

PARAPHILIAS AMONG GAY MEN IN PUERTO RICO

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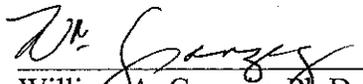
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Abstract

This study was design to gather basic descriptive data about paraphilic behaviors among gay men in Puerto Rico and the relationship of such behaviors with their mental and emotional state.

Participants ($N = 429$) were recruited by availability at gay men socializing venues and events across the entire island of Puerto Rico. As such, results cannot be generalized to the entire gay men population of Puerto Rico.

The results reflect that, the DSM-IV-TR paraphilias most reported by the participants were Voyeurism and Exhibitionism. The most reported less-common sexual fantasies, desires and/or behaviors were observing erotic pictures and partialism. Other DSM-IV-TR specific paraphilias, along with sexual fantasies, desires, and/or behaviors that could be considered under Paraphilias NOS were also reported by some participants. However, the design of the study does not allow differentiating between participants that only fantasized such paraphilias, versus those that have sexual desires and/or act out such behaviors.

Over 90% of the participants reported good self esteem and stable mental and emotional health at the time of the study. Additionally, two-thirds of the participants aver feeling good during the experience of a less common sexual fantasy, desire, and/or behavior; feeling that remains, for the most part, after such fantasies, desires, and/or behaviors have culminated. Moreover, participants tend to view these fantasies, desires, and/or behaviors as normal.

In general, participants do not seek help for these behaviors, however, those who did seek help for their less-common sexual fantasies, desires, and/or

behaviors chose gay friends as the first alternative, while psychologists were the professionals of choice, reporting self-acceptance as the main need for help.

The results suggest that gay men in Puerto Rico, who report a less-common sexual fantasy, desire, and/or behavior, enjoy stable mental and emotional health. Therefore, further studies should address specific differences between paraphilic fantasies versus behaviors and how these differences may be utilized when determining diagnostic criterion in the upcoming DSM-V.

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Vita

Edward H. Fankhanel, M.A., Ed.D, completed his Doctor in Education in Counseling Psychology at Argosy University, Sarasota, Florida, in 2004. Prior to his doctorate in education, he had completed master's degrees in criminal justice in 1983, and in counseling psychology in 1986, both at the Inter American University of Puerto Rico. In the year 1999, he obtained a Certificate of Advance Professional Competence in Forensic Psychology from the Carlos Albizu University, San Juan Campus. He also completed a Sex Offender Treatment Specialist Certification at Ohio University. His Bachelors degree in Sociology is from the University of Miami, Florida.

Dr. Fankhanel is a licensed psychologist in Puerto Rico, a licensed mental health counselor and qualified mental health supervisor in the state of Florida, and a licensed mental health counselor in the state of New York and in Puerto Rico.

Dr. Edward H. Fankhanel is a Diplomate of the American Board of Sexology, a Certified Sexologist from the American College of Sexologists, and a Certified Sex Therapist from the American Association of Sexuality Educators, Counselors, and Therapists (AASECT). He is also a certified clinical mental health counselor by the National Board of Certified Counselors, and a Certified Criminal Justice Addiction Professional from the International Certification & Reciprocity Consortium (IC&RC). Dr. Fankhanel is also a founding member of the Asociación Puertorriqueña de Educación, Consejería y Terapia Sexual (AsPECTS) [Puerto Rican Association of Sex Education, Counseling, and Therapy].

Dr. Fankhanel's professional history includes working with the Puerto Rico Health Department, Sexually Transmitted Diseases Division; The United States Courts, District of Puerto Rico, U.S. Probation and Pretrial Services Office, and as an instructor in psychology for Cambridge College, San Juan Campus, and adjunct professor for the graduate programs in Counseling Psychology at the Universidad del Turabo, Puerto Rico. He also has a limited private practice in psychology.

Dedication

To those who are committed to promote good mental health of all citizens, regardless of ethnicity, religious, political, gender or sexual orientation.

To those who have taken the Hippocrates Oath, to serve in the best interest of the patients, without the influence of groundless and unfounded paradigms.

And, to those that have the constitutional responsibility of being vigilant of the rights of all citizens, including the rights of individuals that have different sexual orientations and sexual lovemaps.

Acknowledgments

Studies that intrude in persons human sexual behavior, specifically when such behaviors depart from the moral majority, require a special people with courage and conviction to embark in a project that may have unpredictable disputes during the course of the study and possible criticism do to the outcomes.

This study was made possible by special persons that had as their North, to seek true knowledge about paraphilic behaviors among gay men in Puerto Rico, because of their conviction to transcend moral and legal paradigms in the search for truth.

Special thanks are given to those anonymous persons that contributed in all the small details of this study. Also, to those who made the technical aspects of this study run smoothly, Jose Aponte, Systems Programmer, Maria A. Cruz and Yvonne Ramirez, for the editing, and Frances Figueroa-Fankhanel, psychology student for her input, and assistance in the recruitment of participants together with Emmanuelle Marrero.

My gratitude also goes to the Dissertation Committee for their support, guidance, and most important, for their trust; also to Dr. Sean Sayers for his outstanding help in preparing the SPSS data program and analysis for this study.

Last and most important, to the gay men in Puerto Rico who took of their time to share some of their sexual intimacies for the sake of scientific knowledge for a better understanding of them as sexual beings.

List of Tables

Table 1 – Frequency of Sexual Fantasies, Desires, and/or Behaviors during
Your Life-Span.....58

Table 2 – How Participants Felt after Experiencing Less-common
Sexual Fantasies, Desires, and/or Behaviors.....61

Table 3 – Persons from which Participants Sought Help due to Emotional
or Psychological Discomforts Related to Less-Common
Sexual Fantasy, Desires, and/or Behaviors.....63

Table 4 – Persons from which Participants would Seek Help Related to a
Less-Common Sexual Fantasy, Desires, and/or Behavior.....65

Table 5 – Reported Counseling Needs of Gay Men with Less-Common
Sexual Fantasies, Desires, and/or Behaviors.....66

Table 6 – Cross Tabulation: Current Religious Practices and Perceived Self-
esteem at the Time of the Study:.....68

Table 7 – Cross Tabulation: Highest Academic Level Completed and the Way
less-Common Sexual Arousal, Desires, and/or Behaviors
are considered:69

Table of Contents

	Page
Abstract.....	iii
Copyright Page.....	v
Vita.....	vi
Dedication.....	viii
Acknowledgments.....	ix
List of Tables.....	x
CHAPTER ONE: THE PROBLEM.....	1
Introduction.....	1
Problem Background.....	5
Rationale and Purpose of the Study.....	9
Research Questions.....	10
Limitations/Delimitations.....	11
Definitions.....	12
Importance of the Study.....	13
CHAPTER TWO: REVIEW OF THE LITERATURE.....	15
Introduction.....	15
Origins of paraphilias.....	15
Medical Evolution.....	16
Legal.....	22
United States Supreme Court Decisions.....	23
Laws of Puerto Rico	25

Psychological Perspectives.....	26
Assessment of Paraphilias.....	35
Treatment of Paraphilias.....	38
Gay Studies.....	40
CHAPTER THREE: METHODOLOGY.....	42
Introduction.....	42
Research Design.....	42
Selection of Participants.....	42
Instrumentation.....	44
Assumptions.....	46
Procedure.....	47
Data Processing and Analysis.....	50
Summary.....	52
CHAPTER FOUR: FINDINGS.....	53
Restatement of the Purpose.....	53
Socio-demographic Profile of the Participants.....	53
Research Question One.....	55
Research Question Two.....	57
Research Question Three.....	62
Research Question Four.....	64
Additional Statistical Analysis.....	67
Summary.....	67

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND	
RECOMMENDATIONS.....	70
Summary.....	70
Conclusions.....	71
Socio-demographics.....	71
Less-common Sexual Behaviors.....	72
Psychological Issues.....	76
Recommendations.....	80
Selected Bibliography.....	86
Appendices.....	101
Appendix A Informed Consent & Instructions: Spanish Version.....	101
Appendix B Informed Consent & Instructions: English Version.....	104
Appendix C Questionnaire: Spanish Version.....	107
Appendix D Questionnaire: English Version.....	114
Appendix E Distribution of Questionnaire.....	122
Appendix F Geographical Distribution of Participants.....	126

CHAPTER ONE: THE PROBLEM

Introduction

Human sexuality has been the subject of extensive discussion in all forums throughout human existence, and sexual thinking and behaving has been greatly influenced by religious, as well as, philosophical and scientific factors (Westheimer & Lopater, 2005). The magnitude of the philosophical, legal, medical, religious, cultural, and moral spectrum of the history of human sexuality would be the subject of several dissertations, however, in order to have a basic notion of human sexuality that will place us in perspective with the current study; a brief synopsis of the historical outlook and changes in human sexuality is presented.

Expressions of human sexuality in all its forms “is unique among human experiences and central to life” (Choduron, 2000, p.vii). These have been documented back to the Stone Age in which female and male genitalia were illustrated in sculptures and an awareness of procreation through sexual intercourse was obtained by watching livestock (Tannahill, 1980). As civilization continued to evolve, ancient Hebrew beliefs of human sexuality originated at about 3000 B.C. These traditions preached solidarity of monogamous marriage and condemned out of marriage non-procreating sexual activity.

Greek philosopher Aristotle spoke about sexual attractions in the arts, literature and philosophy. Eros, the God that involved erotic, uninhibited expressions of sexual desires to reach passionate pleasure, was one of two mayor expressions of human sexuality. Philia, the second one, on the other hand, identified a more elevated expression of attachment suggestive of friendship. Homosexuality was an acceptable lifestyle, usually involving a relationship between an older or mature male with a younger man,

mostly in the adolescent years. The purpose of such relationship was basically for the older male to tutor or mentor the young male through the difficult transition years from boyhood to manhood (Westheimer & Lopater, 2005).

Jesus of Nazareth, who preached of marriage, is claimed by many scholars to have been celibate. As such, early Christian teachings promulgated celibacy as an elevated lifestyle in which victories over temptations of the flesh were proclaimed and marriage was condoned as the acceptable vehicle for sexual expression and procreation.

The Medieval Times, in which a separation between church and state was obscure, promoted and enforced sexual behaviors geared towards procreation. Pleasure of no kind was acceptable and the cause of legal sanctions and religious sin.

Saint Augustine, who lived from 354 to 430 AD, had a more conservative view and worked to eliminate all non-procreating sexual expressions from the followers of the church. Saint Thomas Aquinas followed St. Augustine in the 1200's AD, as the spokesman of the church, and postulated in his book, *Summa Theologica*, about all aspects of human sexuality, expressly indicating that any and all sexual expressions not leading to procreation were sinful. With no doubt, St. Paul, St. Augustine, and St. Thomas Aquinas paved the road for what has become the Roman Catholic Church doctrine on human sexuality until today (Foucault, 2002, 2003a, 2003b; Westheimer & Lopater, 2005).

In the 16th Century, Martin Luther, reacted against the celibacy doctrine of the church and preached his belief that sexual desire was not sinful and that priests should be allowed to marry. Martin Luther was followed by John Calvin who was a firm believer of the benefits of sexual expressions such as the release of daily pressures. This new sexual ideology established by both, Luther and Calvin, was the birthright by which Puritans

who came to North America created a new sexual morality (Foucault, 2002, 2003a, 2003b; Westheimer & Lopater, 2005).

The Victorian Era could be described as the “the time when a population was known for its sexual phobias and straight-laced attitudes towards sexuality...” (Westheimer & Lopater, 2005, p.37). Sexual repression had dominated almost all aspects of everyday life. Such sexual repression was accompanied with the promotion of sexual gender inequality. Women’s taking the passive role in a relationship was just one of the many influences on gender role (Foucault, 2002, 2003a, 2003b).

By 1886, writings of Kraft-Ebing (1886/1965) on sexual behaviors that were not in conformity with the moral standard had appeared in his book *Psychopathia Sexualis*. Among such behaviors, masturbation was attributed to making young men impotent and could lead to homosexuality which was targeted as pathologic. Havelock Ellis’s (1936) *Studies in the Psychology of Sex* came out in 1900. Although he also agreed that homosexuality was pathologic, he disagreed that it was caused by masturbation. Ellis further posited that men were born homosexual; however, masturbation was beneficial since it has the capacity to reduce tension.

Sigmund Freud is one of the most influential figures in modern age regarding our human sexual behavior. He introduced the psychosexual development stages of humans based on the pleasure principle and introduced the term “*libido* which refers to a primitive motivational force in personality that expresses itself sexually and aggressively” (Westheimer & Lopater, 2005, p. 41).

While Freud was developing his psychosexual theory in Vienna, Magnus Hirschfeld founded the Institute for Sex Research in Berlin. A known homosexual, he

dedicated his life to study homosexuality and published over 200 articles, many of them presenting a non-pathological view towards homosexuality (Hirschfeld, 1948).

By 1948, the first sociological study of male human sexual behavior had been published in the United States (Kinsey, Pomeroy, & Martin, 1948). This was followed by a second study, *Sexual Behavior in the Human Female* (Kinsey, Pomeroy, Martin, & Gebhard, 1953). Kinsey's studies brought mainstream America to its feet with his findings which clearly evidenced a difference among the sexual discourse of the time which deviated somewhat to what was actually happening behind close doors.

William Masters and Virginia Johnson, followed Kinsey, this time in a medical study that brought light to the physiological response of human sexuality (Masters & Johnson, 1966), followed by their second book, *Human Sexual Inadequacy* (Masters & Johnson, 1970). Their work became the foundation of sexual therapy today.

As observed, a more profound look at the discussion of human sexuality did not commence until the last few hundred years of human existence, basically through religious doctrines that dictated the norm of most, if not all, aspects of human sexuality.

Outside the interest of learning about heterosexual human sexual relations for procreation purposes, it was not until the early years of the Twentieth century that a more scientific discourse of human sexuality commenced. Sigmund Freud could have well started the scientific study of sex when establishing the psychosexual theory of human development. His postulates generated a wave of research in all domains of human sexuality such as psychological, social, medical, religious, to mention a few.

In the area of *abnormal* or unaccepted sexual behavior, Krafft-Ebing (1886/1965) had published *Psychopathia Sexualis*, discussing sexual pathology, while Wilhelm Stekel

(1930/1971) introduced the term paraphilia into the psychiatric medical literature in 1925. In 1952, the American Psychiatric Association published its first Diagnostic and Statistical Manual (DSM-I) in which sexual deviation (from the norm) was classified a mental disorder. This classification has been revised in the DSM-II (APA, 1968), DSM-III (APA, 1980), DSM-III-R (APA, 1987), DSM-IV (APA, 1994), DSM-IV-TR (APA, 2000), and it is currently under revision for the DSM-V.

Along with the constant revisions of what is considered abnormal, deviant, perverse, atypical, or paraphilic sexual behaviors, societies have created sanctions to control such behavior as well. History dictates that normalcy in sexual behavior is contingent to the time and place in which it is being discussed. Religion, science and social views all influence what, where, how, when, and with whom can sexual relationships or expressions take place with or without sanctions of some sort, therefore, making human sexuality a dynamic behavior in need of constant study.

Problem Background

History has shown that human sexual behaviors have been the subject of constant scrutiny and normalcy of such behavior has been dictated according to social control norms established by a specific society in a specific time. As such, normophilic sexual behaviors, as well as paraphilic sexual behaviors, have proven to be far from static and rather dynamic throughout history.

Some specific sexual behaviors have been the target of such scrutiny through history, sometimes condoned and other times sanctioned, depending on the moral majority rule. Mostly, when condemnation has been the rule of the time, religious

influence on morality, and not scientific data, has been the source to reach such standards of disapproval (Foucault, 2000, 2003a, & 2003b).

In general, sexual behavior that distances from procreation as a final objective has been the target of repression and condemnation by society, specifically in societies where religion has had the greatest influence in controlling, or trying to control, sexual behaviors. Societies in general have “attempted to control the sexual behavior of their members [in such ways that]... Historically, and cross culturally, even an accusation of interest in specific sexual practices could result in death, imprisonment, loss of civil rights, and other social sanctions” (Moser & Kleinplatz, 2005, p.91).

In recent history, sexual pathology was first introduced by Kraft-Ebing (1886/1965) in his book *Psychopathia Sexualis*. Unfortunately, the population of his study was limited to prisoners with mental health conditions and excluded women, thus, creating bias in his findings. Sigmund Freud follow suit in the early 1900’s with his psychosexual development theory, which attributed deviant sexuality to inadequate psychological development.

Recent developments in what may be considered sexual science, have been slowly gaining terrain to change laws and other types of interventions of social sexual control. Taking homosexuality as the classic example, it is observed that having it been once classified as pathological sexual behavior by the leading body of mental health experts in the United States, The American Psychiatric Association, it was subsequently declassified as a mental disorder in 1974 and taken off the DSM-III (APA, 1980). Subsequently, in 1992 the World Health Organization (WHO) removed it from its list of mental disorders and, in June 26, 2003, that the United States Supreme Court, in

Lawrence v. Texas 539 U.S. 558 (2003), reversed and remanded a decision and dictated that two adults engaging in private consensual acts was *not* illegal. These are clear examples that normalcy in sexual behavior is governed by social, religious, moral, political, economic, and scientific influences of a specific time and place.

