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## Chronic Pain as Fluid, BDSM as Control

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### Abstract

*The paper identifies how chronic pain is a disability and lays out the ways in which a cripistemology of chronic pain – and crippling chronic pain – is a productive exploration of pain. After exploring normative discourses of chronic pain through a crip lens, and identifying how pain is not meaningless, but instead imbued with multiple meanings, the paper presents some findings from a recent research project exploring the phenomenological experience of people living with chronic pain who engage in BDSM play. Two dual narratives are identified: pain as a contagious fluid, requiring control of pain and the emotional expression of pain, and the uses of BDSM in that control. The paper offers a crip reading of these non-normative experiences.*

### Why Chronic Pain?

Chronic pain is a disability; while disabled people can experience chronic pain as a part—or result—of their disability, in terms of bodily formations, capacities, or (un)chosen adaptive approaches, others may experience chronic pain as a central aspect of their disability. They may have a diagnosis of one of a host of conditions and syndromes, or may have an undocumented disability (Mollow 2014). This can be understood using the social model of disability as impairment (regardless of documentation/diagnosis), but it has been contested as to whether chronic pain is sufficient to constitute an impairment upon which disability is experienced (Oliver 2013). In addition, a strict binary separation of impairment and disability is not always useful, especially when taking a critical crip approach (Kafer 2013), or exploring bodies and somatic sensation (Morris 1992; Hughes and Paterson 1997), both of which this paper does. It is impossible to fully separate impairment/diagnosis from disability when we consider how sociocultural discourses influence what is understood as impairment/diagnosis or a lack of 'normal' bodily function, and thus this paper refers to chronic pain as *disability*.

Non-disabled and disabled people experience pain, [1](#) but chronic pain is, by being recognised as *chronic*, a difference from the expected/normal. Thus, there is need to consider chronic pain within disability studies, and particularly a queer-crip framework—one that does not rely on the impairment-disability binary, but has space to engage with experiences of weakness, limitation and difficulty imposed on the self by the bodymind—and unchanged by experiences of access, social change, or acceptance.

Pain is defined by the International Association for the Study of Pain (IASP) as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Merskey and Bogduk 1994, 210); it becomes defined as chronic once it lasts for a period of at least 12 weeks (British Pain Society 2014). As far as dictionary-style definitions go, these are not bad—pain is *felt* as somatic sensation, and *felt* as emotion, sometimes in ways that are inseparable to the feeling bodymind. However, these definitions are also problematic; chronic pain can last for years, over lifetimes, and is experienced—felt—very differently from short-term acute pain. It is not enough to consider chronic pain as the same as acute pain but felt over longer. While there is some acknowledgement from medicine that this is so, sociological or psychosocial studies of pain frequently do not make this distinction explicit enough; twelve weeks of pain is very different from twelve months, and different again from twelve years—and hence this is where cripistemologies of pain come in.

This paper forms part of a wider project which seeks to crip chronic pain, and to develop cripistemologies of chronic pain. The project explores the cripistemology of chronic pain; not just what chronic pain is and how normative discourses of pain shape our experiences of 'normal' and 'abnormal' pain, but how chronic pain is felt, experienced, lived, and lived with—and how these experiences affect our knowledge of the lifeworld. Chronic pain impacts, and becomes a part of, the phenomenological self, and thus living with chronic pain produces a particular cripistemology—the understanding of the world produced and narrated by those living with chronic pain is forever coloured by chronic pain. Cripistemologies situate disabled people as alternative experts, as producers of a particular kind of knowledge (Mitchell, Snyder, and Ware 2014; Johnson and McRuer 2014); cripistemological knowledge about chronic pain can therefore only be produced by chronically pained people. This presents a challenge to other knowledge and understandings of chronic pain, which are rooted in discursive constructions of pain, and in medicalised understandings, and as such this paper seeks to challenge and present alternative understandings, while also acknowledging the messy multiplicities of crip experiences and cripistemological knowledges.

