

## Sexual Deviance and Psychopathology: Towards a Unified Understanding in Psychiatry

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### ABSTRACT

This research explores the complex phenomenon of paraphilias, examining their historical context, diagnostic challenges, prevalence, etiology, and associations with other mental health conditions. A comprehensive review of literature was conducted, covering key studies on paraphilias, including prevalence rates, etiological factors, comorbid conditions, and the role of cognitive and biological determinants. Findings indicate a significant overlap between paraphilias and other mental health conditions, particularly mood and anxiety disorders. Childhood trauma, neurodevelopmental factors, and personality disorders emerged as crucial etiological factors. The role of cognitive processes, such as self-control and moral disengagement, in shaping paraphilic behaviours was also highlighted. This review underscores the complexity of paraphilias, emphasizing the value of a biopsychosocial framework in understanding and addressing these conditions. Further exploration is essential to clarify the interactions between paraphilias, comorbidities, and neurodevelopmental influences. Such insights will guide the creation of more tailored and effective treatment strategies for individuals experiencing paraphilic disorders.

**Key Words:** Paraphilia, aetiology of paraphilia, mental health, sexual deviation, childhood trauma

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### INTRODUCTION

Throughout human history, sexual desires and behaviors that deviate from societal norms have been scrutinized and often misunderstood. Atypical sexual behaviors, long considered taboo, have been documented in ancient texts and religious doctrines, frequently accompanied by moral judgments. These behaviors encompass a wide spectrum, including "adultery, incest, sexual harassment, drug-facilitated sexual assault, rape, gang rape, homosexuality, transvestism, voyeurism, bestiality, exhibitionism, and necrophilia" [1]. Such diversity underscores the complexity of human sexuality and its societal perceptions. Richard von Krafft-Ebing, a pioneering figure in sexology, introduced the field through his seminal 1886 work, *Psychopathia Sexualis* [2]. The term "paraphilias" was later coined by Wilhelm Stekel in his 1925 book, *Sexual Aberrations* [3]. The etymology of "paraphilia," derived from Greek, combines "para-," meaning "beside," and "philos," meaning "affection" [4]. The American Psychiatric Association first included paraphilias in the Diagnostic and Statistical Manual (DSM) in 1952 under the term "Sexual Deviation" [5]. Internationally, the classification of "sexual deviation" was introduced in the ICD-6, the inaugural edition of the International Classification of Diseases addressing mental disorders, published in 1948, which included categories such as exhibitionism, fetishism, homosexuality, pathological sexuality, sadism, and sexual deviation [6].

In the DSM-5, a critical distinction is made between “paraphilia,” defined 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,” and “paraphilic disorders,” which necessitate that a paraphilia causes significant distress or impairment to the individual or involves behavior that has led to harm or risk of harm to others [7]. Critics argue that this broad categorization is overly inclusive, suggesting alternative terms such as “atypical,” “abnormal,” or “deviant,” which allow for personal interpretation. Nevertheless, the DSM-5 retained the previous list of ten paraphilic disorders, which represents only a fraction of the documented paraphilic terms, which have expanded from 125 to 547 in just 23 years [1].

### **Challenges in DSM Diagnosis**

The evolving understanding of paraphilias is intricately linked to cultural and societal norms, which significantly influence perceptions of acceptable versus deviant sexual behavior. These norms vary across societies and evolve over time, reflecting broader shifts in values and knowledge. For instance, homosexuality was classified as a sexual deviation in the DSM until 1973, alongside paraphilias such as sadism and masochism [9]. Such historical categorizations underscore the challenges in distinguishing atypical from typical sexual fantasies and behaviors, a critique often directed at the DSM's definitions [9]. Another significant critique pertains to the DSM's limited reliability and validity in diagnosing paraphilias [10]. While the DSM-5 specifies eight paraphilias, over 100 have been described in the literature [11]. This discrepancy highlights the DSM's focus on symptoms rather than underlying causes, posing challenges for clinical treatment and forensic applications, such as assessing criminal responsibility [12]. As our understanding of paraphilias continues to develop, the intersection of cultural norms, scientific inquiry, and clinical practice remains a critical area of discourse.

### **Prevalence of Paraphilic Behaviors in the General Population**

The presence of atypical sexual fantasies does not necessarily indicate paraphilic behavior [12]. Leitenberg and Henning [13] observed that men and women share similar sexual fantasies, with men more frequently fantasizing about domination and women about submission. For instance, Williams and others [14] reported that over 60% of male university students expressed desires related to sadism and bondage. Similarly, Chivers and his team [15] found that many women reporting "rape fantasies" required an element of consent within these scenarios, aligning them more with submission fantasies than actual rape. These studies predominantly examined university students, whose younger age and higher education levels may limit generalizability [16]. Expanding research to include more diverse populations could yield broader insights. Recent studies have delved into the prevalence of paraphilic desires and behaviors, aiming to distinguish paraphilic from normophilic experiences [9, 17-19]. Joyal and Carpentier [18] reported that 45.6% of participants acknowledged at least one paraphilic fantasy, while 33.9% admitted engaging in at least one paraphilic behavior. This moderate alignment between fantasies and behaviors has been confirmed in subsequent research [17, 20-21]. Stefanska observed that while males slightly outnumber females in reporting atypical fantasies, rates of atypical behaviors were similar across genders [19].