Today, some sexual behaviors continue to be considered pathological by the medical society and illegal by the social majority. These behaviors must be carefully studied to enhance our scientific knowledge so that we may continue to better differentiate among unequivocal pathological behavior that may fall within the *mala in se* category of the criminal justice system, versus the *mala prohibita* category which is subject of time and place interpretations, far from any scientific base.

Human behavior, sexual behavior specifically, continues to be controlled by major social organizations (i.e. Government, medical profession, and religion) without any empirically based data to sustain their determinations that such behaviors are *mala in se*. The culprit of these determinations is that they have inevitably created some sort of psychological dissonance among those who engage in such behaviors. One day going to bed as a person with a mental disorder in need of psychiatric treatment, and getting up the next morning as a person who no longer is considered mentally ill (homosexuals in 1972). More so, individuals convicted for engaging in sexual behaviors considered criminal, overnight see themselves having served long prison terms for what now is a sanctioned sexual behavior.

Examples of some countries that have enforceable laws against homosexual sex between consenting adults are: Afghanistan, Barbados, Ethiopia, Fiji Islands, India, Iran, Jamaica, Morocco, Nicaragua, Syria, Saudi Arabia, and Uganda (International Gay and

Human Rights Commission, n.d.). In other countries, like United States of America, including Puerto Rico; such as in Europe, Mexico, Australia, and many South American countries, homosexual sex among consenting adults is not criminalized, however, still considered immoral in many of them. Additionally, some countries that have same sex marriage laws are: Belgium, Canada, Netherlands, Spain, and South Africa; while civil unions are legal in countries like: Denmark, New Zealand, Sweden, and United Kingdom. Other countries may have laws regarding cohabitant recognition or limited partnership benefits (International Survey of Legal Recognition of Same Sex Couples, n.d.).

Despite the medical and legal controls of sexual behaviors, little is known about current trends among the general population in regards to atypical sexual behaviors. The limited information about the prevalence appears to be obtained by the medical community through their DSM subcommittees. Studies about the prevalence of these sexual behaviors among gay men are also lacking.

Even though paraphilias are prevalent in society and the psychiatric community has been active in classifying paraphilic behaviors, paraphilias have not been well studied (Coleman, Raymond, & McBean, 2003) and treatment modalities do not appear to be of general interest among the mental health professionals and the absence of research in such direction is limited. Hence, a need to study paraphilic behaviors among gay and heterosexual people is understandable.

In the past four decades, perhaps since Stonewall (n.d.), where the homosexual rights movement is recognized to have commenced in 1969, some gay men have taken a firm and public stand in the fight for their legal rights. Therefore, reaching out to this population would allow us to gather current information about atypical sexual behaviors

among them and what are their current feelings towards such behaviors. This will provide mental health clinicians with data that will assist them in providing better treatment services if and when requested.

Additionally, scientifically recognized paraphilic behaviors are reported by the medical community, and are limited to a total of eight with a ninth classification that intends to include those behaviors not specifically identified (APA, 2000). However, some 52 paraphilic behaviors were recognized by Money (1988). With the advent of the technological age, a more acceptable attitude toward gay lifestyle, and the change in attitudes towards sex, we must revisit the general population as a whole to acquire current information as to what sexual behaviors are prevalent and which, if any, are truly causing personal, interpersonal or social discomfort, requirements that are needed for a pathological classification according to the psychiatric professionals (APA, 2000).

To date, non-clinical studies have failed to demonstrate that individuals engaging in paraphilic behaviors are different, otherwise, from those who engage in normophilic sexual behaviors (Brown et al., 1996; Wise, Fagan, Schmidt, Ponticas, & Costa, 1991).

Rationale and Purpose of the Study

The basic rationale behind this study is that there have not been any studies done in Puerto Rico that target acquiring specific information about paraphilic sexual behaviors in general, least in the gay population.

This study gathered basic descriptive information that may provide us with a better understanding of gay men in Puerto Rico, specifically, their paraphilic sexual behaviors. This information may allow mental health professionals to better understand

and prepare themselves in the clinical area to provide adequate services to this population.

Information about the existence of sexual arousal and behaviors of a paraphilic nature, as well as, psychological comfort or discomfort towards them, was obtained in this study which does not seek to enquire moralistic, medical, or legal views of these behaviors. The rationale to gather such information from the gay community in Puerto Rico, comes from Kinsey's (1948 & 1952) findings, which were geared from a behavioral interest only and not for medical, moralistic or legality issues.

By acquiring this information, psychologists, psychiatrists, mental health counselors, clinical social workers, sex therapists and other mental health professionals will be able to benefit from proper training as to the clinical diagnosis, management and treatment of such behaviors, if such were the case. A need to redefine normophilic and paraphilic behaviors in this new century is of utmost importance if the mental health profession is to properly and ethically serve heterosexual and homosexual people as to their sexual desires and behaviors.

Research Questions

This study sought information pertaining to the following basic descriptive areas of concern:

1. What paraphilic behaviors are present, if any, among gay men in Puerto Rico?
2. Do such behaviors evoke any psychological discomfort?
3. If psychological discomfort is evoked by such behaviors, are these men seeking mental health counseling or treatment? If not, why not?

4. Which professionals would gay men prefer to receive help related to less-common sexual fantasies, desires, and/or behaviors from?

Limitations/Delimitations

Limitations

This is a descriptive study that used a self-answered questionnaire which was handed out to gay men. It did not seek to collect and analyze data from a moralistic or legal perspective. This study was limited to collecting data regarding basic socio-demographic information of gay men in Puerto Rico, as well as basic information regarding their atypical sexual behaviors and possible psychological discomforts due to the same. Specific limitations included:

1. The sample of the study was limited to gay men in Puerto Rico.
2. The value of the information relied only on what these men reported in the questionnaire with no way to confirm the veracity of it.
3. The sample population was obtained by availability of subjects. Questionnaires were made available at gay bars and clubs, through gay organizations, gay pride parades, and snow-ball effect.
4. The questionnaire did not provide participants the opportunity to specifically differentiate if they had experienced and were reporting either: fantasies, desires, and/or behaviors that are less-common.

Delimitations

The following delimitations have been identified but are not all-inclusive:

1. The value of the data obtained was dependent on the honesty of the respondents, which cannot be measured in this study.

2. The study was limited to gay men that in some way participate or attend social activities where the questionnaires were made available. Therefore, gay men who do not engage in socializing activities with other gay men are not represented in this study, and results cannot be generalized to the entire gay population in Puerto Rico.

Definitions

1. Atypical = departing from the norm, abnormal, anomalous, deviant, unusual or unconventional.
2. Atypical sexual behavior = Sexual behavior not consistent or typical of the behavior of the majority.
3. Less-common sexual fantasies, desires, and/or behaviors = a term utilized by this investigator to refer to sexual fantasies, desires, and/or behaviors that deviate from the norm of society, specifically, for this study, a term less stigmatized than that of paraphilia or related sexual behaviors.
4. Lovemaps = “A personalized, developmental representation or template in the mind and in the brain that depicts the idealized lover and the idealized program of sexueroetic activity with that lover as projected in imagery and ideation, or actually engaged in with that lover” (Money, 1988, p. 127).
5. Normophilic = Sexual behavior that is socially approved (Money, 1988).
6. Paraphilia = (in Greek 'para' παρά = over and 'philia' φιλία = friendship) is a mental health term recently used to indicate sexual arousal in response to sexual objects or situations that are not part of societal normative arousal/activity patterns, or which may interfere with the capacity for reciprocal affectionate sexual activity (Wipi, n.d.).

Importance of the Study

The major goal of this study was to acquire basic information regarding the atypical sexual behaviors of gay men in Puerto Rico and their perceptions as to psychological discomforts due to the same.

The information obtained is intended to provide a better understanding of paraphilic gay men in Puerto Rico, specifically, what atypical sexual behaviors they engage in and if such behaviors influence their emotional and psychological well-being. Additionally, the information compiled addresses the mental health services these men may need to help them cope should emotional and psychological discomfort be evident.

Having basic information as to what atypical sexual practices these gay men have and how they are affected may allow mental health providers to seek proper intervention tools with which to better address the needs of this population.

The long-term effects of the study are that it may help the mental health community rethink as to the normophilic versus paraphilic behaviors and the need for specialized treatment services. The information could also be useful for the recently created DSM-V Task Force of the American Psychiatric Association (APA), that will revise the Sexual and Gender Identity Disorders section of the current DSM-IV-TR. APA has recently stood firm that inclusions and exclusions of behaviors in the DSM should be the subject of scrutiny with evidence based data to support them (APA, 2000). This study, although descriptive, may provide basic data in the areas of paraphilias among gay men in Puerto Rico.

In summary, the data gathered in this study will provide a better understanding of paraphilic behaviors of gay men living in Puerto Rico. It will allow mental health

professionals to better understand paraphilic sexual behaviors among gay men in Puerto Rico and become acquainted with the need, if any, of services to treat them.

The data of this study could also be used by professional schools of psychology, clinical social work, professional counselors, medicine and sex therapy to develop professional competencies to attend this population with ethically correct assessment tools and adequate treatment alternatives.

Lastly, the information of this study will serve as a data base from which other professionals can further investigate this area of concern.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The scientific study of paraphilias is reasonably new. The nature of the behavior itself has not called many researchers to engage in such endeavors. As such, scientific data in the area of atypical sexual behaviors is scarce or non-existent, depending on the specific areas of the diversity of behaviors. In this chapter, information of paraphilic behaviors will be presented from a medical, legal and psychological perspective. These are the areas that address the nature and focus of this study. As was the center of the investigations conducted by Kinsey (1948 & 1952), in the past, this study focuses on behaviors and psychological discomforts of atypical sexual behaviors and does not enter the realm of moralistic or illegal aspects of such behaviors. Therefore, information as to the evolution of the studies of paraphilias in the Modern Age covering the medical, legal and psychological domains will be presented, followed by general studies of assessment and treatment of paraphilias and general gay paraphilic studies.

Origins of Paraphilias

The categorization of some sexual behaviors as pathological predates the American Psychiatric Association (APA, 1952) inclusion of such behaviors as mental disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM). In the beginning of time, and for many centuries, these were considered sinful acts. By the 19th century a change to reclassify them as sexual pathology evolved in society (Bullough & Bullough, 1977). The influence of social, political, religious and historical factors has been evident in the tendency to see some sexual behaviors as pathological (Bullough, 1988; Davis, 1996). This is evidenced by the statement of the American Psychiatric

Association indicating that cultural values are a perplexing influence to the objectivity of the DSM (APA, 2000), thus, in the classification of paraphilias.

The term paraphilia was coined, in 1925, by Wilhelm Stekel (1930/1971), a psychiatrist from Vienna, from the Greek word *para* –beside, aside, beyond, and *philia* – loving, love. Thus defining paraphilia as above or beyond what *others* think of love. It was Benjamin Karpman who introduced the term to the English speakers (Malin & Saleh, 2007). However, such term was not widespread nor used by the psychiatric community in the United States until the DSM came out in 1952 where they were classified as sexual deviations and finally as paraphilias in the DSM-III (APA, 1980). Subsequently, this term was used by psychologist John Money (1984, 1988, and 1989) in his extensive studies of paraphilias.

Prior to the term paraphilia, Sigmund Freud (1905/2000) used the term sexual perversions, when referring to or describing atypical sexual behaviors. Religiously oriented individuals may refer to them as sinful or demonological behaviors, while the criminal justice system proscribes them.

Medical Evolution

“The concept that unconventional sexual interests are mental illnesses or crimes (religious or societal) predates both DSM (Diagnostic and Statistical Manuals of Mental Disorders) and modern psychiatry” (Moser & Kleinplatz, 2005, p. 94).

Kraft-Ebing (1886/1965), an Austro-German psychiatrist and sexologist wrote *Psychopathia Sexualis: A Medico Forensic Study*, better known as the “Psychopathy of Sex,” in which he discussed several case studies of sexual perversity. He included the term paraesthesia to define sexual desires that departed from the wrong objective, that of

procreation. Specifically, he posited that in paraesthesia “there is a perverse coloring of the sexual ideas. Ideas physiologically and psychologically accompanied by feelings of disgust give rise to pleasurable sexual feelings; and the abnormal association finds expression in passionate, uncontrollable emotion” (p.86). As such the results are perverse acts.

Kraft-Ebing (1886/1965) proposed that any and all expressions of sexual instinct that are not aligned with the purpose of procreation should be regarded as perverse. He distinguished between perversion and perversity, specifically, perversions refer to sexual instinct that is caused by disease and perversity referring to vice. Therefore, perversions are psychopathological while perversity may be “induced by conditions other than psychopathological” (p. 86).

According to Kraft-Ebing (1886/1965), paraesthesia could occur in combination with hyperesthesia, abnormal increase of sexual desire, that “arise frequent and violent impulses for sexual gratification” (p. 78). The categorization of these sexual instincts and behaviors are based on moral codes and common law which are also “(established in the interests of the community) of modesty and morality, and that man should, under all circumstances, control this instinct as soon as it comes in conflict with the altruistic demands of society” (p.78).

The American Psychiatric Association published the first Diagnostic and Statistical Manual of Mental Disorders (APA, 1952) which included the term *Sexual Deviation*, as a sub-classification of Personality Disorders, specifically, under

Sociopathic Personality Disturbances. The definition stated:

000-x63 Sexual deviation

This diagnosis is reserved for deviant sexuality which is not *symptomatic of more extensive syndromes*, such as schizophrenic and obsessional reactions.

Definition of Terms

The term includes more of the cases formerly classed as “Psychopathic personality with pathological sexuality.” The diagnosis will specify the type of the pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation). (DSM-I, 1952, pp.38-39)

This was the American Psychiatric Association’s first attempt to classify sexual perversions according to medical standards at the time. However, by 1968, a revision of their affirmations as to what constituted pathological sexual behavior was presented in the DSM-II (APA, 1968). In this version, a more elaborated presentation of the sexual deviations was presented. Basically, dictating that the category of sexual deviations was reserved for “...individuals whose sexual interests are directed primarily towards objects other than people of the opposite sex, towards sexual acts not usually associated with coitus, or towards coitus performed under bizarre circumstances...”(p.44) such as sadism, pedophilia and necrophilia. An exclusion to this classification being if, “normal sexual objects are not available to them” (p.44).

The DSM-III (APA, 1980), created a multi-axial evaluation format of mental disorders. Another significant transformation made in the DSM-III was that it changed from a theoretically based manual, specifically on the psychoanalytical model of illness,

and commenced utilizing an evidence-based data approach in its description of disorders. With this, object observation and empirical research was intended to be the source of conditions to be included in the DSM. These changes brought about a change in the term “Sexual deviation” which was replaced with “paraphilia” that was considered an atheoretical non-pejorative descriptor (Moser, & Kleinplatz, 2005). In this new revision of the DSM, the term “psychosexual disorders” was introduced and such disorders were removed from the personality disorders classification and placed under clinical syndromes (Axis I).

The DSM-III divided psychosexual disorders into four main groups: Gender Identity Disorders which were attributed to incongruence between anatomic sex and gender identity; Paraphilias, which referred to as “unusual or bizarre imagery or acts...of non human objects for sexual arousal...involving real or simulated suffering or humiliation...sexual activity with nonconsenting partners...” (APA, 1980, p.206). Among the specific paraphilias mentioned were: Fetishism, Transvestism, Zoophilia, Pedophilia, Exhibitionism, Voyeurism, Sexual Masochism, Sexual Sadism, and Atypical Paraphilia. The last two main groups included Psychosexual Dysfunctions and Other Psychosexual Disorders in which Ego-dystonic homosexuality was placed.

The ego-dystonic homosexuality classification’s diagnostic feature required “a desire to acquire or increase heterosexual arousal, so that heterosexual relationships can be initiated...” (APA, 1980, p.280). Thus, only homosexuals that are not comfortable with their sexual orientation remained in the DSM, while dismissing of psychopathology those who are ego-systonic with such sexual orientation. Even though this classification

was published in the DSM-III in 1980, it was in 1972 that the American Psychiatric Association had recanted its position of homosexuality as pathologic.

The DSM-III-R (APA, 1987), maintained the paraphilias of the DSM-III. However, it withdrew ego-dystonic homosexuality. Three clear essential features remained for a diagnosis of paraphilic behaviors: “recurrent or intense sexual urges and sexually arousing fantasies generally involving either (a) nonhuman objects, (b) the suffering or humiliation of oneself or one’s sexual partner (not merely simulated), or (c) children or other nonconsenting adults” (p. 279).

By 1994, the DSM-IV was published (APA, 1994) indicating that “The utility and credibility of the DSM-IV required that it...be supported by an extensive empirical foundation” (p. xxiii). However, a revision of the literature conducted by Moser & Kleinplatz (2005) revealed objective data that would support the declassification of the paraphilias.

In the DSM-IV, sexual and gender identity disorders remained within Axis I. Paraphilias included: exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism, and paraphilias not otherwise specified. In this last category several examples are mentioned such as scatologia (obscene phone calls), partialism (exclusive focus on parts of body), klismaphilia (enemas), coprophilia (feces), and urophilia (urine). A text revision of the DSM-IV (DSM-IV-TR) was released (APA, 2000) leaving the paraphilias practically unchanged.