## On terminology

Throughout this paper, I have used the term 'bodymind' rather than 'body and mind' because, as Price explains, a dualistic division of the physical and the mental is less than useful, especially when considering "because mental and physical processes not only affect each other but also give rise to each other—that is, because they tend to act as one ...—it makes more sense to refer to them together, in a single term" (2015, 269). I have combined *bodymind* with the conception of compulsory able-bodiedness (McRuer 2006) to produce 'compulsory ablebodymindedness' (Sheppard 2018) not just because the former maintains the false binary of body and mind, but because it also further maintains the divisions

between 'physical,' 'mental,' and 'cognitive' disabilities that has plagued the social model of disability. Ablebodiedness emphasises that in order to be normal, a person must be read as lacking any disability. It also carries with it the acknowledgement that the experience of being crip includes experience of mental and physical difference within the same person, which cannot always be fully understood as one end or other of a binary.

## The Project and Participants

The ideas and concepts I am putting forward in this paper have their origins in a research project based in the UK, exploring the experiences of people living with chronic pain who receive pain as a part of their BDSM play (Sheppard 2018). I interviewed eight people three times each over the course of a year to eighteen months, taking an appreciative inquiry approach where I began with a short set of initial, deliberately broad, starter questions. My appreciative inquiry approach is rooted in interpretive phenomenological analysis (IPA) (Langdrige 2007a; Murray 2004; Langdrige and Butt 2004), which focuses on "how participants experience their world, and hence enables an insider's perspective" (Murray 2004, 966). Rather than seeking to contend with the narratives, this approach seeks to explore themes revealed through the narrative. The appreciative inquiry approach, which is also intended to enable exploration of those themes as they emerge during the interview, complements this through allowing narratives to stand as told. This approach also fosters a friendly, supportive relationship between researcher and participant, which has the intention of enabling the participant to feel that their narrative is being heard and valued—and that they feel able to contest the researcher's understandings and critiques of the narratives.

This explicit making space for discussion and contention aided the development of my understanding, as well as giving room to the multiplicity of cripistemologies and potential (mis)understandings. As a chronically pained person myself, my experiences coloured my understandings, how I heard—and what I expected to hear. In acknowledging this, and actively inviting participants to speak back to my understandings, not only did this acknowledge spaces for misunderstandings, but re-centred participants as experts in their own lives—instead of ontologically invalidating their narratives, an experience all the participants and myself had shared at some point in in becoming chronically pained (and thus something I was anxious to avoid repeating).

The conversations that came about in response to the starter questions formed the first interview; the second began with a second set of questions developed in response to a deeper post-interview reading of the interview transcript, which enabled a period of reflection on the part of the researcher, and allowed for deeper, slower investigation of emerging themes. Participants were invited to speak back to the research notes, identifying where they saw mis-readings and misunderstandings. The third interview focused on this space for discussing themes and analysis with participants; the questions participants were asked were a mix of questions specific to the participant, and general questions reflecting on the emerging points of convergence and divergence in the analysis. The research process was developed with space for unreliability—unreliable bodyminds and unreliable understandings—on the part of researcher and researched, as well as to build a space in which cripistemological understanding could be reached, in which one person can appreciate the lived experience of another while acknowledging

that a complete and thorough understanding is impossible, acknowledging the lack of a single cohesive shared narrative—indeed explicitly seeking and making space points at which narratives diverged and contradicted, as a part of developing cripistemologies of chronic pain.

The interviews revealed the participants had complicated, highly individual experiences with their chronic pain, but also demonstrated a range of broad themes. This paper focuses on a part of the project as a whole; not all of the participants in the research have their words directly quoted within the paper. The three participants not quoted here told narratives and recounted experiences that focused less on the fluidity of pain—or their engagement with BDSM was different; this reflects both the conversational nature of the interview, as well as the multiplicities of experiences participants brought to the interviews. This is not to say that the narratives of all participants did not influence the findings of the research project as a whole, but that their narratives are beyond the scope of this particular paper—and will be explored elsewhere.

