Curr Sex Health Rep (2015) 7:49–58
DOI 10.1007/s11930-014-0039-1

CURRENT CONTROVERSIES (P KLEINPLATZ AND C MOSER, SECTION EDITORS)

Sadomasochism in Sickness and in Health: Competing Claims from Science, Social Science, and Culture

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Published online: 16 January 2015

Abstract This article reviews and compares competing depictions of sadomasochism (SM) sexuality, examining portrayals that range from sick to healthy, from normal to abnormal, and from dangerous to healing. The body of this article proceeds in four parts. The first section considers the treatment of SM in the Diagnostic and Statistical Manual, Fifth Edition (DSM-5). The second section addresses debates about the costs, benefits, and scientific validity of the inclusion and definition of SM in the DSM-5. It further highlights how quantitative and qualitative empirical studies of SM practitioners indicate that they fall within normal ranges in psychological and social functioning. The third section examines research on one negative consequence of the inclusion of SM in the DSM: It may interfere with the therapeutic relationship with clients who practice SM or have SM desires by reinforcing broader societal stigma and encouraging diagnostic misuse. The fourth section reviews an emerging body of research that reverses the "SM as pathology" discourse by showing the therapeutic and healing potential of bondage-discipline-dominance-submission-sadism-masochism (BDSM) practice and ethos. Based on this review, the conclusion argues that there is no valid reason to continue identifying SM as a potential mental disorder, and furthermore, there are detrimental effects of its association with pathology in the DSM-5.

Keywords Sadomasochism · SM · Bondage-discipline-dominance-submission-sadism-masochism · BDSM · Kink · DSM-5 · Paraphilias · Paraphilic disorders · Forensics and sexuality · Law and sexuality · Societal stigma · Diagnostic misuse · Healing

This article is part of the Topical Collection on *Current Controversies*

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Introduction

This article addresses research on sadomasochism (SM), bondage-discipline-dominance-submission-sadism-masochism (BDSM), and kink—terms that describe a range of desires and activities including, but not limited to, dominance, submission, pain, role-playing, and restraint. While these terms will be used interchangeably, the terms "BDSM" or "kink" tend to be favored in literature that describes the erotic subculture in positive or neutral ways, while "sadism," "masochism," and "SM" can similarly be used not only in positive or neutral ways but also in negative and pathologizing ways.

Regardless of the precise descriptors used, it is apparent that variant evaluations of SM have placed the practice at many different points on the spectrum between sickness and health. The purpose of this article is to review how SM has alternatively been conceived as mentally disordered, benign, healthy, and healing in psychiatry, psychoanalysis, psychology, and social science, with some reference to select cultural representations that offer particular insight into a factual claim.

The body of this article proceeds in four parts. The first section considers the treatment of SM in the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) [1]. The second section addresses debates about the costs, benefits, and scientific validity of the inclusion and definition of SM in the DSM-5. It further highlights how quantitative and qualitative empirical studies of SM practitioners indicate that they fall within normal ranges

in psychological and social functioning. The third section examines research that elaborates on one negative consequence of the inclusion of SM in the DSM: It may interfere with the therapeutic relationship with BDSM clients by reinforcing broader societal stigma and encouraging diagnostic misuse. The fourth section reviews an emerging body of research that reverses the "SM as pathology" discourse by showing the therapeutic and healing potential of BDSM practice and ethos. Based on this review, the conclusion argues that there is no valid reason to continue identifying SM as a potential mental disorder, and furthermore, there are detrimental effects of its association with pathology in the DSM-5.

Section 1: DSM-5

In the most recent DSM-5, "sexual sadism" and "sexual masochism," like all the other paraphilias listed, can be ascertained as benign interests or diagnosed as harmful disorders. This distinction had been implied, but not explicitly articulated, in the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV) and the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR) [2, 3]. In contrast, the DSM-5 explicitly states, "a paraphilia by itself does not necessarily justify or require clinical intervention" [1, p. 686]. In the DSM-5, "Paraphilia denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" [1, p. 685]. A paraphilic disorder is described as a "paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm to others" [1, p. 685–686]. The section on Sexual Sadism Disorder identifies the risk of harm as one towards nonconsenting people. The section on Sexual Masochism Disorder identifies the risk of harm as one towards the self in specific relation to those who practice "asphyxiophilia or other autoerotic procedures," who, it is claimed, risk accidental death [1, p. 695].