Important in the DSM is that intensive sexually arousing fantasies, sexual urges, or behaviors must be present for at least six months so that paraphilic disorders are

diagnosed. Additionally, such sexual fantasies, urges or behaviors must “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B)” (APA, 2000, p. 566). Different from the DSM-IV, the text revision substituted, in the “B” criterion “marked distress” for “Clinically significant distress” together with a change from “interpersonal difficulty” for “impairment in social, occupational, or other important areas of functioning.” However, according to Moser & Kleinplatz (2005), no rationale for these changes was provided.

Moser & Kleinplatz (2005) cite the DSM-IV-TR, as indicating that “many individuals with these disorders assert that the behaviors cause them no distress and that their only problem is social dysfunction as a result of the reaction of others to their behavior” (p.567), therefore, they question why such behaviors are then classified as mental disorders.

The DSM-IV-TR is currently under revision and the DSM-V is expected to be out by the year 2012. A committee to re-evaluate paraphilic behaviors has been established and some scholars have made their voices heard of the need to remove paraphilias from the DSM (Moser & Kleinplatz, 2005). Until then, the DSM-IV-TR classification will serve as medical and social rule when considering atypical sexual behaviors as pathological disorders.

In the past, oral sex, masturbation and homosexuality, among other behaviors, were considered mental disorders. These are now acceptable nonpathologized sexual behaviors. Conversely, other conditions that were not considered mental disorders are now mentioned in the DSM, such as: hypoactive sexual desire and female orgasmic disorder, among others (Moser & Kleinplatz, 2005). As the psychiatric community

continues to use evidence based research to assess which behaviors should be considered for inclusion in the DSM, it is expected that inclusion in the DSM be solely based in what really causes mental and emotional discomfort, and/or distress to the individual.

Legal

Societies in general have “attempted to control the sexual behavior of their members...Historically, and cross culturally, even an accusation of interest in specific sexual practices could result in death, imprisonment, loss of civil rights, and other social sanctions” (Moser & Kleinplatz, 2005, p.91). As such, laws, which serve as social control of behaviors, have been implemented according to the social, religious and moral norms of a specific time and place. In past historical times, proscribed sexual behaviors were considered sinful acts that required intervention by religious courts. As time evolved, and civilization matured, both canon and common law proscribed paraphilic behaviors (Malin & Saleh, 2007). When the medical model emerged in the 19th century a third shift took over the prior sins and criminal categorizations of such behaviors and converted them into “pathology” (Bullough & Bullough, 1977, as cited in Moser & Kleinplatz, 2005).

The legislative history of laws that control sexual behaviors is extensive worldwide. In the United States and Puerto Rico, laws governing sexual behaviors are broad as well. These laws are referred to as “crimes against nature because they break what the medieval church defined as God’s natural law which...is specified as God’s natural law of procreation (Money, 1988, p. 139). Therefore, sex offenses are dealt with incarceration or death, in some instances, taking as a model the philosophy of the Inquisition where offenders were burned (Money, 1984).

Since this study does not seek to look at paraphilic behaviors from a legal standpoint, a brief summary of some important laws is being presented to place the issue of sexual behavior controls in perspective according to the objectives of this study.

United States Supreme Court decisions.

There are four major decisions of the United States Supreme Court regulating sexual behaviors in the United States that are standing as of today. The first one, regarding abortion; the second one, dealing with pornography; a third decision, and most important for this study, the decision on sexual privacy among consenting adults. Another decision is regarding civil commitment of sexually deviant individuals.

The United States Supreme Court, in *Roe v. Wade*, 410 U.S. 113 (1973) decided that women had the right to decide if they wanted to terminate a pregnancy. The Court specifically stated that a woman is free from any legal responsibility if she desires to terminate her pregnancy during the First trimester, if there are reasonable reasons during the Second trimester and for medical reasons during the Third and last trimester. The Court, in making such decision, took into account medical, legal and religious briefs. In their final analysis the Court was of the opinion that termination of pregnancy was a woman's choice. This decision, ended decades of illegal abortions conducted in the United States and liberated women from criminal acts should they so decide to proceed with pregnancy termination.

A second decision was that of pornography. In 1973, the United States Supreme Court legally defined obscenity and clearly differentiated it from pornography, the later one not being a criminal offense. In its decision the Court established several parameters to define obscenity.

In *Miller v. California*, 413 U.S. 15 (1973) obscene materials are defined as those that the average person, applying contemporary community standards, find, taken as a whole, appeal to the prurient interest; that depict or describe, in a patently offensive way, sexual conduct specifically defined by applicable state law; and that, taken as a whole, lack serious literary, artistic, political, or scientific value. What is important about this case is that it clearly states that it is a specific society in a specific time who decides what obscenity is and what is not. As such, it rests in a blend of social, moral, religious, political, medical, and scientific input.

The United States Supreme Court ruled in *Lawrence v. Texas*, 539 U.S. 558 (2003), that criminal convictions for adult consensual sexual intimacy in the home violate their vital interests in liberty and privacy protected by the Due Process Clause of the Fourteenth Amendment. This opinion had a significant impact not only in the gay community, but also to heterosexuals who engage in consenting sexual activities that deviate from the “*norm*.” In the decision, Justice Kennedy, who delivered the opinion of the Court, placed emphasis in the constitutional right of freedom by stating:

Liberty protects the person from unwarranted government intrusions into a dwelling or other private places. In our tradition the State is not omnipresent in the home. And there are other spheres of our lives and existence, outside the home, where the State should not be a dominant presence. Freedom extends beyond spatial bounds. Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct. The instant case involves liberty of the person both in its spatial and more transcendent dimensions. (¶ 20)

Lastly, in *Kansa v. Hendricks*, 65 U.S. 4564 (1997), the Supreme Court, “upheld the constitutionality of the civil commitment of sexually deviant individuals for psychiatric treatment” (Bradford, 1999, p. 209). This decision, paving the way for psychiatric and other mental health professionals to educate themselves and find ways to assess and treat such individuals, among whom we may find some paraphilics.

Laws of Puerto Rico.

In 1974, the *Puerto Rico Penal Code* established legal controls for sexual behaviors. The elements of this criminal code were based in *common law*. Sexual behaviors that were criminalized are found in the Crimes against the Honesty section of the code. This code, which was amended in 1998, stipulated the following sexual behaviors as criminal acts: Articles 99 through 117 refer to the specific behaviors that are criminalized. Article 99 refers to rape, in which, among other possibilities, sets the age of sexual consent at 14 years. Article 100 dictates that any penetration, no matter how minor it is, is sufficient for the criminal act of rape to be consumed. Some of the remaining articles are: Article 102, which expressly classified sodomy as any person who engaged in sexual acts with a person of the same sex or that commits an act against nature. The penalty for such criminal behavior was a fixed 10 year term of imprisonment. Should aggravating circumstance be proven, the penalty was increased to 12 years, and any mitigating circumstances could bring the penalty down to six years; in cases such as these, if the victim was age 14 or under, a term of 12 years imprisonment was ordered. The commentary section of the law provided by Nevares-Muñiz (1998) makes reference to the Sodom and Gomorra, in the Bible, and the *common law* of England as precursors

of such statute. Bestiality is mentioned in Article 104, dishonest expositions in Article 106, obscene propositions in Article 107, and prostitution in Article 107-A.

In 2004, the *Puerto Rico Penal Code* was abolished and the new penal code was enacted after several years of intense debate among political, religious and other socially influencing groups. As a result, the age of sexual consent was increased to 16 years, while bestiality and other paraphilias remained (Nevares-Muñiz, 2004-2005). Even though the tendency was to leave the sodomy statute, the United States Supreme Court decision of *Lawrence v. Texas* (2003) which overrides local law in Puerto Rico, forced the legislature to repeal the sodomy statute which would have become dead law awaiting constitutional challenge in a federal court.

The legal trajectory of laws that control sexual behavior in our society can be correlated with social control norms established by the legal majority, and not necessarily based on scientific knowledge. The established social norm that dictates criminal behaviors through the *mala prohibita* rule and not by the *mala in se* paradigm is to be questioned when such controls may seriously deprive citizens of their liberties. To be serving a 10 or 12 year imprisonment term on one day, and having the penalty vacated overnight due to a change in the law, by legislation or supreme court decision, should be a reason of serious concern for a civilized, knowledgeable and fair society.

Psychological Perspective

Perhaps one of the first psychologists to categorize some sexual behaviors as aberrant due to psychological reasons was Sigmund Freud with his psychosexual development theory. In his essay *The Sexual Aberrations*, contained in his book *Three Essays on the Theory of Sexuality*, Freud (1905/2000) specifies that he takes writings

from many scholars that had previously exposed the subject such as Krafft-Ebing, Havelock Ellis, and Hirschfeld, and that “medical men, who first studied perversions in outstanding examples and under special conditions, should have been inclined to regard them, like inversions, as indications of degeneracy or disease” (p. 26).

Freud (1905/2000) states that the union of the genitals, in the act of copulation that leads to the release of sexual tension and temporary extinction of the sexual instinct, is known as normal sexual aim. On the other hand, “Perversions are sexual activities which either (a) extend, in an anatomical sense, beyond the regions of the body that are designed to the sexual union, or (b) linger over the intermediate relations of the sexual object which should normally be traversed rapidly on the path towards the final sexual aim” (p. 16). Freud further posits that “a perversion has the characteristics of exclusiveness and fixation...[that should therefore be regarded] as a pathological symptom” (p, 27). As such, perversions are defined as parting from a normative heterosexual coital aim.

An axial distinction between sexual object and sexual aim is made by Freud (1905/2000); the first one relating to the person or persons towards whom the sexual activity is geared to, and the latter one, referring to the act in which the sexual instinct and desire is inclined. Since sexual instincts are not limited to the genitalia, having fantasies in other parts of the body and objects may be conceived as normal love and only pathological when they are the sexual aim and object in an exclusive and fixated way.

John Money (1988), conducted extensive studies in atypical sexual behaviors in the famously renowned John Hopkins Hospital. In his book *Gay, Straight, and In-Between*, he wrote about *lovemaps*, and *normophilic* and *paraphilic* sexual behaviors. He

stated that “normophilia is culture bound and subject to high degree of historical and cross-cultural variability” (p. 130). Furthermore, he postulated that the so called normophilic ideal is promoted by a heterophilic (from heterosexual) society.

Money coined the term lovemaps in 1980, and described it as:

Lovemaps! They're as common as faces, bodies, and brains. Each one of us has one. Without it there would be no falling in love, no mating, and no breeding of the species. Lacking a name, however, the lovemap has existed in a conceptually unexplored territory of the mind, unknown to science and scholarly inquiry.

(Money, 1986, p. 15)

Money (1986) defined the term lovemap as a developmental representation or template in the mind, and in the brain, that depicts one's idealized lover and the acts that are desired in the idealistic, romantic, erotic, and sexualized relationship. According to Money, humans are born with no sexual lovemaps. Like language, it is not present at birth and will develop and differentiate in the early years. Optimal prenatal and postnatal circumstances, coupled with age-concordant, sexueroptic rehearsal play and gender-different roles, should allow lovemaps to evolve as healthy heterosexuality and with no complexities (Bergner, 1988; Money, 1986). These lovemaps, however, will not manifest until after puberty. However, when normal heterosexual play in childhood is hindered by way of “too much prohibition, prevention, and punishment...the standard heterosexual lovemap does not develop properly in the brain” (Money, 1984, p.165). As a result, segments of the lovemap become defaced impairing adulthood functioning of sex organs in genital intercourse. This course of action is called hypophiliac solution. Specifically, when lovemaps defy defacement and sex organs are used with exaggeration, defiance and

compulsiveness with multiplicity of partners, it is called the hyperphilic solution. A last possible solution of the partially defaced lovemap is for it to become compromised and distorted by “new elements or relocations that may derive from a history of atypical sexual rehearsal play and/or erotosexual experiences in childhood” (Money, 1984, p. 165).

Money (1986) posited that the matching of daily experiences to erotic and sexually gratifying pleasures eventually evolve to the creation of lovemaps. As the person continues to experience sexual gratification through different experiences, he starts to fantasize on such experiences. Eventually, the person commences to act or translate such fantasies into practice. This is when the lovemap is established. Depending on the developmental experiences that create the lovemaps, they may be considered dysfunctional should they depart from social norms. The social normality can be defined statistically or ideologically. Ideological would refer to what people consider ideal and optimal lovemap and not necessarily statistical norm. Money (1986) states that once a lovemap is formed, it is rather uniquely personalized and tends to remain remarkably stable through life.

Money (1989) points out that lovemaps become ‘vandalized’ instead of developing normally under sub-optimal conditions of suppression (prohibition, and abusive punishment), neglect (deprivation), or trauma (tabooed sexueroetic expressions) during the erotosexual rehearsal play that is necessary during prepubescent and pubescent years, sometimes including adolescent years. These vandalized lovemaps would develop into pathologies of either hyperphilic (erotomatic), hypophilic (sexual dysfunctional), or paraphilic (perverted) attraction patterns of sexual behaviors. Money states that the

child makes an attempt to turn those tragic events into triumph, which is the “rescue of lust from total wreckage and obliteration and its attachments to a redesigned lovemap... as act of defiant self-assertion... who reiteratively dreams and tells... the story of how he/she turned tragedy of suffering into... survival” (as cited in Bergner, 1988, p. 256).

Usually, paraphilic lovemaps remain hidden for years and it is not until puberty that they may flourish. As the pubescent child commences experiencing wet dreams and masturbatory fantasies accompanied by orgasm, the child becomes cognizant of such paraphilic lovemaps as such fantasies are replayed in his imagination or enacted. This tends to occur mostly in boys and men than in girls and women. This is understandable as men are more dependent than women on their eyes for erotic arousal, thus it being through the eyes, ears and other senses that paraphilic lovemaps reach the brain (Money, 1984). Additionally, many “paraphilics rely on fantasy [only] to avoid social stigmatization” (Hickey, 2006, p. 59).

Money (1984) posits that paraphilias may be playful and harmless while others unwelcome to a partner, or dangerous even to a consenting partner. Originally, he identifies 33 paraphilias:

Acrotomophilia (Amputee Partner)	Ephebophilia (Youth)
Apotemnophilia (Self-Amputee)	Erotophonophilia (Lust Murder)
Asphyxiophilia (Self-Strangulation)	Fetishism
Autagonistophilia (on Stage)	Gerontophilia (Elder)
Autassassinophilia (Own Murder Staged)	Hyphephilia (Fabrics)
Autonepiophilia (Diaperism)	Kleptophilia (Stealing)
Coprophilia (Feces)	Klismaphilia (Enemas)

Masochism	Scoptophilia (Watching Coitus)
Mysophilia (Filth)	Somnophilia (Sleeper)
Narratophilia (Erotic Talk)	Stigmatophilia (Piercing; Tattoo)
Necrophilia (Corpse)	Symphorophilia (Disaster)
Pedophilia (Child)	Telephone Scatophilia (Lewdness)
Pictophilia (Pictures)	Troilism (Couple + One)
Peiodeiktophilia (Penile Exhibitionism)	Urophilia or Undinism
Rapism or Biastophilia (Violent Assault)	Voyeurism or Peeping-Tomism
Sadism	Zoophilia (Animal)

During Money's (1988) continued studies on paraphilias, he identified other such as:

1. Adolescentilism (Impersonating an adolescent)
2. Andromimetophilia (Male impersonator's partner)
3. Autagonistophilia (Live-show self-display)
4. Biastophilia (Raptophilia)
5. Catheterophilia (Catheter)
6. Chrematistophilia (Blackmail payment)
7. Chronophilia (Age discrepancy)
8. Exhibitionism (Indecent exposure)
9. Formicophilia (Crawling things)
10. Gynemimetophilia (Female-impersonator partner)
11. Hybristophilia (Criminal convict partner)
12. Infantilism (Impersonating a baby)

13. Mixophilia (Scoptophilia)
14. Morphophilia (Physique discrepancy)
15. Nepiophilia (Infant partner, diaper-aged)
16. Olfacophilia (Smell fetish)
17. Toucherism (Touching a stranger)

Since paraphilias have been introduced with the belief that love is pure and lust is sinful, the fact that the paraphilia harbors dirty or sinful sexual feelings, encourage paraphilic wishes to bring others into their devilish fantasy (Berner, 1988) and to do so, they act their paraphilic fantasies. Because of this, Money (1984) classifies paraphilias into six strategies, each of which “is a certificate of permission to enter what would otherwise be an inaccessible city of lust and ecstasy” (p.186). The *Sacrifice Paraphilias* are those where one or more partners must agree for the degenerated acts of defiling the saint with lust by undergoing penance with a penalty that could entail humiliation to death. Masochism is one example of this classification.

The *Predatory Paraphilias* are those in which the sinful act of lust can only be indulged if it is taken away from the saint by force. Rapism is one example of this paraphilia. The *Mercantile Paraphilias* requires that the sinful act of lust be practiced by hustlers or whores. The *Fetish Paraphilias* allow for a compromise of chastity and abstinence taking a fetish to fulfill the degenerated lust. The *Eligibility Paraphilias* require that the eligible partner be beyond the limits of being saintly. As example, social status or occupation, instead of physique or age discrepancy as in gerontophilia, may establish the eligibility criteria that distance the partner from oneself. Lastly, the *Allurement Paraphilias* which is a displacement paraphilia (the other five categories are

inclusion paraphilias), requires a preparatory erotic and sexual phase prior to genital intercourse. Exhibitionism is one example of this category of paraphilias (Money, 1984).

