Beyond Whips & Chains:

What Medical Students Need to Know about BDSM

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What This Presentation IS:

- It IS about how we, as future physicians, can take a patient-centered approach to treating practitioners of consensual BDSM
- It IS a work in progress, open to community & physician input, and subject to revisions, as I learn more and research reveals more
- It DOES include explicit discussion and images of sexuality
- It IS a final project from the inaugural class of AMSA's Sexual Health Scholars Program

What This Presentation ISN'T:

- It ISN'T going to tell you what kinds of sex you should have
- It ISN'T going to tell you how you should feel about other people's sexual practices
- It ISN'T a comprehensive source of information on safe BDSM practices
- It ISN'T specifically for BDSM practitioners on how to get good care from doctors

We're Going to Be Talking About:

- Basic definitions and vocabulary
- Why sexual health & BDSM matters
- WHO is practicing BDSM & WHY they do it
- WHAT people are doing & how they stay SAFE
- What medical school teaches
- Common misconceptions
- Patient-centered care for BDSM practitioners
- Distinguishing abuse from consensual play
- Case studies & resources for more information

Your Experience Is A-OK

- These are some heavy duty topics!
- All different types of people will be reading this presentation or sitting in this room.
- One person may already be an expert with a bullwhip. Another person might blush bright red at the first mention of sex. Someone else could be curious & neutral.
- Your experiences, emotions, reactions, and analysis may be completely different from another person's here. And that's okay!

Your Experience Is A-OK

- You are invited to feel whatever you feel while discussing these topics and seeing these images
- This is a time and place where you can work through big feelings – "Yay!" OR "Yuck!" – to avoid encountering those feelings for the first time with a patient
- And it's where you can begin to get the knowledge, attitudes, and skills to offer clinical care that is professional, non-judgmental, and culturally competent for future patients who practice BDSM
- Questions are welcome!

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This Wasn't In Stedman's Medical Dictionary… What Does BDSM Mean?

- Different geographical and sub-cultural communities use terms differently and definitions change over time

- So it's important to ask patients what they mean when they are using these words

- But here is some basic vocabulary so we can talk about BDSM practices for right now…

“BDSM”:

- This is a combination acronym that stands for
  - Bondage & Discipline (B/D)
  - Dominance & Submission (D/s)
  - Sadism & Masochism (S/M)

- Sometimes colloquially referred to as “kink” or just “S&M”, “SM”, or “S/M”

- “Leather” -community, -sex, or -people refers to broadly similar concepts, more often but not exclusively in a gay or lesbian context

- A critical component of all these activities is CONSENT – all participants freely choose them without coercion or force

Or In Other Words

BDSM is:

- "an activity in which the participants eroticize sensations or emotions that would be unpleasant in a non-erotic context. … the participants have one another's well-being as their paramount goal."

  - From The Topping Book

- "the knowing use of psychological dominance and submission, and/or physical bondage, and/or pain, and/or related practices in a safe, legal, consensual manner in order for the participants to experience erotic arousal and/or personal growth."

  - From SM 101

“Vanilla”

- Sexual activities or orientations that are NOT related to BDSM are called “vanilla”

- This term doesn’t have pejorative origins – vanilla ice cream is great! But it’s also the “default” flavor for sex and ice cream

Specific Roles

Generally during BDSM interactions one person is directing/guiding the activity or giving sensation.

- This person is typically called the "top", "dominant/dom/domme", or "master/mistress" depending on the context or relationship

- If this person specifically enjoys consensually giving intense sensation or pain to their partner in an erotic context, they also may be called a "sadist"

- The other person is following/responding to the direction or receiving the sensation.
  - This person is typically called the "bottom", "submissive", or "slave" depending on the context
  - If this person specifically enjoys consensually receiving intense sensation or pain from their partner in an erotic context, they also may be called a "masochist"
- A "switch" is a person who can enjoy different roles at different times or with different partners.

A DUNGEON is a room specifically set up for BDSM activities. It is typically furnished with BDSM equipment.

A SCENE is a specific BDSM encounter, lasting for minutes, hours, or days. It can also refer to the BDSM community.

- BDSM activities and interactions are often called PLAY.
- Implements and tools like whips, canes, or clamps can be referred to as TOYS.
- These phrases emphasize the theatrical & creative nature of BDSM.

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Why Should I Care About Sex?

- Sexual health care is part of comprehensive “whole person” health care
- Our patients WILL have questions about sex
- But many WON’T feel comfortable asking us - and we may not feel confident talking to them
- Education & integration of sexual health into clinical practice leads to better outcomes
- Your med school probably hasn’t taught you enough – so learn all you can!

Sex Education Is Fine.
But Why Should I Learn About BDSM?

- Because many of your future patients will do it

- So that you can:
  - Provide patient-centered , culturally-competent care
  - Practice preventive health
  - Improve patient adherence
  - Increase referrals to your practice

- And because the portrayal of BDSM in pop culture is inaccurate & insufficient for professional clinical care

Many of My Patients Do This?!?

- Studies report ranges from 1-25% of the population is or has been involved in BDSM activities (Richters et al 2003, Wiseman, 1996), with higher percentages reporting an interest in these activities.

- Overall estimates of about 10% are common (e.g. Moser & Kleinplatz, 2006 or Easton & Liszt, 2000).

- You WILL have patients who practice BDSM, whether or not you know it…

How will you treat them?

Preventive Health & BDSM

We can empathetically and non-judgmentally help keep our patients safe & healthy by:

- Helping patients understand how their individual health profile may affect their BDSM activities
- Preventing kink injury through general safe practices & harm reduction
- Ensuring that patients feel comfortable coming to the doctor as soon as they need care
- Screening patients for abusive relationships

Patient Voices: Delaying Care

I developed a urinary tract infection but didn't want to go to the doctor because I had flogging marks on my back and ass. The UTI got worse and worse until I started pissing blood and eventually went to the ER but was scared the whole time that I'd be treated badly.

-- S.K.

I had soreness and fissures in the anal area, and could not come up with a "safe" story to tell my doc as to how they might have gotten there. (Somehow telling him I shoved dildos up my ass while my wife used a strap-on on me was a bit difficult to say.) Needless to say, I said nothing.

