# How Did it Hurt?:
## distinguishing between Intimate Partner Violence and BDSM in relationships

*Rachel Anne Kieran & Elisabeth Sheff*

Described as possibly one of the most pathologized groups in alternative sexualities,[1] public confusion and fear regarding BDSM, or kinky sex, shapes negative attitudes towards this form of sexual variation. It is clear that health practitioners and law enforcement officials require a fuller discussion regarding the significant differences between the valid sexuality that BDSM represents and its counterpart of Intimate Partner Violence (IPV). In many instances law enforcement officers have erroneously conflated IPV with BDSM, and have abused laws designed to protect partners from violent abuse in order to legally prohibit, censor and outlaw BDSM.[2]

Meanwhile, the relationship between psychiatry and legal institutions leading to public policy and law making has not been one of scientific neutrality, but one in which psychology has been used to re-enforce moral prejudices in the public domain. We hope to describe these points of conflation, while elaborating upon clear distinctions between the consensual acts of sexual diversity that constitute ethical BDSM and their clear contrast in IPV. This should have many uses in a number of disciplines, not least those of psychology, psychiatry, counselling and psychotherapy, and law.

What used to be commonly referred to as 'sadomasochism' has been updated, expanded, and clarified to become 'BDSM'. This is a distinct term, receiving a great deal of attention to its definition, and has been divorced from the pathological implications of its predecessor in recent literature, studies and research on the subject. Thus, BDSM differs significantly from Intimate Partner Violence (IPV), though it may take some finesse to distinguish between the two at first glance. In this chapter, we explain attitudes towards sadomasochism, define BDSM, explain principles that organize

kink communities and discuss the ways in which the American Psychiatric Association (APA) and the World Health Organization (WHO) classify BDSM. Next we define Intimate Partner Violence (IPV), explain types of IPV, the intention behind it, and differentiate between BDSM and IPV. We conclude with suggestions for practitioners and a list of resources.

## What is BDSM?

BDSM is the practice of consensual exchanges of personal power for the achievement of sexual pleasure. This includes (but is not limited to) negotiated *scenes* involving some combination of corporal or psychic punishment, intense physical stimulation (often pain), role playing and/or fantasy, and/or varied sexual interactions.[3] Until it became clear that this term was overly simplistic, BDSM was referred to as 'sadomasochism'. Since then, practitioners of BDSM or *kinksters* – people involved in 'kinky' or 'perverted' sexual acts and relationships – have expanded the concept to include bondage/discipline, Dominance/submission, sadism/masochism, or any combination of these and other concepts involving power exchange.

### *Bondage and discipline*

*Bondage* means using restraints to limit movement. Participants may use rope, handcuffs, leather straps, a bathrobe belt, plastic wrap, or any of a variety of materials to bind one another to a bed or chair. The bound person(s) often then undergoes *discipline*, or the application of intense physical sensation. This intense sensation may or may not include the application of pain, so it is a misnomer to assume the participants in this behaviour would identify this as 'sadism' and 'masochism'. The most common form of discipline is *impact play* that involves spanking, whipping, caning, slapping or flogging. A complete list of the toys, tools and props used in bondage or any sex play is beyond the scope of this chapter, but may include a variety of formal or improvised accoutrements to meet the desires and needs of participants.

### *Dominance and submission*

The *Dominant* (D) person(s) in a kinky interaction, also known as a *Top*, is the one doing the restraining, providing the discipline or directing the

action. The *submissive*(s) partner(s) or *sub/bottom* is generally the one who is tied up and spanked or ordered to clean the bathroom on hands and knees. Time-limited *scenes* are generally negotiated between both parties in advance. Even ongoing D/s interactions include relational agreements that set out acceptable and unacceptable behaviour – limits on the exchange of power. Because the submissive is the one who structures the scene before play begins and sets the boundaries for what is or is not acceptable, many kinksters say that it is actually the submissive who is in charge. Submissives or *subs* who attempt to exert control during scenes are sometimes said to be *topping from the bottom*.

*Switches* are people who identify as Dominant in some cases and submissive in others. Things like the person's mood, personality or gender of partner, or specific kinky act to be undertaken can all influence the expression of the switch in the moment, and some even move between submission and Dominance in the same evening. Switching is a generational phenomenon, popular primarily among younger kinksters (something we discuss in greater depth below).

