that, not all patients with paraphilia commit sexual offences.

Demographic and clinical characteristics (Thibaut et al., 2010)

Demographic characteristics:

- Age
- Gender
- Marital status
- Number, age & gender of children
- Current and past employment status
- Education status

Clinical characteristics:

- Normal and paraphilic sexual fantasies and activity (intensity, frequency, and type)
- Exclusive/non-exclusive paraphilic behaviour
- Age at onset of paraphilic behaviour
- Type and number of paraphilias
- Gender and age of victims
- Intrafamilial or not
- Internet use or video use
- History of violence, previous convictions for offences (sexual or non-sexual)
- Family and personal history of sexual disorders
- Previous treatments & compliance - Alcohol or illicit drug consumption
- Age of puberty
- Family and personal history of psychiatric disorders, suicide attempts, history of brain

trauma, current dementia, history of violence, history of sexual abuse
- Degree of interpersonal, occupational or social deterioration
- Any history or current evidence of sexually transmitted diseases
- Legal issues

Physical Examination

Examination of external genitalia and secondary sexual characteristics should be done as part of assessment of paraphilias.

Rating Scales

Certain rating scales are useful in the assessment of Paraphilias. Some of these are The Multiphasic Sex Inventory (Nichols and Molinder, 1984); Clarke Sex History Questionnaire (Langevin and Paitich, 2002); Bradford Sexual History Inventory (Bradford et al., 2002).

Specific Hormonal Investigations

Sex hormone profile is useful in evaluation of paraphilias (Kingston et al., 2012). Some hormones have been found useful in predicting recidivism among offenders. (Studer et al., 2005) It is also useful to have baseline levels before starting treatment especially hormonal treatment. Following hormonal profiles are useful.

- Free and Total Testosterone
- Follicle-stimulating hormone
- Luteinizing hormone
- Estradiol
- Prolactin
- Progesterone

Other investigations

Phallometry or Penile Plethys mography is useful in assessing sexual arousal in response to different stimuli (Seto et al., 2008, Blanchard et al., 2001). It has been used in the assessment of pedophillia, biastophillia and sexual sadism.

Neuroimaging

Recent studies suggest that neuroimaging may help in the assessment and guiding the treatment of paraphilic disorders. Kärgel et al. (2015) found that pedophiles who engaged in child sexual abuse demonstrated decreased resting-state functional connectivity (RSFC), between the left amygdala and orbitofrontal cortex and anterior prefrontal regions as compared to those who did not engage in sexual abuse using fMRI. Future studies may validate these findings to be useful predictors of pedophile's proneness to act on his sexual impulses.

Assessment of comorbidities

A range of comorbidities is seen with paraphilias (Gordon and Grubin, 2004), which need to be identified as they may be associated with guilt, depression, shame, and impairment in social and sexual functioning with increased risk of harm to self and others.

- Major mental illness (Kafka and Hennen, 2002)
- Personality Disorders
- Neurological disorders, such as temporal lobe epilepsy or brain trauma (especially before 6 years of age, Blanchard et al., 2002); Klüver Bucy and Kleine Levin

syndromes (50%); Huntington's disease (10%).
- Patients receiving dopaminergic agents (Parkinson's disease) (Guay, 2008).

Guidelines

The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines propose a hierarchical treatment protocol that progresses from psychotherapy (offered at all stages) to the most severe stage where the combination of a GnRH agonist with an antiandrogen and/or SSRI is recommended. According to the great majority of authors, a minimal of 3 – 5 years duration of treatment for severe paraphilia associated with sexual violence is necessary & at least 2 years for mild paraphilias (Thibaut et al., 2010).

British Association of Psycho-pharmacology (BAP) recommends SSRIs as an initial intervention in the presence of dysfunctional mood states or impulsive behaviour. (Winder et al., 2014, 2018). In individuals with increased sexual drive, anti-androgens, and GnRH agonists are recommended as the initial intervention.

The American Academy of Child and Adolescent Psychiatry (AACAP; Shaw, 1999) practice parameters recommend cognitive-behavioural interventions, psychosocial interventions, and SSRIs for children and juveniles who are sexual abusers. The use of anti-androgens is avoided in patients less than 17 years of age due to the risk of delayed puberty and less bone growth.

Hill et al. (2003) formulated a comprehensive treatment plan including psychotherapy and pharmacotherapy on the basis of severity and comorbid conditions. For less severe cases, and with comorbid depressive, anxious or obsessive/ compulsive symptoms, SSRIs are recommended as the first choice of treatment.

Therapeutic approaches

Therapies for paraphilic disorders may target one or more of the following:
1) Patterns of sexual arousal and attraction.
2) Social skills to improve sexual interactions with adult partners.
3) Reduce sexual drive.

Treatment modalities used in paraphilic behaviours can be divided into three categories: Bilateral orchidectomy (Heim and Hursch, 1979), Pharmacotherapy and Psychotherapy. A comprehensive treatment plan should include pharmacotherapy as well as psychotherapy, specifically, behavioural therapy.

1. Bilateral orchidectomy

Surgical castration i.e. removal of testes leads to lowest recidivism rates by reducing circulating testosterone levels, in turn, reducing paraphilic fantasies and behaviours (Level D of evidence). However, it is no longer used in most European countries due to the availability of less invasive alternatives (Stone et al., 2000).

2. Psychotherapy

Psychotherapy includes both individual as well as group/family therapies. Most of these studies are conducted in paraphilias not associated with serious sex offences; hence, the findings cannot be generalized. Longer follow-up randomized controlled trials are required.

Psychodynamic psychotherapy

Through interaction with the therapist, the target is to moderate the drive of id and replace the primitive defenses (splitting, denial) with more mature ones (Stoller 1976; Glasser, 2001). Psycho dynamic approaches were common in the past in the UK (Grub, 2002) but cognitive-behavioural therapy (CBT) based interventions are preferred now.

Aversion therapy

In this, the paraphilic stimulus is paired with an aversive event (Beech & Harkins, 2012). This modifies the sexual arousal patterns. Currently, it is not used as the sole form of treatment (Marshall, 1998).

Group therapy

The group therapy component is intended to confront the denial and rationalization, called 'therapeutic confrontation,' and its purpose to help offenders develop empathy for others using techniques like victim identification (University of Wisconsin, Board of Regents, 2002).

Cognitive behavioural therapy

Cognitive restructuring attempts to eliminate sex offenders' cognitive distortions associated with maladaptive and dysfunctional behaviour. CBT works by targeting problematic arousal, impulse control, empathy for the victim, emotional management, and cognitive distortions. Techniques like covert sensitization, verbal and masturbatory satiation, imaginal desensitization, and biofeedback are commonly used (Thibaut et al., 2010, 2016). CBT has been shown as an effective treatment modality in adult men (L€osel & Schmucker, 2005) and adolescents (Thibaut et al., 2016, Maletzki and Steinhauser, 2002; Kentworthy et al., 2004) (Level C of evidence).

Recently, virtual reality-based interventions have also been used in this population, testing the ability of patients to use coping skills in risky situations (Berger et al., 2018). It was suggested that neuro bio feedback may also be a beneficial intervention (Renaud et al., 2011).

Relapse prevention therapy (RPT)

RPT includes both internal self-management, as well as an external supervisory dimension. RPT provided promising results with cognitive-behavioural approaches, though it has become less widely used after being found ineffective (Fedoroff & Marshall, 2010).

In Canada, RP approaches have become limited or eliminated at some locations and the positive-psychology 'Good Lives Model' (GLM) (Ward, 2002) has largely emerged as the replacement (Marshall & Marshall, 2015).

Pharmacotherapy

Psychotropic Drugs

SSRIs may act by the following possible mechanisms for reducing paraphilic behaviours: (1) non-specific reduction of sexual interest; (2) decreased impulsiveness; (3) reduction in obsessive-compulsive symptoms & concurrent depressive symptoms (Hill et al., 2003). We reviewed the available literature for the efficacy of SSRIs in paraphilias and sex offenders and found the following studies:

Kafka and Prentky (1992) demonstrated the effectiveness of Fluoxetine (20-60 mg/day) for 12 weeks in paraphilic subjects with telephone scatologia, exhibitionism, frotteurism, sadism, fetishism, reducing preferentially the paraphilic behaviours without affecting the normal sexual arousal. A case report considered impaired impulse control as a central component for paraphilias & described treating a patient with exhibitionism and telephone scatologia with Buspirone (Pearson, 1992). Greenberg et al. (1996), found a significant decrease in deviant fantasy in 4-8 weeks with SSRIs in a retrospective study in 58 paraphilics with Fluvoxamine, Fluoxetine and Sertraline being equally effective (76% received concurrent psychotherapy). A combination of psychotherapy and SSRIs was found to be more effective than psychotherapy alone by Bradford and Greenberg (1996). In another study, Sertraline (up to 12 weeks) decreased paedophilic arousal by 53% as assessed by penile plethysmography with improved or unaffected arousal (Bradford, 1999, 2001) & reduced deviant sexual behaviour (Bradford et al., 1995; Bradford, 2000). Adi et al., (2002) suggested preliminary evidence regarding the efficacy of SSRIs in the treatment of sex offenders after reviewing 9 case series but the results were far from conclusive. A review by Garcia & Thibaut, including, 24 case reports, 3 retrospective studies & 5 open studies, found SSRIs to be effective in reducing fantasies and paraphilic behaviours (Garcia & Thibaut, 2011). A double-blind study by Wainberg et al. (2006), found Citalopram to be effective in homosexual males with compulsive sexual behaviour, hence, the findings cannot be generalized to sex offenders. A study by Winder et al., (2018), done on 247 prisoners serving for sexual offences, showed statistically significant change with SSRIs as compared to the control group. There is a lack of controlled, randomized studies evaluating the efficacy of SSRIs for the treatment of paraphilias & WFSBP guidelines (Thibaut et al., 2010) recommended level C evidence for psychotropics. To conclude, SSRIs have been recommended in milder forms of paraphilias, in juveniles, those having comorbid depression and OCD & in maintenance treatment (Bradford & Fedoroff, 2006).

Other psychotropics that have been studied in this population include Lithium, Tricyclic antidepressants, Antipsychotics (thioridazine, haloperidol, risperidone), Anti-convulsants (carbamazepine,

topiramate, divalproate), and Naltrexone. Studies using these agents are limited and have not demonstrated any significant efficacy (Thibaut et al., 2010).

Hormonal Treatment

Oestrogens

Despite its efficacy in paraphilias (Whittaker, 1959; Bancroft et al., 1974), oestrogens are best avoided therapeutically due to various side effects with breast cancer being the most dreaded one. (Field, 1973; Symmers 1968) (No level of evidence and major side effects).

Antiandrogens

Steroidal antiandrogens such as medroxyprogesterone acetate (MPA) or cyproterone acetate (CPA) act by decreasing the circulating levels of both testosterone and DHT (dihydrotestosterone). Also, they block the cellular uptake of androgens by interfering with the binding of DHT to androgen receptors. The depo-Provera scale (Maletzky et al., 2006) is a useful tool to evaluate and decide antiandrogen use in paraphilic subjects especially sex offenders.

Medroxyprogesterone acetate (MPA)

The WFSBP guidelines reviewed 13 open and controlled studies with a total of approximately 600 paraphilic subjects (Pedophilia in 15%) (Thibaut et al., 2010), and found that administration of MPA resulted in the reduction of sexual behaviour, deviant sexual behaviour and fantasies after 1 to 2 months of treatment but an unfavorable risk/benefit ratio & study biases, hence, level C of evidence was noted for its use. A recent Cochrane review in 2015 noted poor evidence of the effectiveness of MPA in reducing sexual recidivism rates and tolerability in sexual offenders (Khan et al., 2015).

Cyproterone acetate (CPA)

The WFSBP guidelines reviewed 10 open and controlled studies with approximately 900 male subjects. A significant decrease in sexual fantasies and absence of deviant sexual behaviour was experienced by 80 to 90% of subjects within 4 to 12 weeks (Thibaut et al., 2010) but significant side effects in the form of hot flushes, hair loss, gynecomastia, weight gain, and osteoporosis were noticed (Gijs & Gooren, 1996). Hence, the WFSBP guidelines again noted a level C evidence for recommendations on the use of CPA due to non systematic decrease in testosterone levels, unavailability of forms other than oral & measurement methods in many countries.

GnRH Analogs

The GnRH analogs suppress the physiologic, pulsatile release of luteinizing hormone from the pituitary gland, in turn, inhibiting testicular production of testosterone. Also, GnRH reduces the sexual behaviour by acting as a neuromodulator at the olfactory bulb or the amygdala (Kendrick and Dixson, 1985; Moss and Dudley, 1989). GnRH analogs are useful in situations where there is a contraindication for steroidal medications or steroidal medications are ineffective or intolerable (Hill et al., 2003; Rosler & Witztum, 2000).

The three GnRH analogs studied as a treatment in paraphillias are Triptorelin, Leuprorelin, and Goserelin (Thibaut et al., 2010). GnRHa has shown better efficacy as compared to previous treatments with psychotherapy, SSRIs or other anti androgens but there is a lack of randomized controlled studies (Garcia et al., 2013).

A review based on two prospective open studies, two retrospective studies, and one case report, observed the disappearance of deviant sexual fantasies with triptorelin between 1 and 3 months (Thibaut et al., 1993; Thibaut et al., 2010). Similar findings have been observed for leuprorelin (Briken, 2002). One retrospective study found GnRHa & CPA to be equally efficacious in paraphilic subjects (Czerny et al., 2002).

The 2015 Cochrane review could not identify any studies on the use of GnRH analogs of sufficient quality which could meet the inclusion criteria for their review (Khan et al., 2015).

The WFSBP guidelines recommend the use of GnRH analogs in Level 5 or higher level i.e. adult males with severe paraphilias, a high risk of sexual violence, and sexually sadistic fantasies and/or behaviour or physical violence (Thibaut et al., 2010).

A recent study observed significant improvement in deviant sexual interests and behaviours with Leuprolide in sexual offenders who were evaluated by using objective psychiatric assessment (Choi et al., 2018). Another recent study examined the effect of Leuprolide acetate LA (Lupron) treatment on violent (including sexual) recidivism by comparing a group of sexual offenders receiving LA and CBT with a group receiving CBT only (Gallo et al., 2018). The first group was found less likely to re-offend than untreated subjects. Many other studies also support the use of Lupron in sexual offenders (Krueger & Kaplan, 2001; Briken et al., 2001; Raymond et al., 2001; Schober et al., 2005).

Surgical	Bilateral Orchidectomy (LEVEL-D)	
Psychotherapy	Psychodynamic Therapy Aversion Therapy Group Therapy Cognitive Behaviour Therapy (LEVEL-C) Relapse Prevention Therapy	
Pharmacotherapy	Psychotropic Drugs	SSRI (LEVEL-C) Fluoxetine Sertraline Citalopram Buspirone Others Lithium TCAs Antipsychotics Anticonvulasants Naltrexone
	Hormonal Therapy	Oestrogens Antiandrogens (LEVEL-C) *Medroxyprogesterone acetate (MPA)* *Cyproterone acetate (CPA)* GnRH Analogs *Triptorelin* *Leuprorelin* *Goserelin*

Table-1. Various therapeutic approaches for Paraphilias with level of evidence

Conclusion

The paraphilic disorders, not only involve deviant sexual interests but also, may lead to subsequent behaviours like sexual offending. Hence, this group of disorders is a potential target for intervention for psychiatrists and treatment is essential for the society at large. The treatment of paraphilias continues to remain far from evidence-based practice & the guidelines and algorithms stand way down the evidence hierarchy, not supported by well-conducted randomised controlled trials. Research regarding pharmacological interventions in women, juveniles and sexual murderers, is scarce with only a few case reports published.