Money (1984) posits that there is no certainty as to how a specific paraphilic fantasy evolves in a person, other than a personalized experience of genital arousal in early childhood. He indicated that, paraphilias are not socially contagious, not voluntary choices, cannot be controlled with will power, and prosecution and punishment do not eradicate them but rather strengthens them. In summary, they are the equivalent to an addiction, defiantly persistent.

Paraphilic lovemaps are distorted cognitive templates that evoke omissions, inclusions, or distortions that under ideal circumstance would have not occurred (Money, 1986). Additionally, Money further indicates that paraphilic lovemaps are like syndromes, which, like epilepsy, an individual cannot control, and is therefore highly resistant to extinction. However, treating paraphilias with pharmacological hormonal medication such as MPA (medroxyprogesterone acetate), in conjunction with psycho-educational treatment to limit their manifestation is fully endorsed (Money, Wainwright, & Hingsburger, 1991).

Money (1988) states that “normophilia is culture bound and subject to a high degree of historical and cross-cultural variability” (p. 130). Current norms in Western societies such as ours, are influenced by Christian culture which for many centuries has only tolerated “premarital chastity; no masturbation; monogamous heterosexual fidelity for life with, until recently, no divorce; no limitation on conception; and intercourse in the missionary position, devoid of passion so as to prevent wantonness, conserve semen,

and prevent self-degeneracy” (p.130). With this description of normophilic behavior, Money (1988) further defines the opposite as:

Paraphilia is defined as a condition occurring in men and women of being compulsively responsive to, and for optimal initiation and maintenance of sexueroetic arousal and the facilitation or attainment of orgasm, obligatively fixed and dependent on unusual, personally or socially unacceptable stimulus either perceived directly, or in the imagery or ideation of fantasy (from Greek, *para-*, beyond, amiss, and by implication altered + *Philia*, love). The antonym is normophilia. Synonyms are, in the law, perversions; in the vernacular, kinky sex. (p. 133)

Healy (as cited in Healey, 2006, p. 64) describes Purcell’s Integrated Model which “proposes that triggering factors (e.g., rejection, isolation, or ridicule) are stressors, ‘constraining or thwarting one’s capacity to cope adequately with everyday life’ (Arraigo & Purcell, 2001, p. 25).” It is during these traumatic circumstances that occur during early adolescence, where paraphilias originate. The child, being unable to develop meaningful relationships, commences daydreaming and masturbating to erotic fantasies which become increasingly conditioned.

Granzig (n.d., ¶ 6) posits that “the greatest sexual organ is what is found between your ears and not your legs.” He further states that desire is the most important requirement in the human sexual response cycle and that “the patterns that shape each individual erotic desire phase are unique” (¶ 9), and important to understand, when clinicians are to provide therapy. Simon and Gagnon (as cited in Irvine, 2003), state that sexual desires evolve into sexual conduct though three levels of scripts: cultural

scenarios, intrapsychic scripts, and interpersonal scripts. These scripts are the sum of all life experiences and unique to each individual, therefore, being responsible for persons sexual fantasies and desires.

Shaffer and Penn (as cited in Healey, 2006) developed a comprehensive classification system of paraphilias in which five categories are established. The nonviolent, physical paraphilias, in which swinging, exhibitionism, and voyeurism are placed; the nonviolent, nonphysical paraphilias where telephone scatologia and technophilia (use of computers) fall into; Sadistic paraphilias, in which sexual arousal and behaviors are achieved by inflicting humiliation and pain; among the paraphilias included in this category are pyromania, and sadism. The masochistic paraphilias, which require being the recipient of bondage, pain or humiliation for sexual arousal; and the sadomasochistic paraphilias in which pleasure is achieved by inflicting pain and humiliation as well as exhibiting masochistic tendencies.

Assessment of Paraphilias

As presented in this Chapter, identification and definition of paraphilias has been evolving through history. From the term sexual perversion to the current term of paraphilia, along with what constitute such behaviors has been a dynamic process that even today continues under revision (Moser & Kleinplatz, 2005) not only by psychiatry (APA, 1952,1980, 2000), but under legal scrutiny as well (Nevares-Muñiz, 1998, 2004-2005).

The current diagnostic criteria of paraphilias are found in the DSM-IV-TR (APA, 2000). Important in the DSM is that intensive sexually arousing fantasies, sexual urges, or behaviors must be present for at least six months so that paraphilic disorders are

diagnosed. Additionally, such sexual fantasies, urges or behaviors must “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B)” (APA, 2000, p. 566). What needs to be stressed is that if paraphilic fantasies are not acted upon, they are considered harmless, as long as the person does not meet Criteria B of the diagnosis. Additionally, if not acted upon, they would be crimeless. The paraphilias may vary in the severity in which they are fantasized and/or acted out. Often, mild variations are manifested leading only to masturbation, or by being acted out with a consenting adult, while “severe versions may entail sexual victimization of children; the use of threats, force and injury to others” (Seligman & Hardenburg, 2000, p. 107) like in cases of pedophilia and other criminal paraphilias.

Coleman, Raymond & McBean (2003), refer to paraphilias as compulsive sexual behaviors (CSB) and differentiate them into two types: paraphilic and nonparaphilic. They basically distinguish them as those which involve unconventional sexual behaviors (paraphilic) and those which involve conventional or normative sexual behavior. Among the conventional or nonparaphilic behaviors we find hypersexuality, promiscuity and nymphomania, all of which may be impulsive or obsessive as well as compulsive, however, no category of diagnosis is provided in the DSM other than the possibility of including them in the Sexual Disorder Not Otherwise Specified (NOS), which indicates in its second criteria a “Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as being used” (APA, 2000, p. 582).

When assessing paraphilias, we must remain cognizant that comorbidity may exist with conditions such as depression, anxiety, and substance abuse (Coleman,

Raymond & McBean, 2003; Seligman & Hardenburg, 2000). Additionally, dementia, manic episodes, mental retardation and even schizophrenia may very well be promoting such behaviors which would constitute a ground for a differential diagnosis (APA, 2000).

Paraphilias are more prevalent in men than in women but are prevalent in people from all ethnic, educational, and socioeconomic backgrounds, and it embraces all sexual orientations (APA, 2000; Money, 1988; Seligman & Hardenburg, 2000). The majority of the persons who have paraphilic fantasies or behaviors do not seek treatment because such pleasure is linked to a social stigma that may cause embarrassment, shyness, or fear (Seligman & Hardenburg, 2000). Most of the persons in treatment have been intervened by the criminal justice system, or are induced by moral influences or other third parties pressure to seek help.

As such, assessment of paraphilic behaviors has fallen mostly under forensic mental health practitioners, most of who rely in the DSM-IV-TR criteria to diagnose them. Instruments such as: The Abel Assessment for Sexual Interests (Abel Screening, Inc., 1995), the Sexual Arousalability Inventory (Chambless & Lifshitz, 1984), and the Sone Sexual History Background (Maletzky, 1991), are a few of the many available tools to conduct screening of sexual behaviors.

A cautionary statement must be made, that sexual offenders, usually pedophiles and rapists, are more prevalent clients among the mental health practitioners within the criminal justice system, and several diagnostic and risk predictor scales have been developed to assess them, however, these paraphilics fall beyond the scope of this study and will not be addressed. The clinical interview and screening instruments appears to be the most accepted form of acquiring data to formulate a diagnosis in the United States.

Treatment of Paraphilia

A review of the literature reveals vast growing interest in treatment modalities for sexual offenders (Schwartz, 2005) of which some (pedophiles, exhibitionists and voyeurs, among others) would be classified as paraphilics under the DSM (APA, 2000). However, other sexual offenders like rapists, and murderers, could fall under other DSM classification, and not necessarily with a differential diagnosis of paraphilia. Sex offenders whose only act has been pornographic photography downloading may not necessarily have all the criteria for a paraphilic classification under the DSM. Lastly, and most important for this study, are those persons that may meet Criterion A (over a period of at least six months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the specific paraphilia is present, and Criterion B (the person has acted on these sexual urges, *or* the sexual urges and fantasies cause marked distress or interpersonal difficulty), however, although present, the individual has not caused danger or harm to others because either the fantasy was and has never been carried out, or if it has, it has been with a consenting adult and it caused no mental or emotional distress in the individual. Therefore, the literature review of treatment presented in this section will be focused on these paraphilics.

The primary two theoretical approaches for treating paraphilias are the psychodynamic or insight oriented and the cognitive behavioral techniques (Seligman & Hardenburg, 2000). Medication has also been recommended for some cases (Money, 1988) and the modality of group therapy appears to be recommended as well (Seligman & Hardenburg, 2000; Schwartz, 2005). Behavioral therapy, although proposed by some scholars (LoPiccolo, 1992), has been criticized by others, specifically aversion therapy

which may be considered dangerous and ineffective (Fog, 1992). Carnes (2001) has proposed the Twelve-Step program similar to Alcoholics Anonymous as he views paraphilias as addictions. Fixed-role therapy (FRT) was introduced by Kelly (1955) and utilizes a dramaturgical approach in which the client is solicited to adopt a new personality. Horley (2005) proposes utilization of FRT in cases in which clients have multiple paraphilias.

Important in the treatment of paraphilias is the motivation for therapy, as court ordered treatment, being an extrinsic motivator to remain out of the criminal justice system, or at least out of imprisonment, is totally different from an intrinsic motivation. Therapy outcomes tend to be most effective when persons seek voluntary treatment which is enacted from some insight orientation. However, most research in treatment focuses on the paraphilics that are court ordered to attend treatment.

When providing treatment, mental health professionals should be cognizant of the difficulty clients may have in reporting atypical sexual behaviors, specifically those that have a psychiatric and/or criminal classification. Empathy is an intrinsic part of the clinician-client relationship. Adequate knowledge in human sexual behavior and specialized knowledge in atypical sexual behaviors are a must to guarantee minimum standards of care. Lastly, dual role may be counterproductive requiring a separation between diagnostician and therapist (Seligman & Hardenburg, 2000) although this may only be necessary in a criminal justice setting.

Surgical castration was the method of treatment for some paraphilias (i.e., sadism and pedophilia) in the past (Bradford, 1999). However, with the advent of civil rights and the development of medication, this technique has become obsolete.

Pharmacotherapy has been utilized in treating compulsive sexual behaviors and could be recommended for severe compulsive paraphilics (Money, 1988). Medication such as Cyproterone Acetate (CPA) as well as Medroxyprogesterone Acetate (MPA: Depo-Provera) are the drugs of choice although FDA approval is nonexistent. Side effects appear to be a major problem due to possible fatigue, hypertension and diminished spermatogenesis as well as possible clotting disorders, and in rare instances feminization effects in the breast and changes in hair distribution. Testosterone, which is the main sex hormone that is produced by the testes, production is lowered thus reducing sexual fantasies and erections while under medication (Bradford, 2001; Kafka, 1996; Rösler, & Witzmum, 2000).

Gay Studies

A review of scholarly articles about paraphilias among gay men resulted productive. Some studies found in the area of assessment include (Coleman, Raymond, & McBean, 2003; Money, 1984; Seligman & Hardenburg, 2000), while in the area of treatment we can mention (Fog, 1992; Gordon, 2002; Kafka, 1996; Marshall, Marshall, & Serran, in press; Moses & Hawkins, 1982; Perry & Barry, 1998), as well as in the criminal area where we found (DeClue, 2007; Frieden, 2005; Healy, 2006; Hickey, 2006; Krafft-Ebing, 1886/1965; Maletzky, 1991; Money, 1990). However, information that directly seeks information on gay or heterosexual persons, relative to their beliefs and non-criminalized paraphilic behaviors is lacking, specifically in Puerto Rico.

Among the studies on several domains of gay issues that have been conducted in Puerto Rico, we can mention Berríos-Rivera (2000), on the life history of homosexual men; Castillo-Martínez, (1985), regarding family adjustment among university age

homosexual males; Jorge (1989), about the formation of the homosexual identity; Ramírez, García-Toro, & Solano-Castillo (2004), studied men coming out in Puerto Rico; and Toro-Alfonso, & Rodríguez-Madera (2004), looked at domestic violence, as well as sexual coercion.

In addition, Fankhanel (1985), reported sexual behaviors among gay men in Puerto Rico and how these behaviors were influenced by the emergence of the HIV/AIDS epidemic. Specifically, the study found that as to paraphilias, sadomasochism acts were not significantly reduced ($t(187) = 0.79, p = \text{NS}$) when acquiring knowledge about AIDS. Of the sample population ($N = 206$), 87.7% did not practice sadomasochism prior to acquiring such knowledge, versus 88.8% after such information had become available to them. Fankhanel (2004) also collected data about sexual behaviors among gay youth in Puerto Rico, which included specific questions on sadomasochism, orgies, fist-fucking, telephone sex, and cyber sex; however, the data obtained in this area was not included in the publication of the study.

Other studies of gay men that may be relevant are: Pérez (1993) who conducted a descriptive study regarding the attitudes, interests, activities, interpersonal relationships and personal descriptions of gay youth in Puerto Rico; and Mercado-Martínez (2000) conducted a study regarding the development of sexual orientation in a group of 29 heterosexual and 29 homosexual adolescents in Puerto Rico. The purpose of the study was to compare if there were any differences between heterosexual and homosexual adolescents during the construction of their sexual orientation. Toro-Alfonso, Varas-Díaz, Andujar-Bello, & Nieves-Rosa (2006) studied strengths and vulnerabilities among gay and bisexual adolescents in Puerto Rico as well.

CHAPTER THREE: METHODOLOGY

Introduction

To understand any particular population, and specifically, any behavior from such population, basic descriptive data should be obtained as a preparatory point from which other specific study needs can be identified (Gliner & Morgan, 2000). A few studies conducted in Puerto Rico have gathered general information about the sexual behaviors of the gay population (Fankhanel, 1985, 2004) but none have looked specifically at paraphilias. Therefore, in an attempt to gather such information, a descriptive study was the focus of this research.

Research Design

A descriptive research methodology was used in this study. The objective of obtaining information regarding the self-reported atypical sexual behaviors of gay men in Puerto Rico, and related mental health issues, was approached with the use of a questionnaire that included information on four basic areas that looked to answer the research questions.

Selection of Participants

Since this study involved the participation of gay men of all ages, including male youth (aged 16 to 21); existing ethical codes to obtain informed consent of minors were used (Code of Federal Regulations, November 13, 2001; Society for Adolescent Medicine, 1995). It has been stated that researchers can bypass parental consent when they have established mechanisms for the protection of the adolescent, and when no state law prohibits the same (Koocher and Keith-Spiegel, 1993).

The Puerto Rico Mental Health Law (Ley de Salud Mental de Puerto Rico, Ley 408, 2 de octubre 2000), explicitly allows mental health professionals to provide up to 4 sessions of psychotherapy for minors between the ages of 14 and 18 without prior parental or tutor consent if the professional determines it to be in the best interest of the minor. Other health laws in Puerto Rico, like the Sexually Transmitted Disease Act (1983) of Puerto Rico, allow services to be provided to minors without parental consent if the nature of the service is to the benefit of the minor and if informing the parents would create undue risks. As such, it can be inferred that public policy in Puerto Rico intends to allow minors to have access to and receive physical and mental health services, specifically in the area of sexuality, without parental consent, as long as the health professional determines it to be in the best interest of the child. This study touches the area of social research, specifically in the area of gay sexuality and most specific, atypical sexual behaviors which are an inherent aspect of mental health services.

Having no identifiable law in Puerto Rico that expressly prohibiting minors (ages 16 to 21) from participating in social research in this area, it could be inferred that it was not illegal to involve gay youths between the ages of 16 and 21 without parental consent for this study. Therefore, acceptance by the youth to participate was considered as informed consent.

The island of Puerto Rico is approximately 100 miles long and 35 miles wide. The geographical composition comprises a central mountainous region which allows us to divide the island into six main geographical areas (metropolitan, north, south, east, west, and central). Because of this geographic composition and in an attempt to have

representation from gay men from all over the island of Puerto Rico in this study, gay socializing venues were identified and visited from around the entire island.

Upon identification of these venues, the investigator approached their owners and, after explaining the purpose of the study, requested permission to visit and distribute the questionnaires in locations where gay men attending were asked to participate in the study.

Instrumentation

A self-administered questionnaire allows for the confidential collection of the data and encourages gay men to provide the required information with privacy and feeling more comfortable in expressing their responses accurately. The uses of self-administered questionnaires further allowed to target and reach a larger sample at the same time (Bourque & Fielder, 1995; Fink, 1995a). Therefore, a self administered questionnaire was utilized for this study.

A self-administered questionnaire, which was prepared and administered in Spanish, the native language in Puerto Rico, was developed by the investigator who also translated it into English and submitted it to the Dissertation Committee for approval.

Since the questionnaire was developed in Spanish, the native language of the investigator and the population studied, no limitations in this area were identified. However, the translation of this questionnaire into the English language, for purposes of the dissertation presentation, may have some limitations in the area of cultural slang, which may differ between the Latino gay population and the North American gay population.

The questionnaires comprise four main areas of information requested:

1. Socio-demographic information.
2. Self-reported less-common sexual behaviors.
3. Mental and emotional comforts and discomforts due to the less-common sexual fantasies, desires, and/or behaviors.
4. Preferred mental health service providers.

