

**THE DEMEDICALIZATION OF KINK:  
SOCIAL CHANGE AND SHIFTING CONTEXTS OF SEXUAL POLITICS**

by  
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A thesis submitted to the Faculty of the University of Delaware in partial fulfillment of the requirements for the degree of Master of Arts in Sociology

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by

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## **ABSTRACT**

BDSM (also known as kink) has been stigmatized through medicalization and legal control since the late 19<sup>th</sup> century. However, the recent publication of the DSM-5 has significantly changed the definition of Paraphilia, which used to be the catch-all diagnostic category for atypical sexual behaviors. This change in the DSM has affected many court decisions by way of excluding past experiences with kink as evidence. Through the analytic lenses of contextual constructionism and Foucaultian theory, this study utilized multiple sources of qualitative data to tap into the ever-changing social contexts and power politics of medicalization and demedicalization of kink. The findings of this study suggest that shifting social and technological contexts have produced what Anthony Giddens terms “institutional reflexivity” that reshapes the organizational behaviors of both institutions of social control social movement organizations, as well as the outlook of sexual politics in contemporary society.

## Chapter 1

### INTRODUCTION

BDSM is an acronym for bondage, discipline, dominance & submission, and sadism & masochism. There are many historical precedents to the term “BDSM” such as “sadomasochism”, “S/M”, “SM”, “S&M” etc. (Weiss, 2011). To avoid confusion, BDSM (which is most commonly used by contemporary BDSM practitioners) is consistently used throughout this study to designate *the consensual practice of dominance and submission, and/or the infliction of conventionally perceived unpleasant sensations for erotic purposes*. BDSM practitioners also use the term “kink” to designate their practice (and correspondingly, identify themselves as “kinksters”), although kink has a slightly broader definition that encompasses fetishism and some other forms of alternative sexual expressions (Weiss, 2011; Lindemann, 2012; Newmarh, 2011). In this study, “kink” and “BDSM” are used interchangeably.

In contrast to conventional sexual activities (or “vanilla sex”), the practice of BDSM/kink stands out as the aberrant “other” that experiences formal and informal social control of various kinds. *Sadism* and *masochism*, which BDSM practitioners refrain from using as identity markers, have long been listed as sexual and psychological perversion by psychiatrists in their professional diagnostic manuals (e.g., in the *Diagnostic Statistical Manual of Mental Disorder* or the *DSM*, compiled by American Psychiatric Association and in the *International Classification of Diseases*



or the *ICD*, compiled by World Health Organization). The risks of harm associated with BDSM practices sometimes make BDSM practices legally controversial (White, 2006; Ridiger, 2006; Weait, 2007; Klein and Moser, 2006; Egan, 2007; Hanna, 2001). In other instances, BDSM is considered morally wrong (MacKinnon, 1989; Chancer, 1992; Hanna, 2001).

However, an interesting turn of events occurred when the recently published DSM-5 (American Psychiatric Association, 2013) explicitly states that practicing or fantasizing about BDSM activities does not automatically constitute “paraphilic disorder”, a clinical condition that requires psycho-medical intervention. Even when it was still under formulation, the proposed (now effected) changes in the DSM-5 had started to affect child custody cases that used to be ruled against the interest of the parents who practice BDSM (Wright, 2010; 2014).

Given the long history of stigmatization and social control of BDSM, as well as the recent institutional changes mentioned above, it is sociologically interesting to ask **to what extent, how, and why BDSM has been (or has not been) demedicalized.** Grounded in the constructionist social problems theory and Michel Foucault (1976; 1978; 1979)’s theory of power, this study employs multiple sources of historical and qualitative data to explore the above questions by contextualizing them in the historical and contemporary **medicalization and legal control of alternative sexuality.**

Exploring these questions has both theoretical relevance and broader social impacts. The successful reclassification of BDSM in the DSM (and very likely in the ICD as well) is, as it seems, one of very few examples of successful demedicalization

that also affects the legal status and public perception of BDSM. Studying the demedicalization of BDSM as an individual case would advance sociological theories of demedicalization and social problem construction. In particular, this study will shed light on the deproblematization of sexuality in relation to the ever-changing social and political contexts of contemporary society. In terms of societal impacts, this study is directly addresses issues such as social movement organizing, health and mental health practices regarding alternative sexuality, as well as changing public perceptions of sexuality and intimacy. This study is also relevant to social policymaking concerning changing legal boundaries of privacy and family as a consequence of the abovementioned issue.

## **Chapter 2**

### **KINK IN THE SOCIAL SCIENTIFIC LITERATURE**

As the very first in academia who systematically study BDSM, early psychiatrists and psychologists conceptualized the practice of, as well as the preference for BDSM as indicative of underlying mental problems. In contrast, sociologists (and some anthropologists) were the first researchers who study BDSM outside of the clinical context. In terms of empirical data, psychiatrists and psychologists draw primarily upon clinical records of individuals who voluntarily seek psychiatric intervention because find their interest in BDSM problematic (Moser and Kleinplatz, 2005) or those of the forensic population (Krafft-Ebing 1999, Krueger, 2010a; 2010b). Social scientists, in contrast, are more interested in “safe, sane, and consensual” BDSM activities practiced by individuals who don’t see themselves or their practices as problematic. Since the late 1970s, there has been a growing body of empirical literature studying BDSM practitioners and BDSM subcultures from social scientists on BDSM subcultures (e.g., Spengler, 1977; T. Weinberg, 1978; Kamel, 1980; Scot, 1983; Smith and Cox, 1983; Kamel and T. Weinberg, 1983; Falk and Weinberg, 1983; Weinberg and Falk, 1980; Lee, 1979; M. S. Weinberg, Williams, and Moser, 1984; Breslow, Evans, and Langley, 1985; Moser and Levitt, 1987; Myers, 1992; Brodsky, 1993; Houlberg, 1991; T. Weinberg and Magill, 1995; Taylor, 1997;

2001; Palandri and Green, 2000; Langdrige and Butt, 2004; Plante, 2006; Dancer, Kleinplatz and Moser, 2006; Cross and Matheson, 2006; Bauer, 2007; Chaline, 2007; 2010; Weiss, 2006; 2011; Stiles and Clark, 2011; Bezreh, Weinberg, and Edgar, 2012; Newmarh, 2010; 2011; Lindemann, 2011; 2012).

Table 1 Review of Literature by Methodology<sup>1</sup>

Methodology	Frequency
Survey	5
Ethnography/participant observation or interviews with members of public BDSM communities	16
Content analysis of popular culture	5
Interviews with informants recruited via BDSM magazines ads	1
Studies of online BDSM communities and interactions	3
Total	30

As is summarized in Table 1, the predominant majority of the empirical literature is ethnographic research on public BDSM communities. Informed by the symbolic interactionist tradition broadly defined (Fine, 1993), most of this literature focuses on the micro-level interactions during BDSM activities and within BDSM communities. Although disagreement exist among these studies as for whether BDSM is primarily about sex (e.g., M. S. Weinberg, Williams, and Moser, 1984; Ussher,

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<sup>1</sup> Studies using the same empirical data are counted as one study

2001; Newmarhr, 2010), these studies collectively corroborate that BDSM is not simply an intrinsic mental problem, but a complicated form of *social* interaction where participants redefine emotional and sensational states conventionally perceived as displeasures into pleasures.

However, BDSM is not simply a microscopic social phenomenon featuring interactions between (or among) participants of a BDSM play. At a macroscopic level, BDSM is a “marked” practice associated with a “marked” population in relation to society at large (Brekhus, 2003). Being associated with BDSM automatically marks an individual often in the terms of stigmatization, which is well documented by the social scientists as well as legal scholars and BDSM activists. A recent survey study among college students (n=469) by Yost (2010) shows that while most respondents reject the idea that BDSM is socially wrong and believe that it should be tolerated to some extent, they also believe that BDSM practitioners are more likely to act violently or become victims of violence. Rather than challenging the privileged status of normative sexuality, Weiss (2006) concludes that popular images of BDSM promote the acceptance and understanding of sexual minorities through two mechanisms: acceptance via normalization, and understanding via pathologizing. Wilkinson (2009)’s study on the mainstream representation of BDSM in the UK yields to similar results. In the courtroom, the practice of BDSM is sometimes framed as sexual assault (e.g., Ridinger, 2006; White, 2006; Weait, 2007), domestic violence (e.g., Klein and Moser, 2006), and/or evidence of disqualification for child custody (e.g., Egan, 2007). Discrimination against BDSM practices and practitioners is also ubiquitous in

workplaces and other social settings. Almost 500 people each year request help from the National Coalition of Sexual Freedom (NCSF), an advocacy group for sexual minorities, because of discrimination or persecution due to their alternative sexual practices (Wright, 2010:1230). A survey study conducted by NCSF in 2008 shows that a total of 1,146 (37.5%) respondents indicated having been discriminated against, having experienced some form of harassment or violence, or having some form of harassment or discrimination aimed at their BDSM-leather-fetish-related business; among all forms of discrimination, 32.2 % of the total respondents report loss of job/contract or loss of promotion/getting demotion<sup>2</sup>. Given its stigmatization, BDSM as a macro-level social phenomenon is at least of interest to scholars of social problem construction, which was alluded to (e.g., T. Weinberg, 1987; 1995; 2006; Ridinger, 2006), but never systematically explored in the empirical literature, and constitutes the major focus of this study.