Future studies including neuroimaging may provide new insights in terms of neural substrates of deviant

sexual interest & aid to screen those at risk for offending and requiring treatment. Further large scale national or international collaborative studies, eliminating methodological and statistical biases, are needed to confirm the efficacy of pharmacological treatments in paraphilias.

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Review Article

Paraphilia: Concepts, Classifications, Epidemiology, Attributes and Management

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Abstract

Paraphilia have always been a debatable and under-researched topic in psychiatric domain, with lots of cultural myths associated with its origin. The aetiology is unclear, with several theories forwarded but none having universal acceptance. Psychotherapy was the mainstay of treatment until antidepressants were found to be effective. With the milieu gradually incorporating several anti-androgens, Gonadotrophin Releasing Hormone (GnRH) and Luteinizing Hormone (LH) analogues; pharmacotherapy was introduced after better understanding developed through extensive research.

Key words: Paraphilia, Concepts, Classification, Management.

Date Received: 24th October 2019
Date Accepted: 24th December 2019

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Introduction

Paraphilia (Greek: para-beside, philos-love) literally translates to loving, besides ordinary/apart from, what is normally acceptable. The word was coined by Friedrich Solomon Krauss in 1903. First used by William Stekel, the word has transcended its meaning and usage throughout the 20th century. In his book 'Sexual Aberrations' (1930), Stekel highlighted the difference between 'parapathia' (neurosis), paralogia (psychosis) and paraphilia (perversion), thus separating paraphilia from the other categories of mental disorders (Giami, 2015).

Stekel had described paraphilia as *"paranormal or dangerous instincts where sexual gratification was not obtained from normal heterosexual intercourse"* (Malin, 2007). However, the credit for popularizing

the term goes to Benjamin Karpman. Sexual deviance was considered a medical phenomenon after Psychopathia Sexualis written by the German psychiatrist Krafft-Ebing, describing sexual murders, was published (Ebbing, 1886).

Society had played a pivotal role in adjudging what is normal and what is abnormal and has shaped the mind of psychologists/ psychiatrists and is doing so even today. Paraphilia have always been a matter of deep intrigue, amazement and moreover hatred which has paved its way for the greater focus on punitive aspects rather than reformative/treatable approach required for them. With the course of changing mentality and acceptability of the different shades of sexuality, the widespread boundaries of paraphilia have gradually shrunken, however debates have ensued, and no single definition, till date, has been enough to encompass everything.

History

The folklore involving paraphilia have always been mentioned in different cultures with a demonic incarnation getting great pleasure using such techniques. Though there is no valid exact documentation pinpointing of its origin and existence, some disorders have been depicted like in 490 B. C, 'The Tomb of Whipping' at Etruscan Tomb near Tarquinia, Italy represented two men beating a woman in an erotic situation. Whipping ceremonies were practiced by ancient Spartans too in around 9th century B.C. (Steingraber & Steingräber, 2006). India too had its own set of Paraphilic admonitions like Sadomasochistic and Fetishist approaches described in length in Vatsyayana's Kama sutra. It describes different hitting practices being executed during love-making to enhance pleasure, after getting acceptance from the partner. There is also mention of objects shaped specifically to stimulate one's genitals for getting sexual gratification. So, Kama sutra may be the first documented proof explaining paraphilia, their limitations and safety regulations. (Steingraber & Steingräber, 2006).

Conceptual evolution and phenomenology

Perception and evidence are the opposing stalwarts, which have gradually shaped the modern understanding of paraphilia. The understanding has changed over the years, as reflected by the difference in stands by DSM and ICD over the years. The first DSM, printed back in 1952 didn't even include paraphilia as a sexual disorder. Back then, Sexual

deviations was the term used for them which was classified under the subclass of Sociopathic personality disturbance. It included all the disorders earlier thought of as psychopathic personality traits and considered to be pathological sexuality. Thus, it included behaviours which were considered pathological back then like masturbation, homosexuality, paedophilia, transvestism, fetishism, and sexual sadism which includes rape, mutilation and assault (Sorrentino, 2016).

DSM II however, continued with the thought of paraphilia being a personality disorder. The major change came with DSM III when it was designated as a psychosexual disorder including psychosexual dysfunctions, gender identity disorders, and ego-dystonic homosexuality with it.

In DSM III R, Paraphilia term was used to describe unusual acts or dreams necessary for sexual excitement and in addition were 'persistent' and 'involuntarily repetitive'. DSM IV and DSM IV-TR have maintained the basic ideology of DSM III along with the definitions, with DSM IV-TR moving transvestism from gender identity disorder to a paraphilia termed transvestic fetishism (Sorrentino, 2016). The major benchmark change again came, when DSM V introduced changes in the definition, and included Paraphilic disorders, thus now Paraphilia, and Paraphilic disorder had separate meanings. There was clarification regarding the difference between thoughts and disorders. Over the years the research into Psychosexual development and societal understanding has been significant, leading to the inclusion of homosexuality, masturbation, and oral sex in mainstream sexual practices, and not a deviation or perversion, as earlier thought of. Several grey areas have remained unclassified, like Incest, which is not legally punitive, nor is acceptable in the mainstream and neither is classified under paraphilia. Similarly, is the state for classifying people who practice BDSM (B/D: Bondage and Discipline; D/S: Dominance and Submission and S/M: Sadism and Masochism). It is believed to be a method of experimentation and enjoyment rather than a perversion. India, has always faced criticism for being a pro-conservative when it comes to sexual issues, but the milestone Judgement in 2018, the scrapping of parts of Article 377 of Indian Penal Code (IPC), changed the perception. Still, the cultural acceptability and the leverage given is too less, to be of any significance for the inclusion of such communities. Unlike many other disorders, the legal stand of Incest is debatable with no law criminalizing it. Thus, the

morals, and principles affecting the conservationist approach are highly questioned in this regard.

Prevalence

There is very limited data available regarding the epidemiology of Paraphilia. Different studies have reported the prevalence as few as 1.7% and as many as 62.4% subjects showing at least some paraphilia related patterns (Mc Manus et al., 2013).

Paraphilic Disorder	Prevalence
Voyeuristic Disorder	Males: 12% Females: 4%, clinically uncommon
Exhibitionistic Disorder	Males: 2% to 4% Females: uncertain but lesser
Frotteuristic Disorder	Males: 30%, clinically 10%-14% Females: lesser
Sexual Masochism Disorder	Males: 2% Females: 1.3%
Sexual Sadism Disorder	2% to 30% 37 to 75% in cases of sexually motivated homicide
Pedophilic Disorder	Males: 3% to 5% Females: uncertain but lesser
Fetishistic Disorder	Not reported in females
Transvestic Disorder	Males: less than 3% Females: extremely rare

Table 1: Prevalence of Paraphilic disorders among males and females

Definition and classification

DSM-5 defines paraphilia as *"any intense and persistent sexual interest other than the sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physiologically mature, consenting human partners"*(American Psychiatric Association, 2013).

Paraphilic disorder is a *"paraphilia that is causing distress or impairment to the individual or whereby satisfaction entails personal harm or risk of harm, to others"* (American Psychiatric Association, 2013). Thus boundaries of clinical relevance are defined. The behaviours may not be 'normophilic' but have no or minimal clinical importance (Bradford & Ahmed, 2014). Next, important change is the inclusion of specifiers to the classification scheme. The first group of disorder

is, 'anomalous activity preferences' subdivided into courtship (voyeuristic, exhibitionistic, frotteuristic disorder) and algolagnic disorders (sexual masochism disorder, sexual sadism disorder).

The second group describes 'anomalous target preferences' (paedophilic disorder, fetishistic disorder and transvestic disorder) (American Psychiatric Association, 2013). The third group earlier under 'not otherwise specified' is changed to 'specified' and 'unspecified Paraphilic disorder' (American Psychiatric Association, 2013). As per the DSM- 5, Criterion A, means that recurrent and persistent sexual arousal must be present for at least six months. Criterion B, requires that individual should have acted on the sexual urges with a non-consenting person or the urges/fantasies caused significant distress in a social, occupational, or other important areas of functioning.

Both must be met for classifying the person as having 'Paraphilic disorder'. Terms like 'in a controlled environment' is used for individuals 'staying in institutionalized settings in which the object used for sexual gratification is restricted'; 'in full remission' refers to 'absence of distress and impairment in social, occupational, or other areas of function for 5 years at least' (American Psychiatric Association, 2013).

ICD-10 includes paraphilia under Section V (Mental and Behavioural disorders) as F65, 'Disorders of sexual preference' describing Paraphilia (WHO, ICD-10 Version: 2015). ICD-11 however, describes it under Section 17- 'Conditions related to sexual health'; 'Paraphilic disorders' (6D30-6D3Z) (ICD-11, Mortality and Morbidity Statistics, 2019), wherein paraphilic disorders are referred to as, *"persistent and intense patterns of atypical sexual arousal, manifested by sexual thoughts, fantasies, urges, or behaviors, the focus of which involves others whose age or status renders them unwilling or unable to consent on which the person has acted or by which he or she is markedly distressed"* (ICD-11-Mortality and Morbidity Statistics, 2019).

Etiology

How and why did paraphilia originate have been a matter of confusion and debate. The association of Paraphilia with genetic and environmental factors, in the past has been dismantled by certain new research papers which are even questioning the validity of their predecessors' work. The most important point is the affection of male gender, in almost all the types of Paraphilic disorders, except the sexual masochism disorder. It can be pointed out that it is a learned behavior associated with variation in the hormonal stimulation and the

androgenic psychology. Three most popular theories regarding the aetiology are-

1) Neurobiological model, where the possibility of linking paraphilia with defective cognitive development abilities suggested that they play a direct role in the pathogenesis of such a disorder/trait (Garcia & Thibaut, 2011).

2) Psychodynamic model, which believes that paraphilia develops as a shield to averse the perpetrators from the anxiety and depression of any painful event. It helped them to cope up with the aggressive thoughts, lack of control and the potential loss of one's physical integrity. For example, diaper fetish is thought of as a wish to return to an infantile state to be cared for, which may be an attempt to make up for the lack of parental care required in early childhood (Garcia & Thibaut, 2011).

3) Cognitive-Behavioural model, which hypothesized that the development of arousal to non-sexual object/behaviors occurs through repetitive and recurrent associations between the thought and pleasurable activity. For example, a child found sudden sexual arousal while accidentally visualizing his/her parents or any two consenting adults being intimate, and later on recollects the memory for masturbation and then the repetitive intrusion of this thought leads to his Paraphilic behavior (Garcia & Thibaut, 2011).

Diagnosis

Since Paraphilia is associated with lots of taboo and punitive outcomes, the self-reporting of such disorders are extremely rare, even when they are distressing for the individual. Such individuals usually live 'hidden' and in complete or partial isolation of the society making contact only when the arousal is triggered. So, in most of the situations, they arrive as a suspect for a possible sexual crime. The evaluation of such an individual requires both clinical and testing components. The clinical component involves sexual history, past history (especially childhood exposure to sexual acts), history regarding the number of partners and practices like masturbation.

A proper psychiatric and medical history is taken to identify any psychiatric or medical comorbidities leading to the perverted sexual preference (Sorrentino, 2016).

Objective assessments include poly -graphs, penile plethysmograph (penile tumescence to sexual stimuli), and the Abel screen test (visual reaction time to sexual interests) which is helpful in delineating problematic sexual behavior and even in seeing prognosis during treatment (Sorrentino, 2016).

Management

The initial management was mainly restricted to surgical castration, done as a punishment for sexual perverts till 1900. The need for a different treatment arose when several psychotherapists argued that treatment reduces the chances of sexual recidivism and proved that if not complete recovery, can change or reduce the sexual proclivity of such individuals. Thus, initially the mainstay of treatment was psychotherapy wherein pharmacotherapy was later added. Different research papers have shown different protocol for the effective management of the disorder. Though an ideal treatment is currently unavailable which would include, reducing distress of the patient, abolishing repeated thoughts and fantasies would have no/minimal side effects, and prevent them from acting out and victimizing others. Individual paraphilic disorder may receive different therapies based upon personal goals of therapy and individuals wish and response to them due to unavailability of a gold standard or a protocol that suits all needs. Most widely used is the Bradford algorithm published in 2001 for the treatment of paraphilia. This was based upon DSM-III-R. The algorithm graded paraphilia from Level 1 to Level 6, based on the severity (mild, moderate, severe, and catastrophic). Level 1 was treated with Cognitive Behavioral Therapy (CBT) for mild cases. Level 2 requires using Selective Serotonin Reuptake Inhibitors (SSRI). Level 3 is proposed to be used when symptoms don't improve with SSRI within 4-6 weeks, thus one need to add low dose of Cyproterone (CPA) or Medroxyprogesterone acetate (MPA). Subsequently, Level 4 involves giving full doses of oral Anti-androgen therapy. Level 5 requires long acting intramuscular hormonal therapy (GnRH agonists) for effective results. Level 6 is for those catastrophic paraphilia wherein, a patient fails to respond to any of the afore mentioned treatment and needs complete androgen suppression with the highest doses of IM therapy combined with LHRH agonists (Bradford, 2001). A nearly identical algorithm was published by Thibaut et al. in 2010 wherein, he recommended treatment with Gonadotropin releasing hormone (GnRH) agonists for Level 5 and Level 6 patients (Garcia & Thibaut, 2011).

Table 2, below is another such algorithm given by Janell L. Carroll (Carroll, 2018).

Individual	It's a one on one therapy with the counsellor directed on improving social skills and controlling the distorted emotions.
Group Therapy	Multiple patients with paraphilic disorders and their interaction is analysed.
Family intervention	Family relations are explored for their role in the disorder.
Cognitive-behavioral intervention	Works on cognition and behaviour. It helps to weaken the relationship between situations and one's reactions to them. The thoughts and behaviours are interpreted.
Systemic desensitization	Done to relieve anxiety. Patients are exposed to threatening situations under relaxed conditions untill anxiety is relieved.
Aversion therapy	Using unpleasant stimuli in a controlled way to change the emotions. Eg- a paedophile given an emetic drug while seeing naked pictures of children.
Orgasmic Reconditioning	It involves reprogramming one's fantasies to a more socially acceptable one.
Pharmacotherapy	Medications are used to improve symptoms and decrease the fantasies and sexual drive associated with them.
Surgical intervention	Rarely used these days to ultimately stop one's sexual drive by castration.

Table 2- Treatment algorithm for treating Paraphilia

Psychotherapy

The psychotherapy given is tailor-made and customized based upon the needs and understanding of the disorder in the patient. The common components include: 1) Educating the patient, and their family members addressing the nature, perceptions, proposed etiology and treatment modality. 2) Supporting the patient, reassuring them and giving them empathy. 3) Addressing the problem points-anger, past trauma or low self-esteem. 4) Problem solving to evaluate the possible advantages and disadvantages of possible solutions and evaluating it (Baez-Sierra et al. , 2016).