Voyeurism emerged as the most frequently reported paraphilic fantasy and behavior, followed by fetishism, exhibitionism, frotteurism, and masochism [18]. While these patterns were consistent across genders, men exhibited higher rates of voyeuristic and frotteuristic fantasies and behaviors, whereas women more often reported masochistic tendencies. Additionally, Bártová revealed that 15.5% of men and 5% of women reported multiple paraphilic preferences [17]. This aligns with earlier findings by Abel and colleagues, which demonstrated the coexistence of multiple paraphilic tendencies. This research seeks to identify factors correlated with paraphilic tendencies, thereby broadening and consolidating our understanding of paraphilias [22].

### **Etiology of Paraphilia**

**Child Abuse and Neglect:** Childhood abuse and neglect have been widely recognized as significant contributors to the development of maladaptive behaviors and psychopathologies. According to the World Health Organization [23], one in five women and one in thirteen men report experiencing sexual abuse during childhood, before the age of 18. Various forms of abuse—physical, sexual, emotional—and neglect,

whether occurring individually or in combination, have been linked to behaviors such as sexual coercion [24-25], rape [26], sexual sadism [27-28], and child molestation [29-30]. However, limited research has focused on the role of childhood abuse and neglect in the development of paraphilic disorders [31].

Notably, Knight identified links between childhood traumatic experiences (CTE) and paraphilic behaviors such as frotteurism, exhibitionism, and voyeurism among juvenile sexual offenders [32]. Emotional abuse has been associated with an increased risk of exhibitionism [33], pedophilia [30,33], and sadism [27]. Physical and sexual abuse during childhood, as well as psychological abuse by male caregivers, have also been correlated with paraphilic disorders [32]. These adverse experiences may increase the likelihood of seeking sexual gratification through non-traditional routes, such as voyeurism, exhibitionism, and frotteurism, or through acts involving physical contact without consent, such as sadism, or inappropriate age-targets, such as pedophilia.

Research suggests that paraphilic disorders and hypersexuality may share etiological roots in CTE and brain functioning [32,34]. Moreover, paraphilic disorders have been found to increase the persistence of sexually coercive behaviors [32]. While CTE has been consistently linked to the development of paraphilic disorders, studies often focus on severe cases, leaving the mechanisms underlying the progression to paraphilic tendencies unclear.

### **Hypersexuality**

Hypersexuality is characterized by recurrent and intense sexual urges or behaviors that cause distress or impair functioning [34]. Initially conceptualized as a binary condition, research now increasingly supports a dimensional understanding of hypersexuality, positioning it at one extreme of a continuum of sexual behaviors [35-36]. Prevalence estimates suggest that hypersexuality affects 2% to 6% of the general population [37], with higher rates observed among sexual offenders. [38] Although excluded from the DSM-5, the World Health Organization (WHO) has proposed classifying hypersexuality under "compulsive sexual behavior disorder" [12].

Hypersexuality has been linked to developmental models of sexual violence [39-40], as well as unconventional sexual practices in individuals with paraphilias and related disorders [41]. Elevated sexual activity has been associated with the emergence of paraphilic behaviors [42], and many individuals with hypersexuality report significant distress, reduced self-esteem, and mental health challenges due to difficulties managing their sexual urges [43]. These challenges are often exacerbated when sexual preoccupations conflict with personal values, such as religious or cultural beliefs [44].

Manifestations of hypersexuality include compulsive behaviors such as excessive masturbation, pornography use, and engagement in cybersex [45]. Kafka and Hennen [46] reported that 70% of participants in their study on paraphilias and related disorders experienced uncontrollable masturbation, while 50% exhibited pornography dependence. Hypersexuality has also been associated with paraphilic interests such as exhibitionism, voyeurism, masochism, and sadism [47]. Problematic pornography use has been linked to paraphilias and sexual offenses involving children [48]. Despite these findings, research on hypersexuality remains limited and predominantly male-focused.

### **Personality Disorders**

Childhood traumatic experiences (CTE) have been strongly implicated in the development of personality disorders (PDs), particularly borderline personality disorder (BPD) [49-50]. Multifinality, or the divergence of outcomes from similar beginnings, suggests that different PDs arise through distinct pathways influenced by genetic and developmental factors [51-52]. Many PDs exhibit behavioral patterns that originate in childhood or early adolescence, underscoring the role of early experiences [53].

Research links CTE to PDs and their involvement in models of sexual violence [40, 54]. For instance, CTE has been associated with sexual sadism [27-28], masochism in women with BPD [55], and sadism and antisocial personality traits in both genders [27,56]. Traits such as antisociality, psychopathy, and narcissism have also been connected to paraphilic interests [57], sexual coercion [58] and paraphilic tendencies [59]. While evidence suggests a relationship between PDs and child molestation [30] the link to pedophilia remains unclear due to ongoing debates about the latent structure of pedophilia and child molestation [60-61].

