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Evaluation of Sexual Behavior and Sexual Functions of BDSM Practitioners: A Controlled Study

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ABSTRACT

Introduction: The purpose of this study was to obtain information about the sexual behaviors, sexual functioning of "bondage-discipline, dominance-submission, sadism, masochism" (BDSM) practitioners.

Methods: The study group (n=141) consisted of 65 women and 76 men who defined themselves as BDSM practitioners included in the study with the snowball technique through websites that are accessible on online BDSM groups. A control group (n=167) who stated that they were not BDSM practitioners was also recruited through websites. Sociodemographic and Sexual Behavior Evaluation Form and Arizona Sexual Experience Scale (ASEX) were used online to gather data.

Results: No significant difference was found between BDSM practitioners and controls with regard to ASEX scores. Yet, in women, the mean ASEX score was lower in BDSM practitioners than in the control group whereas in men, the mean ASEX score was higher in the BDSM practitioners.

Conclusion: Gender might be an important factor in terms of sexual functioning in cisgender BDSM practitioners. Awareness on problems of this sexual minority should be increased.

Keywords: BDSM, masochism, sadism, sexual behavior, sexual dysfunctions, stigma

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INTRODUCTION

BDSM is an acronym for "bondage-discipline, dominance-submission, sadism, masochism" (1). It is difficult to establish a precise definition of BDSM, but it often includes sexual behavior involving some type of exchange of power between partners and/or the use of pain for sexual pleasure, although there are sensations other than pain (1). These practices are based on the consent of individuals (2).

"Kink" is an umbrella term to address a wide range of erotic interests, identities, practices, and relationships (3). Although it is sometimes thought that "kink" always includes genital contact or orgasm, "kink" can serve different purposes. In a study conducted with 1580 participants from the kink community, 126 different forms of erotic stimuli were identified (4). Historically, BDSM has been associated with paraphilic disorders, as BDSM was thought to result from psychiatric illnesses, childhood traumas (5,6) or it does not include sexual behaviors that aim reproduction. DSM-5 includes diagnoses of sexual sadism disorder and sexual masochism disorder. The diagnostic criteria of these disorders emphasize that these practices should contain nonconsenting partners and they must cause clinically significant distress and loss of functionality (7). Having BDSM interests alone no longer meets the criteria for a mental disorder or a paraphilic disorder. It is stated that most BDSM practitioners do not differ from the general population in terms of depression, anxiety, and phobias (8). While sadomasochism is no longer considered a disorder in ICD-11, it has suggested to include some paraphilic disorders, mostly involving a lack of consent from the partner such as coercive sexual sadism disorder (1). These updates can be interpreted as a change to avoid stigma and establish higher tolerance for various sexual fantasies, urges, or behaviors.

Highlights

- **BDSM practitioner men and women show difference in terms of sexual dysfunctions.**
- **Difficulty in the ability to reach orgasm is significant in BDSM practicing men.**
- **The probability of sexual dysfunction was found to be lower in women practicing BDSM.**
- **BDSM group thought that they could not talk about their sexuality comfortably.**

Although BDSM fantasies and practices are common (9), the stigma associated with the sexual behavior of BDSM practitioners is still prevalent among healthcare providers (10). Less than half of kink-oriented patients receiving healthcare can talk about their sexual activities to healthcare providers because they are afraid of being stigmatized (11). BDSM practitioners may seek psychiatric support for both BDSM-related and different mental problems, but most healthcare professionals are not familiar with these practices (12). One of the consequences of prejudices of BDSM practices is that very few studies have focused on sexual functioning and related distress in this population (11).

In a study comparing groups with and without BDSM practices, it is reported that, apart from maintaining arousal, there was no significant

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difference between women in both groups in terms of distress in sexual functioning (13). For men, it is reported that sexual dysfunction is less common in BDSM practitioners, except for premature orgasm and anorgasmia (13). Botta et al. stated that very few of the participants describe distress related to BDSM activities (14).