Psychodynamic therapy

It is based upon creating a rift between the idea that led to the evolution of the behavior in the patient and the behavior showed by the patient there after. The patient is explained the ways to distract his mind from the continuous intrusion of the ideas and thoughts, thereby facilitating the process by which his addiction to the behavior/object can be reduced, done mostly by letting the patient acknowledge and accept these ideas as harmful /invalid.

Cognitive Behavioural therapy

It focuses on changing the distorted cognition and maladaptive behaviors. The person is first carefully analyzed and then his thoughts are allowed to be changed by letting them understand the vicious cycle they are associated with, which is broken by increasing one's calmness and peace of mind.

Behavioural interventions

They include behavioural re-patterning where the therapist gradually implements changes in the patient's behavior to address specific problems leading to patient's distress. The role is to gradually shift the role of the object/behavior to a less prominent aspect, so that it doesn't play a role in sexual activities and sexual gratification. Assertiveness technique is used to teach patient's an alternative to express emotions and constructive approaches to deal with negative emotions.

Couples' therapy- It also plays a significant role in the understanding of the disorder by both the patient, and their partner, so that there is proper understanding of the disorder (Baez-Sierra et al., 2016).

Pharmacotherapy

Following three classes of drugs are helpful in the management of paraphilic disorders.

Antidepressants- SSRIs have potential utility in reducing the sexual preoccupation associated with paraphilia, which is based upon-

1) Monoamine hypothesis
2) Comorbidities associated with paraphilia
3) Their effectiveness in reducing OCDs.

Serotonin is considered an inhibitor of male sexual behavior (proven in rats) (Yells et al.,1992). Clinically, it was seen that SSRIs impair orgasmic functions and erectile ability, even the sexual interest in a dose-dependent fashion. Fluoxetine and Sertraline have been found to have the maximum acceptability and effectiveness (Verma et al. 1989). Tricyclic antidepressants have also been used in the management of paraphilia, and are still being used; (example, clomipramine for exhibitionism) although, the adverse effects have limited its usage.

Hormonal therapy

Oestrogens-Despite its efficacy, several severe adverse effects like nausea, thromboembolism, weight gain, cerebrovascular ischemic disease, and feminization have been reported, reducing its usage in subjects with paraphilia.

Steroidal antiandrogens- (Medroxy progesterone acetate)

It has an off-label use in the treatment of paraphilia. It is a progesterone derivative that gives negative feedback to the hypothalmo-pitiutary axis, leading to controlled release of GnRH and LH. The mechanisms proposed for its action are -

1) Inducing testosterone α - reductase enzyme, increasing testosterone's metabolism.
2) Binding of testosterone to testosterone binding globulin, which decreases free testosterone levels.

The long list of side effects limit its usage, with pulmonary embolism, thromboembolic phenomenon and adrenal suppression being the severe ones (Southren et al., 1977).

Cyproterone

It is a synthetic steroid which acts by binding to all the androgen receptors and blocks testosterone's uptake and metabolism. Acting as competitive inhibitor of both testosterone and dihydrotesto-sterone, it also leads to decreased GnRH and LH release. Various side effects (like sleep disorders, leg cramps, impotence, osteoporosis, depressive symptoms); availability in only oral dosage form and erratic absorption have however limited its usage (Neumann, 1977).

Gonadotrophin-releasing hormone analogues

GnRH agonists act at GnRH receptors present in the pituitary. Initially, there is release of testosterone caused by LH release, thus a phenomenon called as flare-up is associated with them.

However, with their continued usage, there is desensitization of the receptors reducing LH, FSH and testosterone release to levels equaling castration, referred to as chemical castration within 2-4 weeks. Three analogues are- Triptorelin which is a synthetic decapeptide (long-acting 11.25 mg, 3 month formulation or 3 mg, one month formulation). Leuprorelin which is developed as an IM depot with 3.5 or 7.5 mg one month dosage, and 11.25 mg, 3 month dosage. Goserelin (3.6 or 10.8 mg subcutaneous) is given as an IM injection daily or monthly depot preparation. The high efficacy, fewer side effects reported (like bone demineralization, nausea, weight gain, hirsutism, decreased glucose tolerance, mild gynae - comastia, blood pressure changes), shorter dosage regime and increased compliance creates GnRH agonists as the choice for treatment of severe cases (Thibaut et al.,1993).

Luteinizing hormone agonists

LH agonists like long acting preparations of Leuprolide acetate has been used to treat severe paraphilia. It shows promising response in suppression of deviant sexual behavior and is well-tolerated. Limited research and RCT done in this field has reduced its effective usage (Peer Briken, 2001).

Combined psychotherapy and pharmacotherapy

Some psychiatrists believe that a combined therapy serves the best possible outcome in this regard. The general strategy involves education, relapse prevention, cognitive behavioral therapy, sexual impulse control training, empathy training, and biofeedback sessions combined with pharmaco-therapy based upon the requirement (Hanson & Morton-Bourgon, 2005).

Conclusion

Whatever may be the mode of treatment, it is accepted that the treatment of paraphilia should be continued for a longer duration since most of the patients have a chronic history. A treatment ranging from 1-5 years is recommended for patients depending upon the severity of patient's condition. The available data has pointed to the usage of psychotherapy and/or SSRI, anti-androgens and GnRH analogues in the treatment. The research data is limited and a gold standard treatment is currently unavailable. However, the efficacy of the current treatment is strongly highlighted through the meta-analysis, systemic reviews and various research papers published (Hall GCN,1995; Hill A. et al, 2003). This under-researched area still requires a lot of focus so that the social, legal, and mental adversities are reduced.

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Review Article

A Psychometric report on Yost's Attitudes toward Sadomasochism Scale

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Abstract

We collected data from three samples of participants who completed Yost's (2010) Attitudes about Sadomasochism Scale (ASMS) along with a number of other related measures with the goal of providing independent validation of the ASMS. Using a small, university sample and two larger internet samples, we provided concurrent validity by presenting moderate-to-strong correlations of the ASMS with a BDSM semantic differential attitude scale, interest in sadomasochism items, and self-assessed sadomasochism knowledge. Further, the ASMS correlated well with measures of erotophobia--erotophilia (i.e., personal comfort with sexuality). There were differences on the ASMS and its subscales based on participant sexual orientation, with sexual minorities demonstrating more favorable scores on the ASMS compared to heterosexuals. Also, those who self-reported that they were more religious were less favorable on the ASMS. There were no differences on the ASMS as a function of gender (men versus women), age cohort, regional location in the US, or environmental residence (rural, suburban, or urban). A confirmatory factor analysis supported Yost's original factor structure although deletion of a two-item subscale was recommended. In general, attitudes toward sadomaschism were slightly favorable for the entire sample. We concluded that the ASMS is a valid and reliable measure for the assessment of attitudes toward sadomasochism and recommend its use in future investigations.

Key words : ASMS, BDSM, Erotophobia, Erotophilia

Date Received: 11th November 2019
Date Accepted: 29th December 2019

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Introduction

BDSM* (sometimes referred to as SM) is a compound acronym meaning bondage, discipline, dominance, submission, and sadomasochism. BDSM is typically characterized by an interest in consensual sexual play within the areas of pain, confinement, humiliation, and power (Barker, Iantaffi, & Gupta, 2008). Recent research has shown that arousal from or interest in these behaviors is relatively common (Freeburg & McNaughton, 2017; Joyal & Carpentier, 2017; Joyal, Cossette, & Lapierre, 2015) and rapidly growing (Hillier, 2018). The popularity of BDSM in media culture has increased in recent years following a number of films and literature involving the topic (e.g., the documentary *'Kink'* by James Franco and Christina Voros in 2013, the *'Fifty Shades of Grey'* trilogy by E. L. James in 2011, and the consequent films in 2015, 2017, and 2018); however, an increase in popularity has had minimal impact in reducing stigma toward BDSM practices and participants (e.g., Bezreh, Weinberg, & Edgar, 2012) and can even increase stigma via negative portrayals (Yost, 2010). Some BDSM practitioners experience 'felt stigma' – an internalized perception and expectation of being devalued (Gray, 2002) – as a result of their sexual practices, which they may consider a component of their sexual identity (i.e., a sexual behavior preference or orientation; Kolmes, Stock, & Moser, 2006; Worthington, Savoy, Dillon, & Vernaglia, 2002).

Most research related to BDSM stigma focuses on either the felt stigma of members of the BDSM community (Bezreh, et al., 2012; Waldura, Arora, Randall, Farala, & Sprott, 2016) or pathologizing stigma from clinical and legal professionals (e.g., Dunkley & Brotto, 2018; Hillier, 2018; Wright, 2014; 2018). There is a paucity of research examining the general public's attitudes towards BDSM behavior and persons who practice BDSM. As well, consistent use of an established measure of BDSM attitudes is non-existent. Rye, Serafini, and Bramberger (2015) assessed university women's attitudes toward BDSM using a 6-item measure of BDSM beliefs written specifically for the study as no standardized measure existed at the time of data collection (i.e., 2010). Since then, the Attitudes about Sadomasochism Scale (ASMS) was published by Yost (2010). The ASMS was designed to measure participants' attitudes regarding sadomasochism (SM) through four subscales, entitled

* BDSM and SM will be used interchangeably, though the acronyms are not exact synonyms.

Socially Wrong, Violence, Lack of Tolerance and Real Life.

The Socially Wrong subscale consists of 12 items addressing respondents' moral views of SM and the belief that SM is socially objectionable. The items include a mix of belief statements about SM as a practice (e.g., 'Sadomasochism is a perversion') as well as beliefs about SM practitioners (e.g., 'Sadomasochists just don't fit into our society'). The 5-item Violence subscale assesses beliefs about SM practitioners regarding sexual /relational violence and belief in the psychopathology of SM (e.g., 'A Dominant is more likely to rape a romantic partner than the average person'). Lack of Tolerance is a 4-item, favorability-toward-SM subscale whereby items represent positive beliefs about SM and SM practitioners. It is reverse-coded so that higher scores represent more negative responses toward SM so as to be consistent with the other subscales. Finally, the Real Life subscale consists of two items addressing the everyday character of SM practitioners in non-sexual aspects of their lives (i.e., are they passive or aggressive?). These four subscales were derived from an exploratory factor analysis, were supported by a confirmatory factor analysis with a different sample, and were consistent with the literature review provided.

While Yost (2010) presents an excellent psychometric description of the development and validation of the ASMS, no other publications have described psychometric properties of this instrument. Establishing the validity of an instrument allows a field to have a standardized measure that can be used to assess across studies. Therefore, the purpose of the current paper was to present an independent psychometric evaluation of the ASMS.

Yost (2010) tested for relationships between the ASMS and some demographic variables (e.g., gender, religious fundamentalism) but we included other variables in order to extend Yost's findings. Differences in attitudes toward sexual content between men and women have often been reported in the sexuality literature (Cowan & Dunn, 1994; Dawson, Bannerman, & Lalumière, 2016; Doornwaard, Bickham, Rich, ter Bogt, & van den Eijnden, 2015; Peterson & Hyde, 2010). However, some of these gender disparities appear to be dissipating over time and men and women's attitudes toward other sexual practices (e.g., sexual permissiveness, extramarital sex) no longer differ (Peterson & Hyde, 2011). Gender and/or sex differences toward sexuality-related material, behaviors, and groups appear to be minimizing; however, research on gendered attitudes toward BDSM, which is

arguably more sexually extreme compared to '*vanilla*' sexual activity (Turley & Butt, 2015), is minimal. Comfort with sexuality was explored in relation to the ASMS, as well. Further, an individual's age (e.g., Twenge, Sherman, & Wells, 2015), religiosity (e.g., Beckwith & Morrow, 2005; Sümer, 2015), sexual orientation, and geographical location (i.e., within the United States) can potentially impact attitudes toward sexuality and sexual behaviors; therefore, differences in attitudes toward BDSM based on age, religiosity, sexual orientation, and location were also be explored.

Method

Materials

Attitudes toward Sadomasochism scale (ASMS). All participants received the ASMS developed by Yost (2010), which consists of 23 belief-based statements (e.g., 'I think sadomasochists are disgusting', 'Sadomasochism is erotic and sexy') to which participants responded on a 7-point agree-to-disagree scale. The overall alpha for the scale (N=622) was very high (α=.97).

Construct Validity

BDSM-Related Measures. Construct validity is a means of assessing whether a scale is measuring the underlying theoretical construct that it is purporting to measure. One way to establish construct validity of a scale is to correlate the instrument with other measures of the same construct or related constructs. Three instruments were used to help assess the construct validity of the ASMS: traditional BDSM semantic differential attitude assessment (Petty & Cacioppo, 1980), amenability or interest in engaging in SM, and knowledge about SM.

BDSM Semantic Differential Attitude scale. The BDSM Semantic Differential scale asked participants the following question: "My opinion of BDSM* (Bondage, Dominance, Sado-masochism) is:" rated with four pairs of bipolar adjective: unfavourable-favourable, positive-negative, good-bad, and awful-nice, with five positions in between the adjectives. Each adjective pair was coded such that a higher score (5) indicated a more positive attitude toward BDSM and then the four were averaged. The semantic differential scale demonstrated strong internal consistency (N=475; α=.95).

Interest in Sadomasochism. The Interest in SM scale consisted of five items (i.e., 'I have engaged in SM behaviors or practices'; 'I would not object to engaging in SM'; 'I would not object to a partner wanting to try SM with me'; 'I am

* These terms were defined for participants at the beginning of the study

interested in trying SM with a new partner'; and 'I am interested in trying SM with my current partner') to which participants responded on the same 7-point agree-to-disagree scale as used in the ASMS. In its aggregated, averaged form, higher scores represented greater interest. This scale demonstrated good reliability (*N*=654; α=.89).

SM Knowledge (Yost, 2010). Yost also outlined a 5-item, SM knowledge measure using the same 7-point disagree-agree scale (e.g., 'I have never heard of SM before today', 'I know with absolute certainty what SM involves') which was included at the end of the ASMS. We aggregated the items to produce a self-assessed knowledge about SM scale which demonstrated acceptable reliability (*N*=477; α=.78) where high scores represented higher self-rated SM knowledge. This score represented participant familiarity with SM which could be an indirect indicator of openness to learning about SM.

Erotophobia–Erotophilia Instruments. Erotophobia–erotophilia is defined as a dimension of personality theorized as a learned response to sexual stimuli with negative-to-positive affect and evaluation. This personality disposition is believed to determine avoidance or approach responses to sexual stimuli (Fisher, Byrne, White, & Kelley, 1988).

Sexual Opinion Survey. The Sexual Opinion Survey is the classic instrument assessing the theoretical construct of erotophobia –erotophilia. It includes 21-items pertaining to sexuality issues in relation to the self (e.g., 'Seeing an erotic movie would be sexual arousing to me'). There is substantial research supporting the validity and reliability of this instrument (Rye & Fisher, 2020; Rye, Serafini, & Bramberger, 2015). As in many past studies, the Sexual Opinion Survey demonstrated strong internal consistency with the current participants (*N*=456; α=.91).