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<sup>2</sup> [https://ncsfreedom.org/images/stories/pdfs/BDSM\\_Survey/2008\\_bdsm\\_survey\\_analysis\\_final.pdf](https://ncsfreedom.org/images/stories/pdfs/BDSM_Survey/2008_bdsm_survey_analysis_final.pdf)

## Chapter 3

### THEORETICAL FRAMEWORK

#### **Constructionist Perspective on Medicalization and Legal Control**

After Spector and Kitsuse (1973) initiated the constructionist turn in the study of social problems, the analytic focus of social problems study has shifted from how social problems emerge as a result of social dysfunction (e.g., Merton, 1938; Lemert, 1951) to how certain social categories are framed as problematic through claimsmaking and constitutive definitional process (Ibarra and Kitsuse, 1993). Both medicalization and criminalization are fundamentally processes of social construction. Medicalization is “[the process in which] a problem is defined in medical terms, described in medical language, understood through the adoption of a medical framework, or ‘treated’ with medical intervention (Conrad, 2007: 5)”. Similarly, framing and designating certain social issues as illegal in the law is another common way of problematizing these issues by the law and its affiliated institutions. The demedicalization or legalization of a certain issue, on the other hand, is the successful claimsmaking that pushes a social condition towards an opposite direction—deproblematization from institutions of control.

Over the years, there have emerged a considerable number of case studies on the medicalization of various issues, such as the medicalization of ADHD (Conrad and Deborah, 2000; Malacrida, 2004), addiction including drug addiction (Roy and Miller, 2010; Netherland, 2011), gambling addiction (Rosecrance, 1985), sex addiction

(Irvine, 1993), compulsive buying (Lee and Mysyk, 2004) etc., sleeping disorder (Williams, 2002), erectile dysfunction (Potss et al.) etc. There are also well documented studies on demedicalization: masturbation (LoCascio, 2010), homosexuality (Conrad and Schneider, 1992), male circumcision (Carpenter, 2010), breastfeeding (Torres, 2013), and childbirth (Davis & Kim, 2013). While these studies typically delineate the political economy among different invested social actors (such as the medical professionals, the health market, pharmaceuticals, activists, the academics, and the general public as health consumers) in the medicalization/demedicalization process, they do not offer a consistent constructionist framework that explains *why particular troubling qualities were successfully medicalized or demedicalized while others were not without attending to political economic details specific to each case*. In a similar light, case studies on the construction of criminality fail to explain why certain behaviors such as marijuana use (Yankah, 2011), abortion (Kadish, 1967), and vagrancy (Ashworth, 2007) incur incommensurable criminal control, without slipping back to the traditional functionalist (e.g., Merton, 1938; Lermert, 1955) or Marxist (Spitzer, 1975) perspectives which locate crime and its control in social structures. It seems that a truly constructionist perspective on medicalization and legal control, which should rest primarily on claims and claimsmaking, is impossible without attending to these structural “contexts”, manifestation of a theoretical debate that dates back to the 1980s and early 1990s (e.g., Ibarra and Kitsuse, 1993; Best, 1989 Gubrium and Holstein, 2003).

*Strict constructionists* (Ibarra and Kitsuse, 1993) maintain a strong phenomenological position and argue that language or rhetorical styles should be the



central, if not only, analytic focus of social constructionism. This “strong” version of constructionism, albeit most committed ontologically and epistemologically to the phenomenological roots of constructionism, has met with numerous criticisms on its analytic utility. Strict constructionists often inevitably relapse into objectivism that it so vehemently criticizes, since consistently maintaining such a strong position is difficult—as much as language and rhetorical styles are crucial to social construction, language is not completely independent of society and its institutions (Woolgar and Pawluch, 1985; Best, 1993; Holstein and Gubrium, 2003). In response to strict constructionism, Joel Best (1989, 1993) proposes a “weaker” reading of constructionism—*contextual constructionism*. Unlike strict constructionists, contextual constructionists “study claims-making within its context of culture and social structure” (Best, 1993:139). Although the primary concern of contextual constructionists remains the construction of social problems through claimsmaking, contextual constructionists pay closer attention to the structural and cultural contexts of the social problem process. Under contextual constructionism, *resources* and *rhetoric* are seen as constant contexts that affect social problems construction (Best, 2013). Resources are economic, political, and cultural differentials among claimsmakers while rhetoric refers to the framing and reframing (and claiming ownership) of the troubling qualities throughout the social problems process. These contexts, such as economic interests (Best, 1979) and scientific “advances” (e.g., Greenberg, 1998; Haraway, 2003), explain not only the emergence of claims, but also why particular claims receive more public attention and shape public policy (Best, 1989: 247).

On the one hand, contextual constructionism is advantageous for analyzing problematization from institutions of control. First of all, it acknowledges the differences in power and resources among claimsmakers as important contexts in addition to claims and claimsmaking activities, and thus improves the analytic utility forfeited by strict constructionism. In addition, social actors under contextual constructionism don't simply interpret their social situations passively. Instead, they take reflexive and active part in social interactions and are able to reshape their social realities using available material or non-material resources, which accurately reflects another important context of the dynamics of social problems construction. On the other hand, however, contextual constructionism's treatment of institutions and power as "contexts" reifies contexts (Holstein and Gubrium, 2003): it reduces institutional power into economic and political resources in materialistic terms, and disregards the dimension of institutional power that produces discursive legitimacy. Diagnostic categories and laws are not simply the products of institutional power, they in turn legitimize institutional behaviors such as involuntary civil commitment and incarceration, as well as the continued legitimacy of social control.

As in many other cases of social problem construction, *activists* and *experts* are identified as the most common claimsmakers in medicalization/demedicalization and the social construction of criminality. However, claims made by medical and legal experts are not equal in influence compared to those made by activists, who not only lack the comparable economic and political resources, but more importantly, the discursive legitimacy substantiated by formal institutions. Studies on the medical sciences (e.g., Vereko, 2010; Williams, 2002) as well as legal processes (e.g., Cover, 1986) have consistently revealed the effect of institutional discourses on the subjects

of their control: medical diagnosis and legal adjudication, both of which take the form of the experts' interpretation of institutionalized texts, determine normalcy over pathology, and life over death. Institutional power and institutional discourses signify each other, and any effort to disentangle them is an unfaithful reflection of the social problem process, and oversimplifies any explanation as for why certain claims bear greater influence on the construction of social problems. It is important, therefore, to account for this dimension of institutional power by tapping into other theoretical avenues that more accurately address these conceptual relations.

### **Power and the Institutional Control of Sexuality: Fusing the Foucaultian Perspective**

The problematization of sexuality through mechanisms of legal and medical control was most notably analyzed by Michel Foucault (1976, 1978, 1979). Unlike traditional ethnography, Foucault's archeology of knowledge never dwelled on the subjective experiences of the problem populations. Instead, he focused on how constantly shifting discursive relations, which in his formulation is not distinguishable from power relations, emanating from institutions of control and produces a "problem population". From a Foucaultian perspective, discourse-power is not simply suppressive, it is also productive. The cultural intelligibility, and hence legitimacy, of the institutions of control depends upon their juxtaposition with both institutional, and broader social discourses.