-- subslutd

I've delayed, rescheduled, or missed several doctors appointments because the play I engaged in recently ended up leaving more markings than we thought.

-- D.S.

When Will This Matter For My Practice?

- As a future doc, BDSM may be relevant in several different situations:
  - When a patient wants advice on playing safely
  - When a patient's medical condition requires modification or limitations in their play
  - When BDSM practices directly cause injury (rare)
- These issues can come up in primary care or in any specialty, so we ALL need to know this

When It Matters

- When a patient wants advice on playing safely
  - advanced bondage (breast, genital)
  - play-piercing
  - breath control
  - anal play
  - nipple piercing and breast-feeding

When It Matters

- When a patient's medical condition requires modification or limitations in their play, e.g.:
  - MS: fatigue, overheating, numbness, coordination, sexual dysfunction,
  - CAD, HTN: level of exertion,
  - Diabetes: avoiding hypoglycemia,
  - Asthma: need quick-release restraints, no chest or breath restraint,
  - Epilepsy: awareness of aura, what to do if seizure occurs,
  - LBP, arthritis: avoid putting strain upon joints (usually should avoid this anyway)

When It Matters

- When BDSM practices directly cause injury (rare)
  - Fainting or dizziness
  - Bondage-related - causing nerve damage, joint strain, numbness, or a fall
  - Problems releasing retained rectal objects
  - Accidental injury from a misplaced paddle stroke or knife slip

Patient Voices: Medical Questions

I would like to know what limits someone would have with a 3.8cm aortic aneurysm in the stomach. What about electric play on the testes, flogging, and a butt beating? --Elambus

I've recently been told that my bone density is poor… So my guess is that my heavy flogging days are over. Can anyone shed some light on the actual risks of this, or how I might be able to still continue with what is one of my most favorite kinks? Can I still work with lighter floggers? What about crops, singletails, etc? Would angle of approach make a difference? Or do I just need to end impact play to my back altogether? -- Wendy

I was diagnosed with iron deficiency anemia this weekend and I was wondering if there was anything I needed to know if I was going to play?
-- Tifga

I have TMJ problems. Will getting slapped in the face affect my long term prognosis? Are there things I can do to reduce the effect on this joint? -- S.K.

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WHO Is Doing This?

- All different kinds of people practice BDSM: men, women, gay, straight, single, married, young, old, rich, poor, well-educated, barely educated, of every race, religion, political leaning, and background

- Your bank teller, attorney, mechanic, nurse, boss, best friend, colleague, or children's teacher could be kinky

- Nothing about how a person looks or acts can definitively identify them as a BDSM practitioner

- As clinicians, the only way to know is to ASK

- There’s not a clear line between BDSM and vanilla
- Many people enjoy activities like sensual scratching, nibbling or biting, hair pulling, blindfolds, furry handcuffs, pinning a partner’s wrists down, or gentle spankings
- Some of these people will identify their activities as BDSM, and some people won’t – and that’s fine

- Mainstream sex advice books often include tips on sexual games like the activities described previously to add spark to a relationship - even the Kama Sutra made suggestions about love bites and the most seductive types of scratches and slaps

- This range of activities can be considered a continuum, but everyone gets to decide for themselves whether what they are doing is BDSM

Patient Voices: Why We Play

Endorphins feel good that is why we all do this, the medical community needs to be better educated and not judgmental.
-- Anonymous, nurse for 20 yrs

A good scene is an incredible stress-reliever for both myself and my dominant. It gives us the opportunity to escape the real world, so to speak, for at least a short time and focus entirely on one another… On the psychological side, it's strengthened our bond to one another, deepened our understanding of ourselves, and opened up a much wider path of communication not only between one another, but to other people in general. -- Jenn

I have chronic back stuff, and work is stressful, and I have asthma, and have had a flogging help a LOT with stress, relieve my chronic mid-thoracic pain, and interestingly help with my asthma flair too!
-- Laurel, D.O. (osteopathic physician)

Why Do People Practice BDSM?

- For reasons similar to why people have vanilla sex: connection, sensation, intimacy, creativity, intensity, stress relief, and pleasure
- For some people, BDSM is a central part of a spiritual practice
- Basically, people do it because they like it & it feels good
- While BDSM play can appear scary or unpleasant to outside observers, it's important to remember:
  - What it looks like is different from what it feels like!

But It HURTS, Right?

- Well, sometimes! - There is a wide variety of activities that can be described as BDSM
- Some do involve very intense physical sensation
- Other activities still involve a consensual power dynamic between the top and bottom, but may be entirely focused on controlled sensual experiences, role play, immobility, or emotional interactions
- For instance, if an “evil pirate captain” captures a bottom, gently binds her hands with silk scarves, tickles her feet and feeds her chocolate, is that BDSM? Only the participants get to decide, but it certainly could be

If It's Painful, Why Do It?

- BDSM activities often involve objectively intense sensation, but processing of that sensation is very subjective and varies between people and over time

- The bottom may experience it as pain (and still happily choose to continue) or the bottom may experience that exact same intense stimulation as very pleasurable

- Many BDSM participants report enjoying the endorphins & adrenalin rush of play, similar to the well-known "runner's high"

If It's Painful, Why Do It?

- Research is being done about the neurochemistry of pain, pleasure, and connection

- One study showed increased oxytocin (sometimes called the couple-bonding hormone) and reduced cortisol (stress hormone) levels in couples immediately after a BDSM scene (Sagarin et al, 2009)

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WHAT Are They Doing?