Sexual Liberalism Scale. The Sexual Liberalism Scale (Rye, Traversa, Serafini, & Bramberger, 2020) is a 29-item instrument that assesses comfort with sexuality; it covers more current sexual constructs, such as internet sexuality and sex toy use (e.g., 'Using a webcam with someone in a sexy way is fun'), relative to the items contained in the Sexual Opinion Survey. In the current study, the Sexual Liberalism Scale had good reliability (*N*=438; α=.88). The Sexual Opinion Survey and the Sexual Liberalism Scale were assessed on the same 7-point agree-to-disagree scale used for the AMSM.

Sexual Anxiety Scale. Fallis, Gordon, and Purdon (2020) developed the 56-item Sexual Anxiety Scale (e.g., 'Telling my partner what pleases me and does not please me sexually') to measure erotophobia–erotophilia with a more clinical, functional focus. Specifically, the response scale was more affect-related, ranging from extremely discomforting-to-extremely comfortable on a 7-point scale. This instrument was highly internally consistent (n=75; α=.95).

All erotophobia–erotophilia instruments were coded and averaged such that high scores represented greater erotophilia.

Participants

There were three samples of participants; the first was a university sample who participated as part of a research participation option for Psychology course credit while the other two samples were obtained through Amazon's Mechanical Turk (MTurk) and were paid for completing the survey.

Sample 1: University Men. Male post-secondary students were solicited through an online Psychology research portal website. In total, 82 men completed the questionnaire; however, due to technical difficulties, only 62 were asked about their age and sexual orientation. On average, 92% fell within 19-29 years of age cohort and 92% identified as heterosexual.

Sample 2: MTurk Internet. Using MTurk, 196 people who lived in the United States completed a version of the questionnaire. Due to technical difficulties, no demographic information was collected (e.g., gender composition is unknown).

Sample 3: MTurk Internet. After correcting technical errors, an additional 400 US participants were solicited from MTurk. Approximately 45% identified as female (n=178) and 55% as male (n=217); three identified as non-binary/gender-queer and two provided no response. In terms of sexual orientation, 86% identified (n=343) as heterosexual while smaller numbers identified as sexual minorities: bi/pan n=35; gay/lesbian n=18, asexual n=2, and unknown n=2. Age was measured in cohort groupings: 26% were emerging adults (aged 18-29 years), 37% were 30-39 years of age, 8% were 40-49, 24% were 50-59, 4% were 60-69 years, and 1% indicated they were over 70 years of age.

Sample 3 were asked their ethnicity in free-response format. Coding was difficult as responses involved race or ethnicity or both. Most participants reported that they were White (60%), followed by participants who simply responded

that they were 'American' (19%) About 8% indicated they were Asian and about 7% indicated that they were black/African American while around 4% indicated they were Hispanic/Latino. Slightly over 1% combined identified as Native American or Pacific Islander or Middle Eastern. In terms of their location in the United States, 38% were from the south, 22.5% from the midwest, 21.5% from the west, and 18% from the northeast (based on United States Census Bureau statistical region divisions). When asked about what type of environment they lived, 50% indicated living in a suburban region, 31% in an urban area, and 19% in a rural region.

This group also provided information about how religious they were; on a 5-point ordinal scale, the majority rated themselves as not-at-all religious (53%) while few were extremely religious (5%); these were the poles of the scale. Twenty percent rated themselves as moderately religious, 9% as in between, and 13% as slightly religious.

Procedure

Participants in all samples received the ASMS, the Interest in SM scale, the Sexual Opinion Survey, and the Sexual Liberalism Scale. The University Men and MTurk Sample 3 received the BDSM semantic differential scale and Yost's SM knowledge instrument but Sample 2 did not. Only the University Men Sample 1 was presented with the Sexual Anxiety Scale. Only MTurk Sample 3 received the single item measure of religiosity. It is noteworthy that MTurk Sample 2 was not presented with the last two questions on the ASMS.*

The University Men (Sample 1) signed up for the study on a research participation website. They were given a paper version of the questionnaire and allowed to complete it in a nearby classroom or take it home, complete it, and bring it back to the research assistant at her office. Samples 2 and 3 were solicited through Amazon's MTurk, completed the questionnaire online, and were compensated in American currency. All participants received an information letter before indicating their consent to participate. At the end of the study, all participants were given debriefing materials. The materials and procedures received approval from the Institutional Research Ethics Board.

*The University Men sample preceded the MTurk Samples. The Sexual Anxiety Scale was dropped from the MTurk questionnaire because it was long, expensive, and there already were two measures assessing erotophobia—erotophilia. MTurk Sample 2 had technical difficulties such that several items and instruments were erroneously omitted.

Results

Descriptive information about the Attitudes toward Sadomasochism Scale

The ASMS could range from 1 (most negative toward SM) to 7 (most positive toward SM). Combining all samples into one large group (*N*=670), the actual scores ranged from 1 to 7 with a mean of 5.44, median of 5.86, and mode of 7.00 while the standard deviation was 1.34. On average, the participants were slightly positive toward SM. While the ASMS demonstrated no kurtosis deviating from normal (based on the kurtosis to its standard error ratio), the distribution of the ASMS was significantly non-normally skewed (again, based on the ratio of skewness to the standard error of skewness). Inspection of Figure 1 clearly demonstrates that the ASMS is skewed toward positive evaluation of sadomasochism.

Based on statistics presented by Yost (2010), we estimate that our sample was significantly more favorable on the ASMS scale than the Yost sample ($t(1151)=12.09$, $p<.0001$, Hedges' g effect size=.73). This may be a function of the different composition of our respective samples (Yost had undergraduate students only whereas our sample was predominantly obtained through MTurk) or time (our sample was obtained 5-10 years later, after increased BDSM cultural popularity).

Because the three samples came from different sources, they were tested to determine if there were differences in the total ASMS score.

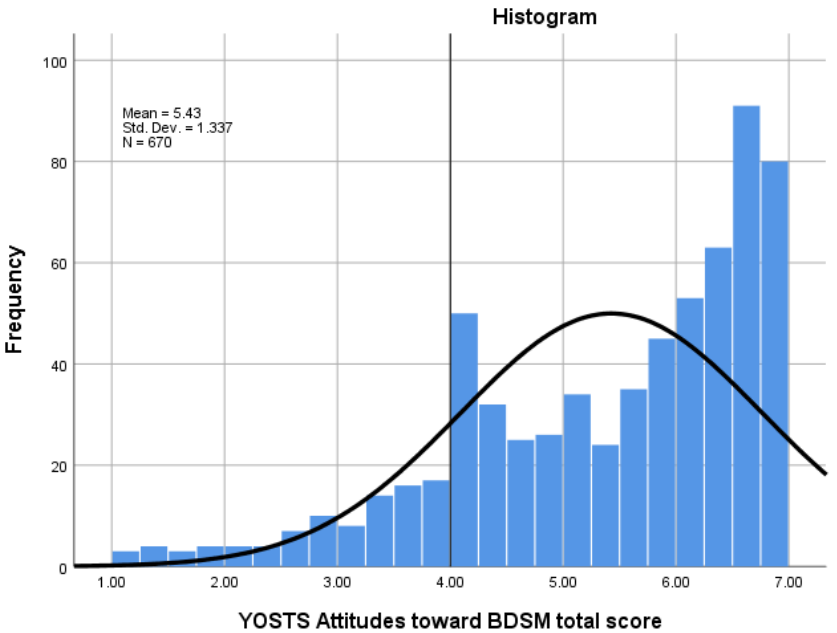

Figure 1: Histogram of AMSM Scores for all participants combined

First, the two MTurk samples were compared and found to not differ on their ASMS scores ($t(587)=-1.53$, ns). Next, university men ($n=81$; Sample 1) were compared to similarly-aged men from the MTurk ($n=61$; Sample 3). There was a significant difference (University Men mean=5.62, sd=0.97 versus MTurk same-aged men mean=5.22, sd=1.24 $t(111)=2.14$, $p<.05$, partial-eta squared=.03). While this was a significant difference, it was not a strong effect. The university men were, on average, slightly more positive in their ASMS scores relative to the MTurk sample of men of the same age (df were adjusted for unequal variance). The University men were also more homogenous in their ASMS scores (i.e., significantly lower variability). There was no significant difference when the 81 university men (mean=5.63, sd=0.97) were contrasted to all 589 MTurk participants (mean=5.40, sd=1.38; $t(130)=1.85$, $p<.07$, partial-eta squared=.00). In short, there is some weak evidence that university men, in particular, might be slightly more favorable toward SM than internet-solicited participants.

Table 1 presents the descriptive statistics associated with each sample for the ASMS and its subscales. The overall scale had very high reliability across samples. As well, most of the subscales had good reliability. Aberrantly, the Lack of Tolerance subscale had low internal consistency for the University Men sample. The Real Life subscale was comprised of two items (rs~low-.70s). It is noteworthy that the use of a 2-item scale is not recommended and is a questionable practice (Eisinga, te Grotenhuis, & Pelzer, 2013; Kamakura, 2015).

Subscale intercorrelations for each sample are presented in Table 2. These correlations indicate that most of the subscales overlap with each other strongly or moderately (rs=~.60 to .90) as well as consistently across samples. The exception was the Real Life subscale; given that there were only two items in this scale, the lower intercorrelations with other ASMS subscales was not surprising.

Demographic Group Differences in relation to the Attitudes about Sadomasochism Scale and subscales

Gender and Age differences. Sample 3 allowed for comparison between men/males and women/females. There were no differences between men/males and women/females on the overall ASMS instrument and no differences on the subscales. As well, there were no differences as a function of age cohort (all $Fs<2.00$ ns).

Sexual Orientation. In Sample 3,

Table 1. Descriptive statistics for the Attitudes about Sadomasochism Scale and subscales for three different samples

	Sample 1	Sample 2	Sample 3		
	University Men	MTurk - no demographics	MTurk Female	MTurk Male	MTurk Total
	N = 81-82	N = 172-190	n = 166-178	n = 200-217	N = 384-400
	Mean Median Mode (sd) α	Mean Median Mode (sd) α	Mean Median Mode (sd) α	Mean Median Mode (sd) α	Mean Median Mode (sd) α
TOTAL ASMS	5.63 5.78 5.70 (0.97) .94	5.53❖ 6.05 7.00 (1.42) .97	5.28 5.76 6.78 (1.51) .98	5.38 5.65 6.74 (1.22) .96	5.34 5.70 6.74 (1.36) .97
Socially Wrong (12 items)	5.80 6.04 7.00 (1.02) .90	5.58 6.12 7.00 (1.52) .96	5.38 5.92 7.00 (1.67) .97	5.53 5.83 7.00 (1.41) .96	5.47 5.92 7.00 (1.53) .96
Violence (5 items)	5.56 6.00 7.00 (1.43) .92	5.62 6.60 7.00 (1.65) .96	5.54 6.40 7.00 (1.70) .95	5.61 6.00 7.00 (1.43) .94	5.58 6.00 7.00 (1.55) .95
Lack of Tolerance (4 items)	5.39 5.50 5.25 (1.00) .68	5.19 5.50 4.00 (1.35) .84	5.02 5.25 5.75 (1.51) .88	5.09 5.25 6.25 (1.32) .80	5.07 5.25 6.25 (1.41) .84
Real Life (2 items)†	4.87 5.00 4.00 (1.41) r_s=.74	nayγ	4.55 4.00 4.00 (1.63) r_s=.76	4.45 4.00 4.00 (1.32) r_s=.63	4.50 4.00 4.00 (1.47) r_s=.70

Notes:
† A two-item scale does not necessarily produce a valid alpha; here, we present the non-parametric Spearman rho correlation between the two items (as suggest by Eisinga, te Grotenhuis, & Pelzer, 2013).
❖This is based on an average of the 21 items presented to participants as the last three items were inadvertently omitted
γThe two items were accidentally omitted from the questionnaire for these participants.

participants were asked to select a sexual orientation label. This allowed for comparison of sexual orientation on the ASMS. The four sexual minority groups (bi/pan *n*=35; gay/lesbian *n*=18, asexual *n*=2, and unknown *n*=2) were amalgamated into one group to compare to those who identified as heterosexual (*n*=343) because of the smaller numbers of participants who identified as a sexual minority. There were significant differences between heterosexual and sexual minority groups for the overall ASMS as well as for each subscale. Inspection of Table 3, which presents statistics associated with these tests, indicates that there was moderate effect size for each test – except for the Real Life subscale – such that the sexual minorities had a significantly higher score (i.e., more favourable) on the various ASMS scales.

Religion. Sample 3 MTurk participants were asked how religious they considered themselves. This religiosity was correlated with the overall ASMS and subscales; the correlations were significant such that those who were the most religious were the most negative regarding SM with the exception of the Real Life scale. While the correlations between religiousness and the ASMS were significant, they were weak – ranging around .25 to .33 (see last column, Table 4). Those who rated themselves on the more religious end of the scale were the least positive toward SM.

Living Locations. Sample 3 MTurk participants were asked in what type of developed environment they lived (urban (*n*=121), rural (*n*=72), or suburban (*n*=193)). These three groups did not differ statistically from each other on the overall ASMS or subscales (all *Fs*<0.80, ns). There were no differences in the overall ASMS and most subscales as a function of US region of residence, either (all *Fs*<4.50, ns). There was a significant difference in the Socially Wrong subscale ($F(3,386)=6.46$, $p<.05$, $\eta_p^2=.02$); post hoc analyses suggest that those living in midwestern states were less likely to judge SM as socially wrong compared to the northeastern states ($\bar{x}_{midwestern}=5.78$ vs. $\bar{x}_{northeastern}=5.16$) while those living in western or southern states did not differ significantly from either midwestern or northeastern state residents. While this was a significant difference, the partial-eta squared indicates it was an extremely weak effect and given that there were five tests, the significance could be a function of Type I error (i.e., a Bonferroni-type adjustment would require $p<.01$ for significance). This effect is thus not judged as substantive.

Table 2. Intercorrelations among the Attitudes about Sadomasochism Scale Subscales for different samples

	Socially Wrong	Violence	Lack of Tolerance	Real Life
Socially Wrong (12 items)	1	.81**** .89**** .89**** .84****	.72**** .65**** .77**** .62****	.33*** na .56**** .41****
Violence (5 items)		1	.60**** .67**** .69**** .58****	.41**** na .63**** .51****
Lack of Tolerance (4 items)			1	.33** na .43**** .12*ns*
Real Life (2 items)				1

Notes: ****p<.0001; ***p<.001; **p<.01; *p<.05
Correlations are for University Men (n=81-82), MTurk Maureen combined-gender Sample 2 (n=183-187), MTurk Women Sample 3 (n=175-178), MTurk Men Sample 3 (n=210-217)

Table 3. Sexual orientation difference test for the Attitudes about Sadomasochism Scale and subscales for an MTurk sample (Sample 3).