Participants are represented here by pseudonyms, but their identities are otherwise as described, using their preferred terms: Charlie, a queer non-gendered person; Catherine, a gender questioning bisexual person; Julie, Natalie, Michelle, and Rita, all bisexual cisgender women; David, a bisexual cisgender man; and Edward, a heterosexual cisgender man. All of the participants live in England. The gender split was roughly as expected, given that diagnoses of chronic pain are more common among women (Hoffman and Tarzian 2001; Bendelow 1993); but due to the dearth of studies of chronic illness and LGBTQ+ people (Boehmer 2002; Jowett and Peel 2009; Proctor et al. 2016) it is impossible to say with complete confidence if the participants here are typical representatives of people living with chronic pain. One of the participants, Michelle, is of dual heritage; <sup>2</sup> the rest are—or pass as—white. <sup>3</sup> The participants are not reflective of the wider population of the UK—disabled or not.

The participants all identified as disabled; however, naming diagnoses or impairments is not particularly helpful—especially given that the participants all had different disabilities, and some lacked formal diagnoses, while others had contested diagnoses and/or undocumented disabilities. All have experienced having an undocumented disability at some point in their lives. Natalie and Edward were the only participants with a single disability (but not the same disability); the other participants had multiple disabilities and multiple diagnoses/impairments. Between them, the eight participants had fifteen diagnoses (contested or otherwise) relating to chronic pain, and seven diagnoses relating to other disabilities—including neuroatypicality, mental illness, and physical disability. In the interviews, conversations focused on chronic pain, but with room to acknowledge the impact of other disabilities and lived experiences on how they lived with and experienced pain.

## On BDSM

For the sake of readers not familiar with BDSM, I want to give a short overview of what it is, as well as a short overview of the participants' practices and places within BDSM. It is important to note the BDSM is socioculturally constructed and thus practices vary from place to place—and while there are points of similarity and concepts shared between cultural locations, there are also distinct differences

across times and places; BDSM relies on—and plays with—social hierarchies (Weiss 2011; Newmahr 2011; Cruz 2016; Langdrige and Barker 2007), and those hierarchies are not uniform between cultures.

The acronym BDSM stands for bondage and discipline, domination and submission, sadism and masochism (Langdrige and Barker 2007; Taylor and Ussher 2001); but it is also referred to here by the participants' preferred term of 'kink.' As a term, BDSM was seen as being a bit clinical—while *kinky* was a more positive self-identifier that would be understood within the kink communities they were a part of. Previous studies of BDSM communities, beyond acknowledging that there are multiple distinct—and often entirely separate—communities within BDSM (Weiss 2011; Newmahr 2011; Bauer 2014; Baldwin 1991; Langdrige and Barker 2007; Taylor and Ussher 2001; Beckmann 2009), paint a broad description of scenes which tend heavily towards being white, non-disabled, and middle-class, although otherwise diverse in terms of practices and sexualities.

Many of the participants felt excluded from the semi-public scenes and spaces of kink because of their disability—as some spaces were felt to be less tolerant of disability, or were simply physically inaccessible—and also because maintaining a regular scene presence could be expensive, thus putting it out of the reach of participants reliant on benefits or in low-paid work. However, all of the participants, with two exceptions, engaged with their local scene to varying degrees, some socialising in kinky spaces on occasion, such as attending 'munches' (social meetings without play, in non-kinky or 'vanilla' spaces), conventions, or clubs. However, only Julie and David described themselves as 'regulars' on their local scene, and Julie stopped attending face-to-face scene events partway through the interview period due to a change in her capacities.