The section on paraphilias thus refers directly and indirectly to three different ways that a person could engage in SM. There is the distinction outlined above between (1) a paraphilia and (2) paraphilic disorder; and (3) there is also an implicit recognition that a normophilic interest in SM is possible. Although the DSM-5 does not outline this third option explicitly, it can be extrapolated that if a person's interest in sadism or masochism is *not* deemed "intense and persistent," does *not* exceed interest in normophilic sex, or does *not* form part of genital stimulation or foreplay, then the interest would *not* be classified as paraphilic.

Section 2: The Benefits, the Costs, and the Scientific Validity of SM in the DSM-5

The scientific basis for the continued inclusion of sexual sadism and sexual masochism in the DSM series—even in the updated and ostensibly more tolerant fifth edition—has generated criticism among scientific researchers and stakeholders.

There is strong evidence that earlier versions of the DSM were misused to pathologize and even criminalize consensual SM practitioners who did not meet the criteria for a disorder [4–7]. Kleinplatz and Moser, leading critics of the DSM's paraphilia section in general, and its inclusion of SM specifically, have argued for the total removal of the paraphilias based on scientific and pragmatic concerns. For example, in a number of articles on the DSM-IV-TR, Moser and Kleinplatz conducted extensive reviews of the empirical literature before concluding that the scientific justification for the paraphilia section is faulty, value laden, lacks empirical support, and can lead to misunderstanding, misuse, and miscarriages of justice [8–10].

Given these critiques, the inclusion of sexual sadism and sexual masochism in the DSM-5 as paraphilias and paraphilic disorders raises a number of questions. First, are sexual sadism disorder and sexual masochism disorder, as defined by the DSM-5, scientifically valid mental disorders, and even if they are, do the benefits of their inclusion outweigh the costs? Second, if sexual sadism and sexual masochism are not inherently disordered, what purpose is served by including them in the DSM-5 as paraphilic interests that can be ascertained? More broadly, does the reconceptualization of the paraphilia section in the latest edition adequately address the problems that resulted from the previous ones? Some of the responses to these questions, cited below, refer to all the paraphilias, but the focus of this review article is their applicability to SM.

Krueger's review of the relevant empirical literature, conducted for the Sexual and Gender Identity Disorders Work Group for the DSM-5, attempts to justify retaining sadism and masochism in the DSM series [11]. Interestingly, Krueger found that non-disordered SM was quite prevalent in the general population and was associated with "good psychological and social functioning" [11, p. 352]. Nonetheless, he posited that sexual sadism should remain in the manual based primarily on its use with forensic populations, and sexual masochism should remain in the manual based primarily on its association with people who engage in asphyxiophilia. Thus, both of Krueger's justifications are based on the purported applicability of sadism and masochism to discrete populations, and both justifications have been contested, as will be shown below.

Forensic and Legal

In his article on sexual sadism, Krueger found that there was little use of the diagnosis outside of forensic contexts. Indeed,

his examination of the US National Ambulatory Medical Care Survey found no recorded diagnoses of sexual sadism or sexual masochism. Of the 32 studies he examined, 28 considered sexual sadism in forensic populations in relation to sexual crimes, and 4 were a mix of forensic and non-forensic populations. For most of the studies, the data was not directly obtained by the authors of the study, but rather by other interviewers. Some were based solely on court records or information gathered by the media. Most studies did not assess interrater reliability, and of those that did, some found good and some poor interrater reliability. Despite the indirect nature and questionable reliability of many of the studies, Krueger concluded that, "Sexual Sadism is a prominent diagnosis and entity in forensic populations. It, along with other psychiatric diagnoses, presents a clear target of treatment" [11, p. 340]. It should be noted, however, that in this article, Krueger did not evaluate literature that measures the efficacy of any treatment that flows from this diagnosis.

There are different responses to Krueger's contentions regarding forensic utility from the perspectives of criminal and family law. For example, a number of researchers and clinicians have raised concerns that the DSM-IV-TR has been misused, and that the DSM-5 may come to be similarly misused, to generate false-positive diagnoses in criminal cases [12–16, 17••, 18••]. Such false-positives can have serious repercussions in the context of sexually violent predator (SVP) laws, which allow for indefinite detention of certain offenders after a prison sentence is served. First and Halon explain that the constitutionality of an SVP designation depends on a finding that the sexual offender is at a higher risk of committing sexually violent acts *because of* a mental abnormality or personality disorder that impairs volition [12]. These laws are thus a form of preventive detention to incapacitate individuals who, due to their mental disorder, pose a threat to society. In a review of paraphilia diagnoses in SVP cases, First and Halon contend that some unjust SVP designations have resulted from mental health professionals who improperly infer that the commission of a sexually violent offense is itself sufficient to establish a mental abnormality, and diagnose paraphilic disorders accordingly. They also contend that the SVP designation is overused due to unfounded assumptions that paraphilias, if present, necessarily cause the sexual crime, or impair volition, within the meaning of SVP laws.