	Sample 3		
	MTurk Sexual Minority n = 57	MTurk Heterosexual n = 343	Test of Difference t(df) † (partial-eta squared)
	Mean (sd)	Mean (sd)	
TOTAL ASMS	6.22 (0.76)	5.20 (1.38)	(127) 8.12**** (.07)
Socially Wrong (12 items)	6.46 (0.80)	5.31 (1.57)	(142) 8.50**** (.07)
Violence (5 items)	6.43 (0.91)	5.44 (1.60)	(123) 6.70**** (.05)
Lack of Tolerance (4 items)	5.90 (1.04)	4.92 (1.42)	(96) 6.22**** (.06)
Real Life (2 items)	4.44 (1.49)	4.78 (1.92)	(127) 2.07* (.01)

Notes: ****p<.0001; *p<.05
† All tests adjusted for unequal variance. When the large variances are associated with larger group, as is the case here, the significance level will be overestimated. This can reduce the power of the test.

In sum, there were no differences on the ASMS for different ages, genders, or living locations. However, there were differences between sexual orientations such that sexual minorities were more favorable on the ASMS than heterosexual people. There was also an impact of self-rated religiosity with those who were the least religious having more positive ratings on the ASMS.

Construct Validity of the Attitudes about Sadomasochism Scale and subscales

Semantic Differential Attitudes toward BDSM. We assessed attitudes toward BDSM using a traditional semantic differential-type of measure consisting of 4 aggregated items ($\alpha_{\text{University Men Sample 1}}$=.86 and $\alpha_{\text{MTurk Sample 3}}$ =.96). The semantic differential attitude correlated moderately with the overall ASMS ($r_{\text{University Men Sample 1}}$=.36 and $r_{\text{MTurk Sample 3}}$ =.69) and with its subscales (see Table 4).

Interest in SM. Five items were included and aggregated to assess interest in SM. Across all three samples, the ASMS correlated moderately with interest in SM such that those with more favorable attitudes expressed greater interest in SM. The Socially Wrong and Lack of Tolerance subscales correlated moderately with interest in SM such that those who expressed that SM was socially wrong and those who had least tolerance for SM demonstrated the least interest in SM. For the two MTurk samples, the Violence subscale correlated moderately with SM interest but weakly for the University Men sample. The Real Life subscale was also very weakly correlated with SM interest such that those who did not think SM roles represented real life personality characteristics demonstrated greater SM interest.

Knowledge about SM. MTurk Sample 3 participants exhibited weak-to-moderate correlations between the ASMS and Yost's (2010) knowledge of SM scale – ranging from .22 to .39. This was in contrast to the University Men Sample 1 where the correlations were weak between the ASMS and SM knowledge (range: .05 to .22). This difference may be a function of greater variability of attitudes in the MTurk sample.

In sum, the ASMS demonstrates convergent validity as evidenced by moderate correlations between the entire scale and three relevant BDSM measures: overall BDSM attitudes, interest in SM, and knowledge of SM. Most ASMS subscales also correlated moderately with these three BDSM measures. The weaker relationships for university men suggest that the ASMS may not have as much ability

Table 4. Correlations of BDSM constructs and the Attitudes about Sadomasochism Scale and subscales.

	BDSM Semantic Differential opinion (4 items with 1 -5 response scale)		Interest in SM (5 items with 1-7 point response scale)			Yost (2010) SM Knowledge		Religiosity❖ (1 item with 1 - 5 response scale)
	University Men (*n*=79-80)	Sample 3 MTurk (*n*=390-400)	University Men (*n*=79-80)	Sample 2 MTurk (*n*=182-189)	Sample 3 MTurk (*n*=390-400)	University Men (*n*=81-82)	Sample 3 MTurk (*n*=390-400)	Sample 3 MTurk (*n*=390-400)
TOTAL A SMS	.36***	.69****	.50*****	.54****	.54****	.20*ns*	.39****	.31****
Socially Wrong (12 items)	.37***	.70****	.50****	.41****	.52****	.21*ns*	.38****	.33****
Violence (5 items)	.35**	.69****	.33**	.47****	.44****	.16*ns*	.34****	.25****
Lack of Tolerance (4 items)	.41****	.58****	.65****	.67****	.64****	.22*	.31****	.29****
Real Life (2 items)	.12*ns*	.33****	.19*ns*	na	.22****	.05*ns*	.22****	.07*ns*

Notes: ****p<.0001; **p<.01; *p<.05

† All tests adjusted for unequal variance. When the large variances are associated with larger group, as is the case here, the significance level will be overestimated. This can reduce the power of the test.

❖Spearman's Rho

to differentiate with samples demonstrating more highly positive attitudes (i.e., those samples with restricted range, less variability).

Erotophobia–Erotophilia. As sadomasochism falls within a sexuality-related domain, we assessed some more general measures of comfort with sexuality –erotophobia–erotophilia– as a means of assessing construct validity of the ASMS. Erotophobia–erotophilia is defined as a dimension of personality theorized as a learned disposition to respond to sexual stimuli with negative-to-positive affect and evaluation. Erotophobia–erotophilia is believed to determine avoidance or approach responses to sexual stimuli (Fisher et al., 1988). Table 5 presents correlations of the ASMS with the erotophobia–erotophilia measures.

The relationships between the ASMS and various measures of erotophobia–erotophilia present a consistent picture. In general, the overall ASMS and the various measures of erotophobia–erotophilia correlate moderately-to-strongly. The University men Sample 1 demonstrated the weakest correlations, as well. The Real Life subscale correlated weakly-to-not-at-all with the various erotophobia–erotophilia scales. Of the instruments, the Sexual Opinion Survey correlated the most strongly with the ASMS and subscales. In general, those with the most positive response to SM were more erotophilic.

Confirmatory Factor Analysis

Yost (2010) asserted that her scale consisted of four factors –Socially Wrong, Violence, Tolerance, and Real Life– based on an initial exploratory factor analysis of 34 items from 213 participants. She then completed a confirmatory factor analysis with the 23 scale items from 258 participants and concluded that the model fit the data well. We conducted a confirmatory factor analysis to assess the factor structure of Yost's ASMS with 462 participants (291 men, 166 women, 3 gender queer, and 2 of unknown genders) who provided complete data for this scale. The fit of the model was not sufficient without modifying the relationships between errors. Using modification indices, error terms were allowed to co-vary between items on different factors if the covariation made theoretical sense (Byrne, 2001; e.g., the items were designated as belonging to different factors but contained the same content such as item 7 'Sadomasochistic activity should be against the law' from the Socially Wrong factor and item 21 'Sadomasochistic activity should be legal, as long as all participants

Table 5. Correlations of sexuality-relevant constructs and the Attitudes about Sadomasochism Scale and subscales.

	Measures of Erotophobia—Erotophilia						
	Sexual Opinion Survey			Sexual Liberalism Scale			Sexual Anxiety Scale
	University Men (*n*=81-82)	Sample 2 MTurk (*n*=183-190)	Sample 3 MTurk (*n*=390-400)	University Men (*n*=95-96)	Sample 2 MTurk (*n*=183-190)	Sample 3 MTurk (*n*=390-400)	University Men (*n*=94-95)
TOTAL ASMS	.47****	.73****	.72****	.29**	.54****	.58****	.35***
Socially Wrong (12 items)	.46****	.70****	.72****	.29**	.52****	.57****	.34***
Violence (5 items)	.38****	.70****	.62****	.20*ns*	.48****	.50****	.30**
Lack of Tolerance (4 items)	.45****	.61****	.59****	.31**	.51****	.51****	.35**
Real Life (2 items)	.17*ns*	na	.34****	.11*ns*	na	.27****	.07*ns*

Notes: ****p<.0001; ***p<.01; **p<.01; *p<.05

are consenting adults' reverse coded from the Lack of Tolerance factor). In particular, we allowed eight pairs of error terms to co-vary in order to reach an acceptable model fit.* With these modifications, the model statistics were very similar to that reported by Yost (2010). The model demonstrated acceptable fit to the data: $\chi^2(216)= 951.62$, $p<.001$; incremental fit index, IFI=.93; comparative fit index, CFI=.93; and root mean square error of approximation, RMSEA=. 086 [range .080 to .092].

A factor containing two items is often considered as unacceptable (Kamakura, 2015); however, it is arguably acceptable to have a 2-item factor if the construct is narrowly defined, the two items are highly intercorrelated, and neither are correlated with other items from the scale (Yong & Pearce, 2013). The Real Life factor borders on unacceptable; while highly intercorrelated (i.e., $r=.72$; just meeting Yong & Pearce's criteria), these items are also modestly correlated with other items from the instrument (average $r=.35$). Moreover, by deleting the 2-item Real Life factor, model fit to the data was improved significantly based on a chi-square difference test ($\chi^2_{difference}=154.02$, df=41). The 3-factor model, with modification allowing 11 pairs of error terms to covary**, demonstrated acceptable fit to the data: $\chi^2(175)= 797.60$, $p<.001$, IFI=.94, CFI=.94, and RMSEA=.088 [range .072 to .094].

In short, our confirmatory factor analysis supported Yost's subscales although we recommend deleting the Real Life subscale.

Discussion

Using large internet samples as well as a small university sample, we present further evidence of the validity of the Attitudes about Sadomasochism Scale (ASMS). The current study found strong internal consistency of the overall scale as well as its subscales and the findings were consistent with much of Yost's (2010) analyses. The instrument and the subscales correlated with other measures of attitudes toward BDSM; specifically, the ASMS related to a general BDSM attitude measure, personal interest in engaging in SM, and self-assessed knowledge of or familiarity with SM (i.e., this last finding conceptually replicating Yost's knowledge analysis).

As well, several measures of erotophobia–erotophilia correlated well with the ASMS and the

*Specifically, item pairs were: 21-7, 12-10, 15-14, 13-8, 16-15, 16-8, 17-11, and 4-3. The item numbers correspond with the item content order presented by Yost (2010, p. 83).

**Specifically, the item pairs were 21-7, 12-10, 15-14, 13-8, 16-15, 16-8, 17-11, 4-3, as well as 3-17, 3-18, and 6-4 (see Yost, 2010, p. 83).

subscales. These findings are consistent with and parallel the relationships of the ASMS with sexual conservatism and attitudes toward lesbians and gay men as presented by Yost (2010). The relationship between religiosity and the ASMS in the current study also conceptually replicated Yost's finding of a moderate relationship between religious fundamentalist beliefs and the ASMS; however, our relationship was more modest – probably because of the use of a one-item measure of religiosity. Additional scale validation was provided by the modest significant difference between sexual minorities and heterosexual participants on the ASMS. Historically, the practice of BDSM was investigated in relation to queer men (e.g., Kamel, 1980; Lee, 1979; Nordling, Sandnabba, Santtila, & Alison, 2006; Weinberg, 1987). Because queer people usually engage in an identity exploration regarding sexuality (Savin-Williams, 2011), they might be more open to non-traditional sexual activities such as BDSM. Alternatively, since queer people are already stigmatized for their sexual orientation, they may be more likely to exhibit more open-minded attitudes toward sexualities considered 'deviant'. Future research would need to specifically examine the psychological roots of differences in attitudes toward BDSM between heterosexual and sexual minority participants.

The lack of differences between genders, different age groups, and geographical locations may also be interpreted as favorable findings vis-à-vis the utility of the ASMS. While some traditional measures around sexuality occasionally find women to be more sexually conservative than men (e.g., see Rye, Meaney, & Fisher, 2011 illustrating equivocal studies of gender differences/no gender differences in the Sexual Opinion Survey), it is heartening that the ASMS did not demonstrate gender differences, at least not with this large internet sample. Given the lessening of gender differences in sexual attitudes and behaviors over time (Petersen & Hyde, 2011), differences in attitudes toward BDSM would not be expected, especially from those in the US where there may be greater gender empowerment of women. Other cultures or specific subgroups, where there is less gender equity and less empowerment of women, might demonstrate gender differences in attitudes toward SM (Petersen & Hyde, 2010). Equivocally, Joyal and Carpentier (2017) found no gender differences for sadism practices or interest in sadism but did find gender differences for engaging in masochism and desire for masochism such that women had

greater prevalence of this behavior and interest in masochism compared to men. Whether these differences in specific SM practices and interests translate into attitudinal differences toward the practices and/or the practitioners is an area for future investigation.

Lack of difference in ASMS scores as a function of age cohort was consistent with Petersen and Hyde's (2010) meta-analytic finding that age of the participant was not predictive of sexual attitudes (specifically attitudes toward premarital sex, homosexuality, and gay men). Again, an instrument that is not sensitive to the age cohort is desirable. However, a more sensitive assessment of age and consequent relationship with ASMS is warranted.

In terms of living location, one might expect that people from the southern states or Midwest (i.e., 'Bible belt') in the United States would be more socially conservative and, consequently, more negative about controversial sexual topics such as BDSM (e.g., Herek, 1994; White, 2014). However, we did not find ASMS differences based on regional division. It could be that the regions, based on US-census divisions, were too broad. The analysis was also conducted with the state as the grouping variable –but low *n*s per state rendered this test suspectable– and also demonstrated no differences on the ASMS. In addition to the region, developed settlement living environments (i.e., rural, suburban, or urban residence) demonstrated no differences on the ASMS. In contrast to our finding, Herek (1994) found those living in a rural environment expressed greater sexual prejudice. The difference may be a function of timing of the study (i.e., 25 years between the two studies) or the issues could differ (i.e., attitudes toward lesbians and gay men versus attitudes toward SM).

A consideration for the findings of this study involves those who participated. People who completed the ASMS were those who elected to participate in a sexuality study; those who volunteer for sexuality studies are sometimes different from the study volunteers for non-sexual research (e.g., Bogaert, 1996). Further, internet versus telephone participants were found to have paraphilia differences in about half of the behaviors assessed with the internet sample having greater paraphilia prevalence (e.g., higher levels of masochism, although not sadism; Joyal & Carpentier, 2017). These are design factors that may have impacted the current results.

Theoretically and practically, traditional attitude assessment involves an overall evaluation of an

attitudinal object. General attitude is thought to be underpinned by a cognitive amalgamation of specific beliefs about the attitude object (Ajzen & Fishbein, 1980; Kruglanski & Stroebe, 2005; Petty & Caccioppo, 1980). As Yost's measure consists predominately of belief-based items, the ASMS is best-suited for research where the goal is to determine specific, in-depth belief-based assessment of SM evaluation (i.e., SM as violent or SM as socially wrong). The strong correlation between the ASMS and the 4-item semantic differential attitude measure support the idea that beliefs theoretically determine attitudes (Ajzen & Fishbein, 1980).

Conclusion

The findings presented in this study support the reliability, the validity, and the factor structure of the ASMS, and, consequently, we endorse the use of the ASMS in research. However, the choice of using this instrument would depend on the goals of the research. If a study's goals need specific belief components addressed (e.g., viewing people who engage in SM as sexually violent versus viewing SM as morally reprehensible) or are studying BDSM in depth, then the use of the ASMS is warranted. If a general attitude toward BDSM is all that is necessary in order to address a research aim, then a 4-item semantic differential scale would be sufficient given the relatively high correlation between the ASMS and the semantic differential assessment (and, fewer items are less taxing on survey participants). Finally, we would recommend omitting the Real Life subscale as it appears less valid and deleting it produced better model fit with the current data.