To the best of our knowledge, there is no study on BDSM in Türkiye. The scarce of knowledge of BDSM practitioners' sexual lives, level of knowledge about sexual and mental health makes it difficult to provide a qualified health service to this community and contributes to prejudices. The aim of our research is to obtain information about the sexual lives, sexual behaviors, and sexual functioning of BDSM practitioners, to determine whether there is a difference about sexual practices between them and those who do not practice BDSM, and to provide clinicians with information about BDSM practitioners' sexual practices and problems, if any. Therefore, we aimed to test the hypothesis that cisgender BDSM practitioners do not differ from the general population in terms of sexual dysfunctions.

METHODS

A hundred and forty-one people (65 cisgender women, 76 cisgender men) aged 18 and over who defined themselves as BDSM practitioners were included in the study with both convenience and snowball techniques through websites that are accessible on the internet and BDSM groups in social networks. In order to reach our research sample in the most accurate way, the most popular Turkish-language websites and social networks used by BDSM practitioners living in Türkiye were chosen. The moderators of the selected websites were contacted and informed about the study. Persons who volunteered to participate were included in the study. The study was carried out with the Google forms survey application, which was sent individually to those who agreed to participate in the research via the internet. Consent was obtained from the participants who identified themselves as BDSM practitioners, and the questionnaire was administered completely anonymously to protect their privacy.

To reach the control group, another form was prepared (which only excludes BDSM practices) and was placed on two popular national websites. With the approval of the moderators of these websites, the control form was advertised. A hundred and sixty-seven volunteer participants (88 cisgender women, 79 cisgender men) who stated that they were not BDSM practitioners and filled out the form completely were determined as the control group.

While 4 trans women, 2 trans men, and 3 nonbinary participants answered the questions in the study group; the questions in the control group were answered by 4 trans women, 2 trans men, and 5 nonbinary people. However, transgender participants' data could not be included in the study, since the number of trans participants is quite small to pursue subgroup analysis.

Data were collected between 01.05.2021 and 31.07.2021.

Measurements

Sociodemographic and Sexual Behavior Evaluation Form

It is a questionnaire prepared by researchers that include questions about sociodemographic and sexual identity-related features, preferences in BDSM practices, sexual development histories, medical characteristics, and sexual health-related knowledge levels. In the form delivered to the control group, there is no statement about BDSM, except for a question asking whether they are BDSM practitioners. First, a BDSM definition was made and participants were asked if they identified as a BDSM practitioner. Then we questioned the sociodemographic characteristics. When questioning sexual identity-related features, definitions were made initially and the participants were asked to mark the option most suitable for them.

In the second part, the medical history of the participants has been questioned: whether they had been diagnosed with a physical or psychiatric illness in the past, whether they have attempted suicide, whether they have received professional help for a sexual problem in the past, whether they have been discriminated against during medical/psychological assistance due to their sexual practices, whether they delay seeking medical/psychological help because they think they cannot talk about their sexuality comfortably.

In the last part of the form, their sexual histories, practices, and sexual health knowledge levels were questioned.

The BDSM group was also asked about their roles in BDSM, their preferred BDSM practices, sexual intercourse during BDSM sessions, their preferred activities during BDSM practices, and at what age they first experienced BDSM.

Arizona Sexual Experience Scale (ASEX)

The scale developed by McGahuey et al. (2000) was prepared in a six-point Likert type, and has separate forms for men/women (15). The validity and reliability of the Turkish form of the scale were established, and the cut-off score of the scale was determined as 11 (16). The increase in score is directly associated with the severity of the sexual dysfunction. There are questions that examine sex drive, arousal, physiological arousal (vaginal lubrication/erection), ability to reach orgasm, and satisfaction from orgasm.