In an article considering lessons learned from the DSM-IV-TR and earlier editions of the DSM, Frances and Widiger also discuss the forensic misuses of the DSM-IV and the DSM-IV-TR that contributed to unfair designations of mental disorder due, in part, to unintentional ambiguous wording in the criteria section of the sexual disorders [17••]. Looking to the future, Frances and Widiger state: "The DSM-5 is being prepared with little or no attention to the methods of evidence-based medicine and risk analysis; to its public health and public policy impacts; to how its suggestions will play in average mental health settings and in primary care; to its effects on health economics; and to its misuses in forensic settings" [17••, p. 125]. They advocate a realist approach to future revisions grounded in scientific methods and empiricism, which would also consider how the DSM gets used and misused in practice.

Outside of the criminal context, there have been some reported benefits of the DSM-5's revised wording with regard to child custody cases. Under earlier editions, SM interest, in and of itself, had been used as an indication of mental disorder and reduced parental capacity, in the absence of disordered symptoms [4, 5]. Susan Wright, a spokesperson for the National Coalition of Sexual Freedom (NCSF) that advocates for the rights of the kink community, has recently reported that the revised DSM-5 criteria have been successfully deployed in child custody cases to challenge the notion that SM is an intrinsically detrimental factor in parenting [6, 19•]. Thus, while the NCSF advocates for the complete removal of the paraphilias from the DSM, its spokesperson also sees the newest wording as an important clarification and a step in the right direction [20]. This is a promising development, and it will be helpful to monitor forthcoming case law to see if the DSM-5 express differentiation between paraphilic interest and disorder will infiltrate other areas of law and regulation.

Asphyxiophilia

Krueger's main justification for retaining sexual masochism rests on its alleged linkage with asphyxiophilia, a practice involving erotic breath restriction or oxygen deprivation. Though statistically rare, Krueger maintains this practice is a risky and sometimes fatal form of masochism and therefore pathological [21]. He cites a 1972 study by Litman and Swearingen [22], which reports that 50 people die every year due to this practice. He further speculates that retaining sexual masochism in the DSM-5 will facilitate more research on asphyxiophilia, which he favors, because so little is known about this practice.

Kreuger's asphyxiophilia justification has been contested by Moser and Kleinplatz, who show that the link between hypoxyphilia (as it was then called) and masochism is tenuous and not convincing [10]. Hinderliter further questions Krueger's suggestion that continuing the inclusion of masochism in the DSM-5 will facilitate research on asphyxiophilia, in light of the fact that the diagnosis has produced almost no research in the area since its inception in 1968 [23]. Moreover, Shindel and Moser argued recently that under this "risky therefore pathological" reasoning, other dangerous and possibly fatal activities (for example, driving or SCUBA diving) should also be deemed mental disorders [24]. In this way, Shindel and Moser show that Krueger's approach can be understood as a form of sexual exceptionalism where sexual

risks are arbitrarily perceived as more problematic than non-sexual risks and thus more in need of intervention.

The Utility of Specifying Benign Paraphilias

The reasons offered for identifying benign paraphilias in the DSM-5 are based on factors related to prevalence and research. For example, the American Psychiatric Association's (APA's) Paraphilic Fact Sheet suggests that ascertaining paraphilias is warranted simply because they are "atypical" [25]. The DSM-5 Paraphilias Subworkgroup offered a practical justification for the inclusion of paraphilic interests, stating that it "leaves intact the distinction between normative and non-normative sexual behavior, which could be important to researchers, but without automatically labeling non-normative sexual behavior as psychopathological" [26]. Blanchard, who served on the Sexual and Gender Identity Disorders Work Group for the DSM-5, echoes the same idea that keeping the paraphilic distinction will assist "scientific research" [27]. In his article on "The DSM diagnostic criteria for pedophilia," he elaborates, "It would prevent a paraphilia from becoming invisible to clinical science just because it lacks any secondary effect of disturbing the individual or others" [28]. In their 2012 review article of the proposed modifications to the Paraphilia section, Krueger and Kaplan re-state Blanchard's justification, suggesting it might support "epidemiological studies of alternative sexual interest patterns using the DSM-5 A criteria without the necessity that these would be disorders" [29, p. 249].