- Consensual BDSM play can take a nearly infinite variety of forms
- One person's play can be *totally* different from another person's play
- So again, it's important to talk to your patient and ask them what they are doing
- But here are some broad categories and photographs to build general familiarity with some practices:

Bondage

- Bondage involves restricting movement for functional, psychological, or aesthetic reasons and can involve:
  - Rope
  - Metal Handcuffs
  - Leather wrist/ankle cuffs
  - Other items (special bondage tape, saran wrap, straight jackets, etc…)
  - Full body or specific parts

Role Play

- Dress up play:
  - French maid
  - Schoolgirl
  - Pony or puppy
- Invoking archetypes:
  - Queen, Goddess
  - Inquisitor
- Enacting roles like:
  - Boss / employee
  - Warden / prisoner
  - Pirate / captive
  - Master / slave

Dominance / Submission

- Various dynamics, interactions, rituals, and agreements intended to emphasize the consensual control of one person over another

- Can involve service (domestic or sexual), special body positions, humiliation play, varieties of training, worship, etc

Impact Play

- This play may involve:
  - Whips
  - Floggers (like a short whip with many strands)
  - Canes
  - Riding crops
  - Paddles
  - Spanking or other impact with hands
  - Other types of toys (quirts, slappers, etc)

Temperature & Fire Play

- This play can involve:
- Ice cubes
- Hot wax
- Fire play (lighting & immediately extinguishing liquid alcohol)
- Fire cupping (heating glass cups that cool and create suction – as shown here)

Sharp & Pointies

This can involve:

- Knife play (w/o cutting)
- Cutting (shallow)
- Wartenberg wheels
- “Play piercing” (temporary insertion of hypodermic needles or sterile jewelry)
- Temporary surgical stapling

And other activities…

- Electricity play (e.g. violet wand, TENS unit)
- Clamps (e.g. clothespins, nipple clamps)
- “Cell popping” or light branding
- Erotic boot blacking
- Sensory deprivation
- Play with latex or leather
- Sensual play with silk/fur

- Imagination is the limit!!

But What About… SEX?

- A BDSM scene, though it typically involves erotic energy, may or may not involve genital sex
- Some genital sexual activities are considered BDSM by some people and not BDSM by other people (e.g. vaginal or anal fisting, strap-on sex with dildos)
- Most BDSM participants also have vanilla sex, even if it is separate from their BDSM play – it's not either/or
- For some people, kink IS sex

OK, But What About Safety?!?

- Safety is central to BDSM communities & is maintained in several ways:
  - SSC / RACK standards
  - Safewords
  - Pre-scene negotiation
  - Safety trainings and educational programs
  - Advanced communication skills

SSC/RACK

- SSC or RACK are common BDSM play guidelines
- SSC = Safe, Sane, and Consensual
  - Play should be safe (don't hit the kidneys), sane (don't amputate a leg even if it seems sexy), and consensual
- RACK = Risk-Aware Consensual Kink
  - Some people prefer this term because it acknowledges that all activities involve some risk but that informed adults can choose to consent to the risk
- Did we mention consent?
  - Underage people, intoxicated people, and coerced people are unable to give consent

Safewords

- A safeword is a code word or signal that the top and bottom agree will immediately stop a BDSM scene
- It indicates an unexpected serious emotional or physical situation and withdrawal of consent
- A safeword can be “no” if both partners agree, but since some people enjoy the illusion of non-consent, it’s common to use unrelated code words like “red”, “pineapple”, or “Nepal”
- A bottom that is gagged or unable to speak can shake a rattle or stomp 3 times as a safeword

Negotiations

- Remember: What it looks like is different from what it feels like
- What looks chaotic & forced from the outside is actually pre-planned and consensual
- Play partners typically go through extensive negotiations before a scene, discussing likes, dislikes, medical and personal limits, safewords, roles, expectations, needs, scope of play activities, and genital sexuality & safer sex
- Each person's limits are respected

Workshops & Education

- There are many books & active online discussion forums about safer practices

- Hundreds of local groups conduct educational workshops, social events, and play parties where BDSM participants learn safe techniques

Other Safety Precautions

- Most semi-public BDSM events involve “Dungeon-” or “Playspace-Monitors” who help ensure that everyone is playing safely
- Ongoing checks during play: e.g. a top will pause from whipping a bottom in order to check the circulation in that bottom’s bound hands
- BDSM equipment that can look intimidating is designed for comfort, like fur-lined leather wrist cuffs
- All these practices allow for the safer practice of BDSM, a paradox described as “looks real scary, feels real comfy” (-- Dossie Easton & Janet Hardy)

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Why Didn't They Teach Me About All This Stuff in Medical School?

- Well, maybe they did

- But you may have learned more about what THIS guy thought than what non-clinical BDSM community research has demonstrated

- Most medical schools only mention BDSM in the context of psychiatry and sexual disorders

- The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) is the psych field's official guide to describing and classifying psychopathology

- The DSM-IV-TR classifies Sexual Sadism & Sexual Masochism as Sexual Disorders - the "Paraphilias"

- This section has been heavily influenced by the theories of Sigmund Freud and Krafft-Ebing – 19th & early 20th century theorists with many ideas about sexuality that are considered outdated or discredited

Current DSM-IV-TR criteria allow for a diagnosis of psychopathology if a patient:

- Has BDSM desires OR has participated in BDSM

AND

- Has experienced distress/impairment OR has non-consensually forced these behaviors on others

- That either/or stuff is important!

- It allows for the diagnosis of an otherwise healthy person who is struggling with the coming out process but is only interested in consensual BDSM play

- This diagnosis is fairly controversial
- Consensual sexual practices can be *different* without necessarily being bad or sick
  - (the DSM also used to say that gay people were automatically mentally ill too)
- No research has shown that BDSM practitioners have anything in common with each other besides liking BDSM
- Many researchers have criticized the DSM as reflecting social standards rather than neutral assessments of mental health (e.g. assuming that heterosexual vaginal intercourse is the ideal)

Turns out that the DSM-IV is currently under revision and status of the Paraphilias is being hotly debated right now. Stay tuned for the DSM-V in 2013!

Patient Voices: Mental Health

A mental health provider should do a quick assessment on a patient who discloses kinky activities to make sure that it is consensual and not harmful, using the criteria of functionality. If the kink is consensual and does not impact the person's ability to function, it is NOT pathological.

I can see this helping people who have serious mental health issues that impact on their decision-making skills. Even if they are a consensual kinkster, their mental illness may still cause them to make decisions that are harmful, just as a vanilla person can, such as dysfunctional, codependent, or destructive relationships.

If the mental health professional labels ALL kinky relationships as destructive, then any potential for helping the person with a genuine problem relating to their mental illness is gone.

-- B.G.

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Common Questions & Misconceptions

Q: Do people practice BDSM because they were abused as children?

A: No

- Some vanilla people were abused as children, and some weren't. Likewise some BDSM practitioners were abused as children and some weren't.