Participants engaged in a wide variety of practices, according to personal preference and the dictates of their play relationships. Given that they all received pain, it is not surprising that they all engaged in some form of impact play—such as spanking, flogging, or whipping—but for some this occurred as a part of other play, while for others the impact play was the focus. Half of the participants were exclusively submissive, while the others were switches, which meant they occasionally played as Dominant. For some participants, play was erotic and sexualised—and sexual gratification was a part of their play—while for others, play was not always erotic, and did not necessarily include (or preclude) sexual gratification; this has been observed in other accounts of BDSM communities (Weiss 2011; Newmahr 2011; Bauer 2014; Langdrige and Barker 2007). The forms of the relationships within which play took place varied as well; Natalie, Catherine, Michelle and Rita all played within committed romantic and sexual relationships—as did Edward at the start of the interview period, and David towards the end of the interview period. David, Michelle, and Rita are all polyamorous (in that they had multiple romantic and/or sexual partners), while Natalie and Catherine were monogamous (having one romantic and sexual partner), as was Edward, though not by choice. Charlie, Julie, Rita, and David all had regular or semi-regular play partners who they were not in committed relationships with, but the frequency and regularity of this play varied, and some of those relationships were not centred exclusively around play scenes. Natalie and Catherine played entirely in private, keeping their preference for BDSM very much apart from the rest of their lives, while the others all had kinky social circles.

Kink pain was identified as a contrast to experiences of chronic pain that, at first look, appears not just distinct, but opposing—why would someone who lives with chronic pain want *more pain*? In the research, it became quickly obvious that one does not lead to the other, but nor does chronic pain make being kinky impossible. The difference between the experiences of chronic and kink pain can be broadly thought of as experiences of involuntary but expected chronic pain, and experiences of chosen, expected pain. Chosen pain, in the case of the participants, came from deliberate, consensual, kink play; it was expected in that they engaged in their preferred practice (such as flogging or caning) knowing beforehand that they would experience pain as a result. Involuntary pain, the experience of which was not the focus of the research, can be understood as pain experienced unexpectedly. Chronic pain, however, is not consented to but it is also *not unexpected*—it is pain that has been experienced for some time, and is expected to continue for an unknown duration.

## Speaking/Hearing Pain

Bodies feel pain—but the normal and proper bodymind is one that is not only able to feel pain at appropriate points, but one that can verbalise their experience and have it understood by others. For the participants, the expectations of *normal* and *abnormal* pain impacted their lived experience of chronic pain; in this section, I want to explore how ableist norms about pain affect how people live with chronic pain—and in particular, how participants felt they were not just unheard, but actively discouraged from talking about or expressing their pain. The sections afterward will explore participants' narratives in more depth, considering how normative expectations of pain shape the stigma they experienced—and how kink was a part of their living with chronic pain.

The chronically painned bodymind—one who is experiencing pain over months or years—is abnormal in that their pain is chronic (rather than an acute event), but also in that they are in pain at all. Discursively, there is an assumption that chronic pain *is the same as acute pain*—just over a longer period of time. Morris, in his text *The Culture of Pain*, describes chronic pain as "a nightmare from which we may never truly awaken—or a waking state in which the nightmare never ends" (1991, 71), but this reveals as much about Morris' fear of chronic pain as it does about how he understands the experience—chronic pain is regarded as a constant nightmare state because acute pain is positioned as torture. Morris' statement effectively demonstrates the discourse that living a good life, a life that contains joy and happiness and pleasure in forms meaningful to the self, while also living with chronic pain is incomprehensible, an unimaginable state—the two are diametrically opposed. To borrow a term from Kumari Campbell (who is describing disability more broadly), living with chronic pain is an *ontological impossibility* (2009)—it is something a person cannot fully comprehend until they themselves live with a disability, and the prospect of being or becoming disabled is in effect horrifying and abject.

This ontological impossibility of chronic pain—the impossibility of imagining living with chronic pain—results in stigma. In effect, in shying away from hearing about other's pain (because they are then forced to confront the possibility of becoming painned themselves), listeners silence chronically painned people. Chronically painned people feel unable to speak of their pain—unable to express emotion related to their pain. Several participants, Julie among them, felt very limited in terms of

freedom to express emotion due to the stigma of expressing contagious pain, and this meant they struggled to engage with the sensation of pain—as having their pain recognised by others was an important part of coming to live with pain. Just as those with undocumented disabilities feel ontologically undermined or invalidated, having pain go unrecognised (or actively disbelieved/denied) impacted participants' sense of self-knowledge, their criplistemologies of self.