However, the APA's claim that paraphilias are atypical is difficult to sustain with regard to SM, given empirical evidence of its prevalence and commonality—particularly if one goes beyond actual practice and also takes into account fantasy, as the DSM does. For example, an Internet survey of 1516 adults from Quebec found that over 50 % of both men and women had fantasies about being sexually dominated [30]. In their study of 55 million erotic web searches, Ogas and Gaddam found that domination and submission, taken together, constitute the sixth most popular category [31, p. 201] The runaway success of the *Fifty Shades of Grey* book series, the subsequent increased interest in kinky spin-off stories, and the rise in the sale of kinky sex toys attributed to the story further undercut any suggestion that SM desire is somehow "atypical" [32–34].

The notion that maintaining the distinction between a paraphilic interest and a normophilic interest will generate useful research also seems without foundation. As Krueger and Kaplan acknowledge, the paraphilias have received scant research funding, and the studies that do exist focus on forensic populations [29, p. 252]. Perhaps it is time to acknowledge that the paucity of research in this area stems from the fact that there is no scientific reason to reify these practices and desires as paraphilic. Furthermore, the accompanying cost in the way of associated stigma, sexual essentialism, and the possible slippage between an interest and a disorder weigh against the continued inclusion.

In this regard, Hinderliter argues, "Including some sexual interests—but not others—in the DSM creates a fundamental asymmetry and communicates a negative value judgment against the sexual interests included" [23, p. 259]. Moser further considers the arbitrariness of the implied distinction between a paraphilic and normophilic interest in SM by pointing out, "The 'sexual masochist' who prefers to be whipped rather than engage in coitus has a paraphilia and the 'sexual masochist' who prefers to be whipped as foreplay to coitus is normophilic" [35•, p?]. From a forensic perspective, First suggests that "…the technical difference between a paraphilia and a paraphilic disorder might be lost on judges, juries, and others not well versed in the subtleties of the DSM and thus the redefinition of paraphilia is likely to blur rather than sharpen the distinction between a disorder and a nondisorder" [18••, p. 192]. Furthermore, as many critics have pointed out, retaining the paraphilia section on the basis of whether it is typical or not, or whether it is accompanied by distress or not, is inconsistent with the reasons homosexuality per se was removed from the DSM in 1973 and ego-dystonic homosexuality was removed in 1987 [8, 10, 23]. Considering the broader ideological basis that underlies the sexual essentialism of the DSM, Daley et al. have offered a critical queer response based on a community-based collaboration in Toronto, which paid particular attention to the impact of the DSM series on the LBGTQ (lesbian, gay bisexual, transgender, and queer) community [36]. The article provides an effective challenge to the DSM's ideological perpetuation of normative sexuality and the ways the criteria for the gender and sexuality disorders "reflect and reinforce an unjust and inequitable gendered, racialized, classed, and sexualized social order [36 p. 1295]."

Moser further critiques the current DSM-5 structure by pointing out how easily one can slip from being "ascertained" as having a paraphilia, to experiencing distress that might lead one to be diagnosed with a disorder [37]. Specifically, he observes that distress can flow simply from being a member of a stigmatized sexual minority—as might be the case, for example, with gays, lesbians, or bisexuals living in a homophobic environment. A person with an otherwise healthy interest in SM could thus wind up being diagnosed with a disorder, based on fear or actual experience of prejudice and stereotyping by the dominant society. In sum, as Moser points out, "No empirical evidence or rationale is given to support the different treatment of distress or impairment for normophilic versus paraphilic interests" [37, p. 1226]. Conversely, there is ample empirical evidence that those who

practice, desire, or fantasize about SM are not different in ways relevant to psychiatry, as will be discussed in the next section.

Empirical Studies on BDSM Practitioners and Populations

For the most part, social scientific studies of BDSM populations have found that practitioners are healthy, well adjusted, and may even have some personality advantages over people who do not practice BDSM. The studies thus challenge the medical-psychiatric and psychoanalytic hegemonic view that associates practitioners with psychopathology or paraphilia.

In an article from 2006, Thomas D. Weinberg reviewed the sociological and social psychological literature on SM practitioners from the previous three decades [38]. In contrast with the implicit assumptions in the DSM series and psychoanalytic literature, the studies showed SM practitioners to be psychologically and socially well adjusted and functional.

Many subsequent empirical studies confirm this finding. For example, Cross and Matheson's 2006 study found no empirical support for the three dominant theories of SM: the psychiatric-medical model that frames SM as a psychopathological issue; the radical feminist model that frames SM as misogyny and patriarchy; and the escape-from-self theory that frames masochism as a strategy of escaping the burdens of selfhood and self-awareness. In particular, through a battery of psychological testing with SM and non-SM populations, examination of virtual SM clubs online, and content analysis of SM-themed Internet chat rooms, the authors found that while SM practitioners seemed to have higher numbers and more diverse sets of sexual partners, they were not more likely to have issues of guilt, psychopathy, psychological distress, mental instability, antisocial tendencies, hostility, or authoritarianism. SM participants in both the real and virtual world experienced SM as a consensual exchange of power.

