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## No Means Yes ... If Consent Is Obtained: An Exploration into the Psychology and Legality of BDSM and Sexual Sadism

Zaina Mahmoud\*

This article looks the differences between BDSM and sexual sadism through both a healthcare and legal lens. Through examination of the psychological characteristics of BDSM participants, it is shown that they are psychologically healthy adults who engage in consensual “kinky” activities, with no malicious intentions. Examining the psychological profiles of sexual sadists demonstrates that these individuals tend to have psychopathic traits and engage in such behaviour with non-consenting persons. Looking at past assault cases related to BDSM and sexual sadism demonstrates the lack of regulation and understanding in the Canadian judicial system when discussing sexual activities.

“BDSM” is an acronym for various sexual preferences that lie outside of the realm of “vanilla” sex: bondage and discipline, domination and submission, and sadomasochism. Sometimes referred to as “kink,” BDSM includes power exchange, role-play, and consent. Power exchange refers to the submissive (“sub”) giving control to the dominant (“dom”) for the course of their relationship (Kleinplatz & Diamond, 2014). Although many participants role-play total power exchanges, it is prior and ongoing consent that distinguishes BDSM from sexual assault—primarily sexual sadism.

At the heart of every definition related to BDSM is consensual pain as pleasure. For a sexual practice to be considered BDSM, it requires one individual to inflict harm or pain, through suppression, physical restriction, and role-playing games on another consenting individual for sexual and/or psychological satisfaction (Kolmes, Stock & Moser, 2006; Wismeijer & van Assen and Marcel, 2013). This type of sexual behaviour is not uncommon: up to 14% of American males and 11% of American females have engaged in some form of BDSM sexual behaviour (Kolmes et al., 2006). Other studies have shown that engagement in BDSM activities is much lower, with a mere 2.2% of men and 1.3% of women partaking in BDSM activities (Richters, de Visser, Rissel, Grulich, & Smith, 2008).

Consent is paramount in these activities, for both the safety and enjoyment of all those

involved. BDSM play is “safe, sane, and consensual” and must be “risk aware consensual kink” (Barker 2013, p. 896). Consent, negotiations and safe-words operate within the BDSM community, ensuring that these practices are safe (Barker 2013). These practices are in place and echo the requirements of the law, whereby consent is in place to ensure that participants are not victims of assault and that they are able to ask their partners to stop at any point.

Many assume that those involved in the BDSM scene are somehow psychologically troubled, whether through a history of sexual abuse, psychopathic streak, or a sexual deficiency, requiring strong stimuli to reach orgasm (Richters et al., 2008). In the largest study regarding BDSM proclivities, Richters et al. (2008) examined the claim that BDSM is practiced by people with a history of sexual coercion, sexual difficulties, and/or psychological problems. There was a significant association between engagement in BDSM and a greater number of sexual partners over the lifetime, but no association between the incidence of sexual coercion before the age of 16 and involvement in the BDSM scene. Among women, engagement in BDSM was significantly related to having been imprisoned within the past 15 years. BDSM participation strongly correlated with a large number of sexual practice measures associated with greater sexual activity and interest in sex. The researchers concluded that BDSM is simply a sexual interest attractive to a minority, and that for the majority of

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participants, BDSM activities are not a pathological symptom of past abuse or difficulty with “normal” sex.

Wismeijer et al. (2013) studied the psychological characteristics of BDSM practitioners ( $N = 942$ ), examining the differences between BDSM participants and a control group, as well as within BDSM participants—specifically focusing on domms, subs, and switches. Switches refer to participants of the BDSM community who take on the role of either “dom” or “sub”, depending on the situation. The researchers assessed psychological well-being based on attachment, the NEO-Five Factor Inventory, and rejection sensitivity.

Attachment style is an important determinant of sexual behaviour and pleasure; securely attached individuals are more likely to

give their partner control and are more open to new experiences in sexual behaviour. BDSM participants were found to be more securely attached than the control group, with female BDSM players having more confidence in their relationships, requiring a lower need for approval, and a lower incidence of anxious attachment.

Given that BDSM participation involves potentially new and unusual sexual experiences, participants would benefit from increased extraversion, openness and conscientiousness. The results of the NEO-Five Factor Inventory are summarized in the table below. As can be seen in Table 1, BDSM participants are more extraverted, open to experiences, and conscientious than the control group. They are also less neurotic than their control counterparts.