Incorporating Foucaultian analytics of power into contextual constructionism more accurately reflects the complicated power politics of social problems construction. Foucault's works revealed and theorized the discursive tension between the law, the mental and physical health sciences, and sexuality. According to Foucault

(1979)'s typology of power, *laws of prohibition* and *Scientia Sexualis* are two sets of institutional discourses regarding sexuality that correspond to two different mechanisms of power: sovereign power and disciplinary power. Modern control of sexuality, as Foucault (1979) and others (e.g., Leon, 2011; Butler, 2004; Rubin, 1984) have suggested, is more complicated than mere legal prohibition; it is often fused with discourses of risk control and medicalization, epitomizing the ideal type of disciplinary power in the Foucaultian typology. However, as much as the modern law has evolved from mere prohibition to a formal rational legal order (Weber, 1978; Unger, 1977), it is not yet entirely free from moralistic sentiments and prohibition. In *Barnes V. Glen Theatre, Inc.*<sup>3</sup>, an influential anti-obscenity case ruled in 1990, Judge Scalia concurred that “our society prohibits, and all human societies have prohibited, certain activities not because they harm others but because they are considered...immoral. In American society, such prohibitions have included, for example, *sadomasochism*, cockfighting, bestiality, suicide, drug use, prostitution, and sodomy”. Although years have passed, it still seems premature to say that such an opinion has become the marginal in the social and political contexts of contemporary American society.

One salient shortcoming of Foucaultian theory, however, is its reticence in whether and how individual social actors may be able to reflexively engage in resistance work against social control, which contextual constructionism makes possible. Although others (e.g., Holstein and Gubrium, 2003) have also made the attempt to merge constructionism with a Foucaultian approach, the theoretical

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<sup>3</sup> 501 U.S. 560, 574-75

approach of this study differs in a number of ways. As opposed to ethnomethodology, contextual constructionism shares more affinity with symbolic interactionism proper (Fine, 1993), in which social actors are simply passively making sense of institutional meanings, but are capable of reflexively arrive at alternative interpretation, and resist against established institutional discourses using whatever materialistic or non-materialistic resources available to them. In addition, unlike constructionist analytics, meanings under contextual constructionism do not simply adhere to the social actors' interaction with isolated, local institutions. More or less universal meanings exist across various modern societies, which are manifested as stability, consistency, and "objectivity". The strategic combination of contextual constructionism and Foucaultian theory provides with this study a unique perspective to examine how institutional power is fused with medical and legal discourses in the social problem construction process in regard to alternative sexuality, as well as how in the shifting contexts of discourse-power, individuals strategically resist against these mechanisms of social control.

## **Chapter 4**

### **METHODOLOGY**

This study is first and foremost a case study of social problem construction. Grounded in the social constructionist literature, case studies of the social problems construction “permits [researchers] to examine dynamic, historical processes affecting the social system (Fine, 1993: 75).” Specifically, while claims and claims-making behaviors are the central units of analysis, a contextual constructionist approach also places the claims of problematization in the context of its history and ever-changing social structures. Informed by Foucaultian theory, the analytic approach of this study is also inevitably historical in nature, since Foucault was interested in the shift of discursive relations, and intended to reveal how historically and culturally located systems of power/knowledge construct subjects and their worlds (Holstein and Gubrium, 2011).

Informed by this epistemological paradigm, the empirical design of this study mirrors previous studies (e.g., Conrad and Schneider, 1992; Leon, 2011; Del Rosso, 2011; Carpenter, 2010) on institutional problematization/deproblematization while accentuating the unique analytic approach (i.e., a Foucaultian contextual constructionism) of this study. Four types of primary and secondary data are collected and used for analysis: (a) narratives and diagnostic criteria from diagnostic manuals (various editions of the DSM and ICD) and the DSM-5 and ICD-11 revision websites, (b) narratives from peer-reviewed psychiatric journal articles (c) narratives on the websites of BDSM organizations, and (d) in-depth interviews with BDSM

activists/organization leaders and psychiatrists. Narratives and content from peer-reviewed journal articles and the Internet are included only when it is directly concerned with the DSM-5 revision project, which renders to 10 articles (including letter to the editor) published between 2008 and 2012 on *Archives of Sexual Behaviors*. In regard to the interviews, 5 individuals in total were interviewed. 4 of them are current or past leaders of national BDSM organizations (whose websites the online content analysis of this study draws upon), and 1 of them is a psychiatrist who was closely involved with the DSM-V and ICD-11 revision projects. Each interview averages 80-90 minutes. The Interviews were approved by the Institutional Review Board of the University of Delaware, and all interviewees signed Informed Consent Forms. The interview guide is attached to this study as an appendix. Both interview and archival data were coded by hand. Coding of the data was conducted by hand. For both textual and interview data, themes were derived after an initial inductive coding process, and a were applied to inform a second round of coding. Quotes are presented (often in chronological order as part of the analytic strategy) in blocks so as to showcase the integrity of the data and its analytic process.

## **Chapter 5**

### **THE PROBLEMATIZATION AND DEPROBLEMATIZATION OF KINK**

Since the DSM-II, sexual sadism and masochism have been listed as sexual deviation. Sexual sadism and sexual masochism are often associated with coercive sexual violence—diagnosis of sexual sadism satisfies one of the conditions necessary for imposing involuntary civil commitment on sex offenders upon their release from prison. Given the strong criminal connotation of the diagnostic categories of Sexual Sadism and Sexual Masochism, and the close association between these diagnostic categories and BDSM practices, consensual BDSM is oftentimes perceived as coercive sexual violence. The following sections provide an analysis of the historic and discursive affinity as well as divergence among the concepts of sadomasochism, coercive sexual violence, and BDSM. As we will see, these discursive relations are shaped by the power relations between different institutions of control and practitioners of BDSM, with the mediation of mass media.

#### **The History of Sadism and Masochism**

Historically, eroticized practices of power and intense sensations (in particular pain) have existed for a very long time. One of the oldest graphical proofs of such practices is found in the Etruscan Tomb of the Whipping near Tarquinia, which dates back to the 5th century BC. Inside the tomb is a fresco that portrays two men who flagellate a woman with a cane and a hand during an erotic situation (Moretti and von Matt, 1974: 762-63). Further reference can be found in Petronius's *Satyricon* where a



delinquent is whipped for sexual arousal<sup>4</sup>. Fantasies about these activities also appeared in literary works such as those of marquis de Sade and Leopold von Sacher-Masoch, after whom Austrian psychiatrist Krafft-Ebing coined the terms “sadism” and “masochism” (Krafft-Ebing, [1886]1999). According to Krafft-Ebing (1999), sadism is the “association of active cruelty and violence with lust” (P. 79) whereas masochism is defined as “the association of passively endured cruelty and violence with lust” (P. 119).

This was the very first occasion where sadism and masochism were conceptualized and defined. Through diagnostic categories, these unusual practices of eroticism/sexuality started to be known as a series of *behaviors* independent of any historical, literary, or social context. Moreover, these practices were treated for the first time as indication of underlying *mental problems*. In *Psychopathia Sexualis* where Krafft-Ebing (1999) introduced these clinical categories, he listed reasons as for why sadist or masochist interests are pathological. For sadism, he argues,

Modern civilized man, insofar as he is untainted, may exhibit a weak and rudimentary association between lust and cruelty. In persons known to have an abnormal (degenerative) predisposition, however, the occurrence of such association may kindle monstrous manifestations of lust-driven cruelty (P.79).

He offers a very similar argument for creating the clinical category of masochism:

Psychologically speaking, the facts of sexual bondage are of greater criminal importance. If sensuality is predominant—that is, if a man is held in fetishistic servitude and his moral power of resistance is weak—

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<sup>4</sup> <http://www.thelatinlibrary.com/petronius.html>

he may be goaded into the very worst crimes by an avaricious or vindictive woman, into whose bondage his passion has led him (P.452).

Krafft-Ebing's acknowledgement that there is probably a "weak and rudimentary association between lust and cruelty" among "modern civilized men" implies that this association is not necessarily *abnormal* in and of itself. He even writes,

Lovers and younger married couples are fond of teasing each other; they wrestle together "just for fun," and indulge in all sorts of horseplay...these atavistic manifestations...no doubt belong to the sphere of psychological sexuality (P.79).