In a similar vein, a large national study from Australia published in 2008 (and referred to in the DSM-5) found that BDSM practitioners were more likely to engage in a wider variety of sexual practices (for example, oral and anal sex, phone sex, sex with multiple partners, group sex, pornographic viewing, and sex toy use), but were no more likely to have experienced sexual coercion, and were not significantly more likely to feel unhappy or anxious or to encounter sexual difficulties [39]. Interestingly, the study reported that men who had engaged in BDSM experienced significantly lower levels of distress than other men.

A 2012 literature review by Powles and Davies sought to question three common beliefs about SM found in traditional medical-psych perspectives, namely that it (1) is an abnormal/deviant practice, (2) manifests in childhood, and (3) originates from childhood abuse [40]. The overall assumption that SM desires reflect psychopathology was also challenged. The results of the review contradicted each enumerated perspective and the overall pathologization of practitioners, showing that (1) SM interest is prevalent, particularly if fantasy is included in the assessment; (2) SM interest develops for most at a relatively mature age; and (3) the majority of practitioners have not suffered childhood abuse. The study found no evidence to support the notion that SM interest is indicative of a psychiatric disorder.

Jozifkova (2013) combined analysis of previous research with the author's observations of BDSM Internet discussions on Czech and Slovak websites. Taking an evolutionary perspective, Jozifkova suggests "…that sadomasochistic sex appears as a strengthened adaptive behavior based on natural patterns of reproduction, rather than as pathology" [41, p. 2]. While affirming SM as a non-pathological alternative sexuality, the article does provide ways to distinguish consensual healthy BDSM from abuse and outlines some of the specific challenges that practitioners may face.

A Dutch study made mainstream headlines in 2013 [42–44] when it suggested that BDSM practitioners were not only psychologically healthy but were in fact healthier than the general population in a number of personality measures [45••]. Based on self-report questionnaires that compared 902 BDSM-identified individuals with 434 who reported no experience with BDSM, the study found that BDSM practitioners reported higher levels of subjective well-being and were less neurotic and less sensitive to rejection, while being more conscientious, more extroverted, and more open to new experiences. Female-identified BDSM practitioners were less anxiously attached than the non-BDSM population. The only area where BDSM practitioners scored lower was on agreeableness. Although this study may have garnered attention in popular media—perhaps due to the wave of popularity enjoyed by the *Fifty Shades of Grey* series—the authors' results were not unprecedented and indeed confirmed some earlier findings in Cross and Matheson's 2006 study and the Richters et al. 2008 study both mentioned above. The authors further conclude that their results support Newmahr's contention that SM is best understood as recreational leisure [46] and not an indication of psychopathology.

An even more recent study in this area, published in 2014 by Faccio et al., examined the ways 50 Italian self-identified BDSM practitioners attach personal meaning to their sexuality, with a focus on the relationship between gender and dominant-passive roles [47]. The majority of interviewees framed their sexuality within positive and normalizing terms. Of relevance to this review article is that the study provided additional phenomenological evidence, taken from yet another national and cultural context, that BDSM is best understood as a sexual subculture and not as pathological.

A 2014 study further advanced the research by exploring differences not only between BDSM practitioners and the general population but also differences between self-identified dominants (80 of 270 practitioners primarily

identified themselves in this category) and submissives (190 of 270 practitioners) [48•]. Evaluated alongside data collected from the general population, both dominants and submissives fell within the normal range for the HEXACO Personality Inventory, which assesses the six major dimensions of personality: honesty-humility, emotionality, desire for control, self-esteem, life satisfaction, and empathy. The one notable difference was that dominants and submissives scored lower on altruism as compared to the general population, while submissives, but not dominants, scored slightly higher on openness to experience. The fact that BDSM practitioners scored within normal ranges in virtually all areas stands in contrast to the medical-psychiatric production of difference between those who do and do not practice BDSM.

Section 3: The Impact of Stigma on the Therapeutic Relationship

As one would find in any community, some BDSM practitioners will seek out mental health services. Moreover, they may have particular types of mental health concerns as members of a sexual minority group that is subject to prejudice and stereotypes. However, as discussed above, the dominant psychiatric discourse at best singles out SM interest as a paraphilia and at worst labels such desires and practices as disorders—and thus renders BDSM practitioners at risk of receiving counterproductive or even harmful treatment. This section considers research that addresses how the association of BDSM with mental disorder creates particular challenges for the therapeutic relationship, and how kink-aware researchers and therapists have responded.

