

Sadomasochism

Charles Moser

To cite this article: Charles Moser (1989) Sadomasochism, Journal of Social Work & Human Sexuality, 7:1, 43-56, DOI: [10.1300/J291v07n01_04](https://doi.org/10.1300/J291v07n01_04)

To link to this article: https://doi.org/10.1300/J291v07n01_04



Published online: 26 Oct 2008.



Submit your article to this journal [↗](#)



Article views: 1



View related articles [↗](#)



Citing articles: 17 View citing articles [↗](#)

Sadomasochism

Charles Moser

The relation of love to pain is one of the most difficult problems, and yet one of the most fundamental, in the whole range of sexual psychology. Why is it that love inflicts, and seeks to inflict, pain? Why is it that love suffers pain, and even seeks to suffer it? . . . [I]f we succeed in answering it we shall come very near one of the great mysteries of love. At the same time we shall have made clear the normal basis on which rest the extreme aberrations of love. (Ellis, 1903/1936, p. 66)

Thus, Havelock Ellis started his discussion of the phenomenon now called sadomasochism (S/M). It is no less intriguing today and, unfortunately, not much more is now known than was known then.

The social stigma attached to S/M is so great that few clients will admit to these interests, for fear of what the psychotherapist or physician will think. As will be seen later, the number of practitioners is so great that it is obvious that all clinicians have contact with S/M practitioners. The lack of understanding of the nature of the S/M subculture and practitioner leads the clinician to make assumptions and errors which may alienate the S/M practitioner-client. The present article seeks to describe the S/M practitioner and the common types of presenting problems encountered by a psychotherapist.

Address reprint requests to Dr. Charles Moser, 2200 Benjamin Franklin Parkway, # E1702, Philadelphia, PA 19130.

© 1988 by The Haworth Press, Inc. All rights reserved.

43

DEFINITION OF THE PHENOMENON

There is no accepted definition of what constitutes S/M behavior and the spectrum of sexual interests of those individuals who adopt an S/M identity is quite broad. Colloquially, we can define S/M as an erotic interest in giving and/or receiving painful (either physically or psychologically) stimulation. It should be noted that the perception of pain is in the judgment of the observer; the recipient may or may not report the experience as painful. From the perspective of the clinician, the colloquial definition is the starting point, though it is clearly inadequate and simplistic. Moser (1979) and Weinberg, Williams, and Moser (1984) discuss the problems with creating an acceptable definition at length.

For the purpose of the present article, an S/M practitioner is an individual who actually takes part in the behavior and self-defines as being involved in S/M or a similar term.¹ Additionally, for the purposes of the present article, S/M practitioners engage only in consensual acts among adults. While members of any group can engage in nonconsensual acts, it has been unfairly and incorrectly assumed that S/M practitioners must somehow be forced or coerced, or force or coerce their partners, into engaging in these activities.

ETIOLOGY

S/M has been ignored by most theorists attempting to explain the etiology of sexual behavior. Most of the theory extant is extrapolation of concepts relating to other sexual variances, often developed without the benefit of contact with actual S/M practitioners.

Several theorists have made statements about the etiology of S/M, again without any validation that these theories have any basis even to a clinical sample. An incomplete listing follows: Krafft-Ebing (1886/1965) suggests that S/M is congenital. Freud explains S/M as a transmutation of the death instinct or simply aggression attached to sex (Levitt, 1971). Stekel (1929/1953) suggested that S/M was a form of psychosexual infantilism, while Reik (1941/1976) suggested that the masochist is afraid of orgasm or something associated with orgasm. Horney (cited in Levitt, 1971) explains

sadism as a neurotic need for superiority and masochism as an attempt to find safety and satisfaction through dependency, while Deutch (cited in Ford & Beach, 1951) believes that masochism is normal for women. Thorpe and Katz (1948) suggest sadism stems from early condemnation and shaming, and dissipates castration fears. Additionally, they suggest masochism is caused by a desire for superiority. Maslow (1942/1963) suggests that S/M interests develop out of feelings of insecurity. McCary (1967/1973) suggests that S/M interests are a response to feeling disgust for anything sexual or fears of castration. It should be noted that none of these theories has been adequately tested nor has any been shown to apply more to an S/M sample than a non-S/M sample.

