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Between submission and pain. Shades of BDSM practices

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Summary

Many people are interested in BDSM practices. Some people practice and others fantasize about participating in these practices. Several elements are related to BDSM practices that are usually unaccepted in a close relationship, such as a strong dependence of one partner on the other or inflicting pain. BDSM practitioners create various relationships, and in a broader context, their communities. From a clinical perspective, an important issue is whether BDSM relation is consensual and serves the personal and relationship development or it can be a premise for the diagnosis of a paraphilic disorder, or recognizing abuse or mechanism of trauma repetition Adequate understanding of the behaviors that may be described by a patient practicing BDSM requires, however, getting to know the specifics of such relationships. The mental and sexual health professional would be able then to evaluate them adequately, without referring to a subjective norm or bias on stereotype or prejudice.

Key words: BDSM, domination, submission

What the various therapists called natural was actually a moral value in medical disguise

Erwin J. Haeberle, The sex atlas, 1983

Introduction

The BDSM acronym refers to practices in which partners set up specific relations. Its particular letters define certain meanings: bondage & discipline, domination & submission, sadism & masochism. We also use the term kink, which as a noun means *inter alia* a turn, bizarreness, a knot, and/or twist; but as an adjective kinky means odd, pervert, bizarre, and in slang it simply refers to a deviant person. This acronym is a common term for non-normative sexual behavior, which most frequently refers

to BDSM and fetishist practices. The concept of kink is included in the broader term of diversities, and more specifically in the term Gender, Sexual and Relationship Diversities (GSRD). GSRD includes behaviors, activities and identities such as transgender, non-heterosexuality, asexuality, non-monogamous relations, and/or BDSM [1, 2].

When discussing the phenomenon of BDSM or S/M[1] relationships, we also consider the terms 'sadism' and 'masochism', which may acquire a variety of meanings [3]. The first meaning which seems apparent is the disorder (nowadays we could use the term 'paraphilic disorders'), which were studied in psychopathology in the 19th century. The concept of sadism originates from the name of the French nobleman and writer Donatien Alphonse François de Sade; in turn, masochism comes from the Austrian fiction writer and playwright Leopold von Sacher-Masoch. The second meaning refers to consensual sexual practices widely known under the previous BDSM acronym. In the third meaning, sadism and masochism are the elements of sexual relation, in which their primary role is to bring variety to sexual life [4]. Paul Federoff [3] described the necessity of differentiating between action and intention, e.g., the intention behind tearing off a person's clothes in consensual BDSM practices is different than in the case of a violent relationship or committing a crime. However, those actions may be very similar to an outside observer.

Robin Bauer [5] points out the consequences of interpreting BDSM as perversion, one of which is the ongoing belief that BDSM and non-BDSM forms of sexuality are clearly different and each person may be classified as one or the other. However, in practice these boundaries are difficult to identify as the boundaries of BDSM and non-BDSM activities are blurred. While taking into account how many people are engaged in S/M relationships or even just fantasizing about them, one could even deliberate whether in reality we deal with minority practices. It is also possible that a minority realizes fantasies that the majority of society does not admit to.

Gemberling et al. [6] have put forward many theories explaining the origins of BDSM practices and therefore their many conceptualizations, e.g., behaviors, sexual attraction, sexual identity, and/or sexual orientation. From the historical perspective, sexual orientation is related to preferred partner gender; however, according to the authors mentioned above, the scope of this concept has recently significantly broadened and now includes other features, such as preferences related to age. One such characteristic behavior may be a preference for relationships based on domination, submission and/or both. Such a juxtaposition clearly shows the traditional classifications of sexual orientations. However, it seems to be debatable to treat activities

[1] The concepts BDSM and S/M in literature are often treated as synonyms. In our paper we make a certain differentiation, which is partly in accordance with the suggestion made by Michael Makai [51]. The concept of S/M is used with reference to the relationship in which the basic element is dependence and experiencing pain, in other words the relationship conditioned by sadist or masochist preferences (but not in psychopathological meaning). On the other hand, the concept of BDSM is related *sui generis* to the phenomenon of creating a relationship or communities of persons practicing conducts based on relations like the ones described above, and also to cultures which are created by such communities.

based on dependency in terms of sexual orientation. It seems to me that the concept of sexual orientation may be useful in the context of the depathologization of BDSM practices but not in the analysis of sexual preferences. Thus, following this stance, we could define a variety of orientations concerning specific and arbitrary concepts of sexual practices.