Table 1  
*NEO-Five Factor Inventory Results in BDSM Practitioners and Control Group*

NEO-Five Factor Trait	highest → lowest			
Extraversion	sub, switch, dom	control		
Openness to Experience	switch, dom	sub	control	
Conscientiousness	dom	sub	switch	control
Neuroticism	control	sub	switch	dom
Agreeableness	control	sub	switch	dom

Rejection sensitivity refers to the overestimation of the possibility of being rejected by others by others and of the emotional impact that will occur following rejection (Wismeijer et al. 2013, p.1945). BDSM practitioners were less rejection sensitive when compared to the control group and had higher subjective well-being scores. This could be due to BDSM scenes frequently dealing with themes of humiliation and rejection, and sensitivity to rejection could result in displeasure. These findings suggest that BDSM practitioners are characterized by greater psychological and interpersonal strength and autonomy, indicating that BDSM practitioners are not psychologically stunted in some way.

However, many BDSM participants believe they receive biased mental healthcare. A study conducted by Kolmes et al. (2006) investigated psychotherapy with BDSM clients. They recruited BDSM participants who were either currently in therapy or had sought out therapy in

the past. Most of the participants had disclosed their sexual proclivities to their therapist and felt they experienced biased therapy as a result. Although most had not sought therapy as a result of their sex life, they were told that BDSM was unhealthy and, to continue with therapy, they had to give up all BDSM activity. Most of the time, BDSM was confused with abuse and they felt they had to educate the therapist about BDSM. Many felt as though the therapist assumed that BDSM interests were indicative of past family/spousal abuse. These biases are seen primarily as a result of sadism and masochism being listed as paraphilias in the DSM-5, and many researchers agree with the detrimental effects of continuing to list these sexual pendants.

Sadism was first coined by Richard von Krafft-Ebing, after the writings of the Marquis de Sade, a French writer and philosopher known for his erotic works that depicted sexual fantasies with themes of violence. Krafft-Ebing

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defined sadism as a feeling of deriving sexual pleasure, sometimes involving orgasm, in response to observing or taking part in cruelty toward human beings or animals. He organized sadism into a number of sub-classifications, divided into two subgroups: mild sadism in a consensual sexual relationship, and injury or death, usually referring to actions that occur within a non-consensual relationship. The former refers to the sadistic activities in BDSM play, whereas the latter refers to the forensically relevant sexual sadism.

Sexual sadism has remained in the realm of mental disorders until the present day. The most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5, has kept it under the section related to paraphilias, much to the outrage of the sexual science community. According to the DSM-5, sexual sadism requires:

“recurrent and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviour over a period of at least 6 months, and the individual has acted on these sexual urges with a non-consenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 2013, p.695 ).

Here, the prevalence is thought to be between 2-30% (APA, 2013, p.695 ). The World Health’s Organization ICD-10 also has a similar definition regarding sexual sadism: “a preference for sexual activity which involves the infliction of pain or humiliation, or bondage; the provider of such stimulation” (WHO, 2014, p. 220).

Sexual sadism is especially studied in forensic populations. Psychologists have examined a multitude of databases with the goal of identifying certain crimes and offenders as sexually sadistic. The National Center of the Analysis of Violent Crime, established in 1984 by President Ronald Reagan, aimed at identifying and tracking repeat killers. Dietz, Hazelwood and Warren (1990) used this to gather 30 cases of offenders deemed to be sexually sadistic so as to conduct their study.

The researchers were careful to distinguish sexually sadistic offenders from offenders who had previously experienced a psychotic break, leading to their bizarre fantasies. After careful selection of the 30 participants, the researchers looked at their personal and offense characteristics.

Since the data was obtained from a small, highly selected pool, it must be interpreted cautiously. Of the 30 offenders, 29 were white, 47% were from homes characterized by parental infidelity and the same proportion had been sexually or physically abused during their childhood. Their occupations varied, but all had contact with the public. Almost all the offenders had carefully planned out their offenses by studying law enforcement procedures, studying and collecting weapons, constructing a torture rack, etc. The majority of the offenders—77%—engaged in sexual bondage of one or more victims. The offenders all performed some sort of forced sexual act on the victim, and many forced the victim to engage in at least three different acts. Every single one of the offenders intentionally tortured their victims, in extreme and exceptionally cruel ways, including electric shock, burning, and amputation.