This invalidation, for participants, was tied to feeling unheard when they spoke about pain—not just not listened to, but that the hearer was either unwilling or unable to comprehend what they participant was saying. Being unheard is sometimes positioned in writing on pain as *being incomprehensible*—pain is positioned as not comprehensible for observers/hearers, or even for those experiencing it. Scarry (1985) and more recently Langdrige (2007b), place pain as without a referent—"it is not of, or for anything, having no referential quality ... [it] represents experience that is not shared—not turned out in the worlds—and therefore not readily accessible to others" (ibid, 94). Pain without referent is positioned as an attack on the phenomenological self by Scarry (1985), as a sensation that destroys who we are and how we relate to the world. Because of this, Scarry regards pain as inexpressible, beyond language.

However, my participants are not the first to have pointed out that it is not that people have a problem *speaking* about pain, but that people have a problem *hearing* about another person's pain (Young 1997; Patsavas 2014; Sheppard 2017)). As Nielsen and Fernandez (2010) and Bourke (2014b) have pointed out, hearing about pain is unpleasant—it can be distressing, and, especially when the speaker is perceived of as returning to a well-worn topic, boring and annoying. This is not because pain is without referent, but because being in pain is ontologically impossible for those who are not in pain. We *want* pain to have a referent, as the normalising discourses of pain require that it *means something*. Pain requires a referent because it demands attention, it focuses on our bodies, on their bounds and limits (Wendell 1996). Pain—whether acute or chronic—requires us to renegotiate the spaces of our lives, of how we relate to and live in the world (Norridge 2010); we are "[cut] off from other people's reality" (Wendell 1996, 170) not because pain lacks meaning, but because chronic pain makes us abject, monstrous, other.

## Chronic Pain as Failure and as Fluid

Viewing chronic pain through a crip lens exposes the discursive construction of chronic pain, and allows us to critique normative constructions of pain. Through a crip lens, we notice that the normal bodymind is imagined as pain-free. Compulsory ablebodymindedness positions ideal humans as those who have the capacity to experience pain—indeed being able to feel pain is necessary to learn about danger—but the ideal ablebodymind is a healthy one; they do not (or should not) get sick, and, being young and athletic, they recover quickly from injury. They fit the neoliberal risk society ideal of a flexible body (McRuer 2006), which, on the rare occasions they do get sick or are injured, recovers quickly and completely before returning to productive work. As pain is positioned as negative and dehumanising even when it is necessary, a normal, proper and rational human also seeks to avoid pain in their lives, and to end it quickly when it is unavoidable.

Combined with the assumption that a painful life is not a worthwhile one, there are a huge range of cures, treatments, and pain management or rehabilitation programmes pushed at people living with chronic pain—by medics and non-medics alike. These cures can range from prescription medication and various therapies, to dietary and 'lifestyle' changes (some of which may be presented as a therapeutic regime); the majority can be grouped under neoliberal rehabilitation practices, making a profit while promising (and not necessarily delivering) to make the person living with chronic pain as close to discursively normal as possible (Mitchell and Snyder 2015). Efficacy and success varies hugely from person to person, and treatment to treatment; accessibility varies widely as well—some cures are expensive, others require the person to live in an area near to various facilities, or care providers, others require large amounts of free time or energy to undertake. Many require us to have all four: money, time, energy, and to live in the right location. What all do, regardless of efficacy or accessibility, is reinforce that a life lived with chronic pain is no life at all. In addition, as Patsavas (2014) has pointed out, the emphasis on cure and treatment pushes responsibility for ending pain onto the person living with chronic pain—they are responsible for finding a cure to try, and responsible for making what can be significant life changes, or enduring unwanted side effects for months; they are responsible for continuing to try further cures when each (inevitably, perhaps) fails. Chronic pain is thus cast as a personal failure; if a chronically pained person continues to be in pain, it is because they have not tried hard enough—they have failed to control their pain and failed to control their bodymind. People living with chronic pain thus experience stigma from two sides—the stigma of failing to be normal, and the stigma of being in pain—and so engage in stigma management alongside pain management.