When selecting the title for the questionnaire, attention was given that it did not contain any stigmatizing or other judgmental phrases that would in some way predispose the participants not to provide truthful information. Because the word *paraphilia* is socially stigmatized and carries a mentally dysfunctional and criminal connotation, the word was changed for the phrase *less-common* in the title and throughout the questionnaire.

After the questionnaire was prepared (Appendix C: Spanish Version; Appendix D: English Version), pilot testing was conducted with 12 gay men, who were selected by availability to determine its clarity, comprehensiveness, and acceptability (Fink, 1995b; Rea & Parker, 1997). The participants of this pilot test were encouraged to comment on all areas. The researcher had to establish priorities as to the domains to research and the specificity within these domains because of the limitation of time available to complete the questionnaire in a gay socializing venue. Once completed, 750 questionnaires were printed. The purpose of the study, instructions, informed consent, and confidentiality issues were also explained in a cover letter.

Assumptions

This study was limited to collecting data regarding basic socio-demographic information on gay men in Puerto Rico, as well as, basic information regarding their less-common sexual fantasies, desires, and/or behaviors and mental health issues. Specific limitations included the following:

1. The sample of the study was limited to gay men in Puerto Rico.
2. Less-common sexual behaviors was defined as paraphilias contained in the DSM-IV-TR and other selected paraphilias that may be more evident among gay men.
3. The value of the information obtained relies only on what these gay men reported in the questionnaire.
4. The sample population was obtained by availability of subjects. Questionnaires were made available at gay bars and clubs, through gay organizations, gay pride parades, and HIV/AIDS prevention groups. Therefore, results cannot be generalized to the entire gay population in Puerto Rico (Elze, 2003; Hershberger & D'Augelli, 1995).
5. The questionnaire was developed and administered in Spanish, the main language of the investigator, and the population to be studied; therefore, no problems in content interpretation were foreseen. However, when translating the questionnaire from Spanish to English for final presentation in the dissertation, minor translation changes may have occurred.
6. The questionnaire did not provide participants the opportunity to specifically differentiate if they were reporting the experience of either: fantasies, desires, and/or behaviors that are less-common.

Procedure

A preliminary list of 50 questions geared toward answering the research questions were prepared by the investigator. After analyzing the complexity of the information being requested, and due to the time constraints identified when administering questionnaires in gay socializing venues (Fankhanel, 2004), a total of 24 questions were selected for the pilot study and presented to the investigator's Dissertation Committee for approval. Once authorized, the questionnaire was pilot tested among a group of 12 gay men which included youth, white-collar and professionals. These men commented, asked questions, and reported opinions as to the content of the questionnaire and its clarity, purpose, and objectives. Input from the pilot study basically required clarity in the questions and simplification of the responses. Upon correction, the Dissertation Committee provided input and the final version was prepared and approved (see Appendix C: Spanish Version; Appendix D: English Version).

The final questionnaire included a loose leaflet with information on the purpose of the study and consent form, as well as a list of places where the participants could seek help (i.e., mental health clinics, gay organizations) should they want to do so as a result of their participation (see Appendix A: Spanish Version; Appendix B: English Version). Prepaid stamped and self-addressed envelopes were also prepared, and a U.S. Post Office box was rented for those subjects who decided to mail in their questionnaires. A Hotmail address was also established for those participants who wished to obtain further information as to the results or any related information pertaining to the study.

The questionnaires were distributed by the investigator to gay men, at gay socializing venues such as: gay bars, discotheques, HIV/AIDS support groups, gay pride

parades (two in Puerto Rico), and within the gay community. The owners of the establishments provided an area separated from the main socializing room (e.g., dance floor), with proper illumination, chairs and tables, where the participants were able to complete the questionnaires with minimal interference. The investigator personally solicited participation from gay men, who were considered to assent to participate when voluntarily accepting to complete the questionnaire.

Information provided to the participants was limited to the purpose of the study and the procedures by which they could participate. Clarification was provided on a one on one basis when participants had questions regarding to the content and meaning of words or phrases in the questionnaire.

Throughout the data collection process, questions that were identified as creating confusion among respondents were those following question number 12 (report on the frequencies of less-common sexual behaviors). Specifically, question 13, which required respondents to report how they felt “during the fantasy, desire and/or behavior”; question 14, which asked the respondent to identify how they “felt after experiencing the fantasies, desire, and/or behavior;” and question 15, which asked the respondent to mention both, the age in which they had the first sexual fantasy of a less-common sexual behavior, and the age in which they acted such less-common sexual behavior for the first time. A review of the first 50 questionnaires that were completed revealed that 15 of those participants who had reported less-common sexual behaviors were responding that questions 13, 14, and 15 “did not apply” to them, an apparent misunderstanding of the question. To address this issue, the investigator had to commence explaining the relevance of those questions (13, 14, & 15) to question number 12, at the moment the

questionnaire was handed out, or sometime during the process of completing the questionnaire. However, this was not always possible since on occasions the amount of participants completing the questionnaire at the same time was significant, not being always possible to address this issue among all participants. Because of the value of the information gathered in the remaining of such questionnaires, they were not eliminated from the study. As such, results from these questions is far from accurate and should be considered as being conservative from what the reality may be.

Subjects who decided to complete the questionnaire onsite submitted it to the investigator in a sealed envelope. Those participants who decided to take it and complete it elsewhere were provided with a pre-addressed stamped envelope for mailing.

The investigator was the only one to screen questionnaires for completeness and to determine whether the selection criterion had been met for a respondent to be accepted for inclusion in the study and data analysis. At this point, data was entered into the Statistical Package for Social Sciences (SPSS) program, Version 16.0, for a preliminary analysis of the matrix. The data from all questionnaires were entered only by the investigator to increase identification, interpretation and data entry purity.

The expectation of gathering a total of 100 acceptable questionnaires between the months of March through June 2008 were surpassing as a total of 429 acceptable questionnaires were received. Distribution commenced on March 5, 2008, and ended on June 23, 2008, a period in which a total of 485 questionnaires had been distributed, of which 422 were completed in person and 19 submitted through the U.S. Mail, for a total of 441 received questionnaires. Of these 441 questionnaires, 12 were found not to meet inclusion criteria for a variety of reasons (not living in Puerto Rico, being female,

inappropriate responses, leaving most of questionnaire uncompleted, responding to be heterosexual, etc.). A total of 429 questionnaires were used to conduct the statistical analysis of the study. Appendix E shows a specific list of dates and locations, as well as the numbers of questionnaires distributed, and received.

Data Processing and Analysis

The questionnaires were evaluated for inclusion criteria by the investigator. In order to be acceptable and included for tabulation, the subject had to indicate in the questionnaire that:

1. The participant was male.
2. The participant was a resident of Puerto Rico at the time of the study.
3. The participant reported in question 7 one of the following responses: has had sex with: men only, both men and women, or had not had sex as of the day of the study. Additionally, the participant must have responded in question 8, one of the following: to consider himself gay, bisexual, gay-experimenting, transsexual/transgender, or, not to be sure. If a participant indicated to be heterosexual in question 8, but responded having sex with men in question 7, he would be accepted in the study, as were those who reported being gay, bisexual, gay experimenting, or transsexual/transgender but , did not report having sex with anyone as of the time of the study.

The questionnaires were processed for data entry into the appropriated computer statistical program (SPSS). To assure quality control of data entry, questionnaires were assigned a number as the data was entered; after every 20 questionnaires, data input verification was conducted. Once all questionnaires determined acceptable had been received and entered, a tally report was printed for visual inspection and identification of

data entry errors which, when identified, were corrected. Subsequently, a statistical analysis for descriptive data was prepared and performed.

The data analysis made and presented in Chapter Four includes the following:

I. Socio-demographic information

Basic data analysis that involved descriptive representation for each question in this area (questions 1, 2, 3, 4, 5, and 6) was conducted. This allowed for a basic description of the socio-demographic composition and selection criteria of the population of the study.

II. Self-reported less-common sexual behaviors

Descriptive data analysis was also conducted with the questions relating to this research area. Specifically, this was question 12. In this section, a basic description of the frequency of the less-common sexual fantasies, desires and/or behaviors was gathered. Selection alternatives for frequencies comprised: never, only once, 2 to 10 times, 11 to 20 times, more than 20 times, over the life course. No distinction is made as to whether the reported less-common sexual behavior was just fantasized, desired and/or acted upon.

III. Mental and emotional feelings gay men reported were diversified in the following area:

A. Questions 10 and 11: perceptions of their current self-esteem and mental and emotional health at the time of the study.

B. Questions 13 and 14: Feelings during and after a less-common sexual behavior.

IV. General questions regarding control and opinions of less-common sexual behaviors were asked in questions 16, 17, and 18, specifically, if the person

considered himself to be in control or not of his behavior, and perceptions of normality of such behaviors.

- V. Other mental health issues questions comprised questions 19, 20, 21, 22, 23, and 24. A descriptive analysis was also conducted of these responses. The findings are presented in the subsequent chapter in narrative form. Tables are used to present the data as well.

Summary

The information sought in this study, and the methodology utilized to attain it, has been employed by other studies conducted in analogous populations. Therefore, it is considered to meet the standards of practices utilized by professionals in this field and adequate and proper for this study.

The lack of professional research not only sustained the objectives of this study, but also encouraged it and specifically delineated the benefits it could have for gay men, public health services, and mental health services in general. Therefore, this methodology attempted to generate appropriate information to provide a descriptive picture of gay men in Puerto Rico, their less-common sexual behaviors, and related mental health issues. These results are presented in the following chapter.

CHAPTER FOUR: FINDINGS

Restatement of the Purpose

The purpose of this study was to obtain descriptive data regarding paraphilic sexual behaviors of Puerto Rican gay men. The lack of studies in the continental United States and Puerto Rico regarding this area of human sexual behaviors allowed the investigator to be creative in the approach and contents in which this study would be addressed, specifically, as a descriptive study.

The justification of this study relies in that paraphilic behaviors need to be studied in the general population and, specifically, within the gay population as they are an area of concern among mental health professionals who need to be cognizant of such behaviors to be able to address the needs of this population. Additionally, should studies of paraphilic behaviors be conducted among gay men in the continental United States, the specific behavioral characteristics and psychological needs may not be consonant with those of gay men in Puerto Rico that have different idiosyncrasies due to the difference in cultural values and religious beliefs. Therefore, the need to study gay men in their specific cultures and subcultures is important (Savin-Williams, 2000) as influencing variables may affect such behaviors (Fankhanel, 2004).

In this chapter, descriptive data analysis is presented utilizing the total population of the study ($N = 429$) for all statistical analysis unless otherwise indicated.

Socio-demographic Profile of the Participants

The subjects were recruited from gay socializing venues such as gay bars and clubs, gay pride parades, identified gay beach, as well as other gay venues throughout the island of Puerto Rico.

The total sample consists of 429 gay men between the ages of 17 and 58 with a mean age of 30.29 ($SD = 9.631$). Two participants failed to report their age. Gay men from the entire island participated and are represented in the study, specifically, representation from the San Juan Metropolitan area comprised 52.0% of the sample while 12.8% reported to live in the Northern part of the island (excluding San Juan), 7.9% in the South, 7.7% live in the East, 12.4% in the West, and 7.2% from the center of the island (Appendix F).

Ethnic composition of the sample included 416 Puerto Ricans (97.0%), while 5 (1.2%) identified themselves as Cubans, 4 (4.9%) North American (non-Latino), 2 (.5%) Italian, and 1 (0.2%) Mexican.

The participants in this study were self-identified gay (90.4%), bisexual (6.1%), experimenting-gay (1.9%), or transsexual (0.9%) men, while 1.2% responded not to be sure of how they consider themselves. Participants further responded that they had had sex with men only (93.9%) as of the time of the study, while 4.4% reported having had sex with both, men and women, and 1.6% indicated never having sex with another person. Examination of the participant's current religious practices revealed that 40.1% reported not practicing a religion, while 39.9% indicated to practice Catholicism, 11.9% Protestantism, 7.9% indicated other religions, and one respondent (0.2%) stated to practice both Catholicism and Protestantism. Of those that reported to practice "other religions," Wicca religion was mentioned by four respondents, as was Santeria. Buddhism and Metaphysics was indicated by two respondents, and Deist, Yoruba, Adventist, and the Osha religion by one each. Atheism was reported by one respondent as well, while the remaining did not specify a religion.

Yearly household income between \$0 and \$10,000 was reported by 19.3% of the participants. Twenty-five point six percent indicated a yearly household income between \$10,001 and \$20,000. Seventeen point one percent indicated it to be from \$20,001 to \$30,000, as well as for the income from \$30,001 to \$40,000, and 20.8% indicated \$40,000 or above.

Highest educational level achieved by the participants at the time of the study revealed that 0.7% did not complete an elementary education while 0.5% had. Junior high school was completed by 0.9% and high school by 15.3%. Technical courses had been completed by 10.1% and 15.7% reported an associates degree. Thirty-eight point three percent had completed a bachelor's degree, 14.8% a master's degree, and 3.8% a doctorate degree.

Research Question One

What paraphilic behaviors are present, if any, among gay men in Puerto Rico? The participants were asked to report the age of first less-common sexual fantasies and behaviors, as well as, the frequencies, if any, of specific less-common sexual behaviors. Overall, participants stated having their first less-common sexual fantasy at the average age of 16.88 (minimum age 6, maximum age 38). Additionally, they were asked to report the age in which they first acted out a less-common sexual behavior for which the average age was 18.15 (minimum age 6, maximum age 50).

Participants were specifically asked to report any less-common sexual fantasies, desires, and/or behaviors during their lifespan. The question did not allow making a distinction between having had fantasias alone, or having acted out on such fantasias.

There were five frequency categories from which to select: Never, once only, 2 to 10 times, 11 to 20 times, and 20 or more times.

The paraphilic feelings, desires and/or behavior that was most reported was that of observing erotic pictures or films which was reported by 93.3% of the participants. This was followed by having sex with a person at least 10 years older (79.30%), towards specific body parts (75.70%), and the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity (50.0%).

When reviewing question number 12, specifically, item “having sex with a person at least 10 years younger__ or 10 years older __ than you,” some participants responded the general question, and did not specify if the attraction was to younger or older, therefore, results were provided in the three possible alternatives.

Participant’s least reported less-common sexual fantasies, desires, and/or behaviors included: use of feces (1.70%), animals (2.40%), and inserting a catheter in their penis urethra (3.8%).

In question number 12, specifically, the item “nonliving objects (examples: shoes, underwear, odors, etc.),” some participants provided the specific object; among those reported were: underwear (3.0%), dildos (2.8%), odors (0.9%), and bananas, leather, and sunglasses which were reported by only 0.2%.

Few participants provided specific body parts in question 12, item “attraction to specific body parts.” Three participants reported buttocks, one participant feet, and one participant teeth.

Lastly, participants recorded other circumstances that sexually aroused them that were not included in question 12. Among those are: orgies (5 participants), public places

(4 participants), swinging (3 participants), sex among three persons ‘threesome’ (2 participants), heterosexual men (2 participants), beach (2 participants), finally, priest, dark rooms, role play, locker rooms, and swallowing semen (one participant each). A full statistical description of all 21 items can be seen in Table 1.

Research Question Two

Do such behaviors evoke any psychological discomfort? Specific questions included feeling during and after experiencing less-than common sexual behaviors, questions related to the perception of normality of these behaviors, suicidal ideation and attempts, and self control, among others.

Prior to questioning the possibility of psychological discomfort due to less-common sexual fantasies, desires, and/or behaviors, participants were first asked about their perceived self-esteem, as well as, their mental health, at the time of the study.

As to their self-esteem, 73.2% indicated to perceive it as very good, while 20.5% stated it to be good, 4.9% regular, 0.5% poor, and 0.2% perceiving their self-esteem to be very poor. Regarding how they perceived their mental health, 72.7% mentioned it to be good, 22.4% stable, while 3.5% reported unstable, and 0.7% perceived themselves to be in crisis.

A total of 310 participants (72.3%) reported feeling good during a less-common sexual fantasy, desires, and/or behavior, while 46 (10.7%) stated to feel reasonably fair, and 4 (0.9 %) mentioned they felt bad. A total of 66 (15.4%) of the participants responded that this question did not apply to them.

