

## Is SM pathological?

Peggy J. Kleinplatz & Charles Moser

ARE SEXUAL SADISM and sexual masochism [SM] pathological? To some, even the question must seem absurd. It is already a foregone conclusion. Sexual sadism and sexual masochism have been classified as pathological by the various editions of the major psychiatric nosologies, currently the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*, American Psychiatric Association [APA], 2000) and the *ICD-10 (the International Classification of Diseases)*, produced by the World Health Organisation). Popular opinion would indicate that SM seems 'weird' or 'sick'. But by what criteria should we be making such determinations and who should be designated to make these assessments?

One of the difficulties in designating any set of proclivities as pathological is the lack of criteria for what constitutes 'normal' or 'healthy' sexuality. Although there are some parameters for normal physiological responses, sexology is sorely lacking in models covering the spectrum of sexual interests, desires, and behaviours, that are problematic to 'normal' and 'optimal' sexuality. The lack of objective criteria makes it all too easy for mental health professionals to rely upon predominant cultural values to guide assessments (Moser & Kleinplatz, 2002; Moser & Kleinplatz, in press). Also missing are ways to distinguish 'inherently' problematic interests from the problems caused by discrimination against sexual minorities.

At present, Western clinicians tend to think of 'normal' sexuality as monogamous, procreation-oriented intercourse, featuring the heterosexual, young (but not too young) and able-bodied. Attempts to regulate

human sexuality, to greater or lesser degree, have always been with us, but have caused great hardships to sexual minorities. Although two thousand years of Christian history dictated prohibitions against sexual sins, chief among these was lust – sex for its own sake. During the Victorian era, new social domination by the natural sciences evoked the need to justify oppression, repression and suppression of human sexuality in pseudoscientific terms; thus, there was an emphasis on 'science' and 'social hygiene', even if the same old taboos were now justified in new terms.

Over the last 100 years, a wide variety of sexual 'disorders' have gone in and out of fashion and correspondingly, in and out of psychiatric focus. These include nymphomania, satyriasis, masturbation, oral sex, homosexuality, hypersexuality, sexual addiction and the entire category of unusual sexual interests known collectively as the 'paraphilias'. This latter category includes sexual sadism and sexual masochism. Some of these were quietly removed from the psychiatric nosologies, others with great fanfare (e.g. the controversial removal of homosexuality from the *DSM* by the APA in 1973) while still others, including SM, continue to be classified as pathological. But other than social convention, by what criteria are behaviours to be judged as pathological?

Originally, the *DSM* was based in psychoanalytic theories of psychopathology. Currently the *DSM* is intended, '... to be neutral with respect to theories of etiology' (APA, 2000, p.xxvi), based on objective observation, and able to support its statements with empirical research. However, various critiques have questioned whether

science can ever be value-free (e.g. Dineen, 1999; Kutchins and Kirk, 1997). Even when we attempt to rely on allegedly empirical criteria, the application of them requires human judgment.

For example, some would claim that statistical criteria are important. However, this line of reasoning, even if it were to be applied consistently – and it is not – is irrelevant. Uncommon phenomena or attributes might be considered more worrisome, but there are many rare entities that are perfectly healthy (e.g. an IQ of 160, a natural blonde). Masturbation and a preference for oral sex were deemed pathological at one time even though they were widespread. Correspondingly, many pathological conditions are quite common (e.g. cancer, hypertension, hypercholesterolemia). This criterion of prevalence is questionable. Nevertheless, SM is not rare. Statistics on its prevalence are typically estimates. Kinsey *et al.* (1953) found that 22 per cent of the men and 12 per cent of the women in their sample had at least some erotic response from sado-masochistic stories, and 50 per cent of men and 55 per cent of women reported having at least some erotic response to being bitten. Janus and Janus (1993) reported that 14 per cent of men and 11 per cent of women in their sample had personal experience with sadomasochism. More recently, Renaud and Byers (1999) found that 65 per cent of Canadian university students have fantasies of being tied up and 62 per cent have fantasies of tying up a partner.

#### **Distress and dysfunction/impairment**

The *DSM* uses the criteria of distress and impairment/dysfunction: 'Fantasies, behaviors, or objects are paraphilic only when they lead to clinically significant distress or impairment (e.g. are obligatory, result in sexual dysfunction, require participation of non-consenting individuals, lead to legal complications, interfere with social relationships)' (APA, 2000, p.568).