### *Sadism and masochism*

*Sadism* is the experience of pleasure as a result of inflicting pain or humiliation to a willing lover, and *masochism* is the state of eroticizing and finding pleasure in that suffering or mortification. Many individuals who identify as *sadists* discuss consent and pleasure as central to their enjoyment of their partner's pain: beating or molesting non-consenting people would not provide the same satisfaction because the pleasure of the recipient is integral to the experience. Some *masochists* prefer physical pain that accompanies intense stimulation, and others prefer the psychological pain of humiliation, though many like to blend both forms of pain.

### *Play*

Experienced kinksters commonly negotiate and plan a scene before *playing* (participating in a specific sexual activity), and the people with whom they enact these kinky scenes are called *play partners*. While most play happens in private, using improvised equipment from the kitchen or hardware store, some kinksters play in rooms called *dungeons* that are equipped with special furniture, such as spanking benches. Some people build home dungeons

in their basements and many major urban centres have public dungeons that charge admission and enforce safety rules.

Together, these elements constitute BDSM. Individual categories often intersect in specific ways, so that many Dominants are also sadists, and many submissives are also masochists. However, this is not a hard and fast rule. Many submissive individuals desire power exchange without pain in their relationships – some people may want to be bossed around but not spanked or humiliated because they are not masochists. Often those who identify as sadists desire the exchange of pain without ongoing power exchange – sometimes a sadist wants to smack someone's bottom, but not discipline them for accidentally getting a speeding ticket as they would if they were also that individual's Dominant. While these terms broadly define behaviours, they are also often central to the identity of the participating individual. Each person's needs are so personal and distinct that the possible permutations of power exchange are endless – who, when, why and how are individual and specific.

### *Fetishism*

It should be noted that nowhere under this umbrella of BDSM does a concept reside specific to sexual arousal driven by certain objects or body parts – fetishes. Despite this, the spirit of fetishism, intense interest in a particular sexual object or activity, seems to find overlap and acceptance in the BDSM community and is widely accepted as part of the *kink* paradigm. The use of objects to accomplish the intense physical sensation desired during bondage, or to inflict desired pain, has furthered this association. It is important to note, however, that BDSM interactions can occur without these and that the arousal is not necessarily linked to the object itself.

### *Kink community organizing principles*

People in organized BDSM communities often refer to an organizing belief in ensuring that behaviour remains 'safe, sane, and consensual'.[4] *Safe* means playing within limits that leave no lasting damage or undesired effects. *Sane* means carefully and thoughtfully considering the scenes prior to engaging in them. This also refers to considered decision-making regarding more long-term exchanges of power. While *consent* initially appears to be

self-evident, kinksters routinely debate the nature of true consent and most ultimately agree that it is generated between informed adults with no coercion. Consent is a key element of *power exchange* in which kinksters negotiate transferring personal power from one person to another. Usually this exchange occurs for a specific set of activities and a limited period of time, however long the particular scene lasts. Sometimes kinksters in long-term relationships establish a *24/7* agreement that makes the power exchange a permanent feature of the relationship.

A more recent iteration of safe, sane, and consensual is 'risk aware' sexuality that relies on informed consent and negotiated boundaries. In general that includes using a *safe word* to end a scene if the submissive partner is not enjoying what is happening, and meticulous attention to potential health consequences of behaviour – using condoms or other barrier methods to contain fluids that might otherwise spread sexually transmitted infections. Awareness of STIs is high in kink communities and this contributes to the high numbers of moral and ethical codes in operation regarding the safety and well-being of the players. Group norms require that players regularly sanitize the toys or implements they use in kinky play and never use the same toy on different people if it has any fluids on it. Blood spatter is a serious *faux pas* in public dungeons and kinksters who play there take great pains to contain fluids of all sorts.