Statistical Analyses

All the data obtained in the study was analyzed using the IBM Statistical Package for Social Sciences (SPSS) program version 21.0 package program (IBM Inc., Chicago IL, USA). In the study, categorical independent variables were shown with frequency and percentage values; continuous variables with mean and standard deviation values. Skewness and kurtosis indices, histogram graph, QQ plot graph, and Kolmogorov-Smirnov normality test were used to determine whether the variables showed a normal distribution. Descriptive statistics were used to determine the participants' characteristics. Regarding the hypotheses, Chi-square analysis was used to determine history of psychiatric disorder frequency and the discrimination and help-seeking behavior of BDSM practitioners compared to the control group. An independent t-test was used to examine the hypothesis that BDSM practitioners do not differ from the general population in terms of sexual dysfunctions. In the post hoc power analysis, we assessed the statistical power of our study. The analysis revealed a power of 0.961 for comparing ASEX scores between female BDSM practitioners and the control group. For the comparison of ASEX scores among male groups, the study exhibited a power of 0.817. $P \leq 0.05$ was considered statistically significant.

RESULTS

There was no significant difference between the BDSM practitioners and the control group in terms of age, gender, and education level. The comparison of the general characteristics and medical/sexual histories of the BDSM practitioners and the control group is shown in Table 1.

The mean age of the participants to start BDSM practices is 24.1 (*SD*=4.12). In terms of the distribution of participants according to their BDSM roles, 17.7% (*n*=25) described themselves as submissive, 21.3% (*n*=30) as dominant, 44.7% (*n*=63) as switch (which can be flexible between dominant or submissive), and 16.3% (*n*=23) as other. Regarding the BDSM practices

Table 1. General characteristics of BDSM practitioners and control group

	BDSM Practitioners n (%)	Control Group n (%)	p values
Gender			
Female	65 (46.1)	88 (52.7)	0.249
Male	76 (53.9)	79 (47.3)	
Sexual orientation			
Heterosexual	85 (60.3)	132 (79.0)	**<0.001**
Homosexual	38 (27.0)	22 (13.2)	
Bisexual	18 (12.8)	13 (7.8)	
Marital status			
Single	122 (86.5)	84 (50.3)	**<0.001**
Married/partnered	19 (13.5)	83 (49.7)	
Having children			
No	123 (87.2)	136 (81.4)	0.166
Yes	18 (12.8)	31 (18.6)	
Educational level			
High school	8 (5.7)	11 (6.6)	0.740
University and above	133 (94.3)	156 (93.4)	
Working status			
Employed	122 (86.5)	150 (89.8)	0.528
Unemployed	10 (7.1)	7 (4.2)	
Student	9 (6.4)	10 (6.0)	
Information on medical history and sexual life			
History of physical illness			0.905
Yes	11 (7.8%)	13 (7.8%)	
History of psychiatric disorder			0.411
Yes	29 (20.6%)	29 (17.4%)	
Suicide history			0.053
Yes	24 (17.0%)	16 (9.6%)	
History of sexual violence			**0.019**
Yes	72 (51.1%)	63 (37.7%)	
	M (SD)	**M (SD)**	
Age	31.0 (5.17)	31.6 (5.27)	0.101
Age of first sexual intimacy	17.3 (3.37)	16.6 (3.82)	0.088
Age of first sexual intercourse	19.0 (2.86)	20.2 (3.36)	**<0.001**

p: p value, SD: standard deviation

that are most frequent, it was seen that 42.6% (*n*=60) of them practice bondage-discipline, 29.1% (*n*=41) dominant-submissive, 12.8% (*n*=18) sadism, 12.1% (*n*=17) masochism, and 3.5% (*n*=5) other practices. When it was evaluated whether there is vaginal and/or anal penetration during sexual practices, 12.8% (*n*=18) of the participants stated that they almost never had penetration, 60.3% (*n*=85) of them had penetration sometimes, and 27% (*n*=38) of them stated they had penetration frequently.

No significant difference was found between BDSM practitioners and controls with regard to ASEX scores. In women, the mean ASEX score was lower in BDSM practitioners than in the control group. In men, the mean ASEX score was higher in the BDSM practitioners. The comparison of ASEX item scores for each gender is given in Table 2.

A detailed comparison of the discrimination and sexual characteristics of both groups is shown in Table 3. To investigate differences in sexual attitudes among genders, we employed a chi-square test, analyzing both BDSM practitioners and control groups separately for each gender. Our analysis yielded no statistically significant differences in sexual attitudes between the genders.