Guidelines and Best Practices for Therapists

In 2004, Kleinplatz and Moser published a set of guidelines on working with BDSM clients, drawing on their own clinical experiences and research, as well as the American Psychological Association's guidelines for psychotherapy with lesbian, gay, and bisexual clients [49, 50]. They emphasized the need for mental health professionals to improve their interactions with this population by, among other things, developing awareness of BDSM issues, addressing their own biases and stereotypes, understanding the issue of repressed desire, and not assuming that BDSM is related to the reasons why therapy is sought or needed. In response to indications in the DSM (then the DSM-IV-TR, but still present in the current DSM-5) that distress over SM desire would lead to a diagnosis of mental disorder, they argued

> …distress over BDSM interests may signify "normal," internalized BDSM negativity rather than evidence of disorder. The role of the therapist in this instance is to validate the distress rather than to "cure" the BDSM desires. Distress and dysfunction need to be understood in the context of discrimination and stigma rather than simply eliminated. [49, p. 4].

A number of articles have drawn on clinical experience and empirical studies to build and expand on the insights contained in the Kleinplatz-Moser guidelines. For example, Barker et al. have written multiple articles on the challenges BDSM practitioners face when seeking therapy and the need for kink-aware trained professionals [51, 52]. As with Kleinplatz and Moser, they critique the DSM-IV-TR's inclusion of sadism and masochism, explaining, "being involved in BDSM may well involve 'significant distress or impairment in…functioning' for a time, precisely because of the stigma, social unacceptability, discrimination and prejudice surrounding it" [51, p. 108–109]. The articles offer alternative frameworks, approaches, and practical tools for training students and service providers when working with BDSM clients.

Nichols has also elaborated on the need for a non-pathologizing therapeutic approach when working with the BDSM community and couples [53, 54•]. In particular, she addresses the need for therapists to self-interrogate their own preconceptions and the potential for countertransference, and ways that therapists can become more educated on the community and the specific challenges that BDSM practitioners may face. For example, clients with internalized shame and guilt may seek therapy to be "cured" of their "sickness," and as noted above, their desires combined with their distress could qualify them as having sexual sadism disorder or sexual masochism disorder according to the DSM-5 and earlier editions. As Nichols points out, this is comparable to gays and lesbians who would have still qualified as having "ego-dystonic homosexuality," a diagnosis that operated between 1973 and 1987, even after homosexuality per se had been removed from the DSM. Kinky clients may also experience a range of common issues that take on particular forms because of their kink. For example, couple discord may occur if a kinky client has not disclosed her desires to her partner or if the partner is not kinky or expresses a negative reaction towards kink. Finally, Nichols also addresses steps a therapist can take if it is suspected that BDSM is manifesting in conjunction with non-consensual violence or manipulation or is being expressed in an unhealthy way.

Two empirical studies with therapists document some of the problematic issues but also show that therapists are becoming more knowledgeable, open minded, and adept at working with BDSM clients. In 2007, Lawrence and Love-Crowell published a study based on semi-structured interviews with 14 therapists experienced in working with BDSM clients [55]. The interviewees stressed the importance of maintaining a non-judgmental attitude and the need for

cultural competence of BDSM values and practices. Lawrence and Love-Crowell also noted that the American Psychological Association's Guidelines for psychotherapy with lesbian, gay, and bisexual clients offered a starting point for developing BDSM-specific guidelines and best practices [50]. The study further found that BDSM was rarely a central issue in therapy; rather, relationship issues were the most common presenting concern. An additional finding of note was that therapists who work with BDSM practitioners may themselves experience discrimination, given the stigma associated with BDSM.

In 2013, Kelsey et al. conducted a large Internet-based survey of 766 therapists in the USA to assess their attitudes towards BDSM clients [56]. Encouragingly, their hypothesis that the majority of therapists would hold negative, pathologizing views of BDSM was not borne out; to the contrary, 67 % of those surveyed believed that "BDSM can be part of a healthy, long-term relationship." However, more worrisome was that while 76 % of participants reported working with a BDSM client, only 48 % saw themselves as competent in this area. Reinforcing all of the previously mentioned studies, the authors advocated for more specific training in this area and the need for therapists to understand their own limitations and to refer BDSM clients elsewhere if they are not sufficiently competent or knowledgeable about the subculture to provide effective assistance.