There is a considerable amount of psychoanalytic literature on the etiology of sadomasochism (Panken, 1973; Schad-Somers, 1982), and some literature from the behavioral perspective (Annon, 1974/1975). Despite the preponderance of these hypotheses, there is no accepted understanding of what causes an S/M sexual orientation, or for that matter any other sexual orientation, to develop.

As S/M behavior is seen transhistorically (Ellis, 1936) and cross-culturally (Ford & Beach, 1951), we can assume it is part of the repertoire of innate human sexual behaviors. Behavior which appears to be analogous to S/M is also common among mammals. For example, Kinsey, Pomeroy, Martin, and Gebhard (1953) name 24 different mammalian species which bite during coitus. Additionally, Gebhard (1976) remarks "From a phylogenetic viewpoint it is no surprise to find sadomasochism in human beings" (p. 163).

HISTORY

Prior to Krafft-Ebing (1886/1965), S/M was neither a sickness nor a sin (Bullough & Bullough, 1977). It seems that behaviors that we might consider to be S/M were commonly found in ancient marriage manuals (Kokkoka, 1150/1965; Nefzawi, 1400/1964; Vatsyayana, 450/1964). It was only in the late fifteenth century that the first unambiguous case report of S/M was reported, and then as a medical curiosity rather than a problem (cited by Ellis, 1936). Other case reports written in a similar vein followed, but S/M was still seen as a curiosity rather than pathology. While S/M behavior prob-

ably existed before the 15th century, historical accounts do not include enough information to ascertain whether the behavior was done consensually and/or for erotic purposes in order to make an unambiguous categorization.

S/M PRACTITIONERS

There have been several recent studies of S/M samples, in an attempt to describe the individuals who engage in the behavior (see Breslow, Evans, & Langley, 1985, 1986; Moser & Levitt, in press; Spengler, 1977). These studies have for the most part not found any significant differences between S/M and non-S/M samples. The S/M samples have tended to be better educated and more affluent, but this skew is probably due to who is likely to participate in this type of research project. It is expected that S/M practitioners span all socioeconomic classes and groups. None of the studies was random, so it is not known if all sexual orientations are equally represented. Nevertheless, heterosexual men and women, bisexual men and women, and homosexual men and lesbians are represented in these studies.

There is great diversity on the estimates of the number of S/M practitioners in the general population. At least part of this variance is due to the different ways S/M or similar concepts are presented or defined in these general studies of the sexual behavior. The estimates range from about 50%, those who report at least some erotic response to being bitten (Kinsey et al., 1953), to approximately 5%, those who report obtaining sexual pleasure from inflicting or receiving pain (Hunt, 1974). It is the present author's best guess that approximately 10% of the adult population are S/M practitioners. This number is similar to estimates of the number of homosexuals in the adult population, but obviously the visibility of these groups is quite different.

There is some question of whether as many women as men are S/M practitioners. This relates to an important theoretical question: Is S/M similar to homosexuality where there are a significant number of men and women involved in the behavior or to fetishism where few or no women are involved in the behavior? The latest

data suggest that a significant number of women are involved in the behavior (Breslow et al., 1985; Moser et al., in press).

S/M practitioners tend to at least try many different sexual behaviors and are not exclusive in their S/M interest (Moser et al., in press). Most report that they do not need to engage in S/M behavior or fantasy to reach orgasm (Moser et al., in press; Spengler, 1977). Though Breslow et al. (1986) asked the question differently and found that for approximately 70% of their sample, orgasm was easier to achieve if S/M was involved.

It is important to note by its absence any indication that S/M practitioners have any common psychopathology or symptoms. While the studies of this population are still sketchy, no consistent picture of S/M practitioners has emerged in the clinical literature. There have been some limited attempts to use psychological testing to see if an S/M sample differs from a control sample. None of these studies shows any significant difference between the S/M group and the control group (Gosselin & Wilson, 1980; Miale, 1986; Moser, 1979).

S/M practitioners report an interest in assuming both the dominant and submissive roles, with relatively few individuals indicating exclusively dominant or submissive interests (Breslow et al., 1985, 1986; Moser et al., in press; Spengler, 1977). There is some indication that more people prefer the submissive role to the dominant role, though they engage in both behaviors, but this is not substantiated at this time.

While there is some disagreement, there is little doubt that at least some S/M practitioners are able to sustain long term relationships. The role of S/M in these relationships varies in a number of ways. Some couples only engage in S/M during some sexual interactions, some always have at least an element of S/M in all sexual interactions, some employ S/M role-plays throughout the relationship but not at all times, and some attempt to live out the S/M roles at all times. Some individuals see S/M as part of foreplay (a sex-style), others see it as part of a lifestyle, while still others fluctuate between these two states (Breslow et al., 1985, 1986).