- Moser (2002) reports that there is no evidence that the incidence of childhood abuse is different within and outside the SM community

Q: Are BDSM practitioners crazy?
A: No

- Cross & Matheson (2006) conducted empirical research on a non-clinical population of BDSM providers and "found no support for the view that sadomasochism is an illness – [their] measures of mental illness did not differentiate sadomasochists from non-sadomasochists"

- Connolly (2003) "Indeed, if anything, our findings suggested that members of the BDSM community are less likely than others to present with major disorders…Moreover, BDSM players had no greater levels of psychological sadism or masochism, disorders in which the sufferer either derives pleasure out of genuine cruelty (not the play-acting kind) or compulsively seeks out harmful levels of pain"

Q: Is BDSM the same as abuse?

A: No

- BDSM practices are neither an indication of NOR protection from abuse
- Many BDSM communities do substantial work to educate members on the warning signs of abuse and unhealthy relationships
- There are many ways to distinguish abuse from BDSM. Some examples are included in this list from a kink organization on the next few slides:

- **SM:** An SM scene is a controlled situation.
- **ABUSE:** Abuse is an out-of-control situation.

- **SM:** Negotiation occurs before an SM scene to determine what will and will not happen in that scene.
- **ABUSE:** One person determines what will happen.

- **SM:** The “bottom” has a safeword that allows them to stop the scene at any time should they need to for physical or emotional reasons.
- **ABUSE:** The person being abused cannot stop what is happening.

- **SM:** Knowledgeable consent is given to the scene by all parties.
- **ABUSE:** No consent is asked for or given.

- **SM:** Everyone involved in an SM scene is concerned about the needs, desires and limits of others.
- **ABUSE:** No concern is given to the needs, desires and limits of the abused person.

- **SM:** The people in an SM scene are careful to be sure that they are not impaired by alcohol or drug use during the scene.
- **ABUSE:** Alcohol or drugs are often used before an episode of abuse.

- **SM:** After an SM scene, the people involved feel good.
- **ABUSE:** After an episode of abuse, the people involved feel bad.

Q: Are physicians legally mandated to report consensual BDSM as suspected abuse?

A: No

- All states require physicians to report suspected child or elder abuse
- Some states require physicians to report suspected domestic abuse / intimate partner violence, but consensual BDSM is not abuse and does not need to be reported under those statutes
- Laws vary state-to-state regarding mandated reporting of specific types of wounds (e.g. intentional wounds from knives, guns, etc.) This may be independent of consent, or may depend on assessment of “criminal intent”. Know the laws in your state!

Q: But is it a problem if I report all BDSM activities?
A: YES!

- BDSM practitioners often face legal discrimination in several areas:
  - Child custody
  - Security clearances
  - Employment

- As a result, BDSM practitioners may be reluctant to disclose their consensual activities for fear that your actions as a physician may place them in serious jeopardy, even if they are in healthy, consensual, and safe relationships

Quick True/False Quiz:

- Only (men or women) are tops, and only (men or women) are bottoms - FALSE
- BDSM leads to criminal activity - FALSE
- In real life tops are all wimpy or all mean and bottoms are all executives or all sniveling - FALSE
- BDSM is anti-feminist or degrading to women - FALSE

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Patient Voices: Fears

I'm currently trying to induce lactation [as part of BDSM activities] and have a concern that I won't be able to get proper breast examinations because of it. My mother had breast cancer in her 30's and I need to be checked, but I've heard doctors don't examine if there is milk expressing, so that's a concern as well.

-- D.S.

I had a sub that had multiple sclerosis. She went to the emergency room often. Lucky for me the ER docs never noticed marks. Her regular doctor knew what we were in to, but I was always nervous about her going to the ER cause they would have called the cops, then what? I would have been in the slammer. Just so much as a red mark could land a dom in the slammer… The medical community needs to know and understand more about people like us.

--FlotsamNJetsam, concrete repairman

Checking Ourselves

- Providing excellent patient-centered care about sensitive topics like sexuality requires us to understand our own personal biases

- If we know where we're coming from, it is easier to interact non-judgmentally, helpfully, and professionally with patients, even if their practices or value systems happen to be different from ours

- Consider your own response to the following scenario:

Pretend for a moment that you're a doctor, and a man comes to your office to have you treat his broken leg…

"How'd you break the leg, Charlie?" you ask.

"Football game," he answers, wincing as you examine the break. "I went out long and my buddy Steve just tagged me."

You set the bone and it heals, and Charlie is fine.

But six months later Charlie is back again, this time with a smashed finger.

"What happened, Charlie?" you inquire.

"Football again," he replies. "I was holding the snap and I didn't get my hand out of the way fast enough when Tom kicked the ball."

You put his finger in a splint and in a few weeks Charlie is fine again.

But three months later Charlie is brought in on a stretcher with what turns out to be a concussion.

"What happened this time, Charlie?" you ask.

"Football," he says in a blurry voice. "That new guy, Frank, has a really mean block, and I just got hit."

As a responsible physician, you'll probably advise Charlie to be a bit more careful in his game, but you're not likely to suggest that he's emotionally disturbed, or that he should stop playing football - and if you did, Charlie might well think you were overstepping your bounds: he likes to play ball, it's good exercise, it's a chance to unwind with his friends, and, well, you take a few risks to have a good time in life.

Now imagine the same set of scenarios, but each time Charlie comes to your office the reason he gives for his bruises and scrapes is that he likes to be whipped, or he likes rough sex.

Now do you think he's in need of psychotherapy to cure what ails him? Now would you suggest he stop doing what he enjoys?

Assessing Personal Biases

Take a moment to consider the following questions:

- Do you think that BDSM practitioners should not hold certain jobs or social positions? If so, why?
- How do you think you would feel if a family member came out as kinky?
- How do you think you would feel if an established patient suddenly came out as a BDSM practitioner?

Values and Attitudes

What are your first reactions to the following statements? How strongly do you agree or disagree and why?

- I am comfortable talking with my patients about sexual behaviors other than penile-vaginal intercourse.
- Being kinky is a lifestyle choice.
- I would be upset if someone thought I practiced BDSM.
- If an adult child of mine came out as kinky, I would think I did something wrong as a parent.