Picking up on this idea, Pillai-Friedman et al. note that sexuality professionals who work with the kink community must receive tailored and relevant education in order to provide appropriate care effectively. In a 2014 article, they outline a three-prong training program that would address possible negative countertransference on the part of the therapist and strategies for helping BDSM clients work through their life challenges [57]. In addition, the NCSF offers a directory of kink-aware professionals in the medical and legal fields who are sensitive to the relevant challenges and issues [58].

Empirical Work on Clients' Experiences with Mental Health Services

In 2006, Kolmes et al. published a study based on responses that 175 BDSM-identified people had provided to an Internet questionnaire dealing with issues in accessing mental health services [59]. In their section on "Ethical Considerations," the authors emphasized the importance of the American Psychological Association's Ethics Code for Psychologists, in which Standard 2 mandates that psychologists must work within their area(s) of competence or risk serious harm to their clients [60]. Unfortunately, the study revealed that some psychologists were not following this Standard in relation to BDSM populations. A number of problems were flagged, including fear of disclosure, therapist bias against BDSM, therapists conflating BDSM with abuse and/or assuming the desires are a result of abuse, poor boundaries on the part of the therapist, and therapists' lack of education and awareness of the kink community and its practices. The study concluded that there was a strong need for BDSM-specific training for mental health professionals.

In 2009, Hoff and Sprott analyzed the therapy experiences of 32 BDSM-identified heterosexual couples, focusing specifically on how stigma can affect the therapeutic dynamic [61]. They found that relations with therapists ranged from negative to positive and that BDSM stigma had multiple detrimental effects on the therapy-client relationship in some cases. For example, some clients were directly judged and pathologized when they disclosed their BDSM sexuality. In three cases, the therapy sessions were terminated because of therapist anti-kink bias. Stigma also had a censoring effect on some clients who chose not to disclose their sexuality because they believed strongly they would be judged negatively. The author concluded by advocating that therapists understand that BDSM is not inherently pathological, educate themselves on the values of the community, and take their cues from their clients about how relevant or irrelevant BDSM is to the therapy.

Section 4: BDSM—Not Just Benign But Healing

The previous section suggested that pathologizing perspectives on BDSM may contribute to distress and stigma which perversely justifies the pathologization in a feedback loop. This section shows that it may also contribute to the neglect of possible health benefits of kinky practice. While the empirical research described in "Section 2: The Benefits, the Costs, and the Scientific Validity of SM in the DSM-5" undercuts the DSM approach by largely portraying SM practitioners as "healthy" and "normal," an emerging body of research goes even further by also positioning BDSM as healing and transformative.

Drawing on her clinical experience, Kleinplatz goes against the pathologizing grain of the traditional medico-psychiatric discourse and explores what can be learned about human sexual potential from SM practitioners [62]. In a 2006 article, she shares two case studies of couples with whom she was working. In her therapy, Kleinplatz investigated with them how recognition, acceptance, and, in some cases, enactment of BDSM fantasy could help move past sexual dysfunction, dissatisfaction, disconnection, and trauma and towards intimacy, pleasure, and self-knowledge. Kleinplatz' goal in the article is not to prescribe SM or any specific technique as healing but rather to examine how those at the erotic margins may have important insights on how anyone might heal and enhance sexuality.

Three chapters in the 2007 anthology *Safe, Sane and Consensual* address the potential for SM to be healing,

enlightening, and empowering. The first by Barker et al. is arguably the most comprehensive [63]. On the one hand, it delves into the ways many in the community attest to BDSM as healing and therapeutic and shows how this reverses the dominant notions of BDSM as sick and destructive. On the other hand, it also outlines some of the political pitfalls of this claim, which can include unwittingly transferring stigma to kinksters who do not fit themselves within a "healing" framework, reinforcing the alleged divide between mental health and illness, creating a utilitarian imperative for BDSM (i.e., that BDSM is only acceptable when used as a tool for promoting overall mental health), and perpetuating the notion that all BDSM practitioners are sick and in need of healing. In this way, the chapter demonstrates the need to be cognizant of the ways "healing" narratives can be used against the BDSM community.

Two other authors address the power of BDSM theory and praxis within therapy and self-actualization techniques. William Henkin—a psychotherapist and sexual therapist who has written widely on BDSM—explores, as the title of his essay states, "Some Beneficial Aspects of Exploring Personas and Role Play in the BDSM Context," taking into account both the personal benefits, as well as the risks [64]. In her chapter, "Shadowplay: S/M Journey to Our Selves" [65]—and in her book, *Radical Ecstasy: SM Journeys to Transcendence*, co-authored with Hardy—Dossie Easton similarly draws on her work as a psychotherapist and educator, but also on her personal experience as an SM practitioner and lover [66]. These texts explore SM as an ecstatic-sexual practice that resonates with multiple philosophical and spiritual traditions.