The scale of the phenomenon

Research on the scale of BDSM practices reveals different results regarding the frequency of occurrence. Several factors may cause this. Firstly, access to minority groups is limited; therefore they are less represented in the research. Secondly, it may be caused by interviewing on the innermost aspects of life and the fear for assessment of sexual behaviors. Such questions may lead to interviewees being forced to confront their not totally accepted desires, fantasies and/or behaviors. As a result, they may avoid sincere responses how often they occur.

Alfred Kinsey [7, 8] was interested in the frequency of S/M behaviors. His report showed that 12% of women and 22% of men admitted being excited by S/M stories, and 55% of females and 50% of males reacted to gnawing. Although this research was highly criticized, its results were significant. Therefore it is worth bearing it in mind.

In the table below, we show selected research data related to the popularity of BDSM behaviors. The results are varied but they raise questions concerning whether this is a minority group and/or whether these practices frequently occur in the general population.

Table 1. **Selected research data on the popularity of BDSM behaviors and fantasies related to them**

Authors	Number of tested individuals	Number of people practicing BDSM	Number of persons fantasizing
Richters et al., 2003 (Australia) [9]	19,307 (F: 9,134; M: 10,173) age: 16–59	2 % males 1.4% females	
Zurbriggen, Yost, 2004 (United States) [10]	162 (F: 77; M: 85) age: 21–45		
Långström, Seto, 2006 (Sweden) [11]	2,450 (F:1,171; M:1,279) age: 18–60	2.2%	
Langdridge, Barker, 2007, meta-analysis of the USA research [2]		5–10%	
Richters et al., 2008 (Australia) [12]	19,307 (F: 9,134; M: 10,173) age: 16–59	1.8% (M:2,2%; F: 1.3%)	

table continued on the next page

Oliveira Júnior, Abdo, 2010 (Brazil) [13]	7,002 (F: 45.4%; M: 45.6%) age: M: 35 (mean) F: 36 (mean)	S/M 9 %	
Jozifkova, 2018 (Czech Republic) [14]	673 (F: 297; M: 376) age: 25–44	45.8% (F: 51 %; M: 39.5 %)	
Faccio et al. 2014, (Italy) [15]	343 (missing data on the number of females and males) age:18–66	50% (F: 24%; M: 26%)	
de Visser et al., 2014, repeated research (Australia) [16]	20,094 (F: 10,037; M: 10,056) age: 16–69	M: 2.5%; F: 1.6%	
Yule et al., 2016 (Canada) [17]	297 (F: 206; M: 91) age: 19–70		F: 32%, M: 30%
Joyal, Carpenter, 2017 (Canada) [18]	1,040 (F: 565; M: 475) age: 18–64	Masochism: 19.2 % (F:23.7%; M:13.9%) Sadism: 5.5% (F:3.9%; M:7.4%)	Masochism: 23.8 % (F:27.8%; M: 9.2%) Sadism: 7.1% (F: 5.1 %; M:9.5%)
Holvoet et al., 2017 (Belgium) [19] ,	1,027 (F: 568; M: 459; other: 2), age: 18–65	47% at least once; 12.5% regularly active; 7.6% admitted that they actively practice BDSM behaviors	22%

Between perversion and diversity

Peggy Kleinplatz and Charles Moser [20] argue that the main problem with analyzing S/M behaviors is that there is no adequate normal and healthy sexuality model. Although we have criteria for the physiological aspects of human sexuality, we do not have a model to study objects of desire or the behaviors that do not constitute so-called 'optimal sexuality'. This lack of objective criteria gives rise to a situation in which even mental health professionals may invoke systems of values that dominate in certain cultures and classify S/M practices and their symptoms accordingly. Such an approach could lead to discrimination against sexual minorities.