The roles employed are quite varied. The roles of "master/slave," "dominant/submissive," "guardian/child," "employer/servant," "owner/owned," etc. are distinct and imply different re-

lationship characteristics and help shape the acceptable acts that take place.

There is evidence that the respondents to the various studies did not believe that their S/M interests were a psychological problem and that they did not wish to change their S/M orientation (Breslow et al., 1986; Moser et al., in press).

While the S/M participants report some concern that their S/M activities will escalate to a dangerous level (Moser et al., in press), this concern seems to be misplaced. Lee (1979) found no incidences of this and no incidences were found after a search of the medical and psychiatric literature.²

S/M BEHAVIORS

S/M behaviors can be generally divided into two types, physical and psychological. Usually, S/M practitioners enjoy some combination of these two types, but some individuals are quite specific about which behaviors they enjoy and which they do not. These preferences are not only within groups like physical, but may be as specific as being beaten with a blue whip 2'3" long by a blonde woman who speaks soothingly. It should be noted that participation in any of the following behaviors does not mean that an individual is involved in S/M. The following behaviors include behaviors common to some S/M practitioners, but not every S/M practitioner enjoys any or all of these behaviors.

Physical behaviors: The physical behaviors may be further subdivided into the following categories: bondage, physical discipline, intense stimulation, sensory deprivation, and body alteration. These categories are not meant to be mutually exclusive.

Bondage or restraint ranges from being held down or tied in such a manner that the person could escape if he or she tried, to behaviors involving elaborate restraints that leave a person completely immobilized. This category also includes the partial immobilization through the use of handcuffs, leashes, constricting clothes (e.g., corsets), etc.

Physical discipline ranges from slapping to whipping to caning. These behaviors can be of low intensity such that no marks are left, of moderate intensity such that only a redness that will disappear in

a few hours or days is left, or of high intensity so that extensive bruising, welts, or other lesions are left for several days or even weeks. Often, the recipient of these blows does not recognize what level of tissue damage has been inflicted nor does the intensity of the pain experienced necessarily relate to the tissue damage inflicted.

Intense stimulation activities include scratching, biting, the use of ice on skin, hot wax on skin, etc. These are activities that produce strong sensations with little or no tissue damage. The range of these behaviors usually involves duration or manner. Scratching someone's back a few times can be quite pleasing, but scratching someone's back for an hour can be quite painful. Also included in this category are any behaviors or devices that increase sensation. For example, a spanking on wet skin is more intense than on dry skin; dropping hot wax from several feet above someone is a very different sensation from dropping it from a few inches above them.³

Sensory deprivation can also heighten sensations as well as intensify feelings of vulnerability. For example, a blindfold deprives the wearer of knowing when or where the next blow is to be struck. Not being braced for the blow may increase the sensations as well as focusing the recipient on the sensation without any other distractions. Other examples of sensory deprivation devices include hoods, ear plugs, gags, etc.

Body alteration activities involve tattooing, piercing, branding, burns, etc. While many of these activities are meant to be permanent, they often are not. These behaviors may be seen as proof of S/M commitment, beautifying, or as sensory enhancements.

It should be noted that the activities that cause more physical damage have the lowest frequency (Moser et al., in press). S/M practitioners want to engage in the behavior. If the behavior disabled the recipient, then that person would not be available for S/M interactions in the future. In addition, the dominant partner would gain a reputation for "going too far" and other submissive partners would be hesitant to become involved with that dominant. The result is that most S/M organizations stress and teach safety, and serious injury is rare.

Psychological feelings: Psychological pain is induced by feelings of humiliation, degradation, uncertainty, apprehension, powerless-

ness, anxiety, and fear. These feelings are often triggered by specific acts for each individual. In the S/M subculture the most common psychological aspect of the interaction is humiliation, but there is no behavior that is universally humiliating to everyone. It is important to note that some people would find submission very humiliating and not desire it, while obviously some people seek out this feeling. Given that not everyone has the same likes and dislikes, it should not be surprising that S/M participants view these feelings differently.

These psychological feelings are generated by both verbal statements and actions taken. For example, verbally berating the submissive (e.g., "You are a poor excuse for a slave"), requiring the submissive to do menial or embarrassing acts (e.g., clean the toilet or kissing the dominant's feet), being left alone in a vulnerable position (e.g., being left alone without money, keys, or identification), etc.