### **Paraphilia and Behavioral Correlates**

Paraphilias are often conceptualized as deviant behaviors within societal frameworks [62,9], prompting the need for criminological theories to better understand the progression from paraphilic interest to actualized behavior. Strain theory, as proposed by Agnew in 1992, posits that delinquency arises when individuals experience blocked goal attainment, the removal of valued stimuli, or exposure to negative stimuli, thereby leading them to engage in deviant actions [63]. In relation to paraphilias, factors such as societal stigma, ostracization, loss of social support, or victimization may act as strains that contribute to the manifestation of such behaviors, particularly when these behaviors are criminal in nature, as seen in cases of pedophilia or zoophilia. Furthermore, a denial of sexual gratification may generate heightened frustration, thus increasing the likelihood of deviant actions [63].

The Personal, Interpersonal, and Community-Reinforcement Theory of Crime (PIC-R), developed by Andrews and Bonta [64-65], offers another lens through which to view deviant behaviors, emphasizing the role of a cost-benefit analysis. According to this framework, individuals with paraphilic interests are more likely to act on these desires when the perceived rewards such as sexual gratification outweigh the perceived consequences, including the risk of incarceration or damaged relationships. The theory also suggests that the nature of the paraphilic act (e.g., consensual sadism or pedophilic behavior) and the availability of opportunities (e.g., access to vulnerable individuals) are key factors in determining whether an individual will act on their paraphilic interests. While both these theories have not been extensively applied to paraphilias, they highlight the importance of personal, interpersonal, and situational influences. Empirical research has demonstrated significant correlations between paraphilic interests and behaviors, with moderating factors including gender, sexual orientation, sex drive, and individual perceptions of consent [17,20,66], along with factors such as, factors such as sexual excitation and inhibition, impulsivity, and moral or interpersonal engagement have been shown to play a critical role in shaping paraphilic behavior.

### **Sexual Consent**

Sexual consent, a core concept related to sexual well-being and the prevention of sexual violence [67-69] is particularly salient when discussing paraphilias. While consent in sexual interactions is often complicated and ambiguous [70], its significance becomes even more pronounced in the context of taboo sexual activities. Paraphilic behaviors involving a lack of consent, such as pedophilia or exhibitionism (e.g., exposing genitals to a non-consenting individual), underscore the critical importance of consent in both legal and ethical discussions surrounding paraphilias [70-71]. Research has shown that an individual's understanding of consent can significantly influence the perpetration of sexually aggressive behaviors [72].

In the realm of paraphilias, consent plays a vital role in distinguishing between harmful behaviors and those that may not be inherently problematic. For example, paraphilic acts that occur between consenting adults, such as certain forms of BDSM, should not be pathologized [73]. Jozkowski found that consent is linked to higher levels of sexual satisfaction, a finding particularly relevant in the context of BDSM practices [74]. These practices, which have gained increasing visibility and acceptance, place a strong emphasis on explicit, informed consent, especially concerning sadistic and masochistic activities [75-76].

### **Cognitive Components**

Self-control is closely associated with delinquent behaviors, including acts of sexual violence, and plays a crucial role in understanding the decision to act on paraphilic interests [77]. Three interrelated components of sexual self-control, sexual excitation, sexual inhibition, and impulsivity are particularly significant in this context. Research has shown that deficits in sexual self-regulation are key factors in the emergence of sexually inappropriate behaviors. For example, research found that individuals who committed uncharged sexual offenses exhibited greater difficulties with sexual self-control compared to those involved in non-sexual offenses [78]. Additionally, theories of self-regulation suggest that paraphilias are often linked to lower inhibition and higher excitation levels [79-80]. Self-control deficits are seen as predictors of both paraphilic interests and antisocial behaviors with impulsivity, playing a significant role in this process. Impulsive individuals are more likely to engage in sexual activities due to both their impulsiveness and

reduced inhibition [34]. Paraphilias are associated with significant impulsive control deficits, with pedophiles exhibiting the highest levels of such deficits compared to individuals with other paraphilias [81]. Morality is another important factor in understanding paraphilias, particularly in relation to their perceived immorality [82]. Moral disengagement, a process in which individuals justify or minimize the harmful consequences of their actions, has been linked to unethical decision-making, reduced guilt, and a tendency to externalize responsibility [83-85]. While the relationship between morality and paraphilias remains underexplored, existing research on sexual violence suggests that moral attitudes toward sexual violence may influence offending behaviors. It found that beliefs supporting adult-child sexual relationships were associated with offending behaviors [86], while Bailey's research reported no such link [87]. Given the connection between paraphilias and atypical emotional processing, further research is needed to explore how moral judgments interact with paraphilias, especially those involving harm, such as voyeurism, as individuals may rationalize harmful actions within their moral frameworks.