Table 2. Comparison of ASEX item scores for each gender

	Female Participants (n=153)				Male Participants (n=155)			
	BDSM (n=65) M (SD)	Control (n=88) M (SD)	p	Cohen's d	BDSM (n=76) M (SD)	Control (n=79) M (SD)	p	Cohen's d
Drive	1.83 (0.63)	2.82 (1.23)	**<0.001**	**1**	1.99 (0.82)	1.86 (0.76)	0.36	0.16
Arousal	2.26 (1.09)	2.92 (1.17)	**<0.001**	**0.58**	2.41 (0.98)	2.11 (0.95)	0.6	0.31
Lubrication/ Erection	3.22 (1.49)	3.67 (1.31)	**0.047**	**0.32**	2.30 (1.05)	2.03 (0.95)	0.085	0.26
Orgasm	2.45 (1.12)	2.60 (1.34)	0.45	0.12	3.08 (1.24)	2.46 (1.21)	**0.002**	**0.5**
Satisfaction with orgasm	2.62 (0.82)	3.10 (1.01)	**0.002**	**0.52**	2.17 (0.93)	1.85 (0.91)	**0.03**	**0.34**

Independent samples T-test: values in parentheses indicate standard deviation.

Table 3. Questions about sexual attitudes

		BDSM n (%)	Control n (%)	p
Can you comfortably talk about your sexual desires and expectations with your partner (s)?	N	18 (12.8)	40 (24)	**0.018**
	Y	123 (87.2)	127 (76)	
Do you take into account whether the people you have sex with consent to your wishes/actions during the intercourse?	N	6 (4.3)	6 (3.6)	0.73
	Y	135 (95.7)	161 (96.4)	
Have you received any structured education about sexual health and sexuality in the past?	N	112 (79.4)	125 (74.9)	0.409
	Y	29 (20.6)	42 (25.1)	
Do you think you know enough about HIV and other sexually transmitted infections and prevention methods?	N	31 (22.0)	32 (19.2)	0.307
	Y	110 (78.0)	135 (80.8)	
Do you use an effective protection method (condom, etc.) for sexually transmitted infections during your sexual relations?	N	34 (24.1)	46 (27.5)	0.234
	Y	107 (75.9)	121 (72.5)	
Do you use an effective protection method during your sexual relations?	N/A	27 (19.1)	19 (11.4)	
	N	23 (16.3)	32 (19.2)	0.118
	Y	91 (64.5)	116 (69.5)	
If you come into contact with blood during sexual intercourse, do you think you take adequate precautions to protect yourself?	N/A	72 (51.1)	126 (75.4)	
	N	52 (36.9)	16 (9.6)	**<0.001**
	Y	17 (12.1)	25 (15.0)	
Do you masturbate regularly?	N	18 (12.8)	55 (32.9)	**<0.001**
	Y	123 (87.2)	112 (67.1)	
Have you sought professional help for a sexual problem in the past?	N	107 (75.9)	136 (81.4)	0.189
	Y	34 (24.1)	31 (18.6)	
Have you been discriminated against due to your sexual practices and sexuality during any medical/psychological assistance you have received in the past?	N	64 (45.4)	153 (91.6)	**<0.001**
	Y	77 (54.6)	14 (8.4)	
Have you delayed seeking medical/psychological help because you thought you could not talk about your sexuality comfortably?	N	53 (37.6)	141 (84.4)	**<0.001**
	Y	88 (62.4)	26 (15.6)	

Chi-square test.
N/A: Not applicable (Does not meet the condition of the question.); N: No; p: p value; Y: Yes.

DISCUSSION

In the female group, the reported rate of sexual dysfunction was lower in the BDSM group. In the male group, the reported rate of sexual dysfunction was higher in the BDSM group. While there was no difference between the BDSM group and the control group in terms of medical history; BDSM practitioners reported significant difficulties in accessing healthcare services due to discrimination.