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Case Report

The Relevance of Drive and Relational Theories in the Context of Homosexuality and Masochism: A Case Study

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Abstract

This paper discusses the use of psychodynamic approaches in the treatment of paraphilias. The paper will demonstrate the use of drive and relational structure theories as to the application to a psychotherapy case with a client in his 30's who is of mixed descent both Indian and White. The paper will review how both the drive and relational structures were utilized in the case, how it has impacted the treatment, and how it has impacted the life of the client. The outcome of the case resulted in a client who was better able to understand his relational patterns and how the paraphilia was related to his history. He reports being less disturbed by the fantasies and has also changed his behaviors. The paper will provide recommendations for clinicians considering a psychodynamic approach in the treatment of paraphilias.

Key words: Homosexuality, Masochism, Paraphilia, Psychodynamics, Psychotherapy

Date Received: 08th November 2019
Date Accepted: 28th December 2019

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Introduction

According to the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) (American Psychiatric Association, 2013), a paraphilia can be defined as a *"...intense and persistent sexual interest in genital stimulation*

or preparatory fondling with phenotypically normal, physically mature, consenting human partners (p. 685)." This is differentiated from a paraphilic disorder which is a disorder defined as*"...currently causing distress or impairment to the individual...has entailed personal harm, or risk of harm, to others"* (American Psychiatric Association, 2013, p.685). Without arguing for the adequacy or appropriateness of these descriptions, we can see that the qualitative difference is not necessarily a difference of behavior itself but one of distress, impairment, or harm. This guides clinicians to differentiate between the expected variation of human sexual interest and that which is pathological.

A review of the literature will show that cognitive-behavioral therapy (CBT) and behavioral therapies, in general, dominate the available guidance for clinicians (Kaplan & Krueger, 2012; McManus, Hagreaves, Rainbow & Allison, 2013). Yet, literature shows conflicting results in efficacy regarding the utilization of CBT and behavioral therapies as a form of treatment for this population. For instance, Thoder and Cautilli (2011) and Edwards et al (2012) reported a decrease in paraphilic symptoms utilizing CBT. Meanwhile, both Kaplan and Krueger (2012) and Beech and Harkins (2012) report that the effectiveness of this treatment in the paraphilic population is extremely limited and lacks evidence. Not only are there conflicting findings, but also CBT and behavioral approaches focus mainly on symptom reduction and behavioral modification (Kaplan & Krueger, 2012). An alternative or adjunctive consideration to a cognitive-behavioral or behavioral approach would be an approach using the psychodynamic theories (Fong, 2006; Sadaat, 2014). Psychodynamic theories can help understand the etiology and maintenance of the paraphilia, along with exploring the shame, avoidance, anger, and impaired self-esteem and efficacy that are common in these individuals (Fong, 2006). Given the vast array of psychodynamic theories, it could be overwhelming for a clinician to determine how to determine which approach to utilize. According to Greenberg & Mitchell (1993), the psychodynamic landscape can be divided into two camps, drive structure, and relational structure models. Although it has been argued that this over-simplifies the

vast array of theoretical approaches (Gill, 1995), this article will work from this perspective for simplicity and to provide guidance to others looking to incorporate this into their work.

Case Conceptualization and Treatment

Identifying Data

The client entered therapy identifying as a gay, white, male. Though the client entered therapy identifying as such, his ethnic identity does vary depending on his mood state and his context. However, he has recently been considering how this identity vacillates and has been holding his Indian identity more consistently. Biologically he is half white (maternal side) and half Indian (paternal side). The client was born of a marital union and reports that both parents are alive and their marriage is intact. The client is in his latter 30's and resides on the east coast of the United States of America with his partner to whom he is married.

Developmental History

The client was raised on the west coast of the United States of America with his biological mother and father. In discussing developmental history, the client stated that developmental milestones were met within age expectations. In discussing his relationships within the family, he describes a distant relationship with his father and an enmeshed relationship with his mother. According to the client, his father was absent from home often due to being on work trips. On the other hand, the client reports that his mother was involved in most of the client's activities. Despite active involvement in his life, the client expressed that his mother encouraged his involvement in church, which endorsed homophobic ideologies that will contribute to the upcoming conceptualization of the client. Additionally, the client stated that his mother also endorsed negative attitudes toward Indian culture.

Contextual Variables

The client is currently employed as a manager in the field of customer relations. The client is a current homeowner in a major metropolitan area with his partner. According to the client, all basic needs are being met.

Cultural Factors

As previously mentioned, the client is both white and Indian, though the client discusses that he can often be white-passing. It was reported by the client that if people recognize that he is of mixed background, they do not assume that he is of Indian descent. Despite being of mixed background, the client was raised to largely deny his Indian heritage, which was encouraged by his mother. More specifically, the client states that he was 'raised white'. The client is currently married to a white male and is also in therapy with a white / native American psychologist.

Sexual History

The client reports having sex before the age of 18 years. He has been sexually active with men exclusively. Until recently, he reports having had intercourse with three men and has a history of long-term relationships. His first relationship, during college, started when he was still unsure of his sexual orientation. However, his more recent sexual history shows an increase in sex with strangers and one instance of hiring a sex worker. An additional complication was his devotion to his church and a discrepancy between the teachings of the church and his behavior. The client also states that he has a preference for 'dominant men'. Typically, these men are dominant physically but also hold power in other ways like finances.

Presenting Problem

The client originally presented to therapy for general symptoms of anxiety and depression, and difficulties in his marriage. These concerns have been part of the ongoing treatment plan. During treatment, the client presented with paraphilic fantasies, specifically with fantasies of sexual masochism. Though in the sessions the symptoms of anxiety and depression were addressed, for this journal, the client's presented problem of paraphilic fantasies will be the focus of this conceptualization.

Mental Status

The client denied episodes of depressed mood, diminished energy, loss of appetite, sleep disturbance, or suicidal ideation lasting two or more weeks. No periods of elated mood or hyperactivity lasting one week or more were reported. He denies thought broadcasting, thought

insertion, thought withdrawal, auditory distortions, and hallucinations, grandiose beliefs, persecutory beliefs, or feelings of being controlled. He had experienced more than four anxiety or panic attacks that were not situation-specific. The client had reported fear of certain social situations. He also admitted having had unwanted, repetitive thoughts. He denied having performed repetitive acts. His sleep pattern was characterized by somnambulism, waking up too early and having trouble falling back to sleep, awakening from nightmares, excessive daytime somnolence, and feeling unrefreshed by sleep.

The paraphilic fantasy is experienced by the client through frequent and disturbing masochistic fantasies that result in psychosocial difficulties. He reports that these fantasies interfere with his functioning such that he can become distracted in social and work settings. Additionally, the fantasies have been detrimental to his relationship and have negatively impacted his sex life with his partner. There was an escalation in the masochism when the client hired a professional sex worker to fulfill his masochistic desires. This moved the masochism from being primarily fantasy-based to impacting his behavior. The diagnosis of sexual masochism disorder meets the criteria for the DSM-5 (American Psychiatric Association, 2013).

The mental status was initially assessed through the completion of the Quickview Social History (Giannetti, 1983) and client report. Due to the dynamic nature of the treatment, the ongoing assessment was based on the client's report of symptoms. The client was seen for therapy once weekly for 44 sessions across 14 months.

Diagnosis

The client was diagnosed having 302.83 (F65.51) Sexual Masochism Disorder as per DSM-5 diagnostic criteria.

Drive Formulation

As previously stated, psychodynamic theories can help understand the etiology and maintenance of the paraphilia, along with exploring additional factors that may be present during the treatment of these individuals (Fong, 2006; Sadaat, 2014). Therefore, the treatment of the client involved

both the use of drive and relational approaches to therapy. With the superego acting as the moral belief system, using the drive perspective assumed that the client had an imbalance between his id and superego (Boag, 2014). On the other hand, the id is the unconscious that consists of the 'dark, inaccessible part of our personality', that is also the source of drives, impulses, and desires which serves as a starting point to understand the client's deepest desires about sexual masochism (Boag, 2014, Freud, 1933). Exploring this with the client revealed a rich internal world where he was able to live out a masochistic experience with a fantasy partner who is dominant and sadistic. The client speaks of this relationship as a place where he is controlled, dominated, and sexually submissive. However, he also speaks of tenderness in this relationship. He expressed fantasies of being 'tied up and used'; along with the desire to be told what to do. While exploring the id part of his ego structure, we also explored the superego to understand the rules that conflict with his desires. This ruleset was informed in large part by his religious upbringing, where he learned that being gay was a sin and unacceptable due to the church emphasizing the belief that sex was an act between a man and a woman. Due to this, he learned to hide his sexual orientation for many years, while living the first couple of decades of life believing and living as if being gay was bad. Additionally, his religious upbringing also impacted the client's views of masochism. Along with emphasizing that sex was an act between a man and a woman, the church also emphasized that sex was an act solely for procreation. Therefore, he viewed his masochistic behavior as immoral. Before therapy, the client was unable to find an ego compromise that would allow him to function without feeling the constant battle of the id and superego.

Drive Treatment

Through the process of therapy, the client was able to start questioning the rules in the superego and reestablishing a new set of rules that he chose for himself as opposed to those that were imposed on him. Additionally, he was able to fully explore his id impulses and desires and destigmatize them. This has allowed for a restructuring of what is an acceptable sexual

behavior. Before therapy, he would play these fantasies out in his head and eventually they became behaviors, which he later described in therapy how they would interfere with his functioning while keeping this therapeutic process a secret. Allowing himself to consider his masochistic desires as acceptable provided him the space to start exploring more sexual interests in his life in a more balanced way. The client found that in real life his paraphilic fantasies held less interest for him. This knowledge rendered the fantasies less useful and they have ameliorated across time.

Relational Formulation

Relational structure theory was also utilized in this treatment. As previously mentioned, the client presented with difficulties in his marriage, which through the therapeutic process the writer and client determined the relational structure conflict as the source of the difficulties. The relational structure conflict interfered with their sex life, created distance between him and his husband, and created a sense of isolation for the client. To repair these areas the therapist utilized a relational approach, which can be comprised of elements from several psychodynamic theories. The therapist relied primarily on object relations and interpersonal theories to inform the treatment. Object relations assisted the therapist and client to explore early relationships and how he learned to vacillate between object and person with primary male figures in his life. On the other hand, the interpersonal theory was utilized for the more pragmatic part of therapy and helped the client and therapist challenge the early object relations and develop new ways of relating.

Considering the client's object relations resulted in an understanding of his experience of men. As mentioned previously his father was fairly absent due to traveling for work, however, it should be noted that his father was emotionally unavailable as well. Related to this he internalized an anti-Indian bias from his mother; which impacted the way he saw Indian culture and ultimately how he saw his father and himself. Due to the absent father figure the client had been searching for a masculine object in his adult life. He describes the type of partner he is attracted to as

masculine, dominant, and confident, who can 'take control'. In some ways, it seems as though he was seeking some characteristics that were missing in his early life. Due to the drive conflict, spoken of earlier, he could not allow this relational structure to be realized. He would enter a relationship with the type of man that he desired but would find a way to ensure that the relationship failed. The mechanism he used was to ultimately find the flaw in the man he was dating and move from being dominated to the dominator. Utilizing traditional analytic language, he would castrate his partner. This process maintained unsatisfying relationships and led to more and more dependence on his paraphilic fantasies.

Relational Treatment

The client utilized therapy to understand this relational process, he was then able to consider that the very nature of the process would repeat itself until he considered other alternatives. The consideration of alternatives was complicated as his relationship with his husband was developed as consistently as his previous relationships. If the client were to consider an alternate way of relating, he would need to find a new way to be in his current relationship. Ultimately, he valued his relationship and determined that he wanted to find a new way to relate to his partner. This process involved his acute awareness of when he vacillated between object and person while relating to his partner. His awareness has allowed him to hold his partner as more of a person and less of an object across time. The client is continuing to work on this but has made meaningful shifts in his relationship resulting in feeling more connected with his partner. This has also resulted in less reliance on paraphilic fantasies and more engagement in reality.

Summary and Recommendations

Depending on the nature and severity of the paraphilia, psychodynamic approaches are a helpful approach to utilize or integrate into a treatment plan (Lothstein, 2019). By using psychodynamic approaches to evaluate past relationships, they help us answer the question of the etiology and maintenance of the paraphilia (Lothstein, 2019). For

instance, Lothstein (2019) states that the roots of the paraphilia can be traced back to the family, culture and the individual's experience as a child. The paraphilic behaviors are then maintained as they allow the individual to feel alive, contained and secure (Lothstein, 2019) while creating a false sense of confidence (Sadaat, 2014). Understanding the etiology and maintenance may help clinicians to understand the more pragmatic work that needs to be done. In this particular case an interpersonal approach was utilized for the pragmatic portion of treatment, yet integrating a cognitive behavioral approach at this point would have likely been effective as well and allowed for flexibility based on clinical experience and preference.

Before utilizing an approach like this there are some specific recommendations. First, clinicians would benefit from understanding how to work with psychodynamic approaches and how to differentiate between drive and relational approaches. As mentioned previously, Greenberg & Mitchell (1993) provide an in-depth look at this and may be a reasonable starting point for a clinician. Second, clinicians are advised to identify a qualified supervisor to guide them through this process. Third, assess the client to determine the appropriateness of fit for a dynamic approach. This may include assessing the client's ability to engage in insight-oriented work, client fragility, concrete versus abstract ability, etc.

Along with these recommendations, clinicians should be aware of the complexity of treating paraphilic disorders, along with the role that the clinician has on that treatment (Sadaat, 2014). Problems in treatment can occur if the clinician lacks understanding, empathy, and communication; thus clinicians working with paraphilic disorders may be well advised to explore their own biases (Sadaat, 2014). Understanding one's own biases is critical given that some behaviors can be seen as an expected variation of sexual expression or a paraphilia depending on several factors, including one's religious affiliation and cultural background (Bhugra, Popelyuk, & McMullen, 2010; McManus, Hargreaves, Rainbow & Alison, 2013). A lack of understanding bias may result in over pathologizing clients; which further emphasizes why clinicians

mustn't lack knowledge or attention to this disorder, and concurrent disorders (Sadaat, 2014). Therefore, part of this process may involve clinicians educating themselves about the broad range of sexual behaviors and understanding their reactions as they learn about these.

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Case Report

Sexual Sadism: 'The Elephant in the Room'

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Abstract

In India, the act of Sadomasochism can be dated back to the ancient times of Kamasutra where it had been intended to increase lust. Also, many acts of non-consensual sexual sadism (especially in torturing enemies) can be seen in history. The present article describes a case of sexual sadism and reviews the current diagnostic approaches of sexual sadism and its medico legal implications. The reported cases of sexual sadism indicate just a tip of the iceberg as most of the cases go unreported in a country like India, where any talk of sex or divorce are a taboo. Only, when it becomes extremely unbearable do women seek medical treatment and bring to light the torture they had been subjected to through the years. This article describes the medico legal implications so that the public can be educated and emphasises the importance of diagnosing the person and treating him/her early so that the assailant doesn't become a threat to the society.