When asked about how participants felt after an atypical sexual fantasy, desire, and/or behavior, a variety of responses were received. The majority reported to feel good

Table 1

Frequency of sexual fantasies, desires and/or behaviors during your life span

Intense sexually arousing fantasies, sexual urges or behavior involving...	<i>n</i>	Never %	1 Only %	2-10 %	11-20 %	21 plus %
Exposure of your genitals to stranger	424	60.4	9.2	18.4	2.4	9.7
Non living objects	413	79.7	7.5	6.5	1.9	4.4
Touching and rubbing against a nonconsenting person	424	80.7	8.5	8.3	.9	1.7
Sexual activity with a child under age 13	424	95.3	3.5	0.0	.2	.7
The act of being humiliated, beaten, penetrated with a fist, bound or otherwise made to suffer	427	84.3	5.9	7.9	.9	1.6
The acts in which the psychological or physical suffering of your sexual partner is sexually exciting to you	426	85.2	6.1	5.9	.9	1.6
The act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity	427	49.9	20.1	17.8	3.7	8.4
Asphyxiation during masturbation-orgasm	421	86.8	5.4	4.0	1.7	2.1
The use of feces	416	98.3	.5	.5	.2	.5
Inserting a catheter in your penis urethra	425	96.2	1.9	.7	.7	.5
Animals	418	97.6	1.2	1.0	0.2	0.0
You dress as a female	424	84.0	7.1	4.2	0.9	3.8
A partner that dresses as a female	422	91.0	4.5	2.4	0.7	1.4
Viewing your partner having sex with another person	426	75.8	11.3	8.2	2.6	2.1
Observing erotic graphics or films	425	6.6	8.7	25.6	8.2	50.8
Tattoo/piercing	421	55.3	14.0	20.4	3.8	6.4

Continues

Table 1 (continued)

Intense sexually arousing fantasies, sexual urges or behavior involving...	<i>n</i>	Never %	1 Only %	2-10 %	11-20 %	21 plus %
Attraction to specific parts of the body (feet, hair, teeth, butt, etc.)	416	24.3	10.8	27.2	8.9	28.8
The use of enemas	408	81.9	3.9	5.9	2.2	6.1
Urine (golden showers)	423	87.0	4.7	6.4	.7	1.2
Having sex with a person at least (general response)	423	27.2	18.2	30.0	6.9	17.7
10 years younger	175	20.6	21.1	31.4	9.7	17.1
10 years older	172	69.2	7.0	12.2	2.3	9.3
Other circumstances	332	89.8	3.9	1.5	1.5	3.3

(50.3%) followed by satisfied (29.1%), and relaxed (25.4%), as the major three responses (see Table 2). When looking at negative feelings, guilty was the most mentioned (5.6%), followed by scared (4.7%), and shame (4.2%). One point seven percent stated they felt to be in sin. Fifty-six participants (13.1%) indicated this questioned did not apply to them. Participants had the option of reporting more than one response.

Participants were asked if they consider having lack of control which leads them to perform less-common sexual acts, to which 84.4% responded no, and 15.2% stated yes. When participants were asked about how much control they have over themselves during the less-common sexual fantasy, desire and/or behavior, 63.6% posited that they consider having total control over their acts, while 16.1% stated to be partially in control, and 1.6% mentioned to lose all control over their behavior. A total of 17.5% informed that this questioned did not apply to them.

When asked how they consider less-common sexual fantasies, desires and/or behavior, 68.5% specified them to be normal, while 9.1% stated them to be abnormal. Twenty percent informed that they were not sure.

Participants reported that, at the time of the study, they were not concerned (62.5%), little concerned (7.7%), moderately concerned (2.1%) or very concerned (0.9%), about their less-common sexual fantasies, desires, and/or behaviors.

In the area of mental health issues, participants were asked about suicide ideation and attempts. Of all the participants, 4.0% stated having experienced suicidal ideation. Of these participants, the mean amount of suicidal ideations reported were 3.13, ranging from 1 to 12. As to suicidal attempts, 3.3% reported them with a mean of 3.42 attempts, ranging from 1 to 12 attempts as well.

Table 2

How participants felt after experimenting a less-common sexual fantasy, desire, and/or behavior

Positive Feelings	%	Negative Feelings	%
Good	50.3	Depressed	2.1
Relaxed	25.4	Hopeless	0.5
Calm	10.7	Scared	4.7
Normal	20.3	Guilty	5.6
Satisfied	29.1	Empty	3.0
Fascinated	13.3	Lonely	1.9
Tranquil	14.7	In sin	1.9
Indifferent	5.4	Sick	0.5
Excited	14.5	Shamed	4.2
Other	1.4		

Note. $N = 429$. More than one selection was possible by participant.

Research Question Three

If psychological discomfort is evoked by such behaviors, are these men seeking mental health counseling or treatment? If not, why not?

Participants were asked to report from which persons they sought help from if an emotional or psychological discomfort was present due to less than common sexual feelings, desires and/or behaviors. A total of 64 (14.9%) participants reported not seeking help and 65 (15.2%) indicated that they had requested help from someone.

Those who indicated not having sought for help despite having emotional or psychological discomfort reported their reasons as: not knowing where to seek help (2.3%), feeling shame in seeking help (3.7%), and being fearful in having to mention it to someone (3.5%).

Participant that indicated having sought help upon an emotional or psychological discomfort due to less common sexual fantasies desires and/or behaviors reported seeking such assistance mostly from gay friends (9.2%), followed by psychologists (4.7%), siblings (4.2%), and their mothers (3.7%). Sex therapist, priest, ministers or other spiritual leaders, and school personnel were the least sought for requesting assistance in these matters (0.7% each) (See Table 3).

Eleven point nine percent of the participants reported that the assistance they got was helpful, while 2.1% stated that the help received was not beneficial. From the few responses recorded as to if the help sought was beneficial or not, participants stated, “I have taken control over my life” (assistance provided by psychologist, psychiatrists and his father); “more or less helpful” (assistance sought from siblings, psychologist, counselor and gay support group); “did not resolve my problem” (assistance sought from

Table 3

Persons from which participant sought help due to emotional or psychological discomfort related to less common sexual fantasy, desires and/or behaviors

Person seeking help from	%
Gay friends	9.3
Psychologist	4.7
Siblings	4.2
Mother	3.7
Heterosexual friends	3.5
Counselor	2.6
Psychiatrist	1.6
Physician	1.6
Father	1.4
Gay support group	1.4
School personnel	0.7
Priest, reverend, etc.	0.7
Sex therapist	0.7

Note. $N = 429$. More than one selection was possible by participant.

psychologist and psychiatrist); “mothers guidance never fail” (assistance provided by mother and siblings); “felt comfortable” (assistance was sought from siblings and gay friends); and two participants stated not having sought help because “I was lacking information” and “I prefer to keep it a secret.”

Research Question Four

Which professionals would gay men prefer to receive help related to less-common sexual fantasies, desires, and/or behaviors from?

When participants were asked their opinions as to where they would seek help for the less-common sexual fantasies, desires and/or behaviors which they may not feel good about, they indicated they would consider seeking help from gay friends (47.6%), psychologists (40.3%), followed by sex therapist (24.0%). School personnel were the least reported (0.5%), followed by priests, reverends or other spiritual leaders (2.6%) (see Table 4).

In seeking information about what participants think are the counseling needs of gay men because of their less-common sexual fantasies, desires and/or behaviors, the majority (52.0%) stated that counseling should be geared to self acceptance, followed by behavior modification (31.9%). Eighteen point six percent stated that gay men have no need to seek counseling due to their less-common sexual fantasies, desires and/or behaviors (See Table 5). Other responses provided include: for anxiety, to take control, and for security and health purposes.

Table 4

Persons from which participant would seek help related to a less common sexual fantasy, desire and/or behavior

Person seeking help from	%
Gay friends	47.6
Psychologist	40.3
Sex therapist	24.0
Gay support group	22.8
Mother	19.6
Counselor	19.6
Psychiatrist	17.2
Heterosexual friends	17.0
Siblings	10.3
Physician	7.9
Father	4.7
Priest, reverend, etc.	2.6
Other	2.1
School personnel	0.5

Note. $N = 429$. More than one selection was possible by participant.

Table 5

Reported counseling needs of gay men with less-common sexual fantasies, desires and/or behaviors

Person seeking help from	%
For self acceptance	52.0
For behavior modification	31.9
For compulsive/impulsive behavior	30.3
No need to get help	18.6
For moral issues	17.7
For legal conflicts	13.5
For religious issues	10.0
Other	2.3

Note. $N = 429$. More than one selection was possible by participant.

Additional Statistical Analysis

Correlation analysis was performed to observe possible relationships between religious practices and educational levels with the way participants feel during a less-common sexual fantasy, desire, and/or behavior, as well as how they consider them.

No correlation was found between participants' religious practices and whether they perceive less-common sexual fantasies, desires, and/or practices as "normal," "abnormal," or "not sure" (Question 17). When analyzing participants' religious practices with their perceived self-esteem at the time of the study, it was observed that in general all participants, regardless of their religious or non religious practices reported a very good self-esteem at the time of the study (See Table 6).

A significant statistical significance at $p \leq .10$ using Cramer's V (see Table 7) was found when comparing participants educational level and how they consider less-common sexual fantasies, desires, and or behaviors (Question 17). This significance is not found at the $p \leq .05$ using Cramer's V. Participants with higher educational levels tend to consider less-common sexual fantasies, desires, and/or behaviors as normal, over those with less education.

Summary

In summary, this chapter has presented the findings obtained from the 429 respondents who completed the questionnaire, which was developed to try to obtain data to answer the research questions. In the following chapter, a summary, conclusions, and recommendations are presented.

Table 6

Cross tabulation: Current religious practices and perceived self-esteem at the time of the study

What are your current religious practices?	How do you perceive your self-esteem at this time?					
	<i>n</i>	Very good %	Good %	Regular %	Poor %	Very poor %
None	171	71.3	22.2	5.3	1.2	0.0
Catholic	170	76.5	18.2	4.7	0.0	0.6
Protestant	50	68.0	30.0	2.0	0.0	0.0
Catholic/Protestant	1	100.0	0.0	0.0	0.0	0.0
Other	34	79.4	20.7	4.9	0.5	0.2

Table 7

Cross tabulation: Highest academic level completed and the way less-common sexual arousals and/or behaviors are considered

Highest academic level completed	How do you consider less-common sexual arousals And/or behaviors?			
	<i>n</i>	Normal	Abnormal	Don't know
Did not finish elementary school	3	100.0%	0.0%	0.0%
Elementary school	2	50.0%	50.0%	0.0%
Junior high	4	100.0%	0.0%	0.0%
High school	64	68.8%	10.9%	20.3%
Technical course	42	81.0%	2.4%	16.7%
Associate degree	66	59.1%	6.1%	34.8%
Bachelor degree	157	69.4%	9.6%	21.0%
Master degree	62	69.4%	14.5%	16.1%
Doctorate degree	16	93.8%	6.2%	0.0%

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study has addressed some issues regarding paraphilic behaviors of gay men in Puerto Rico. Chapter One provided information as to the background problem of this study, specifically, how human sexual behavior has evolved through history, giving special attention to nonnormophilic sexual behavior. The lack of in-depth studies specifically targeted towards gay paraphilic behaviors deprives of adequate knowledge in order for mental health professionals and the health department to properly serve these gay men in Puerto Rico.

Chapter Two provided a review of the evolution of paraphilic behaviors in the last two centuries, current diagnostic criteria, and a brief presentation of law as it affects sexual behavior. Lastly, research conducted among gay men, in Puerto Rico and elsewhere, as it relates to the subject of this study.

A detailed description of the methodology utilized to conduct this descriptive study was presented in Chapter Three. The following components of the methodology were outlined: the creation of an instrument, the selection of subjects, and data collection and analysis. In addition, the limitations encountered were clearly offered.

Chapter Four provided the findings of the study. Specifically, the chapter offered descriptive data gathered from the 429 participants who responded to the 24 items of the questionnaire. The conclusions and recommendations of this study are presented in this chapter.

Conclusions

The investigator of this study, which was conducted in the island of Puerto Rico, was able to recruit a total of 429 gay men, all living in Puerto Rico at the time of the study, from which the majority (97.0%) reported being Puerto Rican. As such, findings of this study represent this specific ethnic group which is an important variable when studying sexual behaviors among different gay cultures (Phillips, Ingram, Smith, & Mindes, 2003; Savin-Williams, 2000).

Although we cannot generalize the findings to the entire gay men population of Puerto Rico, an adequate sample of gay men who attend gay socializing activities and clubs throughout the entire island is represented in this study (see Appendix F).

Socio-demographics

Gay men who participated in this study came from all socio-economic classes and educational levels. Many participants expressed not to practice a religion as of the time of the study (40.1%), while 39.9% reported to practice Catholicism, 11.9% Protestantism, and 7.9% other religions such as Wicca, Santeria, Buddhism, Metaphysics, Deist, Yoruba, Adventist, and Osha, with less than five participants each.

The findings of this section of the study suggest that Puerto Rican gay men who attend gay socializing venues or organizations come from all social classes and educational levels. In the area of religion, findings of this study reveal that half of the gay men who participated maintain the Latino culture core beliefs by practicing Christianity (over 50%) or related religions.

Less-common Sexual Behaviors

The participants were asked to report less-common sexual fantasies, desires, and/or behaviors. The usage of such terminology, instead of *paraphilic behaviors*, was selected because it is less moralistic, has less negative psychological implications, and it is noncriminally inclined, allowing participants the opportunity to provide truthful responses.

Specific less-common sexual fantasies, desires, and/or behaviors were selected from a variety of possibilities (APA, 2000; Money, 1984, 1988). The use of paraphilic behaviors officially identified in the DSM-IV-TR (APA), allowed for gathering of data that could be used within the mental health professions. Other paraphilic behaviors were selected by the investigator based on nonscientific criteria, by specifically questioning gay men at large that live in Puerto Rico who provided input as to what paraphilic behaviors tend to be most evident. It should be clarified that the questionnaire did not allow participants to specify if they were reporting either a sexual fantasy, desire, and/or the acting of such behavior.

In analyzing the data collected in Question 12, (see Table 1) about specific paraphilias; the first seven items refer to the paraphilias mentioned in the DSM-IV-TR (APA, 2000). It is observed that the first one, which corresponds to Exhibitionism, was not reported by 60.4% of the participants, while 9.7% indicated experiencing it over 20 times during their lifetime. Thirty-nine point seven percent of the participants reported at least one experience during their lifespan.

The second item of Question 12 corresponds to Fetishism, for which 79.0% reported never experiencing such fantasy, desire, and/or behavior. Twenty point thirty

percent reported at least one experience. As to Frotteurism, the third item in Question 12, some 80.7 % have not had such experience, while 19.40% report at least one. In regards to Pedophilia, 95.3% of the participants reported never having such paraphilic fantasies, desires, and/or behaviors, while 4.40% reported at least one experience. Sexual Masochism was not reported by 84.3% of the participants and 15.40% did report them. Sexual Sadism was not reported by 85.2%, and 14.50% stated at least one experience. The last DSM-IV-TR (APA, 2000) paraphilia included in Question 12 was Voyeurism, for which 49.9% reported no sexual fantasies, desires, and or behaviors ever, while 50.0% did report at least one experience during their life span.

In summary, DSM-IV-TR specific paraphilias are not reported by the majority of the gay men who participated of the study, being voyeurism the most reported (50.0%), followed by exhibitionism (39.0%), and pedophilia the least reported (4.40%). Other paraphilic fantasies, desires, and/or behaviors that were included in the study could probably fall under DSM-IV-TR (APA, 2000), classification as Paraphilia Not Otherwise Specified (NOS). Among them, the most significantly reported in question 12 (see Table1), were: observing erotic pictures and photographs, for which 93.3% reported at least one experience, while 50.8% reported 20 or more during their lifespan, and partialism (specific body parts) which was reported by 75.70% of the participants.

This data reflects that most participants are drawn to sexual fantasies, desires, and/or behaviors of non-personal contact and could be a reflection of the advances of technology by which internet photography can easily be accessed to satisfy sexual needs impersonally. Additionally, partialism was also significantly reported, which may indicate that paraphilic fantasies, desires, and/or behaviors are directed to the person, for

the most part, rather than to fetishes for which only 20.30% reported at least one experience.

Paraphilic behaviors that may be of health risk issues, such as urophilia (golden showers) were reported by 13.0% of the participants, while 2.20% reported animalism, 1.70% the use of feces, asphyxiophilia by 13.20%, use of catheter in the penis by 3.8%, enemas by 18.10%, and tattoos/piercing by 44.60%. Even though we cannot differentiate among those who only fantasize such behaviors from those that act on them, it is evident from the data that these practices may be present among this population to some degree.

Question 12 included the item of having less-common sexual fantasies, desires, and/or behaviors towards persons at least 10 years older or younger. Seventy-two point eight percent of the participants reported this question in the affirmative; however, not all reported the specific age range (older or younger). Therefore, data was entered for all three possible responses for which the results reveal that 72.8% indicated to have less-common sexual fantasies, desires, and/or behaviors with persons at least 10 years older or younger, while 79.30% of the participants were specific in indicating them to be towards persons at least 10 years older, and 30.80% at least 10 years younger (see Table1).

Ninety-five point three percent of the participants reported not having sexual fantasies, desires, and/or behaviors towards children under the age of 13. Of those that report such fantasies or behaviors (4.4%), we are unable to analyze if they would fall under DSM-IV-TR classification for pedophilia because the data of the study does not provide information as to when in the life course were these fantasies, desires and or behaviors present. Should they have been present only during the participants early adolescent years, Criterion C (DSM-IV-TR) of the diagnosis would not be met.

The study of age preference differences is limited, both, among heterosexual and homosexual persons because of Western society's unlawful and psychological deviant views that exist towards this specific sexual issue (Brongersma & Naerssen, 1990). However, some studies like that by Hayes (2001) reveal that, "The preferences of homosexual men and women were similar to those of heterosexuals, although more homosexuals stated a preference for a partner younger than themselves" (p.125). Findings in the current study provide data that suggest the existence of such age discrepancy preference, although inversed (preference in older men) among gay men in Puerto Rico.