We suggested that BDSM practitioners would not differ from the control group in terms of sexual dysfunctions. A shift in power dynamics is at the heart of the BDSM plays (17). When we look at the frequency of the participants in our study according to their BDSM roles, almost half of them defined themselves as a "switch". It is stated that a significant subgroup of BDSM practitioners switches between dominance and submission depending on different factors such as mood and partner (18). Therefore, it is conceivable that the power preference in BDSM may not always be constant over time. When evaluating whether there is vaginal and/or anal penetration during sexual practices, about a quarter of the participants stated that there was frequent penetration in our study. Botta et al. (2019) states that 54.6% of male participants and 63.2% of female participants often/always prefer penetration during BDSM practices (14). The exchange of power between partners is sexually arousing for most practitioners. Even in the general population, it is reported that the exchange of power between the partners during sexual intercourse and the behavior of domination/submission are stimulating (19). Therefore, BDSM practitioners may not always need sexual intercourse to maintain arousal or orgasm. Considering the ASEX scores in the study, the probability of sexual dysfunction in both the BDSM and control groups

was higher in the female sample, while the ASEX scores were higher in the control group than in the BDSM practitioner women. It is observed that there are difficulties in sex drive, arousal, and vaginal lubrication functions in women in the control group. It is reported that during BDSM practices, women may have less anxiety about their bodies and sexual performance, express themselves more easily and freely, and may have less difficulty in maintaining arousal (13). This may explain the lower scores of sexual dysfunctions in BDSM practitioner women in our study.

In the male participants group, the probability of sexual dysfunction was higher in the BDSM practitioner group. In the BDSM group, difficulty in the ability to reach orgasm and satisfaction from orgasm functions is significant. To understand whether a sexual problem can be considered as sexual dysfunction in the BDSM group participating in our study, it is necessary to first understand whether it causes distress in participants. In the study of Pascoal et al. (2015), although premature orgasm and anorgasmia were equally disturbing individual sexual problems in both BDSM and non-BDSM male groups, no significant difference was found between the two groups (13). BDSM activities can be based on various plays in which intercourse or orgasm are not in the foreground (13,19). Early orgasm may cause more problems in the BDSM group than in the control group, as it may interrupt the scene in the BDSM group due to the difficulties experienced by men in the refractory period in arousal after orgasm. Therefore, premature ejaculation in men participating in our study may not be desired in BDSM practices, so ejaculation may take a long time, and the orgasm experienced before the planned moment may cause dissatisfaction because it interrupts the activity. Further studies are needed to understand the reasons for the described difficulty in ejaculation in BDSM practitioner men.

According to the reports of the online participants, no difference was found between the groups in terms of physical and psychiatric illness and past suicide attempts in this study. The belief that psychiatric disorders are more common in BDSM practitioners has been disproved by studies showing that their psychological functioning and attachment styles were not different from the general population (8). The results of our study supports the opinion that being a BDSM practitioner does not increase the susceptibility to psychiatric disorders. In our study, participants were asked about their psychiatric background and no scale and interview were applied to detect any psychopathology. This is an important weakness of our study. Studies including more detailed psychiatric interviews are needed to discover the frequency of psychopathology in BDSM practitioners.

In our study, the reported rate of sexual violence in the past was higher in the BDSM group than in the control group. Although studies suggest that there is no relationship between trauma and BDSM behavior (20,21); 7.9% of the males reported sexual abuse compared to 1–3% in the general population in a study investigating the history of childhood abuse in BDSM practitioners; and in women, it was found to be 22.7% and 6–8%, respectively (22). The rates of discrimination against sexual minorities are high (23). Discrimination against BDSM practitioners due to their non-normative sexual practices can be similarly high. Larger-scale studies are needed to elucidate the relationship between trauma and BDSM.

According to our results, more than half of the BDSM practitioners reported that they were discriminated due to their sexual practices and sexuality during a medical/psychological assistance they received in the past. Moreover, most of the BDSM group stated that they postponed seeking medical/psychological help because they thought that they could not talk about their sexuality comfortably. Waldura et al. (2016) state that less than half of kink-oriented patients receiving healthcare can talk about their sexual activities with healthcare providers because they are afraid of being stigmatized (11). Increased stigma by healthcare providers leads to non-disclosure of kink involvement and delay in seeking care (24). If healthcare professionals gain sufficient knowledge about the practices of BDSM practitioners, it may improve the discrimination experienced by patients with BDSM practitioners in accessing healthcare.