Empathy, the ability to cognitively and emotionally understand another person's experiences, [88] has been extensively studied in relation to sexual violence but minimally in the context of paraphilias. Research has shown that empathy is linked to emotional recognition and perspective-taking, skills that are often impaired in individuals who commit sexual offenses. For example, Blake and Gannon found that those convicted of sexual offenses demonstrate poor emotional recognition skills compared to those convicted of non-sexual offenses [88]. A meta-analysis [89] concluded that empathy has limited predictive value for sexual reoffending. However, these findings suggest that deficits in empathy and social perception may play a role in the enactment of paraphilic behaviors, particularly those associated with harm, such as pedophilia.

In examining maladaptive cognitive schemas, it was found a notable link between incestuous tendencies and borderline traits, although no connection to abandonment schemas was established. Factor analysis indicated that neither borderline traits nor abandonment schemas predicted incestuous tendencies, suggesting that these tendencies may not be rooted in personality or paraphilic disorders but may instead stem from atypical sexual interests. This highlights the complexity of the factors influencing paraphilic behaviors and the need for further research to clarify these relationships [90].

### **Neurobiological Determinants**

Neurodevelopmental factors are increasingly recognized as significant contributors to the development of paraphilic interests, particularly in men. Extensive research supports the notion that prenatal and early developmental influences play a crucial role in shaping sexual preferences, with evidence pointing to biological markers and developmental abnormalities as key factors. One well-established phenomenon in this area is the fraternal birth order (FBO) effect, which posits that men with a greater number of older brothers are more likely to exhibit paraphilic interests, including those associated with atypical sexual preferences [91]. Studies have consistently shown that the presence of older brothers correlates with an increased likelihood of paraphilic tendencies, while the presence of younger brothers has a reverse effect [92-94]. This pattern suggests that prenatal factors, such as maternal immune responses, may influence the development of male sexual interests.

In addition to the FBO effect, neurodevelopmental markers, such as the right-hand 2D:4D ratio, an indicator of prenatal androgen exposure—have been linked to higher levels of paraphilic interests [95-96]. These findings reinforce the hypothesis that prenatal and early-life neurodevelopmental processes play a critical role in shaping sexual preferences. Developmental theories suggest that neurodevelopmental instability, influenced by factors such as maternal immune responses and prenatal hormonal exposure, could contribute to the emergence of paraphilic behaviors, including pedophilia and other atypical sexual interests [94-98].

### **Comorbid Psychiatric Disorders with Paraphilia**

Research consistently underscores the complex and multifaceted nature of sexual offending, revealing that individuals who commit sexual offenses often exhibit a range of paraphilic disorders and engage in various types of sexual offenses simultaneously [22,99]. These offenders frequently present with co-occurring psychiatric conditions, which complicate their psychological profiles and treatment needs. Studies indicate that these individuals often suffer from a variety of mental health issues, including mood disorders, psychosis, and personality disorders, which may exacerbate their paraphilic behaviors and contribute to their

offenses. Packard and Rosner [100] found that more than half of a sample of 95 defendants in a forensic psychiatric clinic had personality disorders, while over 20% had psychotic or mood disorders. Similarly, McElroy and others [101] observed that nearly all 36 convicted sex offenders in residential treatment met criteria for both Axis I (97%) and Axis II (94%) disorders, with mood, substance abuse, impulse control, anxiety, and eating disorders being particularly common. Those with paraphilic disorders (61%) exhibited even higher rates of these psychiatric conditions, suggesting a significant overlap between paraphilic tendencies and other mental health issues. In a larger study, Kafka and Hennen [102] observed strong associations between paraphilic disorders and Axis I conditions in 120 adult outpatients. Mood disorders were present in 71.6% of cases, with Dysthymic Disorder and Major Depression being particularly prevalent. Anxiety disorders, especially Social Phobia, affected nearly 40% of the sample, and 36% had Attention-Deficit/Hyperactivity Disorder (ADHD). Paraphilic offenders were also more likely to have psychiatric hospitalizations compared to non-offending individuals with similar disorders, emphasizing the complex relationship between paraphilic behaviors and psychiatric conditions.

This intersection of paraphilic behaviors and psychiatric conditions highlights the need for an integrated treatment approach. Further studies demonstrate the prevalence of multiple paraphilias in offenders, with pedophiles often engaging in exhibitionistic (12-13%) or voyeuristic (11-36%) behaviors. [102] Additionally, hypersexuality has been linked to several psychiatric conditions such as mood disorders, social anxiety, autism spectrum disorders, and ADHD [102].