Keywords: Sexual sadism, Paraphilia, Sexual deviance

Date Received: 27th October 2019
Date Accepted: 04th December 2019

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Introduction

The term Sexual Sadism was coined from the philosopher and writer Marquis de Sade Donatien Alphonse Francois, who was famous for his liberative sexuality, eroticism of violence and cruelty. Austrian psychiatrist Richard Freiherr Von Krafft-Ebing was the first to attempt to describe this sexual disorder in his book Psychopathia Sexualis (1886). Kraft-Ebing, defined sexual sadism as the experience of pleasure

resulting out of cruelty and punishment directed toward humans or animals, or the desire to humiliate, strike, hurt and even destroy others in order to experience sexual pleasure (Long pre et al., 2019). Hence, he initially classified sadism under the perversion 'lust murderer'.

Sexual sadism is different from sadomasochism as the word itself is formed from two words; sadism and masochism. Here, one partner will be the sadist who gets sexual arousal from inflicting pain or humiliating pain on the other while the other is the masochist who enjoys pain or humiliation (Hyde & DeLamater, 1999). But in India, a sadomasochist couple is difficult to find, as most of the marriages are arranged by families and the individuals know little about each other before their marriage.

The prevalence of sadism is largely unknown. The DSM-5 estimated the prevalence of sadism as 2 to 30 percent (APA, 2013) with higher rates among committed sexual offenders (about 10%) and those who have committed sexually-motivated homicide (37-75%) (American Psychiatric Association, 2013). This wide range of prevalence speaks to the need for new epidemiological studies both domestically and internationally. But in a country like India, where talking about sex to a third person or getting divorced from your husband is considered a taboo, extracting the exact data is always a challenge. The woman never tells on her partner unless something grievous happens. This taboo makes it difficult to know the prevalence of the perversion in our country.

Case history

A 37 year old female was presented in the emergency of JPNATC, AIIMS, New Delhi with a history of assault by husband. No one was accompanying her and she looked frightened. The patient was reluctant to reveal details to the emergency physician. All her vitals were normal and she was conscious and oriented. There was history of an object being inserted into her vagina. The emergency physician informed the duty gynaecologist for examination.

The gynaecologist noticed she was already traumatised and after gaining her trust she asked the history in detail. The patient

revealed that her husband had been drunk and while performing sex had tied both her hands together with a *'dupatta'* and started whipping her with his belt. He strangulated her with a nylon rope and inserted a *'chapathi'* rolling stick into her vagina. After the incident she had severe pain in the vaginal area. She had previously been subjected to such acts but the insertion of object was for the first time. The gynaecology resident called the forensic resident for help in the examination and documentation of the injuries.

On examination

On examination of her neck, a pressure abrasion was noted showing the pattern of a rope measuring 18 cm x 0.5 cm, horizontally placed and over the front of neck. There was a small reddish blue contusion over her right wrist measuring 3 x 0.4 cm. Diffused reddish blue contusion present over the buttocks area with showing patterned contusion of size 10 x 4 cm over the back of left thigh and another 4 x 2 cm extending from the diffused contusion to the outer aspect of back of thigh. On examination of the vagina, there was reddish contusion over the anterior and posterior wall of lower part of vagina. After the examination, the police were intimated.

Discussion

The lady was tortured by her husband for his sexual pleasure. However, she told nobody for fear of the humiliation she and her family would have to face from society, as it would have led to problems in the relationship with the husband's family and ended in separation /divorce. Furthermore, as it was related to sex, she was unable to speak to anyone in her family. All these taboos forced her to suffer to a very large extent but when things became too extreme, she asked for help. This scenario made sure that the sexual sadist did not receive any psychiatric help. Hence, this case proves that the prevalence of similar instances always go unreported because of the prevailing social factors. In the case of this lady, the husband was said to consume alcohol every night even though she was unable to identify the quantity. In some studies, significant co morbidity has been identified between sexual sadism and substance use disorders and alcoholism. In fact,

sexual sadism had the highest mean score, when different types of paraphilia had been correlated with the mean score of Michigan Alcohol Screening Test (MAST) (Allnut et al., 1996).

Marshall and Hucker developed a dimensional scale of sexual sadism which was first of its kind. The sexual sadism scale (SSS) had 35 diagnostic criterias (Marshall & Hucker, 2006) and later Mokros, Nitske and colleagues evaluated SSS for its psychometric properties and designed a new scale composed of 11 items and named it as severe sexual sadism scale (SeSaS) (Mokros et al., 2012). Cross validation of the original structure was done on a new sample. The limitation of the scale was of negative interim correlations and only the initial study has reported a maximum score of 11. The SeSaS items are dichotomous (yes/no) and coded with 1 and 0 respectively. A value of 4 or above considered indicative of sexual sadism.

Items in the Severe Sexual Sadism Scale

1. Offender is sexually aroused by sadistic acts
2. Offender exercised power /control/domination over victim
3. Offender humiliates or degrade the victim
4. Offender tortures victim or engages in acts of cruelty on the victim
5. Offender mutilates sexual parts of the victim's body
6. Offender engages in gratuitous violence wounding towards the victim
7. Offender keep records (other than trophies) or trophies (eg hair, underwear, ID)
8. Offender mutilates non sexual parts of the victim body
9. Victim is abducted or confined
10. Evidence of ritualism in the offence
11. Insertion of object into bodily orifices

In the present case, when we compare the SeSaS scale with the history of the wife, we get a score of 5 which is indicative of sexual sadism. Hence, SeSaS scale should be used as a screening in all reported cases of domestic violence and divorces, thereby helping the government provide proper treatment where required and not just imprisonment or divorce.

Medico legal implications

Two scenarios arise in each and every case. One is that of sadomasochism, where the lady is

presented to the emergency for treatment only if she gets hurt. Here, the emergency physician faces the dilemma of whether or not to make it a medico legal case and intimate the police. The other scenario is where consent is not present, and the lady is tortured and seeks treatment only when she is severely hurt. In this case, the husband typically pleads that it had been with consent, but after so many years, the wife is alleging abuse with other dubious intentions. To understand the role of consent, we can go though Spanners case which was a case of sadomasochism.

Spanners case

In the late 1970's and 1980's, a group of homosexual men in the UK documented the SM activities at their play parties (gatherings to practise sadomasochism), through photographs and videotapes. One of the videotapes came into the possession of the Greater Manchester police. Numerous identifiable men were seen engaged in sexual activities such as beatings, genital abrasions and laceration. Following this, 'Operation Spanner' was launched to search the home of the owner and his associates (White, 2006).

Around two to three hundred individuals were interviewed in the enquiry that followed. No medical attention was required by any of the men as none of them had suffered any grievous injuries nor had there been any murders. In late 1989, following the interviews, charges of assault, aiding and abetting assault and keeping a disorderly house were filed against 16 men, while a further 26 men were cautioned. The charges specifically included grievous and/or actual bodily harm on oneself and on others, aiding and abetting grievous bodily harm on oneself, conspiracy to commit assault, publishing indecent material, conspiracy to distribute indecent material, conspiracy to distribute indecent material and keeping a disorderly house (White, 2006).

In Dec 1990; during Spanner case trial Judge Rant ruled that, a defence of consent was ineligible and the events in question fell outside the exemptions to the law of assault. Thus, on the advice of their legal counsel, all 16 men plead guilty to a number of offences and were either jailed or fined. On appeal, even though the convictions were upheld, the sentences for the defendants were curtailed on grounds that they might have been

not aware that activities they performed were illegal (Robert & Ridinger, 2006).

A case was registered with the European Court of Human Rights (ECHR), Strasbowg, in March 1993, alleging that a breach of Article 8 of the European Convention on Human Rights (1950), had been committed by the UK government in the Spanner trial. Article 8 establishes a right to privacy, which was considered to extend to private expression of sexuality. The European Commissioners who reviewed the case in Dec 1995, recognised that the case was about 'mutual sexual gratification' and not violence, and hence should be sent to the ECHR. However, they opined that the UK govt was within its rights to intervene. The ECHR, in Oct 1996, reviewed the appeal, and unanimously upheld the UK judges' verdict, on Feb 19, 1997. They ruled that the government for the sake of public health, has a right to intervene in the private sexual activities of their citizens (Robert & Ridinger, 2006).

The Indian Law

In India as per IPC (Indian Penal Code) 87, consent is not valid in any act intended to be likely to cause death or grievous hurt (Indian Penal Code, 1860). This is not specifically mentioned in relation with the consent for indulging in sadomasochist activities. The Domestic violence act 2005, describes domestic violence as any act that harms or injures or endangers the health, safety, life, limb or well being, whether mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse. The act defines physical abuse as any act or conducts which is of such a nature as to cause bodily pain, harm, or danger to life, limb or health or impair the health or development of the aggrieved person and includes assault, criminal intimidation and criminal force. It also mentions that sexual abuse includes any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of women. So every woman who gets sexually tortured should know her rights and how they can report the issue while remaining immune. On registering a case under sexual sadism which can be included in the sexual abuse of the domestic

violence act 2005, she will have the right to get a protection order, residence order, compensation, free legal aid and right to file an FIR under section 498A (Protection of Women from Domestic Violence Act, 2005). Section 498 A of IPC deals with cruelty by husband or relatives of husband and punishment with imprisonment which can extend up to three years term and might be obliged to pay fine. The other sections of IPC which can be charged accordingly are 323 IPC causing simple hurt, section 324 causing hurt by dangerous weapons or means, section 325 causing grievous hurt and section 326 causing grievous hurt by dangerous weapons or means (Indian Penal Code, 1860).

Conclusion

Sexual sadism is a paraphilia where only the tip of the iceberg can be seen. The extent of the issues will be exposed, mostly, only at the time of interrogation/investigation of murder or when the tolerance of the partner comes to an end. In India, where any talk about marital sexual experiences is considered private and women tend to sacrifice or suffer extremely for fear of humiliating her family, many of these cases of sexual deviation go un-reported. The onus should be more on treating this as a condition which requires psychiatric intervention so that the assailant doesn't turn out to be a threat to the society. At the same time, the fact that this in turn is a criminal activity should also not go unknown.

Treatment typically involves psychotherapy and medications. Cognitive-behavioural therapy and cognitive restructuring can also help the person whereas medications like antidepressants sometimes in combination with antiandrogenic drugs can help in suppressing the sex drive.

Conflict of interest statement

The author reports no conflicts of interest. The author alone is responsible for the content and writing of this article.

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Debate

Decriminalize Paraphilias - Why though?

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Abstract
Paraphilias are disorders of sexual preferences. Paraphilias cause serious distress and impairment to the suffering individual. Stigma around the illness makes treatment inaccessible. Paraphilic behaviors often lead to crimes. Most of the paraphilias are as such punishable by law. Thus, the persons with paraphilia are often found in prisons and not in hospitals. Although paraphilias are considered as psychiatric illnesses, there is less emphasis on treatment and rehabilitation of individuals with these illnesses. While safety of victims is a priority, decriminalization of paraphilias is a debatable issue.

Keywords: Paraphilia, Sexual deviations, Sexual preference, Mental illness, Stigma, Decriminalization, Law

Date Received: 22nd October 2019
Date Accepted: 15th December 2019

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Introduction

Psychiatric nosology, and to some extent, our understanding of the paraphilias has seen many changes over the years. The law, however, might not have kept up with the same pace. The International Classification of Diseases in its 6th edition (World Health Organization, 1948)first addressed these behaviors as sexual deviations which at the time included homosexuality as well. Up until the 9th edition of ICD (World Health Organization, 1978), these were called sexual deviations and the definitions were vaguely focused on the act rather than the arousal pattern and distress. The term deviation is used concerning the socio-cultural norms rather than to the biological origins of disorders focused by clinicians. The ICD-10 (World Health Organization, 1992) used the term disorders of sexual preference and defined them likewise with some focus on individual distress. The ICD-10

also stated that *"Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here"* (WHO, 1992). Therefore, homosexuality was not considered a mental disorder in ICD-10. Cultural and social factors related to sexuality like social rejection and isolation, stigmatization and criminalization can impact a person's psychological experiences and behaviors which may not reflect an underlying disorder. *"Besides, social or political disapproval has at times resulted in abuse of diagnoses-especially psychiatric diagnoses-to harass, silence, or imprison persons whose behavior violates social norms or challenges existing authority structures"* (Cochran et al., 2014). The ICD -11 (WHO, International Classification of Diseases, 11th Revision, 2019) working group on classification of sexual disorders and sexual health also seems to have arrived on a similar understanding . It advocates for the removal of Fetishism, Fetishistic Transvestism, and Sadomasochism categories from paraphilic disorders (Krueger et al., 2017). The ICD-11 has made a more inclusive and clear attempt at defining these behaviors as it replaces disorders of sexual preferences with Paraphilic disorders, *"persistent and intense patterns of atypical sexual arousal, manifested by sexual thoughts, fantasies, urges, or behaviors, the focus of which involves others whose age or status renders them unwilling or unable to consent and on which the person has acted or by which he or she is markedly distressed"* (WHO, International Classification of Diseases, 11th Revision, 2019).

The most recent edition of the diagnostic and statistical manual of mental disorders describes paraphilias as *"any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners. They cause distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others"* (Edition, 2013).

Sexual masochism, sexual sadism, fetishism, and transvestism are not considered under criminal behaviors. The rest are punishable by law. However, non-consensual sexual sadism may amount to physical or sexual abuse (De Lisi et al., 2017). Sexual sadism is not specifically mentioned in ' The Protection Of Women From Domestic Violence Act, 2005' document but, if amounting to

The following disorders come under paraphilias as per DSM 5 (Edition, 2013)

Paraphilic disorder	Sexual gratification is derived from
Exhibitionism	Exposure of genitals
Fetishism	Use of non-living objects
Frotteurism	Touching and rubbing against a non -consenting person
Pedophilia	Focus on prepubescent children
Sexual Masochism	Receiving humiliation or suffering
Sexual Sadism	Inflicting humiliation or suffering
Transvestic Fetishism	Cross-dressing
Voyeurism	Observing sexual activity

Table 1: Description of various paraphilic disorders in DSM-5

physical or sexual abuse, it is considered domestic violence and is punishable by law (Protection of Women from Domestic Violence Act, 2005). Most individuals with paraphilia are diagnosed when they are exposed after they have acted upon these impulses. This is also important to understand that the law does not punish a person with disorder unless they have committed the acts per se. Likewise, criminal intent is not part of the diagnostic criteria of any of these disorders.

The psychiatrists are divided on the belief of whether it is right to criminalize these behaviors or to treat these individuals at par with individuals with similar crimes but not having the disorder. The most important defense is that at the end of the day, people with these disorders have a neurological dysfunction and need therapy more than incarceration. The criminalization of paraphilias remains debatable, as persons with these disorders indeed cause harm to unsuspecting individuals.

The exact estimates of prevalence of paraphilias are not available (Seto, Kingston, & Bourget, 2014). Evidence supports that patients with paraphilia may have more than one comorbid paraphilic disorder. Paraphilias, can be comorbid with other psychiatric disorders and in certain cases be a symptom of a primary psychiatric disorder. For example, paraphilia may present as an early manifestation of psychosis (Kar & Dixit, 2019; Lesandric, Orlovic,

Peitl, & Karlovic, 2017). Apart from psychosis, anxiety disorders, mood disorders, attention deficit hyperkinetic disorder, and substance use disorders can be associated with paraphilias (Seto et al., 2014). Thus, psychiatric comorbidities run high with paraphilias. Voyeurism, exhibitionism and sexual masochism are common forms of paraphilia among psychiatric inpatients (Marsh et al., 2010).