Kink communities (and a whole host of other sexual minority subcultures) in the United States have grown rapidly since the advent of Internet technologies. They have now become large enough to self-segregate primarily by sexual orientation and age and, to a lesser degree, by specific kink (although extremely specialized fetishes proliferate on the web). For instance, most public play parties are geared specifically towards either gay leather men, lesbians/leather dykes, or bisexual/heterosexual people. This is in part due to the origins of the BDSM subculture in the United States which began as a gay male phenomenon (see Chapters 5 and 15 by Nick Field in this book) that later diverged to include lesbian, heterosexual, and bi/pansexual communities.[5] Kinksters often meet in non-sexualized settings (restaurants or bars) at what are called *munches*, where they socialize, meet potential partners, chat and learn skills or get advice. Regular gatherings, ranging from munches to weekend-long conventions, often focus heavily on education,

emphasizing the ideals of 'safe, sane and consensual' while offering practical advice on implementing these.

One consequence of the rapid growth of interest in kink is a significant generational gap between the *Old Guard* who identified as kinky long before the advent of Internet communications and the *whippersnappers*, or younger people who became kinky in the era of the World Wide Web. The Old Guard generally had to expend considerable effort and personal resources to seek and establish kink communities, often at great social expense. In so doing, they established clear hierarchical rules called *protocol* that govern interaction and solidify identities such that it is difficult to transition between Dominant and submissive. Whippersnappers are generally disdainful of elaborate rules and wish instead to focus on the fun, eschewing form for orgasm. In smaller communities, the whippersnappers and the Old Guard play together, but in bigger urban centres with large enough kink populations to sustain a diverse community, whippersnappers are likely to self-segregate from the Old Guard.

While most current academic knowledge about BDSM relies on the comparatively small group of people who engage in kinky play in public dungeons or attend munches,[6] the vast majority of people who have kinky sex do so in private, at home, with their bedroom doors closed. Many of them might not even think of themselves as kinky, and instead consider it just something they do with their partner and might not discuss with others. Thus, what research exists is further limited by the fact that those who have disclosed have chosen to do so. There are certainly a multitude of voices that are not heard due to either their limited visibility in the kink *scene*, or an unwillingness to disclose kinky behaviours or identity.

Most popular knowledge regarding BDSM appears to be informed more by media representations than by personal interactions with kinksters. The assumption that these representations are added for dramatic emphasis, audience titillation or sheer shock value may lead to the conclusion that kinky sex is only something that happens on TV and in the movies. The reality, however, is that the increasing representations of a diversity of sexual experiences most likely reflects actual diversity in the sexual behaviours of the population. The popularity of books reflecting BDSM relationships, for example, suggests that interest in BDSM exists at a level that supports a small industry. An Internet search reveals a

multitude of fiction and non-fiction titles in this area, of which *Fifty Shades of Grey* is a very poor example, but one that brought the idea of kink to mainstream attention.

### *Classification of sadomasochism – early conceptualizations*

Early sexologists[7] and psychologists[8] pathologized sadomasochistic behaviour as unhealthy, psychopathic, or perverted, though later scholars have contested these classifications.[9] Feminists have discussed sadomasochism,[10] with some celebrating it as an avenue to women's sexual empowerment,[11] while others link it to misogyny, violence against women[12] and self-mutilation.[13] And as with so much behaviour that is infrequently observed, social norms have reinforced assumptions that kink equals abnormality or pathology.

### *Classification of sadomasochism – DSM-5 and ICD-10*

The American Psychiatric Association (APA) recently released the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM),[14] a book that has been extremely influential in the United States as the legally accepted system of classification for clinical – and therefore social/criminal – definitions of 'abnormality'. The DSM categorizes observable clusters of symptoms into labels for disorders ranging from major depressive disorders, anxiety and phobia disorders, to psychoses and eating disorders. The DSM includes a section on 'abnormal' sexual behaviours under the label 'Paraphilic Disorders'.

The detail that is often lost in examining the DSM (past and present editions) is that diagnosis with any syndrome is predicated on the presence not only of characteristic symptoms (depressed mood and others in the example of depression), but additional criteria. These additional criteria almost exclusively include the presence of 'marked distress or impairment of functioning', implying that if the presenting symptom is not a source of distress or dysfunction for the patient, then they do not meet the criteria for clinical diagnosis. This is one of the essential facts to retain when engaging in clinical discussion of sexually diverse behaviour.