This stigma around failure to control their pain and their bodymind was particularly significant for participants; they all felt a measure of social pressure to control their pain, and some had internalised this pressure. Julie, when asked why she deliberately sought out pain in kink play, explained:

*"Controlling pain is important. Whether that be resting to decrease some pain, using painkillers if they work, moving position at the simplest level. Kink is taking this to its natural conclusion by making pain to control." (Julie, interview two).*

Chronic pain is not constant, it can come and go, get worse or better, and change in sensation—in many ways, the only thing that is reliable about chronic pain is the unreliability. The complexity of juggling social pressure to meet normative expectations, and thus to control—and to be seen to control—chronic pain and the bodymind is made more urgent and complicated by living with an unreliable bodymind, one which may not always have the capacity to control, or when pain may be unpredictable in its ebbs and flows, when it occurs and how painful it may be. As a result of this unreliable bodymind, the need to control pain—to control the painful bodymind—is also something participants required of themselves. In discussing their experiences of chronic pain and pain management, the participants' narratives frequently returned to control—a need for control, experiences of losing control, and how they controlled their lives to live with chronic pain. In controlling her emotional expression of pain—through limiting when, where, and to whom she expressed this pain, Julie felt she gained a measure of control over her pain—but this was not felt entirely positively, and Julie also felt she had lost a measure of connection to her bodymind, feeling she was unable to

experience the full range of sensation and emotion because she deliberately denied pain. Julie explained that she struggled to engage with her body and at all, as controlling her emotional response to pain required her to ignore, or not acknowledge, not just the sensation of pain, but other sensations as well;

*"I deal with not dealing with it... And so then the, um, the kind of kink pain is kind of dealing with it and kind of exploring through that ... so it's not shutting it all out as far as I can, it's actually experiencing it" (Julie, interview one).*

Julie's response to a painful bodymind included a reliance on a binary division of body and mind, and mind over body. BDSM provided a space for her to re-engage with her body and the emotional responses to her pain.

Thinking through a crip lens, the need for control of the sick or disabled body ties to the normative demand that we control our bodies properly, and behave appropriately (Liddiard and Slater 2017; Patsavas 2014), but also to the demand that we seek ways to control our lives to avoid pain, or seek to control pain once it is experienced. In addition to bodily control—control of movement, of bowels and bladder, and of vocalisation—we can explore control of pain in terms of normative expectations of emotional control, and the demand that in order to perform as normal, we control our emotions, showing particular emotions only in particular spaces, or in the view of particular people.

One of the participants, Charlie, felt that pain is sometimes reacted to as though it were a bodily fluid—one that should be properly contained within the body, and certainly not allowed to leak out in the view of others;

*"[Pain] doesn't necessarily impact on people in the sense that you're not going to piss on somebody's seat with your pain, but... so it's slightly different, but... So in some ways, there's even less scope for it to spill out, because people don't see it when it does" (Charlie, interview two).*

This need for bodily containment is echoed in discourses of leaky bodies, particularly bodies which menstruate, the incontinence of very young or very old bodies, and the incontinence of disabled bodies (Liddiard and Slater 2017). Failure to contain leaks—failure to keep uncontrollable leaks private—is incompatible with proper ablebodymindedness, and a failure of proper self-control. Expressing pain works as a leak because it is horrifying, abject. The unimaginable horror—the ontological impossibility—of pain results in pain being reacted to in the same way as leaks of physical fluids, as though observing and acknowledging the expression of pain will make that pain contagious—will cause the observer to feel that pain. Thus, expressions of pain are not *not understood*, but deliberately ignored; it is not a failure to express pain by the person in pain, it is an unwillingness to 'catch' pain on behalf of the witness, and unwillingness or inability to imagine oneself in pain. When the person in pain identifies their pain as chronic, when they repeatedly speak of being in pain, the failure of empathy and the increased stigma they experience (Hoffman and Tarzian 2001; Nielsen and Fernandez 2010; Morris 1991; Wendell 1996; Bourke 2014b) is because the experience of being constantly in pain is one that is so awful to witness that the witness feels compelled to push them away. Thus, the person in pain is compelled to control their pain, and their expression of pain—and also to perform their control, to make their control visible to others.