Both physical and psychological behaviors are devised to emphasize the transfer of power from the submissive to the dominant partner. S/M practitioners often report it is this consensual exchange of power that is erotic to them and the pain is just a method of achieving this power exchange.

TYPES OF CLINICAL PROBLEMS

S/M practitioners, like members of any other sexual orientation, can have psychiatric problems. These problems may or may not have any connection to the individual's sexual interests. The determination of whether S/M interests are causing, exacerbating, or irrelevant to the problem is difficult, and requires considerable knowledge of the S/M community and the spectrum of S/M practices. Given that there are few experts on sadomasochism, a non-judgmental approach and a desire to learn more about S/M is essential to anyone dealing with S/M practitioners. Recognition that S/M is not a comfortable subject for the clinician is adequate reason for referral.

The following are types of problems that the author has seen in approximate order of the most frequent to least frequent complaint. Obviously, the reputation of the author would tend to cause some

prospective clients either to seek out or avoid the author. Therefore, the ordering should not be construed as a reflection of the actual incidence of the problem among S/M-identified individuals.

(1) *Am I normal?* By far the most common and easiest problem with which to work, is this one. Many people beginning to explore their S/M desires are concerned that S/M is a pathological condition that leads people to commit heinous crimes and will be detrimental to the quality of their life. It is common for S/M practitioners to believe that their interest in S/M will escalate to a point where dangerous activities are commonplace, and major injury is just a matter of time. In fact, this is false; few injuries result from S/M interactions (Lee, 1979).⁴ Reassurance, education, and referral to a support group often solves this problem in as little as one session and rarely more than six sessions.

Untreated, these individuals often present as stating that the S/M lifestyle was problematic for them and they had to give it up. It is important to note that some individuals give up specific sexual behaviors for a variety of reasons and that is not necessarily contraindicated. Nevertheless, denial of one's sexual orientation is usually considered to be problematic. Individuals who present with this concern should be seen as in a similar state as homosexuals going through the "coming out" process.

(2) *Can you make these desires go away?* Some S/M people yearn for a more mundane sexual lifestyle and wish to change their sexual orientation. Unfortunately, sexual orientation is either impossible or very difficult to change, as studies of people attempting to change homosexual orientation indicate. It is important to point out that you can help individuals add new behaviors to their sexual pattern. Thus, you can help an S/M practitioner eroticize non-S/M behaviors, but attempts to uneroticize S/M behavior is rarely, if ever, lasting or successful. There is also an ethical question of whether this is appropriate or not.

Attempts at reassurance and education are occasionally helpful, but most clients seeking to change their sexual orientation will not be satisfied with anything less than rigorous therapeutic intervention. Individuals who present with this problem can be seen as analogous to individuals with egodystonic homosexuality, as described

in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (1980).

(3) *The S/M is destroying our relationship.* Most couples have at least occasional relationship problems and couples who practice S/M as part of their sexual pattern are no different. It is common for the couple to blame the S/M aspect of the relationship for the problems, but couple therapy often uncovers more mundane causes. In either case, mundane or S/M-oriented causation, traditional couple therapy is often helpful. Knowledge of the S/M subculture is essential for the couple's therapist to make a meaningful intervention.

It is interesting to note that not all S/M practicing couples are composed of a dominant and submissive partner. Many of the couples experiencing problems are composed of two primarily submissive individuals who take turns playing the dominant role with each other. This obviously can become a problem area over time. A smaller number of couples exists where both partners are primarily dominant, but these tend not to engage in S/M acts with each other.

(4) *I cannot lead this double life anymore.* There are numerous examples among S/M practitioners of discrimination when their sexual behavior became known. People have lost jobs, been disinherited, lost friends, lost custody of a child, etc., due to their S/M behavior. This has led many individuals to be exceedingly secretive about their S/M activities. Use of pseudonyms, post office boxes, and other devices to confer anonymity are common. This can lead to stress and dissatisfaction with the S/M lifestyle. Denial of S/M interests can eventuate in stress and dissatisfaction with the vanilla (the S/M subculture's adjective for non-S/M) lifestyle.