The newest edition, *DSM-5*, took a further step towards depathologizing sexually diverse behaviours in its labelling conventions. The DSM is an evolving document, as was made evident by the success of the 1973

proposition paper and subsequent activism that would eventually lead to the removal of the category of 'homosexuality' as a clinical diagnosis of abnormality and disease. It would, however, be more than a decade before all references to 'homosexuality' were removed from the DSM in the text revision of the 3rd edition. In past editions of the DSM, behaviours categorized as 'paraphilic disorders' were labelled simply by their defining characteristic and given the titles of 'Exhibitionism', 'Voyeurism', 'Sexual Masochism', 'Sexual Sadism', etc. Editors of the most recent edition made a deliberate change in nomenclature that now emphasizes the distinction between the characteristic behaviour and a syndrome that would represent a mental disorder. Each of these categories has now been designated a 'disorder' (e.g. 'Fetishistic Disorder' rather than 'Fetishism'). The implication is that the psychiatric community recognizes a distinction between engagement in fetishistic behaviour and a syndrome of behaviour that is the cause of distress and dysfunction constituting a mental disorder.

Sadly, the same change has not been reflected in the WHO's *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision (ICD-10). The ICD-10 retains only one category – 'sadomasochism' for 'a preference for sexual activity which involves the infliction of pain or humiliation, or bondage', and asks that the clinician then specify a type.[15] While this abbreviated category does recognize that 'often an individual obtains sexual excitement from both sadistic and masochistic activities', there is no mention made of what would differentiate SM *behaviours* from a *syndrome* of distress and dysfunction. As in many minds, both the implication and the assumption remain that to merely engage in SM behaviour is to have a mental disorder, when this is simply not the case.

### *BDSM vs paraphilia*

In its discussion of 'paraphilic disorders', the *DSM-5* implicitly differentiates between functional sexual diversity and syndromes meriting clinical attention. The DSM defines paraphilic disorders as including fantasy, urges or behaviour 'generally involving nonhuman objects, the suffering or humiliation of oneself or one's partner, or children or other non-consenting persons'. With the exception of the latter, however, diagnosis is limited to patterns in which the defining behaviour has to be accompanied by distress and dysfunction which persists over time. With regard to the diagnoses

relevant to BDSM, Sexual Masochism Disorder and Sexual Sadism Disorder, the *DSM-5* further states very clearly that the individual must have acted on these sexual urges with a non-consenting person, or must have experienced 'clinically significant distress or impairment' as a result of their fantasy/desire.

Clearly, the *DSM-5* is working to distinguish pathology from the practice of consensual, ego-syntonic BDSM engaged in by functional adult participants. It is crucial for mental health and legal practitioners to look past initial reactions to obviously sensational features of the behaviour under discussion and attempt to assess the function and impact of this behaviour on the life of the individual before assigning judgment or clinical diagnosis. Any individual may have a sexual preference that appears to express many of these disordered behaviours without *necessarily* having a paraphilic disorder. They may have a fetish (many people do!), but function well, experience no distress, and put neither themselves nor others in danger. The exception to this would be cases where an individual involves another sexual partner without obtaining consent, or involves another who cannot give consent. This is outside the spirit and accepted practice of consensual BDSM.

## What is Intimate Partner Violence (IPV)?

The second wave of the feminist movement in the 1970s brought attention to a domestic phenomenon that had largely been ignored, which activists framed as a particularly gender-bound problem. This led to a popular misconception that 'wife battering' only occurred in heterosexual marriages and was exclusively perpetrated by men. While this focus has shifted with research evidence that shows violence between romantic partners occurs in all kinds of relationships, the misconception persists; this is despite the 1999 CDC (Centers for Disease Control) recommendation, cited by Mitchell and Anglin, that the term 'Intimate Partner Violence (IPV)' be adopted to better reflect that this phenomenon is not limited by gender or marital status.[16] 'Domestic violence' also remains a common term, but mistakenly implies that IPV only occurs in shared living situations. Scholars have routinely provided only the most cursory explanations about what constitutes an 'intimate partner', such as 'current or former partner or

spouse',[17] or have failed to clarify the meaning at all, instead relying on a culturally accepted definition.[18] Nicolaidis and Paranjape[19] note that this allows for broad definition of the concept, but that the operational definition used for research purposes must be specified in its use when interpreting any survey results.