Patients Are Unlikely to Disclose BDSM Until They Know It's Safe to Talk to You

- Remember that a patient walks into your office with a lifetime of experiences that affect their fears, hopes, and expectations
- They may also carry worries from stories they've heard from other people
- When clinicians initiate non-judgmental discussions of sexuality, patients are more likely to be honest about their practices

Patient Voices: Deceiving Docs

I've lied to doctors who saw bruising on my stomach and said my sister and I got into a "slap fight" over clothing. (Not at all true, but less "odd")

-- D.S.

I had heavy rope marks horizontal on my chest above my tits from a bondage session. Of course the doctor asked about the (for her) strange marks. So I told her I was wondering myself, but I guess it could be from the chest strap from a heavy backpack during a long hike the weekend before. She took that – even though I don't think she really believed it.

-- Dev F

I would never tell my doctor that I am a masochist. I met a woman whose doc had made a note of it in her medical records, which were reviewed by her insurance company when she was diagnosed with breast cancer. Her policy was cancelled because she had not disclosed that she participated in risky sexual behavior, and she had to file bankruptcy because she couldn't pay the bills for her cancer treatment.

-- anonymous

Taking a Comprehensive Sexual History

- Introduce the subject
- Assure & maintain confidentiality
- Normalize a wide variety of behaviors
- Ask about partners, activities, and concerns
- Remember that medical risk is primarily related to specific practices, not identity
- Check out the resource guide for excellent articles about taking a sexual health history

Suggested Key Phrases

- Begin with: “Sexual health is important to overall health; therefore I always ask patients about it. If it’s ok with you, I’ll ask you a few questions about sexual matters now.”

- “My patients participate in a wide variety of sexual practices, including oral, anal, vaginal intercourse, sex toys, as well as role play, bondage, intense sensation, or other activities. Different activities have different health risk factors and implications for how I can best care for you. What types of sexual activity do you participate in?”

- Finish with: “Do you engage in any sexual activities about which you have health questions?”

Hints for Patient-Centered Care

- Ask questions about new terms & activities
  - “You say you enjoy ‘breath play’ – can you give me more details about how you and your partner engage in this activity?”

- Be honest about what you do and don’t know
  - "I don't know much about that activity, but I'd like to learn in order to make sure to give you the best care. If you feel comfortable, would you tell me more about this?"
  - or “Let me read more about this activity and consult with my colleagues to find answers to your questions.”

Hints for Patient-Centered Care

- Ask relevant questions, but beware of unprofessional questions designed to satisfy your personal curiosity

- In general, use the patient's own language to describe their identity and relationships
  - Someone who calls herself a "bottom" may be irritated if you assume she's also "submissive"
  - Be cautious with reclaimed in-group terms, even if the patient uses them (e.g. "fag", "pervert", etc.)

- Ask if the patient has any medical concerns or questions about his or her play

Hints for Patient-Centered Care

- Give bottoms and masochists the same amount of pain medication as anyone else when appropriate
  - Just because a person can eroticize pain in specific contexts does NOT mean they enjoy the uncontrolled pain of a stubbed toe or broken arm

- Treat all patients – including submissives –with respect
  - Eroticizing control by a specific other person does not mean they want or will tolerate being pushed around by you

Hints for Patient-Centered Care

- Ask patients who they want to be a part of their medical decisions & to have access to their medical information
  - A male slave may want his wife AND his master included in major medical decisions
- Be cautious & consult the patient before including notes about BDSM in the medical record
- Take responsibility for your own feelings & reactions – refer if you can't give good care

Patient Voices: Good Care

I do, however, have a very open-minded doctor that I have talked kink with. I have discussed male chastity and orgasm denial with her, as well as genital needle play. In both cases she sat and listened, forcing herself to remain detached and professional even though she was somewhat embarrassed (particularly on the subject of genital needle play.) After listening to my concerns, she answered my questions in a professional matter, pointed out safety issues from a medical standpoint and applauded my wife and I for working to keep our relationship fresh and interesting. Her open-mindedness and frank discussions about safety have really shown the wife and I what a good doctor she is.

-- Ann's Toy

My doctor's questions are phrased in a way that have no judgment attached, and get to the point of what is important for the doctor to know. Also, he always has his role as a caregiver in mind. When I tell him what I put in what orifice, he doesn't go "Why did you do that?" he just asks questions to make sure that I'm doing whatever I'm doing in a safe way.

-- Reese, 21, student

Potential Practitioner Pitfalls

- Not asking about marks or bruises
- Filing an abuse report every time you see marks
- “Outing” a patient in ANY context
- Assuming all BDSM is abuse
- Assuming BDSM can’t be abusive
- Making up answers that you don’t know
- Referring for psych care unless you have a clear reason to suspect anxiety/depression etc

Patient Voices: Confidentiality

My concerns with explaining to doctors what I engage in has largely been the worry that it will get out. Certainly I'm aware of confidentiality, but I'm always aware of insurance and charts, it is out there. This could prevent medical care later if my HMO decides it was pre-existing or due to my "risky" activities. I simply worry that things will wind up in the chart that do not need to be there.

It wouldn't just be embarrassing or expensive (if medical treatment is later denied) – it could mean my job. Until I'm open about what I do and have my own practice I would be driven out of my job by parents with torches if they ever found out I was working with their children [as a mental health therapist.]

-- D.S.

We're Going to Be Talking About:

- Basic definitions and vocabulary
- Why sexual health & BDSM matters
- WHO is practicing BDSM & WHY they do it
- WHAT people are doing & how they stay SAFE
- What medical school teaches
- Common misconceptions
- Patient-centered care for BDSM practitioners
- Distinguishing abuse from consensual play
- Case studies & resources for more information

- Hopefully, it's clear by now that BDSM play and relationships are NOT the same thing as abuse

- But when treating kinky patients, you may encounter marks, stories, or relationship structures that are very different from vanilla patients

- These differences may lead you to wonder if you are hearing about consensual activities or abuse

- Screening for abuse isn't just good patient care and an ethical responsibility – as mandated reporters for some forms of abuse, correctly recognizing and responding to suspected partner abuse is a legal requirement in some states

- BUT assuming or reporting abuse when there is none can cause substantial direct harm to our kinky patients

- Fear of being inaccurately reported for abuse is a common reason BDSM practitioners give for avoiding medical care

- These slides will begin to help you tell the difference between consensual BDSM and abuse

Screening for Abusive Relationships

1. Are your needs and limits respected?

2. Is your relationship built on honesty, trust, and respect?

3. Are you able to express feelings of guilt or jealousy or unhappiness?

4. Can you function in everyday life?

5. Can you refuse to do illegal activities?

6. Can you insist on safe sex practices?

Screening for Abusive Relationships

7. Can you choose to interact freely with others outside of your relationship?

8. Can you leave the situation without fearing that you will be harmed, or fearing the other participant(s) will harm themselves?