The researchers found that regardless of the sex of the victim, the offenders tended to commit forcible penetration of the anus and mouth, rather than vagina, probably because these penetrative acts are seen as more degrading than vaginal penetration. Given the small and carefully selected population, no concrete conclusions regarding sexually sadistic offenders can be drawn. The lack of empathy and emotionality experienced by the offenders was thought to reflect psychopathy and narcissism.

These links are reinforced by the findings Mokros, Osterheider, Hucker, and Nitschke’s research into a model explaining the comorbidity of psychopathy and sexual sadism (2011). Through an exploration of 100 male forensic patients, half of whom were diagnosed as sexual sadists, Mokros et al. (2011) examined the prevalence of psychopathic and antisocial tendencies. Of the 50 sexual sadists, 31% of the sexual sadists had a concomitant diagnosis of antisocial personality disorder. After administering the PCL-R (Psychopathy

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Checklist-Revised) and examining both DSM and ICD criteria, the researchers found that psychopathy and sexual sadism share important characteristics like detachment, callousness, and lack of remorse about the suffering inflicted on others.

Both psychopathy and sexual sadism are likely characterized by deficits in the processing or experience of emotions as well as by behavioural consequences of this condition, primarily evidenced by a disposition toward instrumental violence, which refers to actions that cause harm but are not motivated by causing harm. Sexual sadists share with general psychopaths the relative inability to mirror the suffering of others emotionally.

Robertson and Knight (2014) sought to determine the role of sexual sadism and psychopathy in the prediction of non-sexual violence and sexual crime behaviours, as well as the relation between sadism and psychopathy facets. Using 314 incarcerated adult male sex offenders, the researchers administered the PCL-R, MIDSA (Multidimensional Inventory of Development, Sex, and Aggression) and USAG (Unsocialized General Aggression) to test their hypotheses. They found that sexual sadism and psychopathy are significantly, positively correlated.

The correlation found between sexual sadism and psychopathy is due to the similarities between the different facets of the PCL-R and sexual sadism. For both diagnoses, there is evidence of a desire to control and dominate others, organized and planned out offenses, and evidence of early behavioural problems, such as verbal and physical aggression. The researchers also noted that sexual sadism was associated with non-sexual violence, sexual violence, increased instances of violence, and elevated severity of violence. Sadists may not be aroused by the sexual acts themselves: these acts may be a means of degradation and control. It is important to note that results of the aforementioned studies pertain to sexual sadists and not sadomasochists in the BDSM community. The potential for confusion is at the source of the stigma associated with sadism. This confusion has led to many complaints regarding the DSM's diagnostic criteria for sexual sadism. Krueger (2010) addressed these

criticisms through extensive empirical literature review from 1900-2008 on sexual sadism.

The DSM and ICD diagnoses of sexual sadism have been cited as "pathologizing, stigmatizing, and discriminating" (Krueger, 2010, p.325) against individuals who engage in alternative sexual practices. Sweden and Denmark have removed sadomasochism from their official lists of diseases and mental disorders to avoid such discrimination. Although the definition of sexual sadism has changed from the DSM-III to the DSM-5, many key features have remained. BDSM practitioners believe that this updated definition stigmatizes their sexual proclivities, especially since their sadistic tendencies do not increase in severity over time. This increase is solely seen in sexually sadistic serial offenders. It is important to note that power, and not the giving and receiving of pain is at the core of consensual BDSM activity, whereas pain and power are at the heart (or lack thereof) of sexual sadism.

Krueger concludes that sexual sadism should be retained in the DSM, as it is a prominent diagnosis in forensic populations, however there should be some changes in the diagnostic criteria, including the exploration and validation of other possible items that may be relevant to sexual sadism in the clinical and forensic areas. A diagnosis of sexual sadism bears serious implications for decisions related to an offender's confinement and release, which makes it important to ensure that professionals understand and apply this diagnosis appropriately. The changes in the diagnostic criteria in tandem with the development of a scale would aid with the diagnosis of sexual sadism.