### *Types of Intimate Partner Violence – intimate terrorism*

Nicolaidis and Paranjape[20] explain that the classic paradigm of IPV is informed by research done at grassroots level with individuals seeking refuge in domestic violence shelters from the most severe forms of abuse. They suggest that in these cases, a controlling partner, limiting the access of the victim to resources, has fostered a narrow conception of IPV defined by a power differential and the intent to limit resources through threat and violence. This has, Nicolaidis and Paranjape[21] assert, led to arguments for a broad definition of IPV including physical, sexual and emotional manipulation. This is similar to the model of 'intimate terrorism' proposed by Johnson[22] and others in which 'the perpetrator uses violence in the service of general control over his or her partner', and attempts to exert 'coercive control' over all realms of the victim's life, including children, society, emotions, economics and self-esteem. Johnson notes, however, that this 'intimate terrorism' may be met with compliance, helplessness or reciprocal violence and resistance. In extreme cases this 'violent resistance' can lead to the death of one or both partners.

### *Types of Intimate Partner Violence – situational couple violence*

Different perspectives on IPV have arisen from other avenues of research. In the example of 'family conflict research', informed primarily by survey data of undergraduates and general populations, a picture has arisen of violence taking place in response to intermittent conflict, 'perpetrated by men and women at similar rates'.[23] In this definition, IPV is divorced from power dynamic and intent and defined by the physical act itself, ranging from a slap on the cheek to intense physical assault. This is more similar to the pattern identified as 'situational couple violence',[24] which is 'situationally provoked, as the tensions or emotions of a particular encounter lead someone to react with violence.' This is often a response to stress, reflective of a dearth of alternative coping skills, or a result of substance use.

The current WHO definition of IPV focuses on 'behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of aggression, sexual coercion, psychological abuse and controlling behaviors'.[25] Nicolaidis and Paranjape[26] suggest that each group of IPV researchers has been influenced by their sphere of investigation, as with forensic researchers whose definitions rely on whether behaviour violates a particular legal code. While differences remain within the public health system, mental health professionals appear to maintain a perspective similar to the broad, coercion-focused traditional definition of their medical counterparts. Both types of IPV require differing approaches to prevention and treatment. As such, situational couple violence may often be dismissed as 'fighting' and treated more from an anger management perspective, while intimate terrorism (particularly in cases where the victim responds passively) is more often identified as IPV and treated within this definition of the relational behaviours.

### *IPV in the DSM-5*

For those in mental health professions, the *DSM-5* also provides definitions for 'Spouse or Partner Abuse' of varying types: physical, sexual, psychological and neglect. While these are not considered 'mental disorders', they are included as 'other conditions that may be a focus of clinical attention'. The *DSM-5* defines physical abuse as 'non-accidental acts of physical force that result, or have reasonable potential to result, in physical harm to an intimate partner or that evoke fear in the partner',[27] though editors include an exception for actions with the purpose of defending oneself or one's partner.

*DSM-5* editors identify physical or psychological coercion in compelling sexual activity *against the will of the partner* (italics inserted), or with a partner who is *unable to give consent* (italics inserted), as key to sexual abuse. Whether the activity is completed or not is irrelevant – the abuse is defined by the exertion of physical or psychological force in attempting to pursue the act. While psychological abuse may co-occur with either of these, the *DSM-5* defines this category independently as 'non-accidental verbal or symbolic acts by one partner that result, or have reasonable potential to result, in significant harm to the other partner'.[28] The *DSM-5* provides examples of such harm, including humiliation, interrogation,

restriction of activity or economic resources, restriction of access to assistance or social support, threats of harm, harming objects or individuals significant to the victim, stalking, or 'trying to make the victim think that he or she is crazy'.[29] The *DSM-5* also provides a classification for 'Partner Neglect', defined by the deprivation of basic needs resulting in physical or psychological harm and noting that this generally occurs in the context of relationships in which 'one partner is extremely dependent on the other partner for care or for assistance in navigating ordinary daily activities'. While this is common in a long-term care situation, extreme cases of IPV can manufacture such conditions of physical and psychological dependence.

### *Intent of IPV*

Despite their variations, we can draw several conclusions from the existing mental health literature on IPV and abuse. Behaviourally, a theme of *non-consensual* harm or induction of fear emerges. The implication of intent to produce fear or harm in such contexts, as well as to isolate individuals from external support or resources is also common. Whether these actions cross the threshold of criminal behaviour, or lead to a need for medical care, they are carried out in the spirit of control and conflict, without the consent of the victim.