However, it is salient that Krafft-Ebing was concerned about the potential victimization that such a peculiar interest may induce "in persons known to have an abnormal (degenerative) predisposition", which is why this association must be contained in a sane, as opposed to "degenerative" mind so as to avoid "monstrous manifestations of lust-driven cruelty". Most clinical cases that Krafft-Ebing used to demonstrate the necessity to create these categories (especially sadism) involve some kind of violence and/or criminality ranging from murder, rape, mutilation, to brutally killing animals (Krafft-Ebing, 1999: 79-185). When instances of "ideal sadism" arise where "a vivid sadistic impression suffices to provoke ejaculatory gratification...sadism is merely an equivalent of coitus" (Krafft-Ebing, 1999: 108). In sum, his arguments for medicalizing sadism and masochism were based upon the potential detrimental *social* consequences that sadist or masochist desires might arouse rather than the latent desires themselves.

Where sadomasochistic activities cross legal boundaries, it falls upon the criminal justice system rather than psychiatry to intervene as an institution of social control. But since these desires only manifest in a dangerous way when they occur in a

person who possesses “abnormal predisposition” or “degenerative mind”, these individuals and their associated behaviors may be controlled and monitored for the protection of public interests if receiving timely psychiatric diagnosis. According to Krafft-Ebing (1999), the diagnostic criteria for sadism or masochism are not a specified list of observable behaviors but *intrinsic* mental dysfunction (degeneracy) of which sadism and masochism are some of *many* manifestations. Since no behavioral diagnostic criteria were specified, it leaves psychiatrists with the ultimate authority to assess when and where clinical diagnosis should apply.

Undoubtedly, Krafft-Ebing’s conceptualization of “sexual pathologies” was filled with outdated and precarious psychological concepts that are no longer treated as valid in modern psychiatry or psychology. Modern diagnostic criteria of clinical psychology have shifted from the obscure ideas of heredity and degeneracy to observable behavioral patterns. The historical development of this paradigm shift in psychiatry can be traced in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. When it first appeared in the DSM-I in 1952, sexual sadism was mentioned only once (and there as no mention of sexual masochism in the DSM-I) under Sociopathic Personality Disturbance (000-x60):

*Sexual Deviation.* This diagnosis is reserved for deviant sexuality which is not symptomatic of more extensive syndromes, such as schizophrenic and obsessional reactions. The term includes most of the cases formally classed as “psychopathic personality with pathologic sexuality.” The diagnosis will specify the type of the pathologic behavior, such as homosexuality, transvestism, pedophilia, fetishism and sexual sadism (including rape, sexual assault, mutilation) (APA, 1952: 38-39).

This conceptualization, as we can see, is very similar to that of Krafft-Ebing (1999)’s in that these “sexual deviations” are not in and of themselves problems, but

are indicative of an underlying mental disorder such as schizophrenia. Starting in the DSM-II (APA, 1968), however, “sexual deviation” started to be conceptualized as an independent category of mental problem:

*Sexual Deviation* (302.6). This category is for individuals whose sexual interests are directed primarily towards objects other than people of the opposite sex, toward sexual acts not usually associated with coitus, or toward coitus performed under bizarre circumstances as in necrophilia, pedophilia, sexual sadism, and fetishism. Even though many find their practices distasteful, they remain unable to substitute normal sexual behavior for them (APA, 1968: 44).

The effort of making sexual deviance an independent mental disorder eventually consummated in the DSM-III-R (APA, 1987) where conditions such as sexual sadism, sexual masochism, fetishism, pedophilia etc. started to be classified under the category of *paraphilias* in place of the obscure term of Sexual Deviation. The number of diagnostic categories in the DSM grew from 60 categories in the DSM-I (APA, 1952) to almost 300 in the DSM-III-R (APA, 1987). In addition, more specific behavioral criteria for sexual sadism and sexual masochism were prescribed:

#### Sexual sadism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The person has acted on these urges, or is markedly distressed by them (APA, 1987: 288).

#### Sexual masochism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.

B. The person has acted on these urges, or is markedly distressed by them (APA, 1987: 287).

In subsequent editions of the DSM, paraphilia continued to be used as the umbrella term to designate what used to be considered “sexual deviation”. In the meantime, the diagnostic criteria become increasingly more specific and behaviorally orientated. In the DSM-IV-TR (APA, 2000), for example, sexual sadism is classified under paraphilia with the following diagnostic criteria:

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The person has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty (APA, 2000).

The diagnostic criteria for paraphilia in the DSM-IV-TR exclude individuals who engage in BDSM activities with consenting adults. However, paraphilia is used both as a generic concept that groups sexual sadism, sexual masochism, fetishism and other atypical sexual behaviors together, as well as a diagnostic category of mental illness. There is a conceptual difference between paraphilia as a *descriptive category* and paraphilia as a *clinical condition* that needs to be distinguished; otherwise it would be conceptually impossible to say that someone has a paraphilia without the implication that this person is diagnosed with paraphilia, the mental disorder. To remedy this conceptual inconsistency, the recently published DSM-V (APA, 2013) replace the term “paraphilia” with “paraphilic disorder” as a diagnostic category.

Although over the years, more and more specific diagnostic criteria have been adopted to reflect modern standards of medical science as well as the effort to exclude consensual practices of BDSM, these categories of “sexual pathologies” born under

the influence of 19<sup>th</sup> Century psychiatric theories such as degeneracy are continuously used by psychiatrists and psychologists to this date. The reasons for modern day psychiatrists to retain these categories for discretionary use are essentially the same to those of Krafft-Ebing (1999)'s: the potential risks of harms that BDSM behaviors entail. In the DSM-IV-TR (APA, 2000), for example:

Paraphilic imagery may be acted out with a nonconsenting partner in a way that may be injurious to the partner (as in Sexual Sadism and Pedophilia). The individual may be subject to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts, and individuals with Exhibitionism, Pedophilia, and Voyeurism make up the majority of apprehended sex offenders. In some situations, acting out the paraphilic imagery may lead to self-injury (as in Sexual Masochism). Social and sexual relationships may suffer if others find the unusual sexual behavior shameful or repugnant or if the individual's sexual partner refuses to cooperate in the usual sexual preferences... These individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with sexual partners and society (P. 566).

Nevertheless, while Krafft-Ebing sees "sexual pathologies" as symptomatic of more intrinsic defects and the population needs to be controlled out of a concern for public interest, the modern diagnostic manuals such as the DSM sees the *manifested behaviors* as problematic, which can be, and needs to be *rehabilitated* through psychiatric intervention.

### **Medicalization and the Law**

The diagnostic categories of Sexual Sadism and Sexual Masochism (or paraphilia in general) in the DSM affect the legal status of both coercive sexual offenses and consensual BDSM. Under sexually violent predator (SVP) laws, the diagnostic status of sexual sadism (or "paraphilic disorder otherwise specified") can be

used to fulfill one of the necessary conditions, namely being diagnosed of a mental disorder, to justify involuntary civil commitment (to medical facilities) of sex offenders upon their release from prison. The use of these clinical categories is aligned with the function of the DSM in forensic settings: "...when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination" (APA, 2000: xxxiii).

But even consensual BDSM is a controversial issue in the law. In the past few decades, there have been repeated instances where voluntary practices of BDSM were busted by law enforcement and the participants involved were charged with assault (White, 2006; Ridinger, 2006). A central issue in many of these cases is to what extent is consent to physical harm valid. As a matter of fact, only 13 states in the US explicitly stipulate consent as a legitimate defense for physical harm in their criminal codes. From a legal perspective, consent as a legitimate defense for harm is difficult to establish because in contrast to rape, kidnapping, or theft which are considered "bad" only due to the absence of consent, causing pain, injury, or death is not morally neutral; it is regrettable (Bergelson, 2008: 696). The likelihood of serious harm is high while the social utility of the activity (unlike sports or even body modification) is not compelling (Hanna, 2001:243). Although ethnographic studies (e.g., Newmarh, 2011; Weiss, 2011) have shown that BDSM practitioners don't think of these intense sensations so much as "pain" or "discomfort" as they do pleasure, such a perspective seems so foreign to most people that without a pathological explanation, it is almost impossible for people to make sense of these practices (Weiss, 2006; Yost, 2010).

Before the DSM-5, the pathological definition of paraphilia in the DSM resulted in many problematic cases regarding child custody. A partner's involvement in BDSM is often used as evidence to undermine the person's eligibility for child custody. According to a survey study by the National Coalition of Sexual Freedom<sup>5</sup>, 11.2% of the respondents (out of over 1000) stated loss of child custody because of their involvement in BDSM. In these legal cases (e.g. Klein and Moser, 2006; Ridinger, 2006; Wright, 2006), the court usually consult with an independent psychiatrist who examines both parents' mental states, including their sexual history, to determine if they are qualified for child-rearing.