The authors mentioned above also point out that in the DSM-5 [21] two requirements should be met to properly diagnose paraphilic disorders (or, as it used to be known, paraphilia): (1) the experience of distress and (2) the impairment/dysfunction of day-to-day activities. Persons who practice BDSM seek professional help related to

their sexual preferences mainly for two reasons: (1) when they are in conflict with their partner's preferences; or (2) when they conflict with social norms. In the psychologist's office we usually do not deal with the distress caused by S/M behaviors but with the phenomenon of social stigma. Kleinplatz and Moser [20] also stress that there is no convincing evidence that persons practicing BDSM suffer from sexual dysfunctions, commit crimes, and/or encounter more difficulties in establishing close relationships than persons who are not engaged in such behaviors. Therefore, it is hard to determine whether or not BDSM practices themselves meet the criteria of paraphilic disorders. The DSM-5 introduced a differentiation between consensual and non-consensual behaviors. In the case of the consensual behaviors, if there is no distress, we do not diagnose a masochistic and/or sadistic disorder. In such situations, we deal with paraphilia and not paraphilic disorder.

The ICD-10 [22] does not differentiate sadism and masochism as nosological units, and it suggests diagnosing sadism and masochism with the following differentiation: "If the partner wishes to be a recipient of such sexual stimulation, it shall be defined as masochism; if they wish to stimulate the partner, it shall be called sadism" [22, p. 243). One may guess that this is a continuation of the psychoanalytic approach to understanding two aspects of one perversion; however, one would not find any argument for consensuality. In the ICD-11 [23], when discussing the diagnosis coercive sexual sadism disorder, consensuality is a factor excluding such a diagnosis. It is worth noting that there is not the criterion of masochism in the ICD-11, though when discussing the diagnosis paraphilic disorder involving solitary behavior or consenting individuals, one could read that a person may be so diagnosed if the paraphilic behavior is related to risk of serious injury of the patient and/or their partner. When concluding his deliberation on the ICD-11, Paul Fedoroff [3] states that the diagnosis of sadomasochism that appeared in the previous version may be replaced by coercive sexual sadism disorder or other paraphilic disorder involving non-consenting individuals, where the lack of consensuality is the fundamental diagnostic criterion. Fedoroff also stresses that consensuality is not a binary variable and should be deemed a continuum. Therefore, the diagnostic question should be related to the level of consent between partners for a given activity and not the existence of consent itself.

While analyzing the diagnostic criteria included in the DSM-5 and ICD-11, one could clearly note that consensual sadistic and masochistic behaviors have been removed from the disorders category. The validity of this stance could be supported by research outcomes showing that there are no significant differences between persons engaged in S/M practices and those who are not [24–26].

Therefore, if persons who practice BDSM do not experience fear, shame and/or negative psychosocial consequences of their preferences, they do not need medical treatment [27]. However, it should be stressed that these practices may be related to the experience of humiliation, which could lead to fear and/or shame. But they occur with the consent of the partners under controlled conditions, which lead to their satisfaction. These criteria matter from the clinical perspective because they allow the differentiation

of pathological and non-pathological motivation for building relationships based on dependency and pain. This issue shall be discussed as part of the analysis of various BDSM practices and violence.

From the perspectives of medicine, psychology and/or sexology, sadomasochistic relationships (S/M) were and often still are perceived as a symptom of a disorder. This approach was surely influenced by many factors, one of the most important of which may be the fact that patients who were engaged in S/M relationships due to their disorders and/or experiences of violence were the source of the scientific descriptions of such relationships. For many years there was no research on the functioning of persons voluntarily engaged in consensual S/M relationships. The difference between a kind of transgressiveness and violence in S/M relationships seems crucial in the context of psychopathology and shall be discussed later [2]. The pathologization of S/M relationships has been reinforced also by including sadism and masochism in psychiatric classifications as paraphilia or paraphilic disorders. It often happens though we lack convincing evidence that persons practicing sadistic and/or masochistic behaviors and/or relationships show more symptoms of disorders than those who do not [25].