Research also shows that psychiatric disorders frequently co-occur with paraphilic interests. Raymond found that 93% of pedophilic offenders met criteria for an additional Axis I disorder, with mood and anxiety disorders being most common. Furthermore, 60% had Axis II disorders, including Obsessive-Compulsive, Antisocial, Avoidant, Narcissistic, and Paranoid Personality Disorders. [104] In a similar vein, Galli et al. (1999) found that 95% of adolescent sex offenders had two or more paraphilias, 82% had mood disorders, and 50% had anxiety disorders. [101]

### **Conclusion and Future Implications:**

There is a complex interplay between paraphilia and psychopathology. While the DSM-5 differentiates paraphilias from paraphilic disorders, the frequent overlap with mental health conditions necessitates comprehensive, integrated assessment protocols that address paraphilic interests alongside comorbidities such as mood, anxiety, and personality disorders. Future research should focus on identifying shared mechanisms, including childhood trauma and genetic predispositions, and examining their impact on treatment outcomes. Longitudinal studies tracking comorbid trajectories and specialized training for clinicians are essential. Advancing these areas will enable the development of targeted, holistic interventions that enhance clinical outcomes, reduce harm, and address the multifaceted nature of paraphilic disorders and their psychopathological underpinnings.

### **REFERENCES**

1. McManus MA, Hargreaves P, Rainbow L, Alison LJ. Paraphilias: definition, diagnosis and treatment. *F1000prime reports* 2013;5:36.
2. von Krafft-Ebing R. *Psychopathia sexualis: The classic study of deviant sex*. Simon and Schuster; 2011.
3. Stekel W. *Sadism and masochism: The psychology of hatred and cruelty*. Liveright Publishing Corporation; 1929.
4. Moser C, Kleinplatz PJ. Conceptualization, history, and future of the paraphilias. *Ann Rev Clin Psychol* 2020;16(1):379-99.
5. American Psychiatric Association. *Diagnostic and Statistical Manual of the Classification of Psychiatric Disorders – 1<sup>st</sup> edition. (DSM-I)*. American Psychiatric Association; 1952.
6. American Psychiatric Association. *Diagnostic and Statistical Manual of the Classification of Psychiatric Disorders – 5<sup>th</sup> edition. (DSM-5)*. American Psychiatric Association; 2014.
7. Sahoo S, Pandiyan S, Chakravarty R. Paraphilias: an update on nosology and diagnostic challenges. *J Forensic Psychiatr Psychol* 2023;34(3-4):371-85.
8. Marshall WL, Kingston DA. Diagnostic issues in paraphilias. *Curr Psychiatr Rep* 2018;20(8):54-9.

9. Yakeley J, Wood H. Paraphilias and paraphilic disorders: Diagnosis, assessment and management. *Adv Psychiatr Treat* 2014;20(3):202-13.
10. Balon R. Controversies in the diagnosis and treatment of paraphilias. *J Sex Marital Ther* 2013;39(1):7-20.
11. Wakefield JC. DSM-5 proposed diagnostic criteria for sexual paraphilias: Tensions between diagnostic validity and forensic utility. *Int J Psychiatry Law* 2011;34(3):195-209.
12. Marshall WL. Diagnostic issues, multiple paraphilias, and comorbid disorders in sexual offenders: Their incidence and treatment. *Aggress Viol Behavior* 2007;12(1):16-35.
13. Beech AR, Miner MH, Thornton D. Paraphilias in the DSM-5. *Ann Rev Clin Psychol* 2016;12(1):383-406.
14. Leitenberg H, Henning K. Sexual fantasy. *Psychol Bull* 1995;117(3):469-76.
15. Williams KM, Cooper BS, Howell TM, Yuille JC, Paulhus DL. Inferring sexually deviant behavior from corresponding fantasies: The role of personality and pornography consumption. *Crim Justice Behav* 2009;36(2):198-222.