## BDSM as Control

The need for pain management and the need to find a way of living with a chronically painful body/mind was a recurring theme across interviews. Participants identified that need as both internal—something they desired for themselves—and external, a pressure they felt from others. The narratives of pressure to manage their pain were twined with the stigma of disability and the stigma of being in pain. This paper seeks to present an acknowledgement of this stigma—both external and internalised—as well as participants' desire for and experience of fulfilment and pleasure while also continuing to live with pain.

Julie explained this by contrasting the vulnerability she felt in BDSM with the fragility she felt with chronic pain;

*"Kink pain is about proving otherwise. It's about laying yourself vulnerable, and opening yourself up to your own strength and the strength of others. You are giving something away, but similarly getting so much back. And testing your own resolve. Because in any kink pain situation, you can stop it if it gets too much - even if you then regret it moments later. Chronic pain is nothing of the sort. It tests you. It can, however much you try to rise above it to get through it, bring you crashing down. And you can't say a safeword and step away from it. It makes you fragile, to some extent" (Julie, diary entry).*

Julie's experience was echoed by other participants. What this meant is that in using pain within their play, participants were able to engage emotionally with their pain, and with their bodily selves, in a controlled space, and in ways in which they were in control, rather than relying on the judgement of medics or caregivers. This is because in kink, they had the ability to decide how they received pain, and to call a stop to any activity—as well as the knowledge that the pain is temporary. Kink play is also a space where they are able to be uncontrolled in their emotional response—to give voice to their experience. One of the pleasures of kink was the time and space to engage with pain, as well as an audience willing to witness pain.

The sensation of pain itself is tightly controlled within kink play, as only particular instruments or methods of pain creation are used, and the location on the body is chosen carefully depending on factors from personal preference to a need to reduce the chance of visible marking—for example, flogging the back and buttocks, rather than caning the breasts. Therefore, as another participant, Michelle, explained, the pain from play can feel very different to the already-present chronic pain, in that it is a different sensation, or in a different location in/on the body. Kink provided some of the participants with (in their view) a way to control their chronic pain, through creating increased pain, which will be stopped at any point in the near future, and that they can both plan for and control—through discussion with their play partner, and through calling a stop to the scene, and this sense of control over sensation meant they felt a degree of control over their chronic pain as well;

*"I think, um, I like it because it's being in control of the pain. Or there's a level of, yeah, I'm in control rather than my body being in control. Even though my body then reacts to the pain in certain ways. But it's that I'm deciding to have pain, rather than it deciding to have me, type stuff" (Julie, interview one).*

For other participants, kink pain could overlay—not quite replace—chronic pain; in its urgency and acute sensation, it pulled attention away from chronic pain. Acute pain—in a controlled situation—allowed for a control of pain, again welcoming in sensation, reshaping the context. Edward explained that kink play more generally—not just pain from play—could act as a distraction, taking his mind off of his pain temporarily, as he was focused on performing tasks for his Mistress.

Kink and kinky sex could also be pleasurable, which impacted the pain participants experienced—and thus provided them with another source of control. Natalie reported that orgasm from sex (whether including kink or not) gave her a measure of temporary pain relief, and sex with kink resulted in stronger orgasms, and thus more effective relief—although it was also more tiring for her, meaning it was more costly in terms of fatigue afterwards. Rita also experienced a measure of pain relief from kink play;

*"[The pain] aches less, primarily. I think often because I've been maybe in the sort of very relaxed headspace, possibly my muscles are more relaxed or... But sometimes it feels like the one pain has driven out the other, and then once the... once the kink pain has started to fade, there's still less of the existing pain" (Rita, interview one).*