This situation is similar to homosexual persons when non-heterosexual orientations were classified as a disorder and there was no reliable research that could show that homosexual and/or bisexual persons reveal significantly more mental disorders compared to the general population [28]. A significant influence on the process of depathologization of S/M relationships was made by researchers who analyzed BDSM as a social and cultural phenomenon. They allowed the interested persons to speak about their S/M experience, which was meaningful for them. In this way, a new narrative on BDSM relationships emerged which attempted to understand the variety of motivations behind them. These narratives of the people involved in S/M relationships have become visible in the public space, in social media, where there are users interested in BDSM practices, and in a variety of cultural events and/or films. The process of depathologization goes on and we proceed from perversion to diversity.

While analyzing the functioning of persons who identify themselves with BDSM culture, we need to remember that they are not free of the experience of violence and/or stigmatization due to their orientation [6]. However, their situation is not as severe as it is in the case of non-heteronormative persons. The levels of depression, anxiety and/or stress are similar to that of the general population and they decrease with age. The level of post-traumatic symptoms is slightly higher and correlates with the non-heterosexual orientation; in turn, the risk of suicides is low. This image of the mental health of persons practicing BDSM may be related to the fact that these practices are related to intimacy and take place in relatively closed communities. Therefore, the process of revealing BDSM practitioners' preferences will be controlled to a much greater extent in comparison with, for example, non-heteronormative persons.

While scrutinizing the situation of persons who practice BDSM, we need to consider the fact that they are exposed to minority stress, which has been described in depth in the context of homosexual and bisexual persons [29, 30]. However, there is

a significant difference: minority stress for non-heteronormative persons is related to real discrimination and stigmatization, while those who practice BDSM experience anxiety related to possible disclosure of their preferences and the possibility of discrimination and/or stigmatization because of kinkphobia. The term 'kinkphobia' was used for the first time in a paper published in 1993 by Guy Baldwin and Joseph Bean [31] and it referred to prejudices to persons practicing BDSM. These attitudes are most often driven by sensations of disgust and/or repugnance. In the case of persons who practice BDSM, their mental health may be influenced by internalized kinkphobia, i.e., internalized negative assumptions related to their preferences, which in turn may cause severe inner conflicts [32].

It is worth noting here that there is another aspect to this debate. Considering widespread practices and/or fantasies related to BDSM practices, we may use the term 'marginalization stress' instead of the term 'minority stress', which has been suggested by Christin Richards and Meg Barker [33]. It shall describe the specific emotional stress related to behaviors that the majority of society does not fully accept.

Development of minority communities

As it was mentioned above, engaging in and building S/M relationships used to be pathologized by mental health professionals. At the same time, the community of S/M persons developed. S/M behaviors became the element of sexual life, or their lifestyle or even the part of their identity. When analyzing BDSM communities, some authors' sexual culture theory may be useful [34, 35]. It refers to the system of meanings and practices shared by a community, historically, socially and psychologically conditioned. Currently, in Western societies, there are a variety of sexual cultures which spread and co-exist with each other [2, 36].

Erotic relationships whose essential feature was an exchange of power between a dominating person and a submissive one, or in which partners inflicted and/or experienced pain, have existed for centuries. These practices may be described using current terminology like S/M or BDSM. However, caution should be applied while using this terminology due to the various contexts and meanings that have existed throughout the ages [35]. The concepts of sadism and masochism were introduced in the scientific discourse by Richard Freiherr von Krafft-Ebing, an Austrian and German sexologist, psychiatrist, neurologist, and criminologist; they appeared in the *Psychopathia Sexualis* lexicon, which was published in 1886 [37].

Von Krafft-Ebing discussed sadism and masochism as two separate phenomena. Sigismund Freud interpreted sadism as a step in psychosexual development (oral and sadistic versus anal and sadistic phases), and sadism in adults was understood as a stop in sexual development. Sadism was separated from sexual behaviors and was then related to aggression and/or the death instinct. However, Freud interpreted sadism and masochism as perverse behavior and as present in a variety of human practices [5, 38]. In 1913, Isidor Sadger, an Austrian psychoanalyst, linked sadism and masochism for

the first time and established the term ‘sadomasochism’ [5]. Such an approach to these two phenomena was congruent with Freud’s views, who claimed that both of them are a mixture of pain and pleasure, and the difference between them is that sadism is directed at the external object and masochism is directed at the self.