Even when fear of being found out is not the overriding fear, there are problems with integrating the S/M lifestyle into the everyday world. Some S/M practitioners would like to live their lifestyle 24 hours a day, but cannot due to demands of earning a living or other commitments. That they are not able to live their S/M lifestyle the way they would like is often described by these individuals as being forced to lead a double life.

This problem is often a difficult problem for the individual to work through. Assisting the client in finding a support group, couple therapy, and creative solutions such as working for other S/M

practitioners or in nontraditional jobs where more options are available has been helpful.

(5) *I cannot find a partner.* While the author has not seen many of these individuals professionally, this may be the most frequent complaint in the S/M community. With a small number of S/M support groups, few women who openly admit their S/M interests, and the difficulty in finding a partner who has complementary interests in both type and intensity of activities, it would seem reasonable that this problem would be a major issue in the S/M community. On the other hand, this is a general problem that is affecting the entire single population.

It has been the author's experience that S/M practitioners who complain about the difficulty in finding S/M partners are those who also have problems finding non-S/M partners. Social skill training has been useful in these cases. It should also be noted that many S/M practitioners have been very successful in "bringing out" partners, taking people who have never been involved in S/M and turning them into enthusiastic practitioners. It is not known if these converts to S/M would continue engaging in the behavior if the original relationship broke up, but there are indications that they do in at least some cases.

(6) *Is it violence or S/M?* These cases often come to the author's attention through a legal route. The question arises in relationship to spousal abuse, child abuse, rape, sexual harassment, etc. It has been the author's experience that S/M practitioners are not interested in pursuing their sexual interests unless their partner is willing. This situation is similar to the distinction between rape and consensual coitus. Nonrapists quickly lose interest in coitus if their partner is unwilling. On the other hand, some S/M participants engage in violent acts, either as part of their S/M interests or in spite of their S/M interests.

In these situations, the most important question is "If the victim (this is usually a criminal case) was becoming sexually aroused by being forced, how would that have affected you?" Rapists, sociopaths, etc. report that if the victim was enjoying or aroused by the assault, it would negatively affect their arousal or have no effect. Informal questioning of S/M practitioners suggests that if the person was not enjoying the act, they would stop. This is then a major

difference between these two groups. The distinction is important clinically. If the person committing antisocial acts is truly antisocial, then the prognosis is not good as successful intervention is rare. If the person is a poorly socialized S/M practitioner, then we have several options. Socialization has been an important treatment goal that has helped the individual refrain from antisocial acts in the future.

In the present author's experience, the S/M practitioner rarely commits these violent acts. When an S/M practitioner is involved in violent acts, it is usually seen as separate from the S/M component of their life.

SUMMARY

While there is a paucity of data concerning the psychological problems of S/M practitioners, some preliminary data has been presented. S/M practitioners have not been shown to have any particular psychiatric problems or even any unique problems associated with their activities that interfere with daily functioning. There is no scientific basis to deny S/M practitioners child custody, adoption opportunities, any job, security clearances, or any other right or privilege in this society.

RESOURCES

Support groups for S/M practitioners come in many varied forms. There are general groups, homosexual groups, groups for dominant men and submissive women, groups for dominant women and submissive men, groups around a specific activity which may include both S/M and non-S/M practitioners (e.g., piercing), women's groups, men's groups, etc. These groups organize and dissipate regularly, so no listing would stay current for long. Below, two groups are listed. They are the two oldest S/M groups and both do not limit their membership by orientation or other criteria except an interest in S/M. Both have at least contacts in other cities, if not actual group meetings. Both publish information and magazines with useful information for the S/M practitioner. They are:

The Eulenspiegel Society
P.O. Box 2783
New York, NY 10163

The Society of Janus
P.O. Box 6794
San Francisco, CA 94101

NOTES

1. Other terms include D/S (Dominance and Submission), B/D (Bondage and Discipline), kinky sex, corporal punishment, top and bottom play, M/S (Master and Slave), leathersex, etc.

2. There are some incidences of problems occurring from clearly accidental circumstances. For example, someone contracted an infection after having her nipple pierced. Efforts were made to do piercing under sterile conditions by appropriately trained personnel; nevertheless an infection occurred. Since the infection was not intentional nor due to negligence, it is classified as accidental. It should be noted that most sports (and sexual) activities have accidental injuries associated with their practice.

3. The hot wax used by S/M practitioners is usually paraffin which does not burn. The more expensive beeswax candles can burn and for that reason are rarely used.