The end goal of this behaviour appears to be control or obtaining a position of power in the family or relational system, which is in direct contrast to the stated goal in the case of the paraphilic disorders – sexual pleasure. In this way we can immediately divorce IPV from the *DSM-5*'s Sexual Masochism Disorder, for the goal of the behaviour is different.

### *Prevalence of IPV in specific groups*

In 2000, the Centers for Disease Control (CDC)[30] in the United States examined 'physical assault by a current or former spouse, co-habiting partner, boyfriend or girlfriend, or date' and reported data from the National Violence Against Women Survey. Despite the title, this research collected data from women *and* men, and reported a lifetime prevalence of IPV as being 22.1% for women, and 7% for men. When surveyed regarding 12-month prevalence, rates were notably similar – 1.3% for women and 0.9% for men. The CDC estimated that this represented 1.3 million female victims annually in the US, and 835,000 male victims.

In their 2010 National Intimate Partner and Sexual Violence Survey, the CDC reported similar rates of lifetime prevalence (25% for women) and an increase in reported lifetime prevalence in men (14%, or 1 in 7 men surveyed). It is possible that prevention efforts and public education in this area have led to an increase in male willingness to report a history of intimate partner victimization – a less terrifying likelihood than a 100% increase in the rate of IPV in males.

There continues to be a significant gender split in reported rates of rape and other sexual violence. Women report a lifetime prevalence of 18%, versus 1% for men. Females are more likely to be subjected to more than one form of abuse, males more likely to report exclusively physical IPV.[31] Distinctions between sexual violence within and outside of relationships are not always made in research or reporting. There have long been suggestions that sexual violence is vastly underreported by male victims. This is attributed to the myth that 'men can't be raped', expectations of masculinity and ability to protect oneself, and a history of unfavourable reactions to those males who have revealed sexual assault histories to medical and law enforcement personnel.[32]

Members of sexual and gender minorities have historically faced similar difficulties in finding resources in the face of IPV. Reports of assumptions of blame, disregard of claims, victim-blaming and outright prejudice were, and sadly are, commonplace. One common assumption seems to be that IPV could not occur in relationships involving two women, apparently based on the outdated assumption that 'wife battering' was the exclusive province of heterosexual men. This has been conclusively disproved and in the CDC 2010 report, 44% of lesbian women, 61% of bisexual women and 35% of heterosexual women reported having experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.[33] The report found that 26% of gay men, 37% of bisexual men, and 29% of heterosexual men reported having experienced rape, physical violence and/or stalking by an intimate partner at some point in their lifetime.[34] While they are often under-represented, a subset of cases reported by the National Coalition of Anti-Violence Programs showed that transgender survivors of IPV (as well as LGBTQ youth and people of colour) were 'more likely to suffer injuries, require medical attention, experience harassment, or face anti-LGBTQ bias as a result of IPV'.[35] They were also more likely than other

groups to face 'threats/intimidation, harassment, and police violence' upon reporting IPV.

Notably, these statistics all come from North American (primarily US) samples, both in population survey and incident reporting. Whilst the WHO does recognize IPV as a major concern, it continues to include it in their 'violence against women' prevention efforts, despite having adopted the term 'IPV' in much of their literature. Their 2010 report on IPV goes so far as to state that 'the overwhelming burden of intimate partner violence (physical, sexual and emotional) and of sexual violence is borne by women at the hands of men'. While this is partially explained by their subsequent indictment of gender inequality in social norms leading to a lack of prevention and advocacy, this statement does perpetuate the myth of IPV as an experience exclusive to heterosexual women.

The WHO 2010 report further notes that compared to men, women are more likely to report IPV, seek medical attention and take time off from work and home duties. However, the impact of generations of social norms around masculinity may form an impenetrable barrier to social support and external resources for male victims of abuse. WHO also notes the dearth of population-based surveys collecting data on IPV prevalence outside North America – hence the reliance on US data above. All other data are collected statistics from victim support services and law enforcement, where female victims are overrepresented and minority groups are often unwilling to seek these services. Reasons for this may include social expectations that drive the harassment noted above, as well as the fact that many of these services are made available exclusively to cisgender, heterosexual women. Extant research across multiple countries focuses exclusively on women, and rates of physical abuse of up to 61% and sexual violence of up to 59% have been recorded.[36]

## Distinguishing between IPV and BDSM

There are significant differences between BDSM and IPV, the most important of which is the presence or absence of consent. In BDSM, scenes are negotiated to determine specific and informed consent. Importantly, the person receiving the impact or humiliation can stop it at any point by using a safe word to end the scene.