In the context of BDSM, participants ideally interact voluntarily with predetermined consent based on a mutual understanding of what activities will take place (2). Therefore, BDSM communities care about the rules regarding the boundaries of safe and consensual BDSM (25). In our study, BDSM practitioners reported talking about their sexual desires and expectations more comfortably with their partners, while there was no significant difference between the two groups about getting the consent of their partners during intercourse, taking precautions regarding sexually transmitted infections and contraception.

All of the BDSM practitioners participating in the research are at least high school graduates and most of them are working. The number of single people in the BDSM group is higher than it is in the control group. It is stated that 17.6% of the participants who practice BDSM describe their relationships as non-monogamy, 21% as dating, and 15.1% as polyamory (21). The high number of single people in the BDSM group may be due to the fact that they do not prefer monogamous relationships. The age of first sexual intercourse was lower in BDSM practitioners. This result is consistent with research showing that BDSM practitioners experience more sexuality throughout their lives and have sex at an earlier age (26). Although there was no difference between the groups in terms of age, gender, and education, when considered in terms of sexual orientation, it was seen that the rate of those who stated that they were homosexual or bisexual among BDSM practitioners was higher than the control group. In a large-scale study conducted in Australia by Richters et al. (2008), BDSM practices were found to be more common among homosexuals and bisexuals (20). In an online study, it was stated that almost half of those who stated that they were masochists were bisexual or homosexual (17). The struggle against the stigma that claims that queer sexuality is wrong can be cited as a factor in the easier acceptance and spread of BDSM practices within the queer community (27).

This study has some limitations. Participants were gathered through the internet using forums and social media accounts. We can guess that the high education levels in the study is a function of the online surveys, since people with higher education will be more likely to respond to online surveys. Accessing and effectively using internet is more common in people with higher education. Since internet use and access to these areas are easier for socioeconomically advantaged individuals (13), it may be possible for this group to reach the study. Since the data is collected online, there may be problems with the reliability of the participants and the answers. This may affect the reliability of the study results. To minimize this problem, we did not put the BDSM form on a general website and carefully shared it on a limited platform with BDSM practitioners. Also, we kindly asked the participants to share this form only with their BDSM practitioner friends. Because the study is an online survey, rates of attrition is not known exactly. In the advertisement of the form prepared for the control group, it was stated that the study was about sexual practices, and sexual dysfunction was not mentioned. However, it may still have caused a slight increase in the participation of individuals with sexual dysfunction. Since this is the first study conducted on the BDSM group in Türkiye, using an anonymous online questionnaire has helped us reach a difficult-to-reach group more widely. Although the participants were not asked for their identity information, some participants may have wanted to refrain from participating in the study due to security concerns. BDSM was defined in the informed consent form and it was stated that those who defined themselves as BDSM practitioners should fill out the study form, but the difficulties in determining the boundaries of BDSM may have been confusing for the participants. While only

cisgender participants were included in the study, trans and nonbinary participants were not included. The fact that there were people with different orientations among the cisgender participants may also have affected the difference in terms of the discrimination they were exposed to. Also, it is known that BDSM practices are not only about sexuality and can be applied by people in the asexual-spectrum. Further studies with participants from all gender identities are needed.

In conclusion, in our study, no difference was found in the history of psychiatric illness reported by BDSM practitioners when compared to the general population. Men and women BDSM practitioners show different characteristics in terms of sexual dysfunctions. Since the perception of sexuality is thought to differ culturally, it would be helpful to conduct similar researches in different societies. The discrimination reported by the BDSM practitioners negatively affects their help-seeking behavior and also makes it difficult to conduct research on this group. Therefore, it is important to raise awareness of this issue, both in medical settings and in the public.

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