However, before those behaviors had been medicalized and thus pathologized, they were named in other ways. For centuries, pain and suffering were interpreted religiously. For shamans in various cultures, they were sources of ecstasy and could be found in pagan fertility, gender, and love rites, while for Christian monks they were an instrument for divine sanctions. Starting from the 13th century, whipping fraternities appeared. Spreading of these practices allows us to question the motivation of inflicting suffering – were they always motivated by religious beliefs? In the 18th century a significant change occurred, and since then flagellation has been related not to the back but to the buttocks. Flagellation of buttocks started spreading in libertine circles, largely thanks to de Sade, who contributed to the desacralization of suffering [39]. Also, flagellation became justified by medicine. In the *Traité du fouet et de ses effets sur le physique de l’amour, ou Aphrodisiaque externe, ouvrage médico-philosophique, suivi d’une dissertation sur tous les moyens capables d’exciter aux plaisirs de l’amour, par D****** by François Amédée Doppet, published in 1788 [40], one could read:

Individuals requesting flagellation and ready for embracing always demand that their backs are whipped. Therefore, let us see how the warmth triggered in this place goes down to the genitals. One could note that loins make up a large part of the back between the ribs and pelvis supporting the lumbar vertebrae, under which there are kidneys and numerous blood vessels linked to the vitals. Apparently, heat goes down from the loins to the penis, and in females to the vagina. [40, p. 45–46].

The idea of (medical) benefits from flagellation did not last long. The works of von Krafft-Ebing, followed by Freud and psychoanalysis, developing in the era of Victorian morality pathologized “play with a whip”. Another perspective on flagellation also arose in the 19th century – a legal one. Secularized sexual practices were under legal surveillance. They were not interpreted as a crime if they were practiced in private and with the consent of adult partners. Legal authorities intervened when minors were engaged, when the sexual scandal was imminent, and/or when violence was involved. New ethics appeared, which were based not on religion but on science. People could do whatever they wished in privacy, but the state clearly regulated public activities.

Sexual cultures develop in phases [41]. When examining BDSM culture, general stages of sexual cultures development can be distinguished. From this perspective, the period before 1900 may be interpreted as the first phase, the so-called contact phase. Persons of similar interests and desires start to get to know one another, establish contacts and build communities.

The second phase between 1900 and 1970 has been named the phase of networks. At that time, contacts develop into the form of free gatherings of people with similar preferences. S/M meetings take place in private residences but not in brothels. The time of prostitution prohibition arrives. The practices become more and

more varied. In the 1930s, the culture of fetishism started. The participants of these meetings initiated contact through ads in niche underground magazines. The first S/M magazine, *Bizarre*, was launched. However, S/M practitioners started to fear discrimination and/or legal consequences. BDSM supporters and producers of films and gadgets went underground.

In the third phase between 1970 and 1980, which was called the communities phase, associations appeared which were based on direct contact. The first S/M communities arose in New York and San Francisco. The 1980s were the fourth phase, the so-called phase of social movement. At the beginning of the 1980s the number of heterosexual men who practiced BDSM increased. The HIV/AIDS crisis divided S/M communities according to sexual orientation. Heterosexual persons rejected gays and lesbians and set up their own communities, which were significantly smaller than those created by homosexuals. Perhaps it was influenced by the fear of revealing one's preferences and the social consequences in the form of stigmatization or rejection. It is possible that fear against revealing their preferences and social consequences manifested in stigmatization and/or repulsion.

The fourth phase was also when BDSM persons started a significant social movement that entered the cultural discourse. They organized meetings, conferences and support groups, and they joined events organized by LGBT+ communities. S/M themes appear in films such as *9 ½ Weeks*, *Blue Velvet* or *Pulp Fiction*. Research studies and guidebooks for practitioners began to be published in the 1980s. The emerging internet allowed new possibilities in terms of acquiring knowledge and contacts. However, discrimination and accusations of violence reappeared. The fifth phase, named the phase of sexual culture, has lasted since 2000. BDSM communities now grow and establish joint systems of meanings and practices, they are open to new sexual cultures.

As one can see from this review of the phases of the development of sexual culture, BDSM communities undergo continual changes. Their functioning depends on the cultural and social context. Currently, those who practice BDSM resemble that of the LGB community at the turn of the 1960s and 1970s [5, 34, 42]. Although BDSM culture penetrates social space in many ways, persons who establish S/M relationships are perceived most frequently through the prism of psychopathology.