A documented case (Klein and Moser, 2006) where the mother (Ms. Smith)'s involvement in BDSM practice with her current partner (Mr. Jones) becomes the central issue well illustrates how a pathology-based view of BDSM affects an otherwise non-sexually related issue. After his investigation, the court's independent psychiatrist Dr. Blair drew the following conclusion:

I ponder the effects on the child if [Ms. Smith] were to die or become impaired during sexual activity, especially if the child was in the house.

Although [Ms. Smith and Mr. Jones] describe their activities as a hobby or sport, I believe it is *domestic violence*. Although the child has not observed it, he is exposed to the after-effects. I don't have enough information to understand what the effects on the child might be at this time. However, it would obviously be catastrophic if a mother were injured or died as a result of her behavior and choices. (P. 238-239)

There seems to lack a non-pathological or non-moral conceptualization in Dr. Blair's interpretive repertoire that compelled him to believe BDSM has to be domestic

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<sup>5</sup> [https://ncsfreedom.org/images/stories/pdfs/BDSM\\_Survey/2008\\_bdsm\\_survey\\_analysis\\_final.pdf](https://ncsfreedom.org/images/stories/pdfs/BDSM_Survey/2008_bdsm_survey_analysis_final.pdf)



violence. The linguistic impossibility to conceptualize kink as a normal and healthy practice is the primary source of discrimination against kinksters.

### **Resistance and Mobilization**

In the face of stigmatization and discrimination, BDSM activism has become increasingly visible. The history of BDSM activism is part of the history of BDSM organizations and the LGB movement. Practitioners of consensual BDSM (mostly heterosexual at this time) formed loose social circles in 19th century European cities, and in American cities such as Chicago, Los Angeles, and New York in the 1930s (Bienvenu, 1998). However these circles were very much underground, never developed into more sizable communities with public visibility. After World War II, a group of gay male soldiers returned to their country and formalized the first modern leather scene (Baldwin, 1993). Leather (also known as “leather sex”), which is primarily a gay male practice, shares much commonality with BDSM, although subtle differences between the two practices also exist (Bean, 2004). More importantly, unlike heterosexual BDSM circles, the gay leather scene was more closely organized through the motorcycle clubs, which later became leather clubs/bars (Califia, 2004; Bienvenu, 1998; Rubin, 1994). Compared to their heterosexual counterparts who had only been active in covert social circles and had more social privileges to lose, gay men from the leather community, who were already stigmatized for being gay and had been out about their BDSM orientations for decades were less concerned (Sisson, 2007). They therefore became the new pioneers in the expansion of the kink community. In the early 1970s, the first two formal, pansexual (open to all genders and sexual orientations) BDSM organizations came into existence on both coasts of the United States. Members of these organizations were primarily gay men, which

didn't change until after the 1980s when the AIDS epidemic started to go rampant. Separatism grew within these otherwise pansexual communities, pushing the gay men away from these communities. However, the AIDS epidemic also raised the political consciousness of the LGB community, unifying all kinds of gay and lesbian people, including the leather men, to fight conservative oppositions. In consequence, both leather and BDSM became more visible with the presence of leather men in gay pride parades and other public occasions. The increased visibility of BDSM attracted more members and reduces the separatism within the community, but it also led to an increase in discrimination (Sisson, 2007). Between the late 1980s and throughout the 1990s, four national BDSM-leather organizations were founded. These organizations together become the national governance of the BDSM community, and serve the members of the community in a variety of ways, ranging from preserving the history of the community, to providing legal aid and campaigning for policy change (Bean, 2004).

### **The Polemics and Politics of Demedicalization**

*Activism for Demedicalization.* Depathologizing kink/BDSM is a common goal among all BDSM/kink organizations, since the medicalization of kink/BDSM lies at the center of its stigmatization. The effort to reduce the stigmatization of BDSM by revising the DSM and other important medical documents started as early as the 1980s.

Bob was an activist that I interviewed. Bob has been a long-time activist in the BDSM/kink community since the 1950s. He organized the very first activist group that resisted against the stigmas associated with the medicalization of BDSM. He and a friend of his (who was a psychiatrist) created a list of kink-friendly psychiatrists and psychologists for individuals in the kink community who need psychiatric assistance

but fear their stigmatized condition may be judged or even used against them. He received requests (via mail) from people all over the country, and he replied with contact information of psychiatric professionals who are “kink aware”. In the first few revisions of the DSM, Bob was closely involved as a community member. He provided a lot of useful information for the DSM paraphilia sub-workgroups to consider when they are making changes to these medical categories. Bob admitted, however, that most of his involvement with the DSM revision was kept secretive. No public demonstration or rallies were organized to campaign for that.

Because Bob no longer has the time and energy to manage the organization, this organization is now under the administration of Kelly’s organization, which played a major role in the most recent DSM revision. Kelly leads a national BDSM/kink activist organization that is “committed to creating a political, legal and social environment in the US that advances equal rights for consenting adults who engage in alternative sexual and relationship expressions”. She told me that her personal experience with discrimination led to her participation in, and later, organization of BDSM activism:

I came to my late 20s. And I was discriminated almost immediately. I was a writer. I had actually gotten my degree to be in art history and I started writing rather late as well. But I was trying to get my first book published. And I talked to the publisher and he found out that I was in relationship with a married couple and he assumed...that made me fair game for him...if I sleep with them, I should sleep with him.

Related to her personal experience, Kelly explained why activism is much needed for the BDSM/kink community:

There is activism for gay marriage because you have to fight for that. And the reason we have such [BDSM] activism right here is because we have to fight for our rights. We get such discrimination and persecution and harassment.

According to my interview with Kelly, the role that she and her organization played in the revision was very similar to that of Bob's organization in the previous revisions in that as an active community voice, her organization was simply providing information requested by the paraphilia sub-workgroup. Kelly's organization collected online opinion polls from community members on issues concerning discrimination, as well as comments from community members about the DSM and how that affects their life. The difference between Kelly and Bob's organizations may lie in (1) the size of the organization and (2) the publicity of the organization. Unlike Bob's organization whose involvement in the DSM revision was almost secretive, Kelly's organization is not only more visible in public spaces (e.g., on the internet, academic/professional conferences, and in publications), its campaign for the DSM revision is also explicit on its website. Kelly also organized an online petition where more than 3,000 people signed to support the demedicalization of kink. Unlike Bob's organization, which only focuses on referring kink individuals to professionals who are kink aware, Kelly's organization runs a host of services and awareness raising programs along with activist campaigns.

According to Kelly, her campaign wouldn't have been this successful without the Internet. Firstly, the Internet enables activists from all over the country to participate in BDSM activism with very little cost. In fact, Kelly's organization doesn't even have a physical office; the entire operation is online. Moreover, the Internet enables anonymous participation from BDSM practitioners, most of whom are still very private about their involvement in BDSM.

In addition to Kelly's organization, other activist efforts exist in the kink community. Dr. K is a psychologist by trade, and one of the chief administrators of a

national BDSM/kink community-based research organization that was founded in the mid-2000s. When asked why his organization was established and how it furthered the course of BDSM activism, Dr. K answered:

It was starting to be recognized in the community that these professions, psychiatrist, psychologists, counselors, and doctors are often saying things about BDSM and kink that don't reflect the actual lived experience, and that a lot of it was *pathologizing*. And that this was actually creating social barriers, legal barriers, medical barriers that were really damaging to the community... So there's this concern, I think from the community's side, that the only way to talk to those professions is to talk about *evidence*. That's the language they use. They use the language of *science*... It really comes out of this concern for *stigma*, *disenfranchisement*, and *isolation* from these fairly important intuitions in society.

While Dr. K conceded that opinion polls might be helpful for presenting a general summary of discrimination, it is unlikely to be taken too seriously by institutions such as the APA since psychiatrists have a different standard about the scientific rigor of these studies:

When there isn't a lot of psychiatric research itself, they [psychiatrists] are more than willing to look at studies such as community surveys. That's not really scientifically designed work. They are certainly open to it, but it does have a lower standard. They recognize the weaknesses and limitations of it and for a lot of them *that's enough to dismiss* it because there isn't a large body of work pointing to a particular direction.