4. It seems likely that any injuries clearly related to an S/M interaction would be reported by the press. Similar events (e.g., reports of light bulbs found in a patient's rectum or kidnaping of a woman as a "sex slave") have received more coverage than would be expected by the seriousness of the problem. The lack of stories in the press concerning S/M related injuries and the lack of its mention in other professional journals suggest that the actual occurrence is rare.

REFERENCES

- Annon, J. (1974/1975). *The behavioral treatment of sexual problems* (Vol. 1 & 2). Honolulu: Enabling Systems, Inc.
- Breslow, N., Evans, L., & Langley, J. (1985). On the prevalence and roles of females in the sadomasochistic subculture: Report of an empirical study. *Archives of Sexual Behavior*, 14, 303-317.
- Breslow, N., Evans, L., & Langley, J. (1986). Comparisons among heterosexual, bisexual, and homosexual male sadomasochists. *Journal of Homosexuality*, 13(1), 83-107.
- Bullough, V., & Bullough, B. (1977). *Sin, sickness, and sanity*. New York: Meridian Books.
- Diagnostic and statistical manual of mental disorders* (1980). Washington, D.C.: American Psychiatric Association.
- Ellis, H. (1936). Love and pain. In *Studies in the psychology of sex* (Vol. 1). New York: Random House. (Original work published, 1903)

- Ford, C. S., & Beach, F. A. (1951). *Patterns of sexual behavior*. Scranton, Pennsylvania: Harper & Brothers.
- Gebhard, P. (1976). Fetishism and sadomasochism. In M. Weinberg (ed.), *Sex research*. New York: Oxford University Press.
- Gosselin, C., & Wilson, G. (1980). *Sexual variations*. New York: Simon and Schuster.
- Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behavior in the human female*. Philadelphia: W. B. Saunders Company.
- Kokkoka (1965). *The koka shastra* (A. Comfort, Trans.). New York: Stein & Day. (Originally written 1150)
- Krafft-Ebing, R. von (1965). *Psychopathia sexualis: A medico-forensic study* (F. S. Klaf, trans.). New York: Bell Publishing Company, Inc. (Original work published 1886)
- Lee, J. (1979). The social organization of risk. *Alternative Lifestyles*, 2, 69-100.
- Levitt, E. E. (1971). Sadomasochism. *Sexual Behavior*, September, 69-80.
- Maslow, A. (1966). Self-esteem (dominance-feeling) and sexuality in women. In M. De Martino (ed.), *Sexual behavior and personality characteristics*. New York: Grove Press, Inc. Originally published 1963). (The article was originally published in 1942 in *Journal of Social Psychology*, 16, 259-294.)
- McCary, J. (1973). *Human sexuality* (2nd ed.). New York: Van Nostrand Reinhold Company. (Originally published, 1967)
- Miale, J. P. (1986). *An initial study of nonclinical practitioners of sexual sadomasochism*. Unpublished doctoral dissertation, the Professional School of Psychological Studies, San Diego.
- Moser, C. (1979). *An exploratory-descriptive study of a self-defined S/M (sado-masochistic) sample*. Unpublished doctoral dissertation, Institute for Advanced Study of Human Sexuality, San Francisco.
- Nefzawi, S. (1964). *The perfumed garden* (R. Burton, trans.; A. H. Walton, ed.). New York: G. P. Putnam's Sons. (Originally written 1400 A.D.)
- Panken, S. (1973). *The joy of suffering*. New York: Jason Aronson, Inc.
- Reik, T. (1976). *Masochism in sex and society*. (Originally titled *Masochism in modern man*; M. Beigel and G. Kurth, trans.) New York: Pyramid Books, 1976. (Originally published 1941)
- Schad-Somers, S. P. (1982). *Sadomasochism*. New York: Human Sciences Press, Inc.
- Spengler, A. (1977). Manifest sadomasochism of males: Results of an empirical study. *Archives of Sexual Behavior*, 6, 441-456.
- Stekel, W. (1953). *Sadism and masochism* (2 Vols., L. Brink, trans.). New York: Liveright Publishing Corporation. (Originally published 1929)
- Thorpe, L., & Katz, B. (1948). *The psychology of abnormal behavior*. New York: Ronald Press.
- Vatsyayana (1964). *Kama sutra*. New York: Lancer Books. (Originally written 450 A.D.)
- Weinberg, M. S., Williams, C. J., & Moser, C. A. (1984). The social constituents of sadomasochism. *Social Problems*, 31, 379-389.