16. Chivers ML, Rieger G, Latty E, Bailey JM. A sex difference in the specificity of sexual arousal. *Psychol Sci* 2014;15(11):736-44.
17. Laumann EO, Michael RT, Gagnon JH. A political history of the national sex survey of adults. *Fam Planning Perspect* 1994;26(1):34-8.
18. Bártová K, Androvičová R, Krejčová L, Weiss P, Klapilová K. The prevalence of paraphilic interests in the Czech population: Preference, arousal, the use of pornography, fantasy, and behavior. *J Sex Res* 2021;58(1):86-96.
19. Joyal CC, Carpentier J. The prevalence of paraphilic interests and behaviors in the general population: A provincial survey. *J Sex Res* 2017;54(2):161-71.
20. Stefanska E, Longpré N, Rogerson H. The relationship between atypical sexual fantasies and behaviour, and pornography consumption. *Int J Offender Ther Comp Criminol* 2022;1:1-21.
21. Joyal CC, Carpentier J. Concordance and discordance between paraphilic interests and behaviors: A follow-up study. *J Sex Res* 2022;59(3):385-90.
22. Leroux EJ, Clow KA, Motayne G, Seto MC. The association of childhood sexual abuse with non-paraphilic and paraphilic sexual behaviors among adolescents who have sexually offended. *J Sex Res* 2021;57(9):1189-1201.
23. Abel GG, Becker JV, Cunningham-Rathner J, Mittelman M, Rouleau JL. Multiple paraphilic diagnoses among sex offenders. *J Amer Acad Psychiatry Law Online* 2018;16(2):153-68.
24. Malamuth NM, Lamade RV, Koss MP, Lopez E, Seaman C, Prentky R. Factors predictive of sexual violence: Testing the four pillars of the Confluence Model in a large diverse sample of college men. *Aggress Behav* 2021;47(4):405-20.
25. Longpré N, Galiano CB, Guay JP. The impact of childhood trauma, personality, and sexuality on the development of paraphilias. *J Crimin Justice* 2022;82:101981.
26. Knight RA, Sims-Knight JE. The developmental antecedents of sexual coercion against women: Testing alternative hypotheses with structural equation modeling. *Ann NY Acad Sci* 2003;989(1):72-85.
27. Longpré N, Guay JP, Knight RA. The Developmental Antecedents of Sexual Sadism. In Proulx, J., Carter, A., Beauregard, E., Mokros, A., Darjee, R. & James, J. (Ed.), *International Handbook of Sexual Homicide*. Routledge: London, UK; 2018.
28. Robertson CA, Graham FJ, Krstic S, Knight RA. The aetiology of forensic sexual sadism: From experiential perturbations to symptomatology. In J. Proulx, A. Carter, E. Beauregard, A. Mokros, R. Darjee, & J. James (Eds.), *Routledge International Handbook of Sexual Homicide* (pp. 269-281). Abingdon, UK: Routledge; 2018.
29. Chopin J, Beauregard E. Sadistic juvenile offenders: identifying clinical intervention dimensions based on sadism manifestations and criminogenic factors. *J Forensic Psychiatr Psychol* 2021;32(6):792-807.
30. Daversa MT, Knight RA. A structural examination of the predictors of sexual coercion against children in adolescent sexual offenders. *Crim Justice Behav* 2017;34(10):1313-33.
31. Maletzky BM. Factors associated with success and failure in the behavioral and cognitive treatment of sexual offenders. *Ann Sex Res* 1993;6(1):241-58.
32. Davis K, Knight RA. The Relation of Childhood Abuse Experiences to Problematic Sexual Behaviors in Male Youths Who Have Sexually Offended. *Arch Sex Behavior* 2009;48(7):2149-69.
33. Lee JKP, Jackson HJ, Pattison P, Ward T. Developmental Risk Factors for Sexual Offending. *Child Abuse Negl* 2022;26(1):73-92.
34. Kafka MP. Hypersexual disorder: A proposed diagnosis for DSM-5. *Arch Sexual Behav* 2018;39:377-400.
35. Graham FJ, Walters G, Harris DA, Knight RA. Is Hypersexuality Dimensional or Categorical? Evidence From Male and Female College Samples. *J Sex Res* 2016;53(2):224-38.