The existence of sexual cultures seems to have major significance because they bring together persons whose preferences may exclude them from mainstream society. Sexual cultures play a variety of functions in this context [41]. They establish:

1. boundaries between a given sexual culture and the sexual majority, and thus the boundaries of group membership;
2. the sources of a given sexual culture and its historical context;
3. correct and incorrect behavioral norms in a given culture;
4. specific systems of meanings, behavior and desires characteristic for a given culture;
5. rules for admission for new members;
6. collective sexual identity.

A sexual culture thus creates a space where its members may safely share and explore their preferences. These activities are based on established rules, which increases their safety. A community also contributes to building individual identity through identifying with other members and the system of meanings (codes) related to their specific desires and behaviors. A community also ensures support by establishing groups and personal relations and/or by collaboration with kink-aware therapists.

Construct of pain

Though the experience of pain is not a vital condition in S/M relationships, for many persons engaged in them it has become a significant component. Because the understanding of the pleasure that comes from the experience of pain is not easy, and hence frequently the interpretations of this pleasure are in terms of psychopathological mechanisms. In public space, joining pain with sexual pleasure also encounters major resistance. In our culture, the pain has negative connotations and the discourse on its existence refers to its avoidance above all. However, it is possible that this aversive aspect of pain is not the only one [43].

For years, the relations between pain and pleasure were interpreted by invoking psychophysiology. According to one theory, since the different states of excitement are not differentiated, then pain may be experienced as pleasure. Other theorists stress that the experience of pain may stimulate the release of endorphins, therefore pain may be associated with the experience of pleasure. However, the interpretations that invoke psychophysiology do not explain why pain plays a vital role in this group. Also, the reduction of such a complex and subjective experience to purely psychophysiological issues means that we miss some essential aspect of this phenomenon where the pain is integrated into both the sexual pleasure and the interpersonal relationship [43].

Other authors have pointed out that culture plays a significant role in defining the significance of pain and therefore regulating the sensitiveness to the pain stimulation [44]. We could refer to some initiation rites in many cultures where experienced pain is meaningful [45, 46] and therefore accepted as natural, resulting in regulating the sensitivity of pain stimuli.

Such an interpretation may be similar to the construct of unpleasantness that was introduced by Howard Fields [47], who distinguished two aspects of unpleasant experiences: (1) primary aspect is strictly related to the intensity of stimulation and diversity of sensation (at this level stimulation should be recognized as painful and different from other unpleasant experiences like itching or tickling); (2) derivative aspect, which reflects the process on a higher level where the experience of unpleasant stimuli becomes determined by memories and context where it takes place. It could be suggested that the experience of pain may be interpreted, experienced and endured in many ways. Pain is a multifaceted experience that should not be restricted to neurophysiology as it is how painful sensations are interpreted which matters. From such a perspective, pain does not need to stimulate defense reactions, but it may be voluntarily accepted.

Colin Klein [48] states that suffering is not a feature of pain, rather it is a possible pain response. Similarly, pain/painfulness on an emotional level may be the response to pain. When analyzing the issue of masochistic pleasure, he points to various activities that stimulate pain but also arouse pleasure (such as marathon running, body piercing and some forms of deep massage). According to Klein, differentiating between pain and painfulness may help look differently at the division of experiences into those that give pleasure, those that cause pain, and those that cause neither one nor the other. The category of experiences in which pain is combined with pleasure, emerges here. While relating these remarks to BDSM practices, it can be stated that the pain experienced in these relationships may provoke various experiences, among which painfulness or suffering is only one of them..

To conclude our analysis of pain in S/M relationships, we would like to stress another aspect: the specific incapacity to express the pain in language. Humans may subjectively experience pain, but they cannot share this experience with other people [43, 49]. This incapacity to express the experience of pain and the specific relation of dependency in S/M relations may activate early childhood experiences from the pre-verbal period. These experiences may relate to building relations through bodily contact and situations of dependency, when a care provider decides whether and how the child's pain or discomfort would be alleviated. Therefore, in S/M relations, the regression mechanism may trigger early experiences related to the experience of the body and dependency relation. From this perspective, an S/M relationship may partially recreate early childhood relations, with a feeling of pleasure, but also it may re-activate traumatic experiences. This motif may be essential from diagnostic and therapeutic perspectives that examine whether S/M relationships are consensual. Thus, some researchers stress that the S/M experience may be a correctional (therapeutic) re-creation of trauma in a controlled situation [5].