According to the *DSM*, there is little evidence of distress (APA, 2000, p.566):

'These individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behaviour has brought them into conflict with sexual partners or society.' Furthermore, when distress is manifest, it may result primarily from social stigma surrounding SM. This phenomenon is akin to internalised homonegativity in gay and lesbian individuals (Kleinplatz & Moser, 2004; Nichols, in press). The recommended 'treatment' is to validate the distress rather than to 'cure' the SM desires (Moser, 2001).

As for impairment, this criterion is particularly noteworthy in illustrating the social biases that continue to pervade the *DSM*. For example, the *DSM* considers it a sign of impairment if SM is 'obligatory'; why single out some behaviours as pathological when required for sexual fulfillment and not others? Why not decree that people who cannot reach orgasm during heterosexual intercourse are pathological? Actually, that was precisely the case during the 1950s when women who 'failed' to achieve orgasm during intercourse were labelled 'frigid'. Both increases in scientific knowledge – including knowledge based in self-report data – and changing social mores led to expanding visions of female sexuality. In any case, Langevin *et al.* (1998) demonstrated that most sex offenders sexually aroused by the paraphilias are also aroused by more 'conventional' sexual stimuli. The exclusivity criterion is thus unsustainable either theoretically or empirically.

The next sign of impairment is that the paraphilia 'result in sexual dysfunction'. There is no data to support this assertion, particularly as worded, so as to suggest a causal link. Given the high prevalence of sexual dysfunction in population studies, it is striking that SM participants are *not* presenting in therapists' offices more often.

The stipulation that a diagnosis of sexual sadism or sexual masochism requires participation of non-consenting individuals is similarly odd on several levels: This criterion refers to a crime (i.e. a conflict between the

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individual and society) which is specifically excluded from the definition of a mental disorder. It is all too easy for societies to criminalise and pathologise socially unacceptable behaviour. It is to the APA's credit that they objected to just such mis-use of psychiatry to pathologise and thereby silence dissent in totalitarian regimes. More fundamentally, this criterion suggests a basic misunderstanding of SM. One of the basic tenets of the vast majority of SM practitioners is that all activities be 'safe, sane and consensual'. Any violation of the consent imperative is unacceptable within SM communities (Wright, in press).

The next two indications of impairment, that SM 'lead[s] to legal complications' or 'interfere[s] with social relationships' are equally fraught with bias. Of course, any stigmatised behaviour may lead to legal or social problems. Indeed, SM participants do suffer legal complications; they lose custody of children; they lose their jobs; they lose security clearances. In court cases, the expert witness for the opposition often states, 'We would not be here if SM were not a mental disorder and a psychiatric diagnosis.' This is circular reasoning. One must grapple with whose problem is really in evidence in such cases - that of the actor or that of the perceiver?

This final sign of impairment, that is, 'interference with social relationships', is worthy of special attention. It brings forth many of the myths about SM participants which are then used to justify their need for psychotherapy. The commonality is the notion that SM participants are unable to maintain 'normal' intimate relationships, referred to in the DSM as the capacity for reciprocal, affectionate sexual activity' (APA, 2000, p.567). They are also described as having 'pair-bonding disorders' (Schwartz & Masters, 1983) and a 'courtship disorder' (Freund, 1990). However, there is no evidence that individuals involved in SM have greater difficulty establishing intimate relationships than other people, nor that SM relationships are pathological. Furthermore, roughly half of all American marriages end in

divorce (National Center for Health Statistics, 2005). The average American relationship may not be any more 'healthy' or 'successful' than the average SM relationship.

SM activity is often construed as evidence of sex used in service of affect regulation, self-medication, escapism, acting out and sexual addiction (Carnes, 1991; Goodman, 1992; Hastings, 1998; Levine *et al.*, 1990). This criticism presupposes that mental health professionals have some idea of what proper uses of sexuality ought to be; again, the implication is that sex ought to be reserved for 'sexual' purposes (i.e. tension release, orgasm, procreation) in the context of normative, monogamous, heterosexual relations. It is noteworthy that mental health professionals often refer to behaviours as 'acting-out' or 'escapist' when these forms of behaviour make the disapproving professional uncomfortable. This sort of terminology tends to be employed when certain forms of sexual expression are disturbing to us. This language also is used when mental health professionals act as agents of social control, providing clinical justifications for pathologising what the broader society finds distasteful.