According to Dr. K, useful community based studies should be able to dialog with the scientific community, and reduces stigmatization. For example, he is currently involved in a particular research project examines access to health care for the BDSM/kink population. He and his colleagues are trying to document just how

much and how often people in the kink community will hide or limit their use of health care because of the stigma.

*Psychiatric and Legal Response to Claims of Demedicalization.* Because of its previous history with “the problem population” (such as the homosexuals), APA and WHO alike are making much effort to maintain a good public image by including public participation into the DSM revision project. On the website DSM5.org, general public were able to track changes on the DSM revision process and make comments on these proposed changes throughout the entire revision process, although the public were not able to view comments made by other people. In addition, the APA invited people outside the psychiatric community as advisors to the DSM revision projects. Individuals who were invited by the APA had to promise confidentiality of the issues being discussed at the work group meetings. Although the revised drafts are no longer available on the DSM-5 website, APA published a series of “fact sheets” summarizing what major changes had been made in the DSM-5 and what were the reasons and debates leading to these changes. Concerning paraphilic disorder, for example:

In the Diagnostic and Statistical Manual of Mental Disorders (DSM), paraphilic disorders are often *misunderstood* as a catch-all definition for any unusual sexual behavior. In the upcoming fifth edition of the book, DSM-5, the Sexual and Gender Identity Disorders Work Group sought to draw a line between atypical human behavior and behavior that causes mental distress to a person or makes the person a serious threat to the psychological and physical well-being of other individuals...

*Most people with atypical sexual interests do not have a mental disorder...* To further define the line between an atypical sexual interest and disorder, the Work Group revised the names of these disorders to differentiate between the behavior itself and the disorder stemming from that behavior (i.e., Sexual Masochism in DSM-IV will be titled Sexual Masochism Disorder in DSM-5).

It is a subtle but crucial difference that makes it possible for an individual to engage in consensual atypical sexual behavior without inappropriately being labeled with a mental disorder. With this revision, DSM-5 clearly distinguishes between atypical sexual interests and mental disorders involving these desires or behaviors:

A paraphilia is a necessary but not sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention (APA, 2013: 686).

This is a significant change in the DSM in that according to a national BDSM community service provider, in most child custody cases after the DSM-V, “attorneys were able to suppress the BDSM behavior as not relevant or the judge set it aside from the bench as not relevant, so that child custody could be determined on its own merits” (Wright, 2014).

Dr. S is a psychiatrist who is a key member in the paraphilia sub-workgroup of the DSM-V revision project. My interview with him further corroborates the psychiatric profession’s intention to minimize the negative effects of medical labeling on practitioners of consensual BDSM. According to Dr. S:

You always get into trouble if you try to delineate what is normal and what is not...you get the problem particularly with *labeling*...there is consideration of *not wanting to stigmatize* certain sexual behaviors.

Although records documenting work group meetings during the revision process are kept confidential, plenty of debates reflective of the controversies throughout the DSM revision process took place on *Archives of Sexual behaviors*, a peer-reviewed journal that publishes “empirical research (both quantitative and

qualitative), theoretical reviews and essays, clinical case reports, letters to the editor, and book reviews<sup>6</sup>.”

As part of the DSM-5 revision procedures, Kruger (2010a, 2010b) conducted two comprehensive literature reviews on sexual sadism and sexual masochism. These literature reviews include previous studies that criticize these diagnostic categories from the perspective of the BDSM community. In response, Kruger (2010a, 2010b) suggests that the narrative sections of the DSM should be rewritten to reflect that the fact that much information on sadistic and masochistic behavior is derived from the forensic population and may not apply to community populations, but the diagnostic categories should be retained because of sexual sadism’s prevalence in the forensic population, and the high association between sadism and masochism.

The most heated debates on the DSM-5 revision were about whether a diagnostic category of “paraphilic coercive disorder (PCD)” should be created. The paraphilias subworkgroup of the Gender and Sexual Disorders Work Group for DSM-5 proposed the following diagnostic criteria for paraphilic coercive disorder:

- A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies or sexual urges focused on sexual coercion
- B. The person is distressed or impaired by these attractions, or has sought sexual stimulation from forcing sex on three or more nonconsenting persons on separate occasions
- C. The diagnosis of Paraphilic Coercive Disorder is not made if the patient meets criteria for a diagnosis of Sexual Sadism Disorder (Stern, 2010:1444)

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<sup>6</sup> <http://www.springer.com/psychology/personality+%26+social+psychology/journal/10508>



A few psychiatrists and legal professionals supported this proposal for a variety of reasons. Paul Stern (2010) who was a prosecutor having spent 25 years working on issues related to sexual offending argues that due to the lack of such a category of medical illness, only “a tiny percentage of sex offenders released from prison every year are even considered for SVP assessment” (P. 1444). Stern (2010) explains that “I do not want to detain as SVPs those who should not be held nor do I want dangerous men released to the street because of irresponsible statements made by mental health professionals. I want accuracy” (P. 1444). By “accuracy”, Stern means that the civil commitment of sexually violent predators should involve the identification of only those who properly qualify under the law. The narrower the definition of those eligible for civil commitment, the better. PCD is a more precise—i.e., narrower—definition under which to consider those men who derive sexual pleasure by the use of force or coercion on their subjects. It is a more precise definition than Paraphilia Not Otherwise Specified. More precise means it is more narrow (shrinking the pool).

But Stern (2010)’s later arguments in the same article seem to suggest that accuracy isn’t really what he wants:

It doesn’t take a taxonomic analysis to know that there are men in the world who seek sexual gratification by coercing others to engage in unwanted sexual behavior. It doesn’t require years of study to document that there are men whose urges, fantasies, and behaviors satisfy the PCD descriptors. It is abundantly evident those people exist. A short period of time practicing in this field gives a *disinterested* person that knowledge.

David Thornton (2010), the director of research at Sand Ridge Secure Treatment Center, suggests that PCD should be created because there is a minority of males (among the forensic population) exhibiting higher level of arousal, as opposed

to at least partially inhibited arousal, when salient cues of their partners being coerced is presented. However, psychologist Raymond Knight (2009) does not agree with this line of logic:

Higher plethysmographic responses of rapists to coercive rape scenarios may, however, be better explained by the failure of coercive elements to inhibit arousal to sexual aspects of the stimuli rather than by arousal specifically to the coercive elements (P. 419).

In the face of these discussions, psychiatrist Richard Balon (2012) cautions that the debate is becoming an ideological one instead of a scientific one:

The problem is that the science is not there and thus PCD should not be included in the DSM-5. We should be quite careful in defining new diagnostic entities and their inclusion in our diagnostic classification. The DSM “grew” from 60 categories of abnormal behavior included in its original 1952 edition to close to 400 various diagnoses in the fourth edition of this manual. Is this all real and is all the science supporting this expansion really there? I dare to argue that it isn’t. We have seen the inclusion of new entities of questionable existence even in the area of sexual disorders and paraphilias—take the example of Sexual Aversion Disorder... Unless we have really good data supporting the new diagnostic entity’s inclusion into our diagnostic system, we should avoid it, no matter what the courts, prosecutors or others need. The need would probably, or rather invariably, bring ideology into the equation. That is, hopefully, the last thing we all want (P. 535).

Indeed the psychiatric profession is making a conscious effort to resist excessive intervention into the scientific process. The paraphilia “fact sheet” discusses the legal implication of the DSM revision:

While legal implications of paraphilic disorders were considered seriously in revising diagnostic criteria, the goal was to update the disorders in this category based on the latest science and effective clinical practice.

However, in many occasions (e.g., Krueger 2010a; 2010b), the association with the forensic population is used as a justification to create and retain a diagnostic

category. Even regardless of the influence of the law, the scientific process behind the DSM remains questionable. Blanchard (2011) who serves on the committee of the paraphilia sub workgroup reviews the history of field trials of the DSM diagnostic criteria:

The field trials for DSM-III, which were sponsored by the National Institute of Mental Health, included three patients with paraphilias. That's it. Paraphilia diagnoses were not included in the field trials for DSM-III-R (American Psychiatric Association, 1987) or for DSM-IV (see O'Donohue, Regev, & Hagstrom, 2000, p. 98). Thus, the sum total of patients who have been studied in conjunction with revising the DSM diagnostic criteria for the paraphilias is 3. That is fewer than half the number of paraphilia diagnoses listed in the DSM. *That means that most of the paraphilias diagnostic criteria were never looked at with a single patient as part of the DSM production process ever.*

What about the DSM-5? Blanchard (2011) introduces several studies that examine both forensic and community populations as field trials for the DSM-5. But are the quantity and quality of the research good enough to justify the creation of new diagnostic categories or revision/removal of old categories? Blanchard (2011) concludes his article saying:

In summary, there is a complete lack of information from prior DSM field trials about the usefulness of various elements of the diagnostic criteria for the paraphilias. The amount of available information regarding the diagnostic criteria proposed for DSM-5 is already equal to, or perhaps greater than, the amount of information about the existing criteria (P. 862).