Considering Johnson's model of a partner using violence or restriction of access in order to achieve control, it quickly becomes apparent that there are further bold distinctions between BDSM and IPV. In BDSM, control is given at the outset rather than as the result of a physical struggle, emotional manipulation or the threatening of resources. While partners may negotiate situations in which external behaviours replicate a struggle for physical or emotional control, the reality is that the setting of parameters at the outset gives each partner the control to end this interaction if necessary. Essentially, manipulative efforts to shape behaviour are prevented by honest communication by both parties (see Field, Chapters 5 and 15). BDSM also differs from the model of situationally provoked interpersonal violence – again as a result of its intentional and consensual nature. In IPV, the abuser does not seek the consent of the abused. Without consent to initiate, there is no mechanism in place to stop it. Intent differs drastically as well. In BDSM the intent is to pleasure, excite, arouse or titillate, while in IPV the intent is to abuse or control.

Thus the concept of coercion arises repeatedly in discussions of IPV, particularly of the intimate terrorism type. Coercion is clearly a hallmark of long-term patterns of IPV and may include emotional manipulation through displays of regret or pleading, leverage of financial and physical resources, or physical threats. The question has been posed whether coercion might not be a feature of BDSM relationships also. While it is possible for coercion to exist in any relationship, it is anathema to the organizing principles of the kink community. As noted previously, the value of consent is held supreme above all other values in this community. Were a BDSM relationship to be engaged in under coercion or threat, it would be considered to be IPV, not BDSM, by members of the kink community – and in all likelihood, the community would rapidly mobilize to defuse the situation.

The presence of negotiated consent and absence of coercion excludes BDSM from various 'Spouse or Partner Abuse', types delineated in *DSM-5*, with one exception. Because *DSM-5* defines physical abuse as 'non-accidental acts of physical force that result in harm',[37] it could be argued that regardless of consent or intent, BDSM activities that result in physical marks meet this criteria. While preventing lasting physical harm is a reasonable concern for mental health professionals (and BDSM practitioners, who

often discuss this topic), it seems likely that to categorize safe, sane and consensual BDSM in this way is contrary to the aims of psychological well-being in *DSM-5*. This distinction, furthermore, is a strong argument for consideration of context and the avoidance of dichotomous thinking in diagnosis.

Likewise, the outcomes of BDSM and IPV are different, with victims of IPV generally feeling disempowered, out of control, victimized, helpless or angry,[38] while those engaged in BDSM report experiencing orgasms and often personal growth.[39] In the aftermath of a scene, kinksters may have bruises or welts on their bottoms or back, but very rarely have broken bones, facial lacerations or burns. Sometimes kinksters intentionally engage in tattooing, piercing, scarification or branding[40] that is symbolic and aesthetically pleasing. Survivors of IPV are more likely to have facial bruising, cigarette burns, broken bones, loose teeth, vaginal or anal tearing, or stabbings/cuttings that are not intended to be aesthetically pleasing. When done correctly, kinky sex does no lasting harm and certainly is not fatal, while intimate terrorism leads to the death of at least one of the partners all too often.

Finally, there are drastic differences between how the individuals interact after the episode has ended. At the conclusion of a scene, kinksters generally engage in *aftercare* where they talk and cuddle, reviewing the scene and connecting emotionally in non-scripted interaction. Perpetrators of IPV, however, routinely promise not to do it again or rationalize reasons why it was actually the other person's fault that the violence occurred.[41]

## Addressing IPV and BDSM in the practitioner's workspace

With so many surface similarities and such tension around inadvertently blaming survivors of IPV for their circumstances, or pathologizing healthy sexual behaviour, how do practitioners interact with those they meet in the emergency room or therapist's office without inadvertently shaming or silencing them? The answer is: very carefully. Below we offer some suggestions for how to broach the potentially difficult topic of distinguishing between IPV and BDSM.