What is conspicuously absent from the clinical discourse is the subjective meaning(s) of SM as described by participants. Instead of pathologising SM or reifying viewers' and clinicians' visceral clutch, consider the accounts of participants who indicate that SM may be growth-enhancing and life-affirming. SM participants often describe their experiences as 'coming home' (Kleinplatz, in press).

### But it is wrong to hurt people ... isn't it?

Notwithstanding the lack of empirical evidence of psychopathology among SM participants, the visceral clutch is overwhelming when contemplating giving or receiving pain or enacting dominant-submissive roleplays. It seems 'sick' to get aroused by hurting people or by being subjected to pain. But we attach different interpretations

to pain in different situations, based on our intuitive understanding of pain mechanisms as well as because of moral judgements. Pain is regarded and indeed, processed differently depending on the participants' state of consciousness. The meanings we attach to a given 'painful' event (e.g. athletic competition, ballet performance) help to shape experience. For example, one's mindset affects perceptions of pain in childbirth: An 18-year-old who had endured an unplanned pregnancy, giving birth, alone, with no childbirth education will have a significantly longer labour and require significantly more analgesia and anaesthesia than a well-prepared woman who has a partner and anticipates the birth of her baby eagerly. Does it 'hurt' in both cases? Obviously, it does, but it is not the pain that is front and centre for the latter woman. Many people commonly engage in activities which could be construed as painful by the naïve observer but which are not experienced that way by the participant, e.g. long-distance running. In addition, levels of sexual arousal influence perceptions of pain. Pleasurable stimulation elevates pain thresholds over 80 per cent and orgasm elevates pain thresholds by 100 per cent (Whipple & Komarisuk, 1985, 1988). Even the SM participant who 'likes' pain does not necessarily enjoy dental procedures any more than the average person would.

Context modulates experience. It is essential to attend to that context before determining what is truly harmful versus that which produces intense sensation but causes no danger. Notably, the emergency rooms are hardly overflowing with people hurt in SM scenes. Sports injuries are far more likely to lead to emergency room visits but weekend athletes are not automatically diagnosed with mental disorders. Sports are acceptable, even given all the inherent risks. Not unlike SM, participation in sports requires informed consent. In SM consent is utterly crucial (Wright, in press).

It is precisely this context which illuminates the real basis for the discomfort

surrounding the 'pain' of SM as perceived in our society and as reified in psychiatric and legal codes. In non-sexual situations, Western society often tolerates and even supports pain-producing activities. British law has specifically exempted boxing, football, military service and, in previous years, parental chastisement from legal liability notwithstanding the pain involved; these activities are judged to be in the public interest (White, in press). By contrast, in the infamous Spanner case in the UK, the defendants were SM participants, arrested for their 'violent' acts, who claimed exemption given their mutual consent and well-being. The Spanner case put consent on trial. In appeal after appeal, British courts refused to accept consensual sexual pleasure as a valid exception to the rules prohibiting acts of violence; presumably, unconventional sexual pleasure among men was not seen as in the public good (White, in press). This case highlights the underlying discomfort with SM, such that we criminalise and pathologise that which we collectively cannot abide. When pain relates to sex, then it is pathologised.

Ironically, the emerging empirical evidence indicates that it is not typically the pain which provides arousal in SM interactions but what it represents – the exchange of power. Cross and Matheson (in press) found no evidence of psychopathy, escapism or any form of psychopathology among SM participants. Instead, Cross and Matheson found that power play provided the primary motivation and source of fulfillment.

### Conclusions

In the absence of theory or research demonstrating what constitutes 'normal' sexuality, it is all too easy to pathologise the unconventional based on prevailing social currents. SM is particularly liable to being stigmatised in societies uneasy with sexual pleasure for its own sake. Individuals who are labelled and treated as mentally ill are entitled to feel significant distress about societal perceptions of them; that distress does not signify psychopathology *per se*. The discomfort that

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SM induces in others does not justify the legal and clinical opprobrium typically meted out to sexual minorities. There is no evidence to demonstrate that SM, however common or uncommon, creates personal distress or dysfunction for participants, or otherwise endangers consenting individuals any more than occurs in the course of other, socially sanctioned pastimes. As such, one can only conclude that SM is not pathological. Clinical integrity requires that SM be removed from future editions of the DSM and ICD.

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