The overtone of this statement is that the baseline of previous DSM field trials was so low that it doesn't take a lot of efforts to meet or supersede that baseline level. But this doesn't mean the quantity or quality of the work suffice the scientific standards that APA boasts to maintain.

APA's reluctance to study BDSM or other alternative sexuality in a nonclinical context was a frustration that Dr. K expressed. Dr. K believes that the BDSM community itself should be producing studies that meet rigorous scientific standards to be taken seriously, and eventually contribute to the destigmatization of the community by showing the facts about the little utility of these medical categories and their damaging impacts on the BDSM/kink community.

Dr. S also didn't like the idea of creating a diagnostic of PCD. In addition to the lack of sufficient scientific evidence, he also didn't see the changes with paraphilia in the DSM-5, which specifies the difference between paraphilia and paraphilic disorder, as progressive. Instead, he believes that the proposed revision of the ICD-11, which eliminates some categories without a potential victim such as sexual masochism and fetishism but reserves a category of "atypical sexual behavior" to be a better model for conceptualizing alternative sexual practices that might cause societal harm or distress on the part of the participating individuals. Dr. S explained that this more substantive approach, where the psychiatrist can use his/her discretion when giving these diagnosis, is more superior to following rigid guidelines that sometimes fail to capture the severity or the actual causes of the problems. Ideally, the psychiatrist should be able to judge whether an individual should be diagnosed with paraphilic disorder with more discretion. "It's just like pornography," Dr. S said, "I know it when I see it."

Similar to the revision of DSM-5, anybody can log on the ongoing ICD-11 revision website, and make comments on the ongoing revision, a proposed item was recently added under paraphilic disorder, which seems congruent with Dr. S's ideal model:

Paraphilic disorder involving solitary behaviour or consenting individuals is characterized by a persistent and intense pattern of atypical sexual arousal—manifested by sexual thoughts, fantasies, urges, or behaviours—that involves consenting adults or solitary behaviours, as long as either: 1) the person is markedly distressed by the nature of the arousal pattern and the distress that is not simply a consequence of rejection or feared rejection of the arousal pattern by others; or 2) the nature of the paraphilic behaviour involves significant risk of injury or death (e.g., asphyxophilia)<sup>7</sup>.

This proposal retains the category so that individuals who experience psychological distress may seek professional help, and it bestows psychiatrists with more discretion to give diagnosis. However, the usefulness of such a diagnostic category remains questionable to Dr. K and other psychologists (e.g., Moser and Kleinplatz, 2005), who believe that retaining these categories introduces more problems than it eliminates. Psychiatry and psychology should instead stick to more conservative diagnostic categories, such as depression, neurosis, and anxiety, etc. that are much more established in the empirical literature.

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<sup>7</sup> <http://www.who.int/entity/classifications/icd/revision/en/index.html>

## Chapter 6

### DISCUSSION AND CONCLUSION

The analysis of kink as an empirical case of social problem construction has broadened the theoretical scope of social problem construction to reflect the shifting contexts of contemporary discourses and politics over alternative sexuality.

First and foremost, this study has revealed, explicitly and dramatically, how contemporary institutions of control actively produce social problems and the problem population. Consistent with Foucault's theory, this study shows that the medical sciences have been given much discursive legitimacy that allows them to identify and eliminate medical problems, including many mental problems whose causes and effects are still very much unclear to the scientific community. In contrast to either early psychiatrists who conceptualize the practice of kink as a manifestation of ascribed mental dysfunction that legitimizes involuntary control, or sociological research that repeatedly shows that BDSM is nothing but "edgework play" and "serious leisure" (Newmahr, 2010; 2011), more recent psychiatric classification construes kink as a treatable disorder. As much as modern psychiatry claims to aim at rehabilitation rather than punishment and control, such a promise proves to be difficult to keep. Although contemporary diagnostic criteria of Sexual Sadism and Sexual Masochism lay stronger emphasis on whether the condition causes "distress" or affects "important areas of functioning" as opposed to the criminality or immorality of the act, these diagnostic categories are retained and justified by their prevalence in the "forensic population" and the *potential* criminal consequences associated with them.

The use of potential criminality as a legitimate claim for medical labeling, as well as the lack of empirical evidence from the general population (Blanchard, 2011), weakens the claim that rehabilitation is the goal of medicalization, since the diagnostic categories were retained for the purpose of identifying and subsequently, controlling a population with criminal tendency. The infiltration of the law into the medical discourse epitomizes in the dispute over the creation of Paraphilic Coercive Disorder, a diagnostic category that solely serves to control a particular population of ex-sex offenders. In addition to direct sovereign control, the medicalization of kink appeals to the general public's reluctance to make sense of BDSM practitioners' alternative claims of usually unpleasant physical and mental experiences, and reinforces the social understanding of kink through pathologization. The legitimacy of medicalization is strengthened by the seemingly benign promise of rehabilitation, which compels BDSM practitioners to constantly align their behaviors and how they feel about these behaviors to the diagnostic criteria, a typical manifestation of Foucault's concept of disciplinary control. In sum, (a) psychiatry isn't all that much an independent empirical science free from ulterior political forces that aim at sovereign control, and (b) the claim of rehabilitation strengthens the legitimacy of medicalization and sustains systematic disciplinary control.

Nevertheless, instead of depicting an oversimplified picture of pervasive institutional control, a note on which many Foucaultian studies seem to end, this study also finds that new social contexts have emerged and changed the power dynamics between the institutions of control and the "controlled population". As a recurring theme in the interviews, the rise of the Internet has revolutionized communication, community building, and the mass dissemination of information. In the past, in order

to have a *private* BDSM experience, one had to be at least semi-*public* about their sexual interests such as going to a motorcycle club, or dressing in certain ways that communicate their interests. With the growing popularity of websites such as *Fetlife.com*, which houses 1,762,446 registered members<sup>8</sup> in the U.S alone, such hassles are no longer necessary. The Internet is a hybrid space of both public and private characteristics: it is public in the sense that it has the capacity to network individuals from literally all over the world to one conversation; it is also private since you can be anonymous throughout the entire duration of your interaction with others. This change in communication becomes one of the most important contexts in studying stigmatized behaviors and stigmatized populations, because the Internet allows them to *bypass* stigmas that used to be immediately *discredited* (Goffman, 1963) in public interactions. It thus enamored private individuals with true autonomy and freedom to experience “the alternative”.

The anonymity that the Internet provides has not only enabled social interactions, but also social change. The Internet provides a safe space for individuals with stigmatized status to express their grievances and political agendas without having to expose themselves. In addition, the Internet has also made efficient and economical mobilization possible (Earl and Kimport, 2011). Earl and Kimport (2011) argue that Internet usage changes the actual process of organizing and/or participating in activism, in contrast to the “supersize model” which postulates that Internet usage primarily increases the size, speed, and reach of activism, but not the definitive effect on the processes underlying activism. It is likely that organizations that emerged after

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<sup>8</sup> <https://fetlife.com/countries/233>



the more pervasive use of the Internet will use online tools in systematically different ways than those that predate it (DiMaggio et al., 2001). Although BDSM activist organizations have existed for almost 20 years, most of their national projects against stigmatization started relatively recently, and would not have been possible without the Internet. The Internet has enabled the anonymous participation of public activism, and very low-cost organization of a national social movement, both of which have reshaped the power politics of stigmatized behaviors, as well as social and political movements in developing (and oftentimes, authoritarian) countries (e.g., Yang, 2009; Fletcher, 2008).