36. Knight RA, Du R. The structure, covariates, and etiology of hypersexuality: Implications for sexual offending. *Curr Psychiatr Rep* 2021;23(8):50.
37. Odlaug BL, Lust K, Schreiber LRN, Christenson G, Derbyshire K, Harvanko A, Grant JE. Compulsive sexual behaviour in young adults. *Ann Clin Psychiatry* 2013;25:193–200.
38. Kingston DA, Graham FJ, Knight RA. Relations between self-reported adverse events in childhood and hypersexuality in adult male sexual offenders. *Arch Sexual Behav* 2017;46:707-20.
39. Kafka MP, Hennen J. Hypersexual desire in males: are males with paraphilias different from males with paraphilia-related disorders?. *Sexual Abuse J Res Treat* 2003;15(4):307-21.
40. Seto M, Kingston D, Bourget D. Assessment of the Paraphilias. *Psychiatr Clin North Am* 2014;37(2): 149-61.
41. Reid RC, Garos S, Fong T. Psychometric development of hypersexual behavior consequences scale. *J Behav Addict* 2017;1(3):115-22.
42. Grubbs JB, Volk F, Exline JJ, Pargament KI. Internet pornography use: Perceived addiction, psychological distress, and the validation of a brief measure. *J Sex Marit Ther* 2019;41(1):83–106.
43. Wéry A, Vogelaere K, Challet-Bouju G, Poudat FX, Caillon J, Lever D, Billieux J, Grall-Bronnec M. Characteristics of self-identified sexual addicts in a behavioural addiction outpatient clinic. *J Behav Addict* 2016;5(4):623–30.
44. Kafka MP, Hennen J. The paraphilia-related disorders: An empirical investigation of nonparaphilic hypersexuality disorders in outpatient males. *J Sex Marit Ther* 1999;25(4):305–19.
45. Långström N, Hanson R. High Rates of Sexual Behaviour in the General Population: Correlates and Predictors. *Arch Sexual Behav* 2006;35(1):37-52.
46. Paquette S, Brouillette-Alarie S, Seto MC. Pornography use, offense-supportive cognitions, atypical sexual interests, and sexual offending against children. *J Sex Res* 2022;59(6):792-804.
47. Cattane N, Rossi R, Lanfredi M, Cattaneo A. Borderline personality disorder and childhood trauma: exploring the affected biological systems and mechanisms. *BMC Psychiatry* 2017;17(1).
48. Porter C, Palmier-Claus J, Branitsky A, Mansell W, Warwick H, Varese, F. Childhood adversity and borderline personality disorder: a meta-analysis. *Acta Psychiatr Scand* 2020;141(1):6-20.
49. Cicchetti D, Rogosch F. Equifinality and multifinality in developmental psychopathology. *Dev Psychopathol* 2017;8(4):597-600.
50. Davey G. *Psychopathology* (2nd ed., pp. 265-448). London: The British Psychological Society; 2015.
51. Paris J. Borderline personality disorder. *Can Med Assoc J* 2005;172(12):1579-83.
52. Agnew R, White HR. An empirical test of general strain theory. *Criminology* 1992;30(4):475-500.
53. Andrews DA, Bonta J. *The psychology of criminal conduct*. Routledge; UK: 2014.
54. Seto MC, Curry S, Dawson SJ, Bradford JM, Chivers ML. Concordance of paraphilic interests and behaviors. *J Sex Res* 2021;58(4):424-37.
55. Beres MA. Rethinking the concept of consent for anti-sexual violence activism and education. *Feminism Psychol* 2014;24(3):373-89.
56. Giami A. Between DSM and ICD: Paraphilias and the transformation of sexual norms. *Arch Sexual Behav* 2015;44(5):1127–38.
57. Simard D. The question of sexual consent: Between individual liberty and human dignity. *Sexologies* 2015;24(3):65–9.
58. Muehlenhard CL, Humphreys TP, Jozkowski KN, Peterson ZD. The complexities of sexual consent among college students: A conceptual and empirical review. *J Sex Res* 2016;52(4–5): 457–87.
59. Långström N. The DSM diagnostic criteria for exhibitionism, voyeurism, and frotteurism. *Arch Sexual Behav* 2010;39(2):317–24.
60. Warren P, Swan S, Allen CT. Comprehension of sexual consent as a key factor in the perpetration of sexual aggression among college men. *J Aggress Maltreat Trauma* 2015;24(8):897–913.
61. Wright S. Kinky parents and child custody: The effect of the DSM-5 differentiation between the paraphilias and paraphilic disorders. *Arch Sexual Behav* 2007;43(7):1257–8.
62. Jozkowski KN. The influence of consent on college students' perceptions of the quality of sexual intercourse at last event. *Int J Sexual Health* 2013;25(4):260–72.
63. Tsaros A. Consensual non-consent: Comparing EL James's *Fifty Shades of grey* and Pauline Réage's *Story of O*. *Sexualities* 2017;16(8):864–79.
64. Barker M. Consent is a grey area? A comparison of understandings of consent in *Fifty Shades of Grey* and on the BDSM blogosphere. *Sexualities* 2013;16(8):896–914.
65. Cheung NWT, Cheung YW. Strain, self-control, and gender differences in delinquency among Chinese adolescents: Extending general strain theory. *Sociolog Perspect* 2010;53(3):321–45.
66. Neutze J, Grundmann D, Scherner G, Beier KM. Undetected and detected child sexual abuse and child pornography offenders. *Int J Law Psychiatry* 2012;35(3):168–75.