In analyzing participants responses on less-common sexual fantasies, desires, and/or behaviors, we observe that those which are classified as mental disorders (paraphilias) under the DSM-IV-TR (APA, 2000), and which were reported as being experienced more than 20 times by participants during their life span are: exhibitionism, the most reported, by 9.7% of the participants, followed by voyeurism (8.4%), fetishism (4.4%), frotteurism (1.7%), sexual masochism and sadism (0.6%) each, and pedophilia by 0.7% of the respondents. However, when observing that only 0.9% of the total participants of the study reported feeling bad while experiencing less-common sexual fantasies, desires, and/or behaviors, we may infer that only these participants would meet DSM-IV-TR criteria for diagnosis (Criterion B) because such fantasies and/or behaviors have in fact caused marked distress or interpersonal difficulties. All other participants, that did not report marked psychological distress, but did report one or more of these less-common sexual fantasies, desires, and/or behaviors would only meet DSM-IV-TR paraphilic diagnostic criteria if they have acted on such fantasies, specifically: Pedophilia, Voyeurism, Exhibitionism, and Frotteurism (Criterion B), however, this study

does not allow us to analyze the data to that extent. If they have acted on such fantasies and desires, they could have committed a criminal act, if such act is so classified under penal law, however, why should they be considered mentally disordered individuals under the DSM if there is a lack of mental or emotional discomfort and/or distress? Specifically, those that have not acted out against nonconsenting people.

Once again, the issue of considering behaviors as criminal or mental disorders is delegated to the social majority, in cases of social sanctions, and to the psychiatric community, in cases of mental health. The question of concern, once again being; what criteria are utilized when making such determinations: *mala in se* (based on scientific knowledge) or a *mala prohibita* (based on local and time specific assumptions). Making such determination without scientific knowledge is setting us back four decades when homosexuality was still classified as a mental disorder.

Participant in the study reported having their first less-common sexual fantasy, desire, and/or behavior as early as age 6, and as late as age 38, with an average age of 16.88. Acting on such fantasies and desires occurred as early as age 6, and as late as age 50, with the mean age of 18.15. This data allows for the inference that, for the most part, paraphilias are usually first fantasized and then acted upon. However, a closer look at the responses revealed that in some occasions, participant reported acting paraphilic behaviors first, and then experiencing fantasies and or desires on such acts.

Psychological Issues

The study sought information about mental and emotional issues related to less-common sexual fantasies, desires, and/or behaviors. Prior to asking specific questions on sexual fantasies and behaviors, participants were questioned about their self-esteem at the

time of the study, for which 73.2% reported it to be very good, and 20.5% good. Only one participant (0.2%) reported it to be very poor. Additionally, 72.7% stated to perceive their mental and emotional status as good, and 22.4% as stable. Only 0.7% reported to perceive themselves to be in crisis, none of which requested any assistance from the investigator during the participation in the study. This information allows us to infer that over 90% of the participants reported at least good self esteem and stable mental and emotional health at the time of the study.

Seventy-two point three percent of the participants reported feeling good during the experience of a less-common sexual fantasy, desire, and/or behavior; this feeling appears to remain after such activity has concluded as 50.3% reported feeling good after the activity has culminated, and 25.4% also posited feeling relaxed, 20.3% normal, and 29.1% satisfied. Few participants reported feeling depressed (2.1%), while 0.5% hopeless, 5.6% guilty, and 1.9% to be in sin (see Table 2). As such, it could be inferred from the responses of the participants that, in general, they do not have emotional discomforts due to their less-common sexual fantasies, desires, and/or behaviors. Those that do report, the discomfort may be attributed to issues ranging from religious beliefs to legal ramifications and/or psychological issues. This finding is further supported when 9.1% of the participants reported such fantasies, desires, and/or behaviors as abnormal, even though 20.0% stated they were not sure if they were normal or abnormal and 65.5% posited to consider them as normal.

Religious practice does not appear to have an effect on whether participants perceive less-common sexual fantasies, desires, and/or behaviors as abnormal or normal. Additionally, participants, regardless of their religious practices, perceive their self

esteem as good or very good. Therefore, it could be inferred that gay men in Puerto Rico, regardless of their religious practices, perceive that, at least some less-common sexual fantasies, desires, and/or behaviors, are normal and are not in conflict with their religious beliefs in this area. From the findings of this study, we can also infer that the more educated the gay man is in Puerto Rico, the greater their views of accepting at least some less-common sexual fantasies, desires, and/or behaviors as normal.

In general, participants report to have control of their sexual acts prior to engaging in less-common sexual behaviors (84.4%). However, while engaged in such fantasies, desires, and/or behaviors, only 63.6% posited to be in total control of their acts, while 16.6% reported to be partially in control, and 1.6% to lose all control. From this information we may infer that some participants that believe or understand to have control of their sexual behaviors, do lose such abilities which may lead them to sexually behave against their core beliefs, thus, exposing themselves to the possibility of acting out sexual behaviors they would not necessarily want to under nonsexual impulse scenarios. This data is further supported when we observe that 7.7% of the participants reported to be a little worried about their less-common sexual fantasies, desires, and/or behaviors, in addition to those who reported to be moderately worried (2.1%), or very worried (0.9%).

From this information we can infer that the majority of the participants are comfortable with their less-common sexual fantasies, desires, and/or behaviors, and that they report no emotional or psychological discomforts due to them, while a limited number do report mental and emotional discomforts that may be in need of attention.

A total of 64 (14.9%) participants indicated feeling emotional or psychological discomfort and not seeking help. Among the reasons for not seeking help, 10 (2.3%) indicated not knowing where to seek help, 16 (3.7%) indicated to feel shame in seeking for help, and 15 (3.5%) to feel fear to have to mention it to someone else. We can infer from this data, that there is a need of competent and professional mental health practitioners to serve this population, as well as adequate public health guidance and information as to where services may be obtained.

Suicide among gay men is a prevalent concern, specifically among gay youth in Puerto Rico (Fankhanel, 2004). Therefore, information was sought from the participants that would allow us to get basic data as to the possibility of suicidal thoughts and attempts related to their less-common sexual behaviors. Four percent reported having at least one suicidal thought, while 3.3% reported having attempted suicide at least once. This information, when compared with the findings by Fankhanel (2004) who reported that 18.0 % of gay youth in Puerto Rico had attempted suicide during their life span, is a constant and significant finding that requires further study.

A total of 15.2% of the participants sought help due to emotional or psychological discomfort related to their less-common sexual fantasies, desires, and/or behaviors; specifically, 9.3% indicated their gay friends to be their choice for help. Siblings were their second most mentioned choice (4.2%) followed by their mothers (3.7%). When seeking help from professionals, psychologists were the most sought (4.7%), followed by professional counselors (2.6%), psychiatrists (1.6%), physicians (1.6%), and sex therapists (0.7%). Spiritual leaders were mentioned by 0.7% of the participants.

When participants were asked where they would consider seeking help for a less-common sexual fantasy, desire, and/or behavior, the reported professional of choice was the psychologist (40.3%), who were followed by sexual therapist (24.0%), professional counselors (19.6%), and psychiatrist (17.2%).

This data reveals that gay friends and family members are the choice of preference by those participants that sought help, and mental health professionals, specifically psychologists and professional counselors are considered mostly by those who would seek help. This information is valuable for professional schools in the area of mental health when deciding to establish courses within their curriculums that may provide future mental health professionals with the knowledge and skills to properly serve these clients.

In summary, this study gathered basic descriptive data about less-common sexual fantasies, desire, and/or behaviors among gay men in Puerto Rico, free from other cultural, social and political variables that could affect similar studies if conducted elsewhere where the ethnic minority variable is present. Most important, this information provides us with a general profile of paraphilic behaviors among gay men in Puerto Rico.

Recommendations

The findings of this study provide basic descriptive data on gay men living in Puerto Rico who attend gay socializing venues. Specifically, the data covers socio-demographic description of these men (ages 17 to 58), their self reported less-common sexual fantasies, desires, and /or behaviors, and emotional and psychological issues related to them.

The intent of this study was not to cover all the psychological and behavioral domains necessary to properly and adequately assess less-common sexual fantasies and behaviors in Puerto Rican gay men, but rather to provide a starting data base from which further in depth studies can continue to expand the knowledge required to fully understand these behaviors so that we may ethically gear our efforts to better serve the needs of this population.

First, additional studies are needed to better understand the sexual behaviors of gay men in Puerto Rico. As reported by Fankhanel (2004), these studies “need to be issue specific, and should preferably be conducted using intense interviewing techniques” (p.132), so that the content and variables can be more scientifically pure.

The data obtained in this study only surfaces the enormous amount of information needed to create a better understanding of the existing paraphilic behaviors and how they affect, positively or negatively, gay men in Puerto Rico where cultural issues such as, religion, social stigmatization, and criminal law may have an adverse effect over those who experience less-common sexual fantasies and behaviors.

Mental health issues among gay men who experience paraphilic fantasies and behaviors are another area that requires further study. Issues such as depression, anxiety, impulse control, guilt, and high-risk sexual behavior which may lead to suicide are not to be taken lightly and should be the focus of special attention by all mental health professionals, including graduate schools in the development of specialized courses to provide acceptable knowledge, skills and attitudes among developing professionals. Additionally, mental health allied professions, and colleges and universities offering degrees in such areas, must revisit the focus currently given, if any, to the field of clinical

sexology, an emerging discipline that encompasses many if not all areas of the social sciences and medicine and which is in great need of specialized attention by a specialized curriculum.

Another area that should be considered to broaden the descriptive data obtained in this study may include the presence of what appears to be a congenial relationship among gay men, religions and God. This finding is supported by Fankhanel (2004) who found that 67.3% of gay youth in Puerto Rico perceive that God accepts them as gay, while over 50% of the gay men who participated in the current study reported to practice a Christian religion, and for the most part, perceive their less-common sexual fantasies, desires, and or behaviors as normal. A change in paradigm from being gay and practicing less-common sexual behaviors and not being accepted by God appears to be shifting in the opposite direction and merits additional study.

Future research among gay men, irrespectively of paraphilic behaviors, should look into gay sexual orientation and life style, and the relationship with religious upbringing and current beliefs, as it appears that gay men in Puerto Rico enjoy a close relationship of acceptance with God, despite their sexual orientation and less common sexual behaviors, a paradigm shift from what may be observed in other more conservative Christian societies.

As evidences from the data, some gay men in Puerto Rico report lack of control when engaging in sexual behaviors. This lack of control leads them to engage in sexual behaviors they have reported not be willing to engage in, prior to the instance when the act is occurring. Further studies should seek deeper into cognitions and behavior controls in this area, specifically, if such behaviors may be of high risk. This information will be

of value not only to better understand sexual behavior, but for public health reasons as it may relate to the spread of sexually transmitted diseases.

The findings of this study expose an apparent preference towards either sexually younger or older (at least a 10 year difference) partner. This finding should be further explored as it departs from the current social paradigm that expects sexual partners to be contemporary in age range. Specific causes or triggers to such attraction, and how it's maintained, should be closely looked at.

The results of this study may further serve of value for future research that seeks in depth information as to the variables that could cause a difference between the paraphilic fantasies alone, versus those that act on such fantasies. Seeking information about what specific paraphilias are those which are perceived as abnormal, and which of them cause mental and emotional discomfort will be of great value in narrowing down specific behaviors, whether just fantasized and or acted out. Other research should transcend the gay community and include comparative studies with lesbians and the heterosexual populations. Additional studies may also look at cultural differences between orthodox and non-orthodox countries, specific Latino countries and Anglo American culture as well.

Lastly, research in the area of paraphilic behaviors, in general, is of utmost importance, especially when The American Psychiatric Association is revisiting the DSM-IV-TR, and has specified the use of empirical data when deciding what behaviors will be included in the DSM-V.

Since the majority of the participants that reported less-common sexual fantasies, desires, and/or behaviors specify no mental or psychological discomforts and view such

fantasies, desires and/or behaviors as normal, the psychiatric community needs to take a closer look as to the reasons, if any, to continue to include these less-common sexual fantasies and behaviors classified as paraphilias in the DSM, specifically, those that may be harmful to others but are not acted upon and just surfaces in the mind and are kept in the fantasy stage. Otherwise, continued classification of sexual fantasies, desires, and/or behaviors that are acted upon by consenting adults or sexual fantasies and desires that may be harmful but not acted upon, will continue to create undue emotional and psychological distress upon persons, not because the fantasy or behavior is *mala in se*, but because society, in a specific time and place, for whatever reasons other than scientific, has taken upon themselves to control sexual expressions that are not in agreement with the ruling majority which dictate dissenting behaviors as *mala prohibita*.

In summary, the data collected in this study may be used to conduct future research in that area of paraphilias among gay men, and can well serve as a starting point for research on paraphilias among heterosexual persons in Puerto Rico and other countries.

Finally, as reported by Fankhanel (2004), once again, through their response to this study, the gay community in Puerto Rico, the gay socializing venues specifically, are open to support research that addresses issues of concern among the gay community in an ethically correct perspective. Additionally, gay men in Puerto Rico are equally available to contribute in research that will allow for a better understanding of their sexual orientation and acceptance of their lifestyle within the ruling majority.

The wealth of information that needs to be acquired in the area of human sexual behavior may only be properly obtained through the use of scientifically appropriate

methods under ethical standards, free from the tainted biases of other disciplines or social groups. Therefore, clinical sexology must continue to emerge as an autonomous discipline where the true needs of the stakeholders, sexual human beings, can be fulfilled. This study is a contribution to such discipline.

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Appendix A
Informed Consent & Instructions
Spanish Version

INVESTIGACION

Aviso de Consentimiento Informado

Instrucciones a personas completando el cuestionario

!Saludos! Soy Edward H. Fankhanel, estudiante del programa doctoral en sexología clínica de la American Academy of Clinical Sexologists en Orlando, Florida. Como requisito para la disertación doctoral, realizo una investigación en Puerto Rico. Estoy solicitando su participación voluntaria y la información sobre el propósito del estudio, así como el consentimiento informado están explicados a continuación.

El propósito de este estudio es recopilar información sobre las “conductas sexuales menos comunes entre los gays en Puerto Rico”. Si usted participa en este estudio, se le dará un cuestionario el cual podrá llenar de inmediato y en estricta confidencialidad. Lo entregara en un sobre sellado. También tiene la opción de llevarse el cuestionario y llenarlo en otro lugar de su selección. En tal caso, se le proveerá de un sobre con sello de correo pre-pagado para que lo envíe por correo sin costo alguno para usted. En ningún momento tendrá que escribir su nombre ni ninguna información que lo identifique, garantizando así su anonimato.

Se le pedirá información demográfica básica, así como información sobre sus fantasías, deseos y conductas sexuales. Algunas preguntas estarán dirigidas a emociones, pensamientos y conductas. Su participación tomara unos 10 minutos aproximados.

Su participación es estrictamente voluntaria. Usted puede negarse a participar o, puede discontinuar su participación en cualquier momento que desee o lo estime necesario sin penalidad ni consecuencias negativas.

El propósito de este estudio es académico y la información no será utilizada para otros fines. La información que usted provea será tratada con estricta confidencialidad. En ningún lugar debe poner su nombre ni ninguna información que lo identifique personalmente a usted. Los cuestionarios serán guardados solamente por el Investigador Principal y solamente se presentaran los datos globales del estudio una vez terminado el mismo. En ningún momento se presentará la información de un solo cuestionario.

Usted también tiene derecho a revisar los resultados del estudio. Si desea, puede comunicarse con el Investigador Principal a:

EncuestaPR

PMB 862

San Juan, Puerto Rico 00926-6023

O **ENCUESTApr@yahoo.com**

Su cooperación con este estudio permitirá el que se obtenga información sobre los procesos psicológicos y conductas de los gays en Puerto Rico con el propósito de entenderlos mejor y educar a profesionales de la salud mental en Puerto Rico para proveer mejores servicios que vayan a tono con las necesidades de esta población.

Él usted participar voluntariamente de este estudio se considerara como que usted ha dado su consentimiento a participar.

Lugares donde puede obtener ayuda

Emergencias- médica/emocional. Tel. 9-1-1 Salud Mental AMSCA Tel. 1-800-981-0023

P.R. CONCRA Tel. 787/753-9443 CLETS Tel. 787/754-8118

AsPECTS Tel. 787/518-1096

Grupo Apoyo estudiantes gay UPR – Río Piedras Tel. 787/764-0000 ext. 5683

Appendix B
Informed Consent & Instructions
English Version

ENGLISH TRANSLATION

**Letter of Informed Consent
and
Instructions to Subjects Completing Survey Research**

I am Edward H. Fankhanel, a clinical sexology doctoral student at the American Academy of Clinical Sexologists, Orlando, Florida. As part of my doctoral dissertation I am conducting a study in Puerto Rico. Your voluntary participation is being requested and the information on the purpose of this research, as well as the informed consent is hereby explained in detail.

The purpose of this research is to obtain information about the “Less common sexual behaviors among Gay men in Puerto Rico.” If you wish to participate in this study, a questionnaire will be provided to you. You will be able to complete it immediately and under strict confidentiality. You will place it and return it in a sealed envelope. You also have the option of taking it with you and completing it at a place of your choosing. In such case, you will be provided with a pre-addressed and postage paid envelope so that you can mail it at no cost to you. In no moment whatsoever will you have to write or sign your name or other information that may identify you. This way, we guarantee your identity will remain confidential.

If you participate in this research, you will be asked to provide basic demographic information, as well as your information regarding your sexual fantasies, desires and behaviors. Other questions are in the areas of past or present emotions, feelings, and experiences. Your participation will take approximately 10 minutes.