However, even with improved communication technology, the claim of discrimination against sexual minority couldn't have gained legitimacy if it were not for previous social movements including the civil rights movement, the women's rights movement, and most relevantly, the LGBT movement. Together, these movements have established a dominant discourse about individual rights and freedom regardless of race, gender, and sexual orientation, from which BDSM activist claimsmaking draw its legitimacy from. *Sexual citizenship* (Weeks, 1998) has become a new citizenship claim that enamors sexual minorities with discursive legitimacy comparable to the institutions of control. With this established discursive legitimacy is the increasing acceptance, and popularization of alternative sexuality, well demonstrated in the astonishing public reception of the BDSM themed romance novel *Fifty Shades of Grey*, which sold over 1 million copies according to *New York Times*<sup>9</sup>

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<sup>9</sup> [http://www.nytimes.com/2014/02/27/business/media/for-fifty-shades-of-grey-more-than-100-million-sold.html?action=click&module=Search&region=searchResults%230&version=&url=http%3A%2F%2Fquery.nytimes.com%2Fsearch%2Fsitesearch%2F%23%2Ffifty%2Bshades%2Bof%2Bgrey%2F&\\_r=1](http://www.nytimes.com/2014/02/27/business/media/for-fifty-shades-of-grey-more-than-100-million-sold.html?action=click&module=Search&region=searchResults%230&version=&url=http%3A%2F%2Fquery.nytimes.com%2Fsearch%2Fsitesearch%2F%23%2Ffifty%2Bshades%2Bof%2Bgrey%2F&_r=1)

and is being made into a movie. According to Giddens (1992), beneath the changing public attitudes on sexuality is a new paradigm of sexuality— *plastic sexuality* that focuses on mutual pleasure rather than reproduction or the conventional notion of romantic love which has the underlying detriment of excessive co-dependence. As opposed to the dissolution of intimacy, this paradigm change in sexuality and intimacy, according to Giddens (1992), signifies the increasing democratization of the intimate sphere and the emergence of “confluent love”, a model of intimacy that is genuinely egalitarian since it no longer prioritizes the pleasure of one party over the other.

Perhaps the most interesting finding of this study is how in the face of these changing discourses, institutions of control and its problem population adopt new strategies to their claimsmaking and develop new interactive dynamics. As Giddens (1992; see also Beck, Giddens, and Lash, 1994) eloquently puts, the discursive changes on sexuality and intimacy is indicative of emerging *institutional reflexivity* that qualitatively differs from “one-way intrusion of ‘power-knowledge’ (Giddens 1992: 28)”. Giddens (1992) argues,

It is institutional because it is a basic structuring element of social activity in modern setting. It is reflexive in the sense that terms introduced to describe social life routinely enter and transform it—not as a mechanical process, nor necessarily in a controlled way, but because they become part of the frames of action which individuals or groups adopt (P.28).

The proliferation of discourses on sexuality and intimate life, whether it’s from the community, the medical, or the legal perspective, spurs more reflexive discussions on sexuality, which often leads to the democraticization of the intimate life. The pathological perspective towards BDSM will eventually conflate with the community perspective, if open discussions are cultivated and protected. In this study, such a

conflation is readily observed. For activists, it is no longer enough to appeal to the general public's emotions by parading the streets. It seems more effective to engage with the institutions of control by "speaking their language", namely, producing scientifically sound studies. Psychiatrists are also more cognizant of the effects of excessive stigmatization produced by arbitrarily attaching medical labels. This explains why psychiatrists believe that the proposal for ICD-11 where Sexual Masochism and fetishism are recommended to be removed seeks to establish a more humanitarian approach to diagnosis where doctors and patients are given more freedom to express themselves beyond the established discursive legitimacy of documented diagnostic criteria. For a condition whose problematization rests primarily upon its medicalization, demedicalization is a monumental step towards its complete vindication. This study has shown that it is perhaps not blindly optimistic to say that with reduced social control, more positive media representations, and more intergroup contact, public perception of BDSM will eventually be altered, as it has been in the case of homosexuality, although it is wise to always bear in mind the constant power differentials between the psychiatrists and their clients, and how this power dynamics may manifest under ICD-11 where psychiatrists are still entitled to legitimately attach medical labels to sexual minorities, and are given more discretion to make diagnosis.

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## Appendix A

### APPROVAL LETTER FOR HUMAN SUBJECT RESEARCH



RESEARCH OFFICE

210 HULLIHEN HALL  
UNIVERSITY OF DELAWARE  
NEWARK, DELAWARE 19716-1551  
Ph: 302/831-2136  
Fax: 302/831-2828

DATE: October 28, 2013

TO: Kai Lin  
FROM: University of Delaware IRB

STUDY TITLE: [522213-1] The demedicalization of BDSM

SUBMISSION TYPE: New Project

ACTION: APPROVED  
APPROVAL DATE: October 28, 2013  
EXPIRATION DATE: October 27, 2014  
REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review categories 6 & 7

Thank you for your submission of New Project materials for this research study. The University of Delaware IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a study design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the study and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the study via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All SERIOUS and UNEXPECTED adverse events must be reported to this office. Please use the appropriate adverse event forms for this procedure. All sponsor reporting requirements should also be followed.

Please report all NON-COMPLIANCE issues or COMPLAINTS regarding this study to this office.

Please note that all research records must be retained for a minimum of three years.

Based on the risks, this project requires Continuing Review by this office on an annual basis. Please use the appropriate renewal forms for this procedure.

If you have any questions, please contact Nicole Farnese-McFarlane at 302-831-1119 or [nicolefm@udel.edu](mailto:nicolefm@udel.edu). Please include your study title and reference number in all correspondence with this office.

## Appendix B

### INTERVIEW GUIDES

#### Background information

1. Tell me something about your personal background growing up (e.g., parental situation, environment etc.).
2. When did you start to develop interests in kinky/BDSM practice? Is it related to any of your personal background?
3. How did you respond to that interest (e.g., looking to get involved in local BDSM communities)?

#### BDSM community and activist groups

4. What is your status in terms of your involvement in the BDSM practice/lifestyle? For example, do you have a partner to practice BDSM with you on a regular basis? If not, how do you usually get involved in the practice/lifestyle? How often?
5. How and when (and why) did you get involved with BDSM activist organizations? Can you describe your level of involvement in these organizations?
6. Can you describe the general organization structure of this activist group and your role in it?
7. What is the **organizational structure of the organization**? And which is the emphasis among these different functions? (i.e., research, public outreach, organizing protests etc.). What has this organization (or organizations) achieved in terms of promoting/realizing its agenda? (What difference has it made for BDSM practitioners?) Did you encounter any difficulty as well?
8. What are your views on the change in the psychiatric definition of BDSM? How would you account for this change?
9. What is the role of your organization (and yourself) in this movement?
10. What do you think are the current status of the BDSM activist movement? What



is the next step? (not only BDSM but also other forms of alternative sexuality)

Public attitudes and popular culture

11. How would you characterize the general public's attitudes towards the BDSM community and BDSM activist groups?
12. What are your views on how BDSM is depicted by the popular culture (*fifty shades of grey*)? Do you notice any change over time?
13. What do you think of the Internet? Does it play a positive role in terms of advancing BDSMers rights? What about

Interview Guide with Dr. S

1. Can you tell me something about your job? What exactly that you do and who do you mainly deal with?
2. What gets you into the study of sexual sadism and masochism?
3. What is your role revising the DSM? How are decisions about changing these categories made?
4. Where do you keep records?
5. How should we interpret the recent change in the DSM-V? Do you think it's a substantial change compared to the definition in the DSM-IV?
6. What is the most common way of psychiatric intervention in those who are diagnosed as Sexual Sadism or Masochism?
7. Where do psychiatrists think these disorders are located? At the bio, psycho, or social level?
8. What is the measurement for level of distress?
9. Why were Sexual Sadism and Sexual Masochism NOT included into the first DSM?
10. Why are these categories helpful?
11. What do you think are the major forces pushing for these changes in the DSM-V?
12. (and of course how. Which should depend on his answer and give follow-up questions)

13. Do you think consensual BDSM actives should be intervened psychiatrically at all?
14. How is this related to continuous social grievances for non-discrimination against BDSM practitioners (including child custody cases).
15. How did you work with activists groups? Did you encounter any oppositional protests or demonstration during the process (because that happened to APA when the demedicalization of homosexuality was first brought up)?
16. Why are psychiatrists interested in human sexuality? (again, there should be many follow-up questions)
17. What is the next step? Is it possible that some categories, such as Sexual Masochism, fetishism, voyeurism, that are less harmful and not so prevalent in the forensic population be removed altogether in future editions of the DSM? If psychiatric intervention is to reduce distress, doesn't keeping these categories furthers the social stigmatization?