Rather than simply asking "Did you want this?" which could imply that the victims of IPV brought it on themselves, or that BDSM cannot be

consensual, service providers can *focus on consent* as the major distinguishing factor, using the following questions as guidelines:

- Did you agree to this beforehand?
- Did s/he/they mean their actions to be in fun, were they 'playing' with you in a manner that you were meant to enjoy even though it was rough?
- Will s/he/they stop if you tell them to?
- Do you feel safe?
- Is this part of a power exchange/kinky/BDSM relationship?
- Do you have a safe word?
- Are you able to express feelings of guilt or jealousy or unhappiness?
- Can you function in everyday life?
- Can you refuse to do illegal activities?
- Can you insist on safe sex practices?
- Can you leave the situation without fearing that you will be harmed, or fearing the other participant(s) will harm themselves?
- Do you feel free to discuss your practices and feelings with anyone you choose?[42]

We hope that this will help practitioners begin useful conversations with their kinky clients as well. Many members of sexually diverse groups avoid sharing this with their healthcare and mental healthcare providers out of fear of being shamed or judged. Introducing the question of consent freely and without judgment can powerfully communicate acceptance of sexual interactions and relationships based on power exchange.

## Conclusion

The relation between psychiatry and the law symbolized in the regime of the DSM has admittedly undergone considerable evolution regarding the moral and heteronormative prejudices it has carried through into the term 'disorder'. Nevertheless, such relinquishing of moral projections into psychiatric terminology has been reluctant and driven by social movements outside psychiatry rather than genuinely reflective practices within the profession.

More than merely clarifying the substantial differences between BDSM and IPV, we hope that this chapter will encourage further critical reflection

within the psy-professions regarding their approach to sexuality and the erotic – subjects for which they were, once, famous for having an open-mindedness to discuss with critical reflection before bringing these sensitive topics to the public domain.

## Endnotes

1 Barker & Richards, 2013.
2 Attias, 2004; White, 2006.
3 Langdridge & Barker, 2007; Moser & Kleinplatz, 2006; Weinberg & Kamel, 1995.
4 Barker & Langdridge, 2010.
5 Ridinger, 2002; Kleinplatz & Moser, 2005; Moser 2002; Chancer, 2000; Hoople, 1996; Califia 1979, 1981; Rubin, 1982, 1984; Samois, 1982; Dworkin 1981; MacKinnon & Dworkin, 1997; Jeffreys, 2003.
6 Sheff & Hammers, 2011.
7 Ellis,1926 [1903]; Krafft-Ebing, 1965 [1886].
8 Freud, 1938; Kraepelin, 1906.
9 Kleinplatz & Moser, 2005; Moser 2002.
10 Chancer, 2000; Hoople, 1996.
11 Califia 1979, 1981; Rubin, 1982, 1984; Samois, 1982.
12 Dworkin 1981; MacKinnon & Dworkin, 1997.
13 Jeffreys, 2003.
14 APA, 2013.
15 WHO, 1992.
16 Mitchell & Anglin, 2009.
17 Stewart et al, 2013.
18 Douglas, 2011; Barner, 2011; APA, op. cit.; Decker et al, 2012.
19 Nicolaides and Paranjape, 2009.
20 Ibid.
21 Ibid.
22 Johnson, 2008.
23 Nicolaidis & Paranjape, op. cit., p. 21.
24 Johnson, op. cit.
25 WHO, 2010.
26 Op. cit.
27 APA, 2013.
28 Ibid.
29 Ibid.
30 CDC, 2000.
31 CDC, 2010.
32 Anderson & Quinn, 2009; Davies et al., 2006.
33 CDC, 2010.
34 CDC, 2010.
35 NCAVP, 2013.
36 WHO, op. cit.
37 APA, op. cit.
38 Mitchell & Anglin, op. cit.
39 Ortmann & Sprott, 2012.
40 Scarification involves scratching, etching, burning/branding, or superficially cutting designs,

pictures, or words into the skin in order to form scar tissue as a permanent body modification. Similar to the process of tattooing, in which ink is inserted into the dermis layer of the skin via needle to change the pigment, the goal of these behaviours is a permanent physical change in the appearance of the skin. In general, efforts are made to prevent infection and permanent illness, even while effecting permanent changes in physical appearance.

41 Johnson, op. cit.

42 NCSF, 2003.