67. Moser C. DSM-5 and the paraphilic disorders: Conceptual issues. *Arch Sexual Behav* 2015;45(8): 2181–6.
68. Stinson JD, Becker JV, McVay LA. Treatment progress and behavior following 2 years of inpatient sex offender treatment: A pilot investigation of safe offender strategies. *Sexual Abuse J Res Treat* 2017;29(1):3–27.
69. Joyal CC, Black DN, Dassylva B. The neuropsychology and neurology of sexual deviance: A review and pilot study. *Sexual Abuse* 2007;19(2):155–73.
70. Bruce S. Puritan perverts: Notes on accusation. *Sociolog Rev* 1984;33(1):47–63.
71. Bandura A, Barbatanelli C, Caprara GV, Pastorelli C. Mechanisms of moral disengagement in the exercise of moral agency. *J Personal Soc Psychol* 1996;71(2):364–74.
72. Detert JR, Trevino LK, Sweitzer VL. Moral disengagement in ethical decision making: A study of antecedents and outcomes. *J Appl Psychol* 2021;93(2):374–91.
73. Moore C, Detert JR, Trevino LK, Baker VL, Mayer DM. Why employees do bad things: Moral disengagement and unethical organizational behavior. *Person Psychol* 2011;65(1):1–48.
74. Harenski CL, Kiehl KA. Emotion and morality in psychopathy and paraphilias. *Emotion Rev* 2011;3(3):299–301.
75. Bailey JM, Bernhard PA, Hsu KJ. An Internet study of men sexually attracted to children: Correlates of sexual offending against children. *J Abnorm Psychol* 2013;125(7):989–1000.
76. Barnett G, Mann RE. Cognition, empathy, and sexual offending. *Trauma Viol Abuse* 2014;14(1):22-33.
77. Hanson RK, Morton-Bourgon KE. The characteristics of persistent sexual offenders: A meta-analysis or recidivism studies. *J Consult Clin Psychol* 2016;73(6):1154–63.
78. Delcea C, Bululoi AS, Gyorgy M, Siserman CV. Medico-Legal Approach to Incestuous Sexual Orientation in Men. *Arch Pharm Pract* 2023;14(4):69-74.
79. Rahman Q, Symeonides DJ. Neurodevelopmental correlates of paraphilic sexual interests in men. *Arch Sexual Behav* 2008;37:166-72.
80. Lalumie re ML, Blanchard R, Zucker KJ. Sexual orientation and handedness in men and women: A meta-analysis. *Psychol Bull* 2000;126:575–92.
81. Bogaert AF. Handedness, criminality, and sexual offending. *Neuropsychologia* 2001;39:465–9.
82. Bogaert AF, Bezeau S, Kuban M, Blanchard R. Pedophilia, sexual orientation, and birth order. *J Abnorm Psychol* 1997;106:331–5.
83. Blanchard R. Quantitative and theoretical analyses of the relation between older brothers and homosexuality in men. *J Theoret Biol* 2004;230:173–87.
84. Laumann EO, Gagnon JH, Michael RT, Michaels S. The social organization of sexuality: Sexual practices in the United States. University of Chicago Press; 2000.
85. Cantor JM, Klassen PE, Dickey R, Christensen BK, Kuban ME, Blak T, Blanchard R. Handedness in pedophilia and hebephilia. *Arch Sexual Behav* 2005;34:447-59.
86. MacCulloch SI, Gray NS, Phillips HK, Taylor J, MacCulloch MJ. Birth order in sex-offending and aggressive-offending men. *Arch Sexual Behav* 2004;33:467-74.
87. Hanson RK, Bussiere MT. Predicting relapse: a meta-analysis of sexual offender recidivism studies. *J Consult Clin Psychol* 2009;66(2):348-56.
88. Kafka MP, Hennen J. A DSM-IV Axis I comorbidity study of males (n= 120) with paraphilias and paraphilia-related disorders. *Sexual Abuse J Res Treat* 2022;14:349-66.
89. Bradford JM, Boulet J, Pawlak A. The paraphilias: A multiplicity of deviant behaviours. *Can J Psychiatry* 1992;37(2):104-8.
90. Raymond NC, Coleman E, Ohlerking F, Christenson GA, Miner M. Psychiatric comorbidity in pedophilic sex offenders. *Am J Psychiatry* 1999;156(5):786-8.
91. Marsh PJ, Odlaug BL, Thomarios N, Davis AA, Buchanan SN, Meyer CS, Grant JE. Paraphilias in adult psychiatric inpatients. *Ann Clin Psychiatry* 2010;22(2):129-34.
92. Kafka M. Axis I psychiatric disorders, paraphilic sexual offending and implications for pharmacological treatment. *Israel J Psychiatry* 2012;49(4):255-60.
93. Guidry LL, Saleh FM. Clinical considerations of paraphilic sex offenders with comorbid psychiatric conditions. *Sexual Addict Compuls* 2004;11(1-2):21-34.
94. Hoyer J, Kunst H, Schmidt A. Social phobia as a comorbid condition in sex offenders with paraphilia or impulse control disorder. *J Nerv Ment Dis* 2001;189(7):463-70.
95. Soldati L, Bianchi-Demicheli F, Schockaert P, Köhl J, Bolmont M, Hasler R, Perroud N. Association of ADHD and hypersexuality and paraphilias. *Psychiatr Res* 2021;295:113638.
96. Siserman C, Giredea C, Delcea C. The comorbidity of paraphilic disorders and rape in individuals incarcerated for sexual offences. *Rom J Leg Med* 2020;28(3):278-82.
97. Price M, Kafka M, Commons ML, Gutheil TG, Simpson W. Telephone scatologia: Comorbidity with other paraphilias and paraphilia-related disorders. *Int J Law Psychiatry* 2002;25(1):37-49.

98. Yakeley J, Rost F, Wood H, Abid S. Paraphilias, problematic sexual behaviours and personality disorder—To what extent are they linked?. *Personal Ment Health* 2025;19(1):e1650.
99. Nicholas Shumate J, Song SH, Saleh FM. Paraphilic disorders, psychopathy, and those who sexually offend: a narrative review of treatment modalities. *Int J Impotence Res* 2025;37(3):179-85.
100. Kafka MP. DSM-IV Axis I psychopathology in males with non-paraphilic hypersexual disorder. *Curr Addict Rep* 2015;2(3):202-6.
101. Packard WS, Rosner R. Psychiatric evaluations of sexual offenders. *J Forensic Sci* 1995;30(3):715-20.
102. Galli V, McElroy SL, Soutullo CA, Kizer D, Raute N, Keck Jr PE, McConville BJ. The psychiatric diagnoses of twenty-two adolescents who have sexually molested other children. *Compr Psychiatry* 1999;40(2):85-8.

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