Consensual BDSM and violence

For many persons, including psychotherapists, it is difficult to differentiate BDSM from violence. The most important feature of a BDSM relationship is its consensuality. Even though unpredictable elements or strong emotions like fear occur, both partners agree to establish the boundaries of such an activity and a safeword, which stops a given type of activity or the entire session. Therefore, this allows to control the situation and it is less likely to cause or experience harm. It is essential that specific activities need conscious consent to the undertaken practices aimed at mutual pleasure. Partners' subjective boundaries should be mutually respected. Therefore, one may conclude that some essential aspects of BDSM relationships are communication, openness to preferences, and trust, determining whether a given practice is safe. It is crucial to strictly follow these rules so that practitioners can enjoy the experiences [50–52]. Among BDSM practitioners, there is a motto which in short describes their practices, whose author is probably David Stein – "Safe, Sane and Consensual" [53].

The essential differences between BDSM relations and violence are listed in Table 2. As mentioned above, the essential issue is conscious consent to this type of relation. The BDSM practices in opposition to the violence relation are under control. The dominating partner has to adhere to the rules established earlier, and the submissive person may use the safeword.

Table 2. **Differences between BDSM and violence (based on [32])**

BDSM relation	Violence relation
• consensual	• non-consensual activity
• controlled activity	• non-controlled activity
• safeword	• person experiencing violence may not stop it
• familiarization of partner's desires and needs	• neglecting the needs of the other person
• not using psychoactive drugs	• activity often with the use of psychoactive drugs
• satisfaction after the session	• negative emotions after the violence

An important aspect of S/M, specifically when one partner experiences pain, is so-called aftercare [54–56]. The dominating person's task is to establish an environment for the submissive person's experience of pain and provide comfort both during and after the session. This type of experience may trigger very intense emotions, so the dominating person's task is to help deal with them by creating a relationship based on trust and helping to relieve of the emotions accumulated during the session. This element of the relationship allows the partners participating in a S/M session to experience satisfaction, which is an important factor that differentiates it from violence.

Kink-aware and kink-friendly therapists

In the context of the psychotherapeutic process and taking into account the popularity of BDSM practices, it seems essential to focus attention on this area of patients' functioning in the process of examining their sexuality. Research outcomes show that 25–30% of patients never report to the therapist that he/she is in the S/M relationship, and the most frequent cause of this is fear of disapproval [4, 57]. It seems that these fears are not groundless, as examination of therapists shows that they tend to pathologize not only a patient's practices but even their interests [58, 59]. In research on 175 persons practicing BDSM, one third of them decided not to disclose their practices due to fear of an adverse reaction from their therapists [59]. The respondents revealed experiences in which their therapists considered BDSM a symptom of illness and sometimes asked patients to stop such behaviors as a condition to continuing therapy. Some of these BDSM practitioners claimed that their therapists were kink-aware, but they lacked knowledge on BDSM. The tested group of patients mentioned knowledge and acceptance of BDSM-related lifestyles and experiences as an important aspect of the competencies of a psychotherapist.

Based on her clinical work with sexually diverse clients, Margaret Nichols [4] showed how important it is for a professional to face their own ideas about BDSM practices. The most frequently shared myths related to those practices interpret them as addictive, compulsive, self-destructive, related only to reception/inflicting physical pain, and/or avoiding intimacy. As mentioned above, BDSM practices are perceived as different from 'vanilla' sexuality, while BDSM practitioners may also be satisfied with 'non-climatic'[2] relations. This researcher also stresses that BDSM practitioners are highly diverse, and as such their shared preferences can be understood and accomplished in many ways.