The status quo

Clinicians, lawyers, media, and other professionals frequently confuse paraphilia with sex offenders. This might result from a lack of understanding or disregard for the psychopathology of the paraphilias. Evidence supports the fact that paraphilias are commonly seen in convicted felons, whether they are serving a sentence or not. Along with crimes of the sexual nature, associated with a certain paraphilic specialty, persons with paraphilia also commit crimes like murder, kidnapping, and rape. This strengthens the belief that these paraphilic acts, in reality, are crimes, even though they may or may not be punishable according to law. The intent here is assumed to cause harm; punish unsuspecting victims and ultimately derive pleasure out of the act. This parallels the intent and nature behind any gruesome crime- i.e. the motive, the motive behind the crime.

According to the behaviorist theory, paraphilia starts with a process of conditioning. In which certain non-sexual objects when frequently used and if associated with a pleasurable sexual activity can become sexually arousing (Joyal, Black, & Dassylva, 2007). This, in a way, can go on to describe the fact that they are not disorders, but in reality, are perversions and should be punished. The role of repentance comes to play at the same time, as for that they must be guilty and remorseful. As these acts are committed to deriving pleasure, the feeling of guilt is subsided, as the feeling of pleasure and satisfaction overpowers the same. Thus, the offender will never feel guilty, nor repent and this cycle will continue all over again. The planning which goes into committing the act especially in cases of pedophilia is elaborate, so as to poach a victim, they try to get close to them and gain their trust, which confirms the fact this is a premeditated plan of action and should be punished. In the end, there is an unsuspecting victim harmed in most of these activities, so to be fair and just towards them, these acts have to be made punishable. Also, another theory called the victim-to-abuser cycle theory (Bagley, Wood, & Young, 1994), explains that most paraphilias have their roots in childhood experiences, and they emerge during adolescent years. Intensification of these sexual

forces is seen in adolescent years. Thus, once these childhood victims become young adults, they try to perpetrate similar acts of sexual abuse in young children, thereby starting a new cycle. Thus, the vicious cycle continues with new vulnerable children. Once they are adults, they do have the mental capacity to make correct judgments and act accordingly but act despite knowing better. This puts them in a place to be penalized for the same, even though they may have suffered the same fate in the past, but they choose to continue the same story. In all these arguments a simple fact which constantly remains is that, a victim is involved, who is innocent. A crime is being committed, so for justice to prevail, this is thus punishable, by law.

Is change needed?

People with paraphilias experience major violations of their civil and human rights. As described in the DSM-5/ICD-10 paraphilias are psychiatric illnesses. How can any disorder be punishable? The law is supposed to be objective and based on evidence than popular belief. The clinical perspective is based on science and aims to minimize these biases. The patient and not society should be our focus. In the age of evidence-based medicine, the clinical diagnoses should be free of the beliefs of the so-called experts, political leaders, and the lay public. In most of these disorders, acting out due to the underlying psychopathology remains impulsive. This happens without intent and beyond the mental capacity of the individual which is reduced due to the illness (Beech, Miner, & Thornton, 2016).

Can individuals who are carriers of HIV or Hepatitis B be considered as criminals as they cause harm to their partners? Paraphilias are classified as illnesses, as they have a biological basis to it. Multiple theories explain these, most of them having a psychological concept behind it. This results in a repetitive pattern of sexual behavior that is not mature in its application and expression. Childhood trauma experienced by certain individuals, and their inability to emerge from them may lead to sexual fantasies or unusual sexual acts which becomes a means of obtaining revenge for childhood trauma. These are in fact expressions of hostility, formed due to the regression or fixation during the initial stages of psychosexual development (Bagley et al., 1994). This reasserts the fact that paraphilias are occurring to the immaturity of sexual behavior, which has a psychological basis and is not a deliberate phenomenon, carried out to harm anyone, making it only a disorder, although complex but not invariably punishable. It is though that

deviant sexual preferences arise due to vulnerability (Ward & Siegert, 2002). Vulnerability comes out of deficits in intimacy, inappropriate emotions and cognitive distortions which are in turn linked to early life experiences, biological factors and cultural influences. At the end of the day, paraphilias lead to impaired cognitive functioning and bad decisions. Establishing the nature of paraphilias as an illness, due to cognitive impairment, negates the need for punishment for the same. As we move forward in modern times, society becomes more and more accepting and progressive. Sexual delinquencies for example homosexuality, which was considered a taboo as well as a criminal offense under the law, has been decriminalized, with the most supporting evidence of it being that it is a natural outcome and not an offense. Thus with time, it can be said that some of the paraphilic disorders especially in which no victim is directly involved, happens between consenting individuals may be considered as a normal phenomenon. The ICD-11 (WHO, International Classification of Diseases, 11th Revision, 2019) proposals support the same to some extent. The diagnostic criteria of any paraphilic disorder state that the process must cause distress to the individual, that means it is not happening completely due to the will and along with said pleasure; does trouble the individual. This raises an important point that somewhere in this situation, he may be his victim, and if he is the victim, then how can be punished. Likewise, in earlier times, committing suicide was considered a felony. It was a punishable offense, but now once the biological basis has been established, it has been decriminalized. The same evidence can be used as an adjunct to decriminalize paraphilias. Finally, even if we do punish these individuals, and lebel them as criminals, will these crimes stop? Punishment might not be the best resort we are seeking in such cases. Paraphilias may often occur in association with other psychiatric disorders or as their manifestation. In persons with mental illness, especially psychosis, judgment can be compromised, resulting in poor decision making and ultimately, committing an offense. Paraphilic patients with comorbid psychiatric illness need to be viewed in this light. This symptom (paraphilia) or manifestation can reduce, once the primary diagnosis is taken care of, again reimposing the need for treatment and not punishment.

Conclusion

As is clear from this debate, the incarceration of individuals with paraphilia leads them further away from help and is not reformative. Cognitive behavior therapy, counseling, support groups,

pharmacological management of comorbid psychiatric illness can all help such individuals and in turn, reduce the number of offenses committed by these persons. The status quo act as an agent of social control and at times confuses crimes and moral beliefs with mental disorders. We discussed the basic psycho pathology of paraphilias, nature, and basis as a disorder and as a criminal offense. We try to give a bigger picture of the said disorder. Although, this debate has been much avoided, our point of discussion remains important. The verdict may sway in, either way, this article deals with the topic in hand neutrally, not imposing any ideology or views on anyone. In totality, paraphilias and their effects are an important avenue and proper management guidelines, related to treatment as well as to its legal aspects are needed.

Disclaimer

No part of this discussion should be interpreted as supporting any sexual activity between non-consenting individuals.

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Letter to the Editor

Paraphilia is an Untouched Research Topic in Bangladesh

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Date Received: 29th August 2019
Date Accepted: 28th September 2019

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Introduction

As a term, Paraphilia was nosologically introduced in the third version of Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1987 (Beech et al., 2016). The latest version of DSM (DSM-5) defined paraphilia as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physiologically mature, consenting human partners" (American Psychiatric Association, 2013). However, there are controversies regarding the definition and classification of paraphilia (Mc Manus et al., 2013; Beech et al., 2016). It can be classified as Exhibitionism/Exhibitionistic Disorder, Frotteurism/Frotteuristic Disorder, Voyeurism/Voyeuristic Disorder, Fetishism/Fetishistic Disorder, Pedophilia/Pedophilic Disorder, Sexual Masochism/Sexual Masochism Disorder, Sexual Sadism/Sexual Sadism Disorder, Transvestic Fetishism, Not Otherwise Specified/Other Specified Paraphilic Disorder (Mc Manus et al., 2013; American Psychiatric Association, 2013). Prevalence of paraphilia has been varied because of variations in criteria over time and between cultures (Mc Manus et al., 2013). Prevalence studies have been conducted mostly in the developed countries and different studies revealed different prevalence rates (Mc Manus et al., 2013). Thus, the exact burden of paraphilia is yet to be estimated precisely across the globe.

Bangladesh is a rising economy of South-East Asia with about 160 million population yielding a high density where help seeking path for sexual disorders is obscure (Arafat & Ahmed, 2017; Ahsan et al., 2016a, Ahsan et al., 2016b). There is no specialized service center for patients with sexual disorders, resulting in increased sufferings to the patients as they visit multiple specialties (Ahsan et al., 2016b). There is dearth of studies on sexual disorders focusing the local population to create local evidences. Current article aims to review local evidences on paraphilia/paraphilic disorders in Bangladesh.

Methods

Search was conducted in PubMed, PubMed Central, Google, Google Scholar, and BanglaJOL with following searching keywords without any date range.

Searching keywords

1. Paraphilia in Bangladesh 2. Pedophilia in Bangladesh3. Prevalence of paraphilia 4. Types of paraphilia in Bangladesh 5. Paraphilic disorders in Bangladesh 6. Exhibitionism/exhibitionistic disorder in Bangladesh 7. Zoophilia/ Zoophilic disorder in Bangladesh 8. Necrophilia/ Necrophiliac disorder in Bangladesh 9. Voyeurism in Bangladesh 10. Frotteurism in Bangladesh 11. Masochism in Bangladesh 12. Sadism in Bangladesh 13. Fetishism in Bangladesh

Results

The search did not reveal any research article on paraphilia in Bangladesh, except newspaper reports.

Discussions

In Bangladesh, recently consultant centric personalized and specialized services for patients with sexual disorders have been started as few consultants of several specialties with special training on Sexual Medicine started practicing sexual medicine though the rate is sparse for the huge population. Moreover, existing myths on sex, sexuality, sexual health and sexual disorders have been playing role in seeking appropriate treatment for sexual disorders. Fortunately, in recent times some studies on sexual medicine and sexual dysfunctions have been published, some people have started to think and some physicians have started to acquire special training, expertise and practice. However, the current search revealed no article on paraphilia in Bangladesh. Personal communications with current sexual medicine practitioners revealed that occasionally they get patients with paraphilia and as per their personal opinion, pedophilia, exhibitionism and voyeurism are more in frequency than other

types. Local media reports were also found covering pedophilia (Mahmud, 2019; Dhaka Tribune, 2016). Frotteurism has been noticed inside the public transport of the city; however exact burden is yet to be measured (Brac University, 2018).

Bangladesh is a country with poor health literacy, dilapidated referral system, with abundant sexual myths and misconceptions where the main stream sexual dysfunctions are still under researched (Arafat & Ahmed, 2017; Ahsan et al., 2016a, Ahsan et al., 2016b). Thus, as expected no research on paraphilia in the country was found as expected. As a developing country, mental health, sexual health, and quality of life issues are yet to come to focus. Additionally, paraphilic behaviors are legally offensive to some extent and are considered as a punishable offense which hinders medical care seeking in many aspects in a country like Bangladesh. However, there is a strong possibility of having similar prevalence of paraphilic disorders like in other countries which brings hidden lifelong sufferings to the victims. This article is expected to draw attention of policy makers, psychiatrist, sexual medicine specialists, researchers, social scientists and other stakeholders so that the burden of paraphilia in Bangladesh could be estimated and appropriate measures could be ensured to reduce the sufferings of the patients as well as the victims.

Stakeholders such as sexual medicine practitioners, psychiatrists, psychologists, journalists, media persons, physicians, non-government organizations, and policy makers could take necessary steps to create awareness regarding sex, sexuality, sexual health, sexual disorders, sexual rights as well as to reduce the stigma in a country like Bangladesh. Possible collaboration of police and mental health professionals to address this issue can be an important step. National professional bodies such as Bangladesh Association of Psychiatrists (BAP) could take initiatives to conduct research as well as to create local evidences and formulate culture appropriate interventions. International bodies like South Asian Society for Sexual Medicine (SASSM), International Society for Sexual Medicine (ISSM) could communicate and collaborate with local bodies, local stakeholders and local researchers to address the issue.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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View Point

Zoophilia: Myths in Indian Context

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Date Accepted: 31st December 2019

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Dear Editor, IJHSC

Zoophilia is a paraphilia characterized by arousal and attainment of sexual gratification through contact with animals. It is often used synonymously with bestiality. The prevalence of zoophilia is quite underreported throughout the world due to the taboo nature of the subject and its legal implications. The prevalence of zoophilia is higher in patients suffering from psychiatric disorders. It was found in a study that the prevalence of bestiality amongst psychiatric patients was 55% which was significantly higher than that among medical inpatients (10%)(Alvarez & Freinhar, 1991). Many isolated cases have been reported, but robust research on the topic is still lacking, especially in the Indian scenario. Zoophilia is not a recent concept, it has always been a part of human history.

Sexual contact with animals has its roots in Indian mythology. Mythological tales say that all animals were born when Prajapati and the Goddess of dawn copulated while she adopted different animal forms. Since many Hindu Gods and Goddesses have animal forms, sexual contact with animals was considered as contact with the higher being in the form of an animal (Rosenberger, 1968). Many sculptures on the exterior of the famous Indian temple of Khajuraho depict man having coitus with animals such as a horse. History gives evidence of acceptance towards bestiality in Indian culture in the early times. Historical records say it was punishable by far less amount than was anal intercourse during the time of Kautilya. Animals were kept in harems for sexual indulgence (Bullough, 1976). Even tantrism portrays humans as animals and the ultimate aim of the yogic

practice is to experience sex in its totality by assuming the form of a beast.

There have been reports of public acts of bestiality in the last century. Such acts were encouraged during the festival of Holi amongst women to become closer to God. Youths often had their first sexual experience with an animal even though the reported rates of actual desire for animals are as low as 1% in the adolescent population (Nagaraja, 1983).

In many areas in South India, public ceremonies celebrating human-animal marriage which could essentially be seen as another form of zoophilia. The purpose of such a marriage is that it is believed to bring good luck in the form of rainfall to drought-stricken villages. Another instance of such a marriage between a female and a dog was reported, to ward off evil spirits from the village. Many people believe that bestiality is a cure for many sexually transmitted diseases. These myths propagate by word of mouth and undue media publicity. These myths remain unchallenged due to the taboo associated with the subject.

It is seen that sex with animals may cause more injury in the animal as it does not anticipate such advances. Also, the act of penetration can lead to significant damage to the internal organs of the animal due to its disproportionate size. Zoophilic behavior might go unreported also because the victim in this sexual encounter viz-a-viz the animal is unable to express its condition (Sendler, 2019).

Zoophilia is not only a sexual perversion but is also known to cause many health problems. Diseases transmitted from animals to humans known as zoonoses. Many of these can be transmitted via sexual contact including potentially lethal ones such as leptospirosis and rabies (Sangeeta, 2017). The practice of zoophilia also raises many questions about animal cruelty. The significant underreporting of the prevalence of zoophilia and the health risks it portrays need more attention. It is a community health concern of importance and this deviant behavior should be seen as a whole in perspective of personality and health concerns associated with it. Early identification and addressal of zoophilic tendencies are needed. Awareness needs to be spread about the health risks associated with it and psychotherapeutic interventions should be started in people who have this sexual perversion (Satapathy, Swain, Pandey, & Behera, 2016).

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Designed by : Devi Printers, Bhubaneswar