9. Can you choose to exercise self-determination with money, employment, and life decisions?

10. Do you feel free to discuss your practices and feelings with anyone you choose?

Patient Voices: Abuse Screening

Sometimes I prepare myself with a nice story about what might have happened – and I'm really surprised that the doctor DOESN'T ask about the marks. That's the moment where I feel sorry for those people who experience violence and nobody cares about their situation.

-- Dev F.

I wondered if that GYN "didn't want to get involved." While in some ways this may have made it easier on you both, in another light, it's somewhat unethical. As a healthcare provider, he/she has a responsibility to at least ask and assess that you're safe. The cutting could have been as self-harm (and not BDSM), or signs of spousal abuse. In not asking, they weren't quite living up to their obligation as a health provider, they were opening themselves up to possible legal consequences (if you did something more serious and it came out that they ignored warning signs), and possibly let you down as a client, in not being aware of your safety.

-- Laura Jacobs, LMSW/LSW

Physical Exam

- During a physical exam of a patient, you may notice a variety of different marks or bruises

- A good open-ended question to ask is:

  "How did you get these marks/bruises/welts?"

- This question is non-judgmental and doesn't make the assumption that marks are from intimate partner violence

- Do NOT ask something like "Who beat you up?"

Physical Exam

- BDSM play can leave many types of marks
- Consensual BDSM typically does not leave marks requiring medical care (stitches, broken bones)
- Location and other characteristics can give you *clues* about whether the marks are from abuse or from consensual kink
- But the only way you can know for sure is to ASK THE PATIENT
- Here are some helpful hints to distinguish abuse from consensual kink during the physical exam

Marks: Consensual vs. Abusive

1. SM is less likely to result in facial marks or marks that are received on the forearms (defensive marks)

2. There is usually an even pattern of marks if it is SM, indicating the bottom held quite still during the stimulation, whereas abuse may be more unilateral

3. The marks are often quite well-defined when inflicted by a toy like a cane or whip, whereas in abuse there are blotches of soft-tissue bruising, randomly distributed

Marks: Consensual vs. Abusive

4. The common areas for SM stimulation is on the buttocks, thighs, back, breasts, or the genitals. The fleshy parts of the body can be stimulated intensely and pleasurably

5. SM practitioners usually avoid heavy impact play where major organs are located (e.g. over the abdomen, kidneys, etc.) or directly over the spine

…but remember: ASK THE PATIENT!

Photo Alert!

- The following slides show examples of common marks that clinicians may see with BDSM patients as they could appear the day or so after play

- They are presented here to illustrate some of the concepts described in the previous slides, and to allow future physicians the opportunity to recognize some types of marks and deal with any potentially strong emotional reactions now rather than in the future at the patient's expense

- Your future patients may present with marks that are similar, lighter, heavier, fresher, older, or from different toys or experiences

Consensual Marks: Impact On the Back

Notice:

- Fairly even mark distribution
- Avoidance of the spine & kidneys
- Light bruising over muscled and fleshy areas

Consensual Marks: Impact On the Butt

Notice:

- Fairly even distribution of bruising (despite the top probably being right handed)
- Bruising confined to fleshy areas of bottom and thighs
- Avoidance of sacrum and coccyx
- Bruising is deep, but not damaging

Consensual Marks: Fire Cupping

Notice:

- Circular marks like “octopus tentacles”
- Can be discrete circles, as shown here, or appear more like a stripe indicating that the cup was pulled along the skin

Consensual Marks: Needle Play

- Notice the double dots from each needle's entrance and exit hole
- Small linear bruising (seen here) or scabbing is possible if the needle is extensively manipulated after insertion
- Sterile technique generally avoids infection

Consensual Marks: Caning

Notice:

- Two parallel lines for every mark – “railroad tracks”
- Impact is confined to fleshy areas of the bottom and thighs

Consensual Marks: Rope Marks

Notice:

- Rope marks do not indicate that major pressure was applied over any major nerves or vessels
- These types of marks fade very quickly, typically within hours or a day

We're Going to Be Talking About:

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- Case studies & resources for more information

Case study 1

- A 27 year old woman comes in for her annual GYN appointment. During the pelvic exam, you notice a series of parallel marks along her posterior upper thighs. Do you:

(A) Ignore them and continue the exam
(B) Ask “How did you get these marks?”
(C) Say sternly, “I hope you’re not involved with any of that kinky stuff”
(D) Call your nurse to begin processing domestic violence mandated reporting paperwork

Case Study 1: Answers

- (B) Ask "How did you get these marks?"

- You ask in a neutral, non-judgmental tone, and the patient responds "They're from a caning last week. I'm in a consensual BDSM relationship – thanks for asking!"
  - Ask if she has any questions about her BDSM activities and her health
  - Maintain confidentiality in her medical records unless you have explicit permission to do otherwise

Case Study 2

A 54 year old man comes in to your cardiology practice for follow up care. During the physical exam, you notice a series of heavy bruises along his rib cage. You ask "How did you get these marks?" and after some prodding, he admits that his wife has been physically abusing him & the marks are non-consensual. Do you:

(A) Ignore it and move on with the exam
(B) Say sternly, "Be a man and stand up for yourself!"
(C) Promise you'll maintain confidentiality and not tell anyone
(D) Refer him to domestic violence services and begin processing paperwork for mandated reporting

Case Study 2: Answers

- (D) Refer him to domestic violence services and begin processing paperwork for mandated reporting [if required in your state].

- You thank the patient for sharing this difficult information with you, give him contact information for a local shelter and safety planning services, and tell him that you will maintain his privacy with all other patients & in the community, but that in your state you are required to report cases of suspected abuse [if that is the case in your state].