Your participation in this research is strictly voluntary. You may refuse to participate at all, or choose to stop your participation at any point in the research, without fear of penalty or negative consequences of any kind.

The goal of this study is purely academic and the data will not be used in any different way. The information/data you provide for this research will be treated confidentially. At no time should you write your name nor any information that can personally identify you. All raw data will be kept in a secured file by the researcher. Results of the research will be reported as aggregate summary data only, and no individually identifiable information will be presented.

You also have the right to review the results of the research if you wish to do so. A copy of the results may be obtained by contacting the researcher at the address below:

Encuesta PR

PMB 862

or ENCUESTApr@yahoo.com

San Juan, P. R. 00926-6023

Benefits of your participation may include the acquiring of information about the psychological and behavioral process of Puerto Rican gay men regarding their sexual fantasies, desires and behaviors. This will allow the mental health professionals to provide better services that may help you should you desire to seek counseling related to this area. Accepting to voluntarily participate of this study will be considered implied consent.

Where to get Help

Emergencias- médica/emocional. Tel. 9-1-1 CLETS Tel. 787-754-8118

P.R. CONCRA – Grupos de apoyo. Tel. 787/753-9443 ASSMCA Tel. 1-800-981-0023

Grupo Apoyo Gay UPR – Tel. 787/764-0000 ext. 5683 AsPECTS Tel. 787/518-1096

Appendix C

Questionnaire: Spanish Version

Conductas Sexuales Menos Comunes entre los Gay en Puerto Rico

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- 1) Sexo: Masculino Femenino
- 2) Edad: _____
- 3) Grupo étnico:
Puertorriqueño _____
Cubano _____
Dominicano _____
Norte Americano (no-Latino) _____
Otro: _____
- 4) Reside en:
San Juan Metro _____
PR Norte _____
PR Sur _____
PR Este _____
PR Oeste _____
PR Centro _____
Otro: _____
- 5) ¿Cuál religión practica actualmente?:
Ninguna _____
Católica _____
Evangélica/Protestante _____
Otra: _____
- 6) Ingreso anual familiar:
\$0 ----- \$10,000 _____
\$10,001 - \$20,000 _____
\$20,001 - \$30,000 _____
\$30,001 - \$40,000 _____
\$40,001 o más _____
- 7) Usted tiene sexo con:
Hombres solamente _____
Mujeres solamente _____
Con hombres y mujeres _____
Al día de hoy, no he tenido sexo
con una persona _____
- 8) Al presente, se considera:
Gay _____
Bisexual _____
Gay - experimentando _____
Transexual/transgenero _____

12) Durante su vida, ¿cuántas veces usted ha experimentado fantasías, deseo y/o practicado las siguientes **conductas sexuales menos comunes**?:

	Frecuencias de sus fantasías, deseos y/o conductas sexuales durante su vida				
	Nunca	Una sola vez	2 a 10 veces	11- 20 veces	Más de 20 veces
Fantasías sexuales intensas, deseos y/o conductas sexuales que envuelvan...					
1) exponer sus genitales a un extraño					
2) objetos (no vivos) (ejemplos: zapatos, ropa interior, olores, etc.) escriba el objeto específico: _____					
3) tocar o frotar una persona que no esté de acuerdo.					
4) actividad sexual con un menor de 13 años					
5) el acto real (no simulado) de ser humillado, pegado, penetración de la mano, atado, etc., o que le cause sufrimiento de alguna clase.					
6) el acto real (no simulado) en donde el sufrimiento psicológico o físico (de ser humillado, pegado, penetración de la mano, atado, etc.) de su compañero sexual le excita sexualmente a usted.					
7) el acto de observar a una persona que esté desnuda o realizando un acto sexual, sin que la persona sepa que usted observa.					
8) el auto-asfixiarse durante la masturbación-orgasmo.					
9) el uso de escreta					
10) insertar un objeto por la uretra del pene.					
11) animales					
12) el que usted se vista de mujer					
13) que su pareja se vista de mujer					
14) el usted observar a su pareja o compañero teniendo sexo con otra persona					
15) el observar películas o fotos eróticas					
16) tatuajes/piercing					

17) atracción a partes específicas del cuerpo (pie, pelo, dientes, nalgas.etc.)					
18) el uso de enemas					
19) la orina (“golden showers”)					
20) tener sexo con una persona por lo menos 10 años mayor ____ o 10 años menor ____ que usted					
21) Si hay alguna circunstancia que le excite y/o practique que no se haya mencionado, favor de indicarla aquí:					

CONTINUA EN LA PROXIMA PAGINA

13) Si usted reportó haber experimentado una o más fantasías, deseos y/o conductas sexuales menos comunes, ¿Cómo se sintió usted **DURANTE** la fantasía, deseo y/o conducta?

No Aplica ____ Bien ____ Regular ____ Mal ____

14) Si usted indicó haber experimentado una o más fantasías, deseos y/o conductas sexuales menos comunes, ¿cómo se sintió usted **DESPUES** de la fantasía, deseo y/o conducta sexual? (selecciones todas las que apliquen).

No Aplica ____

Bien ____

Relajado ____

Calmado ____

Normal ____

Satisfecho ____

Fascinado ____

Tranquilo ____

Indiferente ____

Excitado ____

Otro: _____

Deprimido ____

Desesperanzado ____

Asustado ____

Culpable ____

Vacío ____

Solo ____

En pecado ____

Enfermo ____

Avergonzado ____

Otro: _____

15) Si usted indicó haber experimentado una o más fantasías, deseos y/o conductas sexuales menos comunes:

No Aplica ____

¿A qué edad **tuvo** la **1ra fantasía** sexual menos común? ____

¿A qué edad **realizó** la **1ra práctica** sexual menos común? ____

16) ¿Cómo se considera usted **DURANTE** las fantasías, deseos y/o conductas sexuales menos comunes?

No Aplica ____

Totalmente en control de mis actos ____

Parcialmente en control de mis actos ____

Pierdo todo el control de mis actos ____

17) ¿Considera usted que las fantasías, deseos y/o conductas sexuales menos comunes son?:

Normales ____ Anormales ____ No se ____

18) ¿Considera usted tener falta de control que lo lleve a realizar conductas sexuales menos comunes?

No ____ Sí ____

19) Si usted reportó una fantasía, deseo y/o conducta sexual menos común, y se siente emocional o psicológicamente incómodo por ello, ¿ha buscado ayuda (consejería y/o terapia)?

___ **No Aplica**

___ **No** => ¿Por qué no? (seleccione todas las que apliquen)

No sé dónde ir por ayuda ___

Me da vergüenza buscar ayuda ___

Tengo miedo de mencionarlo a alguien ___

Otra: _____

___ **Sí** => ¿Con quién? (Seleccione todas las que apliquen)

Madre ___

Padre ___

Hermanos/as ___

Amig@s heterosexuales ___

Amigos gay ___

Personal escolar ___

Psicólogo ___

Consejero ___

Psiquiatra ___

Médico ___

Terapeuta sexual ___

Grupo de apoyo gay ___

Sacerdote, ministro, líder espiritual. ___

Otro: _____

¿Considera que le ayudaron favorablemente?:

Sí ___ No ___

Explique: _____

20) Al presente, ¿cuán preocupado está usted sobre sus fantasías, deseos y/o conductas sexuales menos comunes?

No Aplica _____

No estoy preocupado _____

Estoy un poco preocupado _____

Estoy moderadamente preocupado _____

Estoy muy preocupado _____

21) Si usted fuera a buscar ayuda por una fantasía, deseo y/o conducta sexual menos común por la cual no se siente bien, ¿a dónde iría a buscar dicha ayuda? (Seleccione todas las que apliquen).

Madre ___

Padre ___

Hermanos/as ___

Amigos/as heterosexuales ___

Amigos gay ___

Personal escolar ___

Sacerdote, ministro, rabino, líder espiritual. ___

Psicólogo ___

Consejero ___

Psiquiatra ____
Médico ____
Terapista sexual ____
Grupo de apoyo gay ____
Otro: _____

22) ¿Ha **pensado** usted alguna vez en suicidarse debido a sus fantasías, deseos y/o conductas sexuales menos comunes?

No Aplica ____ No ____ Sí ____ (cuántas veces) ____

23) ¿Ha **intentado** usted suicidarse alguna vez debido a sus fantasías, deseos y/o conductas sexuales menos comunes?

No Aplica ____ No ____ Sí ____ (cuántas veces) ____

24) ¿Cuáles considera usted son las necesidades de consejería y/o terapia de hombres gay que experimentan fantasías, deseos y/o conductas sexuales menos comunes? (Seleccione todas las que apliquen).

Ninguna necesidad ____
Para que se acepten como son ____
Para conducta compulsiva/impulsiva ____
Para modificación de conducta ____
Para razones morales ____
Para razones religiosas ____
Para conflictos legales ____
Otra razón: _____

GRACIAS!!!

Appendix D

Questionnaire: English Version

Less Common Sexual Behaviors Among Gay Men in Puerto Rico

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- 1) Sex: Male Female
- 2) Age: _____
- 3) Ethnic Group:
Puerto Rican _____
Cuban _____
Dominican _____
North American (non-Latino) _____
Other: _____
- 4) I reside in:
San Juan Metro _____
PR. North _____
PR. South _____
PR. East _____
PR. West _____
PR. Center _____
Other: _____
- 5) What are your current religious practices:
None _____
Catholic _____
Evangelical/Protestant _____
Other _____
- 6) Yearly household income:
\$0 - \$10,000 _____
\$10,001 - \$20,000 _____
\$20,001 - \$30,000 _____
\$30,001 - \$40,000 _____
\$40,001 or more _____
- 7) I have sex with:
Men only _____
Women Only _____
Both men and women _____
I have never had sex with a person yet _____

8) Presently, I consider myself:

Gay _____
Bisexual _____
Experimenting –Gay _____
Transexual/transgender _____
Heterosexual _____
Not sure _____
Other _____

9) Highest educational level completed:

Less than elementary ____
Elementary _____
Junior high _____
High school _____
Technical degree _____
Associate degree Univ. _____
Bachelor's degree _____
Masters Degree _____
Doctoral Degree _____

10) How do you perceive your self-esteem at this time?

Very good ____
Good ____
Regular ____
Poor ____
Very poor ____

11) How do you perceive your emotional/mental health at this moment?

Good ____
Stable ____
Unstable ____
In crisis ____

Continues on next page

12) During your lifetime, how many times have you had fantasies, desires and/or performed the following less common sexual behaviors?

	Frequency of Fantasies, Desires and/or Sexual Behaviors During Your Life Span				
	Never	One only	2 -10 times	11- 20 times	More than 20 times
Intense sexually arousing fantasies, sexual urges or behaviors involving...					
1. exposure of your genitals to a stranger					
2. nonliving objects. (examples: shoes, underwear, odors, etc.) write the specific object:					
3. touching and rubbing against a nonconsenting person					
4. sexual activity with a child under age 13					
5. the act (real, not simulated) of being humiliated, beaten, penetrated with a fist, bound, or otherwise made to suffer					
6. acts (real, not simulated) in which the psychological or physical suffering (of being humiliated, beaten, penetrated with a fist, bound)of your sexual partner is sexually exciting to you					
7. the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity					
8. asphyxiation during masturbation/orgasm					
9. the use of feces					
10. inserting a catheter in your penis/urethra					
11. animals					
12. you dress as a female.					
13. a partner that dresses as a female					

14. viewing your partner having sex with other person					
15. Observing erotic graphics or films					
16. tattoo/ piercing					
17. attraction to specific parts of the body (feet, hair, teeth, butt, etc.)					
18. the use of enemas					
19. urine (“golden showers”)					
20. having sex with a person at least 10 years younger____ or 10 years older ____ than you?					
21. Are there any other circumstances that sexually aroused you that have not been included in this list? Please list them: _____					

CONTINUES ON NEXT PAGE

13) If you indicated having one or more less-common sexual fantasies, desires and/or behaviors, how do you feel **DURING** the fantasy, desire and/or behavior?

Not Applicable ___ Good ___ Regular ___ Bad ___

14) If you indicated having one or more less-common sexual fantasies, desires and/or behaviors, how do you feel **AFTER** such fantasy, desire and/or behavior: (Select all that apply)

Not Applicable _____

Good ___

Relaxed ___

Calm ___

Normal ___

Satisfied ___

Fascinated ___

Tranquil ___

indifferent ___

Excited ___

Other: _____

Depressed ___

Hopeless ___

Scared ___

Guilty ___

Empty ___

Lonely ___

in sin ___

Sick ___

Shamed ___

Other _____

15) If you reported a less-common sexual fantasy, desire and/or behavior,

Not Applicable ___

At what age did you have the 1st less-common sexual fantasy? _____

At what age did you engage in the 1st less-common sexual behavior? _____

16) How do you consider yourself to be **DURING** the less-common sexual fantasy, desire and/or behavior?

Not Applicable ___

Totally in control of myself _____

Partially in control of my self _____

I lose all control of myself _____

16) You consider less-common sexual fantasies, desires and/or behavior as:

Normal ___ abnormal ___ not sure ___

18) Do you consider yourself to have lack of control that leads you to the less-common sexual acts?

No ___ Yes: ___

19) If you reported a less than common sexual fantasy, desire and/or behavior and have an emotional or psychological discomfort about it, did you seek counseling to help you with this situation?

___ Not Applicable

___ No => Why Not? (Select all that apply)

Do not know where to go ___

Ashamed to tell ___

Scared to tell ___

Other _____

___ Yes => With Whom? (Select all that apply)

Mother ___

Father ___

Siblings ___

Heterosexual friends ___

Gay friends ___

School personnel ___

Psychologist ___

Counselor ___

Psychiatrist ___

Physician ___

Sex therapist ___

Gay support group ___

Priest/reverend, etc. ___

Other: _____

Were they helpful?

Yes ___ No ___

Explain _____

20) At the present time, how concerned are you about your less-common sexual fantasies, desires and/or behaviors?

Not Applicable _____

Not concerned ___

Little concerned ___

Moderately concerned ___

Very concerned ___

21) If you were to seek help for the less-common sexual fantasies, desires and/or behaviors that you did not feel good about, from who would you consider getting it: (Select all that apply).

Mother ___

Father ___

Siblings ___

Heterosexual friends ___

Gay friends ___

School personnel ___

Priest, reverend, etc. ___

Psychologist ___

Counselor ___

Psychiatrist ___

Physician ___

Sex therapist ___

Gay support group ___

Other: _____

22) Have you ever thought about suicide because of your less-common sexual fantasies, desires, and/or behaviors?

Not Applicable ____ No__ Yes ____
How many times? ____

23) Have you ever tried to commit suicide because of your less-common sexual fantasies, desires and/or behaviors?

Not Applicable ____ No__ Yes ____
How many times? ____

23) What do you think would be the counseling needs of gay men with less-common sexual fantasies, desires and/or behaviors? (Select all that apply).

No need to get help ____
For self acceptance ____
For compulsive/impulsive behavior ____
For behavior modification ____
For moral issues ____
For religious issues ____
For legal conflicts ____
Other _____

Thank You!!!

Appendix E
Distribution of Questionnaire

Distribution of Questionnaires

Dates/Locations	<u>Questionnaires Distributed</u>		<u>Questionnaire Received</u>	
	In Person	Snow-ball	In Person	By Mail
March 5, 2008				
University	0	5	0	0
March 6, 2008				
Roggies	3	0	3	0
March 7, 2008				
Los Parao	9	0	9	0
March 8, 2008				
PMB	0	0	0	1
March 9, 2008				
Atlantic Beach	13	0	13	0
March 10, 2008				
PMB	0	9	0	4
University	1	0	1	0
March 11, 2008				
Roggies	2	0	2	0
Ballet S.J.	1	0	1	0
University	2	0	0	0

March 15, 2008				
University	1	0	0	0
Los Parao	3	0	3	0
Tía María	8	0	8	0
March 20, 2008				
JA	0	10	0	0
March 25, 2008				
University	0	0	2	0
March 27, 2008				
University	1	0	1	0
March 30, 2008				
MCC	0	30	0	0
April 3, 2008				
University	2	0	2	0
April 4, 2008				
PMB	0	0	0	1
April 5, 2008				
Tía María	17	0	17	0
Kennys	27	0	27	0
April 10, 2008				
Krash	39	0	39	0
April 11, 2008				
PMB	0	0	0	1

April 12, 2008				
Atlantic Beach	15	0	15	0
PMB	0	0	0	12
University	0	8	0	0
April 19, 2008				
Kennys	25	0	25	0
April 20, 2008				
Latino	39	0	39	0
April 26, 2008				
Nova Ley	38	0	38	0
Ultra	13	0	13	0
June 1, 2008				
Gay Pride S.J.	75	0	75	0
June 8, 2008				
Gay Pride C.R.	69	0	69	0
June 23, 2008				
San Juan night	20	0	20	0
<hr/>				
Totals	423	62	422	19
TOTAL Received 441				

Note. PMB= Private mail box; University= university students at/or from some universities; MCC= Metropolitan Community Church; JA = volunteer individual.

Appendix F

Geographical Distribution of Participants



Note. $N = 429$. Distribution of participants' representation of the sample by demographic regions of Puerto Rico: San Juan Metro 52.0%, North 12.8%, South 7.9%, East 7.7%, West 12.4%, and Central 7.2%.