The control of pain-as-fluid and painful bodyminds practiced by the participants seeks not to control the pain directly (as it would be through pain medication or normative pain reduction techniques) but instead to control what can be controlled; namely their bodies' responses to pleasure and new, temporary, pain. For some of the participants, pain play could serve, very literally, as pain relief, as Charlie explained, using medicalised terms;

*"In any sort of kink or sex kind of play ... sometimes I've been able to, uh, extend the period between using analgesia because of the impact of the endorphins, and just, whatever" (Charlie, interview one).*

They identified flogging and needle play in particular as a part of what they called "desensitisation work," (Charlie, interview two). Charlie explained that having pain caused in a particular area helped to dull the sharper sensation they feel due to nerve damage there. For Charlie, desensitisation work was a carefully thought out, and purposeful use of kink pain to help them live with their chronic pain. This parallels to a treatment for painful amputation sites developed and practiced in the mid-20<sup>th</sup> century, called percussion treatment, where the amputation site was hammered on to reduce pain (Bourke 2014a).

To return to the earlier quote about kink as "*laying yourself vulnerable*," Julie frequently expressed discomfort at seeing herself as fragile—due in part to feeling her bodymind was unreliable. However, this contrasted with her description of seeing herself as vulnerable *and therefore strong* when it came to kink. In the context of kink activities, strength means Julie is able to embrace her vulnerability, to be vulnerable both physically and emotionally. This vulnerability is welcomed—even encouraged—in kink; Julie feels able to express emotions, to experience pain, without fear of condemnation. This meant that her kink play served as a space in which to relieve the social pressure to contain responses to pain, echoing discourses of submission as relief from high-stress, high-responsibility employment (Newmahr 2011; Weiss 2011). Kink practices help to construct a space in which the limitations and capabilities of the body can be explored;

*"The focusing pain calms me, the sensations aren't as deep and pervasive as in chronic pain, the pain is specific. I can appreciate it changing sensations, the pain peaking and troughing. I react in many ways to kink pain, it invigorates me, it turns me on, it allows me to breathe deep full happy breaths. My body doesn't cope very well to non-kink, non-chronic pain, it tends to exaggerate the sensations, making a papercut seem highly painful. It goes into shut down mode quite quickly in these situations"* (Julie, interview two).

## Conclusions

To conclude, then. Pain—particularly chronic pain—being fluid, being abject, offers potential for a crisp understanding of why those living with chronic pain are particularly stigmatised. It also explains, in part, why pain is so particularly horrifying to witness—not just because being in pain is ontologically impossible, but because of fear that being in pain is contagious. This combines with normative discourses of pain to require people living with chronic pain to control their pain, and to control their emotional responses to experiencing pain.

For my participants, kink played a part in that control—a narrative that differed from more mainstream, normative-adjacent discourses of why people engage in BDSM—offering them ways of engaging with sensation which they felt more control over, as well as offering them ways of emotionally engaging in pain without being stigmatised for expressing their response. This presentation of kink as almost-therapeutic (I say *almost* because my participants expressed discomfort with presenting kink in this way, especially as it was something they engaged with for pleasure, while therapy was associated with medicine and rehabilitation) is undoubtedly an awkward, problematic one to hear (Barker and Langdrige 2009), but one I would argue is necessary as it reveals a great deal about how people living with chronic pain experience their lived bodyminds.

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## Endnotes

1. The exception here being those with particular congenital disabilities which mean they do not experience exclusively-somatic pain, although they can experience pain from emotional responses (Danziger and Willer 2005). [Return to Text](#)
2. I use their preferred identification; others might prefer 'mixed race.' [Return to Text](#)
3. This paper does not spend much space addressing the role of whiteness or racism in the experiences of participants, save to observe that BDSM communities in the UK are very white, even in otherwise 'multicultural' urban

environments, and experiences and engagements of people with BDSM are impacted by whiteness and racism (Cruz 2016; Newmahr 2011).

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