Case Study 3

A 19 year old woman presents to your family medicine clinic wanting to know how she might need to modify her BDSM play to take into account her Type 1 Diabetes. Do you:

(A) Ignore the question and return to the topic of her most recent HbA1C test result

(B) Ask for more information about which activities she participates in & how they might relate to hypo/hyperglycemic episodes

(C) Tell her that it is not safe for a person with diabetes to engage in any form BDSM play

(D) Report her for suspected domestic violence

Case Study 3: Answers

(B) Ask for more information about which activities she participates in & how they might relate to hypo/hyperglycemic episodes

You inquire appropriately about her specific behaviors, and combine this information with your general medical knowledge about diabetes care, advising her to keep snacks & insulin nearby when playing and to educate her top about the symptoms of hypo- and hyper-glycemia.

How can I advocate for my patients?

- Encourage the DSM revision committee to consider research in non-clinical BDSM communities, and/or advocate for the removal of consensual BDSM from the upcoming DSM-V

- If you continue to learn more about BDSM, consider listing yourself in the National Coalition for Sexual Freedom's (NCSF) Kink-Aware Professionals (KAP) database

- Keep learning, keep listening!

Where Can I Get More Info?

- **Health Care Without Shame: A handbook for the sexually diverse and their caregivers** by Charles Moser
- **When Someone You Love is Kinky** by Dossie Easton and Janet Hardy
- **Consensual Sadomasochism: How to talk about it and do it safely** by William Henkin and Sybil Holiday
- **Dungeon Emergencies and Supplies:** by Jay Wiseman

Or on the internet…

- National Coalition for Sexual Freedom (NCSF)
  (http://www.ncsfreedom.org/)
- Community-Academic Consortium for Research on Alternative Sexualities (CARAS)
  (http://www.caras.ws/)
- San Francisco Sex Information (SFSI)
  (http://sfsi.org/wiki/Main_Page)

Or on the internet…

- LifeStyle Education Project: Erotic Powerplay educational project
  (http://www.lifestyleeducation.net/)

- BDSM participant interviews from the book Different Loving
  (http://gloriabrame.com/diflove/interviewsdiflove.html/)

- Kink Aware Professionals List
  (https://ncsfreedom.org/resources/kink-aware-professionals.html)

In a nutshell:

Be willing to educate yourself, and learn from your [patient]. Take care of yourself. If you feel your own buttons getting pushed, work that through, get some support, get a consultation from another professional on the Kink Aware Professionals List. Read some of the books written by people who have been playing with kink for many years. Avoid judgment and pathologizing. Treat your [patient] with respect. Listen. Listen. Listen.

- From When Someone You Love Is Kinky

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- … and many more! Keep reading, listening, and learning!

APPENDIX A:
Further Advice & Experiences From BDSM Practitioners:

The one most critical thing that must be impressed upon doctors and med students is that kinky patients are just patients like any other, and that they are owed the same level of respect. It is entirely reasonable to ask about the source of any marks, whether that's what the patient is there for or not, but you need to believe the patient if she says they were consensual. In fact, learning to ask specifically using the word "consensual" will help put most kinksters' minds at ease that they will be accepted, and will help them open up more. It's hard enough to get a good history out of the average patient who has no medical training without the added overhead of them feeling like they have to hide information or lie about it.

When there are actual injuries, many kinky people are afraid to tell doctors how they got them for fear of judgment. It's important for the doctor to impress upon the patient that the mechanism of injury may be quite important to know in order to fully assess the injury, and the likelihood of occult further injuries. ER docs and trauma surgeons will probably understand mechanisms of injury better than most primary care docs or other specialists, but it behooves the latter two groups to learn about it. -- Wendy H, paramedic

I was getting at suggesting an ethical way to balance both the needs of the provider to assess for harm, and the needs of the patient around client self determination. It is a difficult balance sometimes... the provider has an obligation to assess, but that does not give the clinician the right to judge. The client also (hopefully) can be open with the provider, and help the provider meet the ethical requirements while still expecting compassionate care. They both have to meet in the middle.

-- Laura Jacobs, LCSW/LSW

I was told by one of my doctors, a shrink by trade, who treats my fibromyalgia, when I told him I was kinky that I "had no moral core". Interestingly, I'd been seeing him for a good many years before that came up, because I didn't find out I was kinky til several years after I started seeing him.

-- Helga

I have delayed care (with strep throat!) because I had bruises and I knew that they would want to give me a penicillin shot in my hip, near the bruised area. I didn't know if it would preclude me from that type of care, and I also just didn't want to have that conversation. -- Minx

I am grateful to have found a kink friendly doctor. I can ask him things like "how much concern should I really have about breast impact?“

-- Ev Lokadottr

I think if I had a male doctor I might have been less open to discuss things so openly due to the stigma that vanilla society often puts on submissive men.

When I decided to talk about my bdsm activities with my doctor I just said to myself, "I have questions and concerns about my health and it is her job to answer them. If she can't handle what I do, then I will find a doctor who can.

-- Ann's Toy

Doctors work for you, so I tend to interview any doctors before I'll work with them. I do the same for psychiatrists, acupuncturists et cetera.
If they're not ok with the fact that I'm kinky, queer, poly and pagan- and that I'm not there to be treated for my kinkiness, queerness or the fact that I'm not a monotheist, then I find another doctor.

-- Julian Wolf

I had some pretty fucking ridiculous bruises the last time I went into my OB/GYN. A friend of mine saw the picture and when I told her my nervousness about the doctor's appointment, she said she'd reschedule ASAP. Considering how long it takes to get an appointment anywhere, (and that I needed a new birth control Rx) there was no way I was going to do that. So I did what my top … suggested: I told my doctor that the awful marks she was about to see under the paper blanket were totally consensual. She asked a couple questions about them when she saw them (Do they hurt now? Are you taking any medicine for these? Do you do this often?), but no legal ramifications occurred. I couldn't really get a clear take on what she was thinking, but she did her job and didn't go apeshit. … I had never been so nervous about a gynecologist appointment in my life.

-- M.E.L.