Nichols [4] also stresses the importance of several issues which need to be faced by therapists, including their views, assessment of, and/or reactions to such forms of sexual activity. A therapist may feel fear, anxiety, or disgust. If a therapist experiences intellectualizing in countertransference, they may be assured that the client's behaviors are self-destructive and might lead to real harm and/or threat to health and/or life – despite the lack of clear indications that the behavior may in fact lead to such situations. A therapist's negative and/or aversive attitudes towards BDSM practices may indicate the unconscious and/or denied threads of his/her sexuality. Analyzing own negative reactions may be helpful in therapeutic work because they may be a reflection of internalized shame and/or clients' hostility towards themselves.

To determine whether a therapist is dealing with so-called healthy BDSM, Caroline Shahbaz and Peter Chirinos [32] suggest questions concerning the consensuality of the relations, the emotions experienced when engaging in BDSM practices, the consistency of the value system with sexual behavior, and/or availability of support from other persons engaged in relationships. Shahbaz and Chirinos stress that although BDSM practices are not therapy, engaging in them may sometimes play a therapeutic role as they may contribute to a higher level of acceptance of sexuality and/or help in the ability to set boundaries.

Keely Kolmes and Geri Weitzman [60] analyzed the differences between kink-aware and kink-friendly psychotherapists. According to this approach, kink-aware therapists can distinguish healthy BDSM behavior from abusive, non-consensual behavior in relationships and interpret BDSM as part of the spectrum of various sexual behaviors. They claim that kink-aware therapists are educated, are able to understand the specificity of the functioning of practitioners and specific problems with which practitioners may seek help, such as the willingness to disclose their preferences, communication about sexual preferences with a partner, negotiation of boundaries inside and outside the relationship, and experienced minority stress [61]. In turn, kink-friendly psychotherapists may have insufficient knowledge on BDSM but may still have an open and non-pathologizing approach to their clients/patients. They may have clinical experience of work with other minority groups, e.g., non-heteronormative persons, which may be helpful in their work with BDSM practitioners [4].

[2] In the BDSM subculture, the notion that something is climatic means that it just relates to those practices.

BDSM practitioners may report other issues to therapists that are not related to their sexual preferences but may also wish to talk about them. The issues that may arise here most often relate to: acceptance of preferences by the patient himself/herself and/or by the partner; fear related to whether such preferences are not a symptom of a disorder; the process of revealing one's preferences; fear of being disclosed or assessed by others, and also the practices themselves, such as the issue of experiencing and setting boundaries in S/M relationships [32].

Recapitulation

As shown in Table 1, the number of people practicing relationships based on domination and submissions, according to various studies, ranges from a few to over 50 percent of the respondents, the number of people fantasizing ranges from a few to over 30 percent. One can ask a question whether the concept of a minority group can be applied to this group. However, there are many stereotypical views regarding their functioning. On the one hand, stereotypical views may result from the long tradition in scientific discourse of pathologizing relationships in which there are elements of domination and the inflicting of pain; on the other hand, this type of relationship is hardly accepted in social and cultural contexts where domination is strongly linked with violence, and pain is strongly linked with suffering, which should be eliminated. The low amount of research on the functioning of persons who identify with BDSM practices seems significant.

Summarizing their research on the functioning of persons who practice BDSM, Shahbaz and Chirinos [32] provide several conclusions:

- there is no convincing evidence that interest in such practices is a result of trauma experienced in childhood and/or sexual harassment;
- these practitioners experience discrimination and stigmatization that is similar to what homosexual persons suffered before homosexuality had been removed from psychiatric diagnostic classifications;
- practicing BDSM is not a reason for stress and/or various dysfunctions, they are rather the result of socio-cultural and political accusations;
- BDSM may be interpreted as healthy entertainment in sexual life.

As for therapists and other mental health professionals who work with people that identify with BDSM culture, it is essential not to pathologize them as a starting point of familiarization with the patient's inner world. Sometimes, these behaviors might be a symptom of mental issues and/or that the patient is involved in a violent relationship, but some symptoms make it possible to discern these individuals from those in healthy and consensual S/M relationships. Professionals need to be aware of their prejudices related to sexual preferences; they should acquire knowledge on the specificity of the functioning of such persons and be open towards possible exploration of the sexuality and relationships enjoyed by these patients.

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