Turley et al.'s 2011 descriptive phenomenological study analyzed four interview transcripts of people who practice BDSM, seeking to explore the everyday lived experiences of the interviewees [67]. Some of the main themes that were identified included BDSM as an authentic fantasy that offers escape from the constraints associated with the human condition, BDSM as rejection of societal rules of proper sexuality, and BDSM as a way to access non-sexual benefits, including spiritual, cathartic, and therapeutic.

Lindemann's qualitative field research on professional dominatrices did not initially set out to examine the therapeutic side of their services [68]. However, some of the benefits noted were that the paid sessions offered clients a safe alternative to sexual repression or even violence, functioned as atonement rituals, provided a forum where clients could gain control over prior trauma, and offered ways to experience psychological revitalization. As in Barker et al.'s chapter, mentioned above, Lindemann also explores some of the dangers associated with the therapy narrative, including the possibilities it will reinforce unwanted medical paradigms or create hierarchies between therapeutic and non-therapeutic pro-domme services.

Hammers (2014) employed affect theory to analyze the ways that BDSM can be a pathway to healing from sexual violation [69•]. The study focused on 20 women who used consensual "rape play" to reenact their sexual trauma and steer "future becoming." This article stands in contrast to the dominant perception that such role-plays are an indication of pathological repetition. The participants in Hammers' research challenge such simplistic and reductionist portrayals, positing rape play not as a means of dwelling on past abuse but rather as a method to realign somatic responses and achieve bodily integrity.

While the research on BDSM as a healing pathway is nascent and requires more systematic study with larger sample sizes to further test this proposition, it does offer an important intervention in the debates about the significance of SM. The research provides some preliminary evidence that the ways BDSM differs from what the psychiatric literature calls normophilic sexuality may be worth studying, not as potential indicators of psychopathology, but in some cases, as potential routes towards healing, self-empowerment, and personal development.

Conclusion

This article reviewed and compared competing and evolving depictions of SM sexuality, examining portrayals that range from sick to healthy, from abnormal to normal, and from dangerous to healing. The idea that sexual disorder, health, and normalcy are empirical facts that can be discerned objectively has been challenged with regard to SM. Rather, such notions are seen to carry with them implicitly essentialist understandings of sexuality's meanings and purposes.

The DSM-5's definition of paraphilic proclivities perpetuates an essentialist viewpoint on sexuality, in its focus on genitals and preparation for intercourse as the signs of normalcy. While recognizing that a paraphilia is not in and of itself a disorder can be seen as a progressive advancement, the reviewed literature highlights serious practical and theoretical problems with the current wording of the DSM-5's definitions of sexual sadism and masochism and their retention in the manual. Among other things, the approach appears arbitrary, unjustly pathologizing, forensically problematic, and inconsistent with numerous empirical studies that have found BDSM practitioners to fall within normal ranges of functioning.

Research suggests that the continued inclusion of sadism and masochism in the DSM-5, in conjunction with broader societal stigma, can have negative consequences on the interactions of BDSM practitioners with mental health professionals. Although evidence indicates that therapists are becoming more aware of BDSM as a benign issue, there are still problems with anti-kink or uneducated therapists. Moreover,

clients may be dealing with societal stigma and/or internalized shame and guilt, which can cause "distress" and therefore signal a disorder according to the DSM-5 criteria. Psychiatry's diagnostic criteria can thus be understood as ironically performative; the distressing condition that it purports to classify *and* treat is actualized, in part, by its diagnosis.

An important counterdiscourse to the DSM-5's pathologizing perspective is found in literature attesting to the potentially therapeutic value of BDSM. At the same time, a number of writers have cautioned that portraying BDSM as therapy could entail political costs, including the reinforcement of utilitarian imperatives for sexuality, and marginalizing those who experience BDSM as simply play or pleasure.

Researchers and health practitioners can benefit from gaining an understanding of challenges to the DSM-5's approach to SM, sociological studies of SM populations (including accounts on the phenomenology of SM), and cultural engagements with this taboo subject. By considering these competing and alternative discourses, a more nuanced approach to SM is advanced, and the ways scientific knowledge interacts with other epistemic and imaginative regimes can be explored.

Compliance with Ethics Guidelines

Conflict of Interest Ummni Khan declares she has no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by the author.

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