I've so far never needed to see a medical professional while I've had noticeable marks from play. I would anticipate a difficult conversation if I did regarding suspected abuse, so I would if at all possible delay visiting any healthcare professional until the marks had gone/nearly gone. I don't want to be a poster child for kink and don't want to have a conversation about it with a doctor, much as my Oxbridge education, status as a lawyer and general middle-class- ness mean that I would have a relatively easy time having that sort of conversation. It'd be relatively difficult for someone to look at me and conclude abuse, if I'm speaking articulately and relatively confidently alone with a health care professional. It's much easier to just avoid that situation.

I am currently considering pregnancy and have been using the internet to see what information is out there about the risks of impact play during pregnancy. This isn't something I would want to ask a midwife as it would be highly likely to lead to a referral to Social Services. I'm in a much better position than most to deal effectively with Social Services because professionally I spend my time forcing them into providing useful services to disabled children, but I would still rather avoid having to deal with this sort of thing if I can.

In an ideal world, I think medical students ought to know that *any* of their patients might engage in these practices and they are unlikely to disclose this, (and it won't be possible to tell from looking at someone) unless there's a good reason for them to do so, … (cont'd)

… so as the professional they need to be proactive about talking about things that might affect types of BDSM play e.g. prescribing a drug that thins the blood may cause bruising beyond the norm, if someone engages in impact play or someone who doesn't drive/operate heavy machinery may need to be aware of the sedative effects of a drug if they are taking them while being a 'top' in a BDSM scene.

They need to know that some subsets of people who do BDSM have more than one sexual partner (in terms of safer sex advice) and that for many people who practice BDSM, 'sex' does not mean 'vaginal penetration with a penis', but has a much broader definition; other objects might be inserted into vaginas and rectums (so does advice not to have 'sex' mean 'no penetration' or 'no semen near the cervix' or something else?). Conversely, they also need to know that some people who do BDSM don't have penetrative sex at all, but do other things.

Here, it's very important to note that people who play with less extreme things do not as a matter of course 'progress' to more extreme play. People tend to find a level of play they are happy with and stick in that general area. Most exploration is done with due care and attention to safety issues. They also need an awareness that people who are seeking help for play having gone wrong (say a lost toy in someone's rectum) are likely to be very embarrassed indeed about the situation and need professional, but sympathetic care.

-- Karen, lawyer

[Distinguishing between consensual BDSM and abuse] is always an interesting topic. There are patterns, but it's far more important overall to get the patient alone and have a good chat, good rapport and good instincts. Granted, the children's hospital did have a "guess the photo" slideshow, but largely to point out that (aside from a few very obvious cases) you can't tell just by looking at the mark.

-- Lara

My personal opinion is that doctors are continually struggling to make an objective diagnosis. Patients are always forgetting, lying, contradicting themselves, exaggerating, missing appointments, incorrectly taking medication, etc. If you provide your physician with factual explanations of your marks that allow him to clearly understand their origin, he will likely be pleased, assuming the marks do not indicate overly dangerous risk-taking.

-- RM

Given that most of us don't know what doctors are required to report, the safest course of action is not to say anything. …Just because it is consensual, does not magically make it ok. For example, North Carolina doctors are require to report all non-accidental knife wounds. If you tell your Dr you got cut while involved in a knife play scene will they report you? I don't know. I know they will probably be worried that someone else will report it, and they will get in trouble with the law if they don't. … Finally, there is nothing more dangerous than someone who decides to help you because you "obviously" are so fucked up that you need them to do it. Most people don't understand BDSM and can not conceive that you could possibly want it.

-- T.H.

My regular MD(female) is a born again Christian, with no tolerance for anything other than married missionary (her choice, and I respect that); fortunately, I have never required medical intervention for anything BDSM related. Until today.

As luck would have it, she (MD) was not in the office today, but her nurse practitioner was (I have never been seen by the NP for anything); given the nature of my needs, I decided that I was going to have to be completely honest and upfront about how I sustained this particular "injury", and risk a bad attitude and lack of understanding.

She was amazing! I explained my involvement in BDSM, told her what the issue was, apologized for being so blunt, and she smiled and said "I appreciate your honesty; as long as it was consensual, I have no problem. Can I put it (mention of BDSM) in your chart?" (I said yes; I'll probably never book an appointment with my MD again!)

When we were done, and we agreed on a follow up in two weeks, she asked me if it would be alright for her to ask -me- some questions at that time, so she could be more informed! I of course said yes!

-- artaith

I had cramping so badly after using an insertable e- stim toy that I had to discuss it with my gyn. She was understanding, asked only the info she needed to know to make an educated decision on my care, and was non-judgmental. After several follow up visits, which included a few more questions, she thanked me for my honesty, because it may help her if another patient ever came in similar issues.

-- Ms. X

I wanted to be a bottom in a fireplay scene with a lady that uses a violet wand to ignite the alcohol. She's experienced and safe and everything, but I have epilepsy, and was a little worried about the e-stim triggering a seizure. So during a visit with my neurologist I brought it up. She happened to have a computer in her office with internet access, so I just did a quick Google search, and showed her a website that explained violet wand fireplay. She was confused on multiple levels. "But why do you want to be on fire? And why do you want to be shocked? It says it hurts.. I don't get it..." She actually specializes in MS, not epilepsy and has never encountered this particular question before, so she brought in a coworker that does specialize in epilepsy. I went through the whole thing again, and he tried to convince me that the violet wands are inherently dangerous- definitely not seizure inducing, just dangerous for anyone. I smiled a big ass smile, and told them that's a risk I'm willing to take. They wanted me to email the results as soon as I've played with a violet wand. The whole time, they weren't judgmental really, but they SURE didn't understand what I liked about it.

-- Dave

I have [talked to doctors about BDSM]. The bruises and welts were too dark and severe to hide. I just smiled bright and wide and said I'm into "rough sex" or bdsm. She just crinkled her nose in distaste and said "beeeee careful!" I said I would. --A

[There are] what I call, [the 4 levels of providers] 1 is BDSM savvy; 2 is BDSM friendly; 3a is BDSM naive but willing to learn; 3b is BDSM naive and unwilling to learn; 4 is the dangerous one - BDSM puritanical troglodyte.

– L.L.

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- Please let me know if you are going to be presenting this at your school – I’d like to know how sexuality education is progressing at other schools. Thanks!!