Nitschke, Mokros, Osterheider and Marshall (2013) sought to develop a scale to help with the vagueness currently surrounding the definition of sexual sadism. They distinguish sadomasochistic role-play, which requires a mutual agreement between consenting individuals who share sadomasochistic interests, from the forensically relevant form of sexual sadism, which requires the coercive subjugation of a person against his/her own will. The former refers to sadomasochism in a BDSM context, whereas the latter refers to sexual sadism and lack of consent. Three behaviours are deemed

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most indicative of severe sexual sadism: (1) the use of threats to evoke fear, not just to gain compliance; (2) cutting, stabbing, strangling, biting, beating the victim during sexual assault; and (3) the infliction of pain to sexual areas by the use of a physical object.

The researchers constructed a 17-item Severe Sexual Sadism Scale (SEAS) after examining past studies of sexual sadism. Some items were considered more important in making a diagnosis of sexual sadism, including the offender being sexually aroused by sadistic acts, the offender exercising power or control or domination over the victim, the offender humiliating or degrading the victim, the offender torturing or acting cruelly towards the victim, and the offender mutilating sexual parts of the victim's body. The researchers proposed that a person would be classified as meeting the diagnostic criteria for sexual sadism if he/she meets at least four of the criteria in the eleven-item set. This scale would serve as a diagnostic aid in the realm of forensic psychology, and hopefully would aid with the distinction between sexual sadism and BDSM in the eyes of the law. When looking toward the law, BDSM is in a grey area. Many Supreme Court of Canada rulings have stated that an individual cannot consent to assault leading to bodily harm (*R v. Jobidon*, 1991). Although this ruling was specifically in relation to a bar brawl that led to manslaughter, other cases have been brought to the Ontario Court of Appeal and the Supreme Court with regards to sexual activities. In each case, the judge ruled against the accused. In cases of sexual activity, the law requires that consent is ongoing and conscious, to ensure that participants are not victims of assault and that they are able to ask their partners to stop at any point. This resonates with the BDSM community's requirements that play is "safe, sane, and consensual" and that it qualifies as "risk aware consensual kink" (Barker, 2013, p.896).

There are many cases related to BDSM activity and the question of whether consent was obtained, including *R v. Welch* (1995), which is considered to be a landmark case regarding BDSM. The complainant testified that she was tied up and beaten all over as well as penetrated repeatedly by the appellant, all without her

consent. The appellant admitted that the conduct occurred but maintained that consent had been obtained prior and that the complainant was enthusiastic about the acts. The complainant suffered severe bodily harm due to these activities, resulting in vitiated consent. As such, the judge ruled that previously obtained consent could not be used as a defense to sexual assault resulting in bodily harm.

However strict BDSM playrooms and dungeons are when it comes to consent and safety, many of the activities that occur would be considered assault (causing bodily harm) and are chargeable offenses—especially if erotic asphyxiation is involved. Such was the case in the ruling of *R v. J.A.* (2011), where one of the participants had inserted a dildo anally on the unconscious partner and bound her wrists. Upon her return to consciousness, they proceeded to have vaginal sex. The partner maintained that she had consented to the erotic asphyxiation and to the sex, but not to the anal play. The courts ruled in her favour and deemed the insertion of the dildo to be assault, since consent does not extend to advance consent to sexual acts committed while the complainant was unconscious.

When separating BDSM from sexual assault, the complainant's consent to the insertion of the dildo is of utmost importance. If her partner inserted the dildo, without her consent, specifically to cause her unwanted harm then this would be considered assault. However, if he was simply acting as her sexual partner and she had previously consented to this act, then he was acting in the spirit of a BDSM relationship. BDSM and sexual sadism are not the same, and although BDSM has elements of sadism, consent, willing partners, and safety are paramount.

BDSM is a form of sexual expression; it is not assault nor is it an indication of underlying psychological issues. Sexual sadism is not within the realm of BDSM and is a form of sexual assault, and frequently comorbid with other psychological issues, such as narcissism and psychopathy. Much like how the difference between consensual coitus and rape is consent, the difference between consensual BDSM and sexual violence is consent. By conducting a review of psychological articles related to the

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mental well-being and psychological characteristics of BDSM participants, it is clear that they are individuals who are in no way acting out instrumental aggression towards another non-consenting individual. Looking at studies related to sexual sadism demonstrates that these individuals are acting out violent tendencies on unwilling victims. These differences are important in understanding and differentiating these sexual proclivities for both the healthcare and judicial system.

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