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## Surrendering Safely: Increasing Clinicians' Understandings of Kink

Richard S. Laska

*St. Catherine University*

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Surrendering Safely: Increasing Clinicians' Understandings of Kink

by

Richard S. Laska, B. A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

# INCREASING CLINICIANS' UNDERSTANDINGS OF KINK

## **Abstract**

Social workers may be uncertain of the appropriateness of asking about kink behaviors during a sexual health history and be concerned about their lack of knowledge or preparation to discuss kink with clients. Understanding the subjective experience of individuals engaging in kink could help professionals understand the variations, challenges, and benefits of kink. The purpose of this study was to learn of the benefits and challenges of engaging in kink that clients report to their clinicians. In addition to this, participating mental health clinicians were asked to report different outcomes from different kink practices and what internal processes occur that lead to these various outcomes from their perspective. Eight interviews were conducted and data were analyzed using both inductive and deductive approaches in which categories emerged and were then linked to the literature review. The findings suggest that there are specific qualifications practitioners should have to be kink culturally-competent. The findings also indicated there are potential physical, psychological, and interpersonal benefits to engaging in kink. This study lastly found that internal stigma, external stigma, community issues, and interpersonal issues were the primary reported challenges for those engaging in kink. This research suggests that engaging in kink can lead to empowerment and self-actualization.

# INCREASING CLINICIANS' UNDERSTANDINGS OF KINK

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Sexuality and sexual health are integral parts of a human's life. Fifty-two percent of men and 63% of women report sexual dysfunction; seventy-five percent of couples in therapy report sexual concerns (Nusbaum & Hamilton, 2002). However, only 35% of physicians and 24% of mental health practitioners report regularly taking sexual health histories (Timm, 2009). Social workers are experienced in working with challenging issues such as meeting basic needs, abuse, violence, anger management, trauma, and mental health. However, sexual health is an element they continue to neglect, which is common among mental health practitioners (Timm, 2009). This could be due to personal discomfort or a lack of knowledge and preparation (Nusbaum & Hamilton, 2002; Timm, 2009). Despite these issues, exploring sexual health with clients is important because providers can assess the risk for sexually transmitted infections (STIs) and the Human Immunodeficiency Virus (HIV), pregnancy, safer sex practices, sexual abuse and rape, and sexual dysfunction (Nusbaum & Hamilton, 2002). Social workers in their various roles at in-patient, out-patient, residential, and medical organizations, are in a unique position to discuss sexual health and sexuality with clients. This clinical exploration can enhance the therapeutic alliance, promote trust, establish openness, and address core issues related to the client's authentic self (Timm, 2009).

Taking a sexual health history is important but in order to enhance the effectiveness of the history, practitioners should be aware of how their beliefs, values, and experiences may impact the assessment. There are cultural scripts, or dominant social messages about the scope of normalized behavior, that identify acceptable and unacceptable sexual relationships: the procreative script in which sex is only for procreation with a monogamous partner, the relational script in which sex is only to be engaged in while in a partnership with another individual, and the recreational script in which all sex is appropriate as long as it is consensual (Levine &

Troiden, 1988). In addition to the context within which sex occurs, certain activities and behaviors are viewed as culturally appropriate and inappropriate for example, homosexuality was viewed as culturally inappropriate, pathologized in the DSM until 1973, and stigmatized due to these cultural determinations (Lawrence & Love-Crowell, 2008). As a result of this stigmatization, individuals may experience shame related to the sexual expression of their authentic selves.

Similar to homosexuality, kink falls outside of hetero-normative sexual activity. Kink includes bondage, domination, submission, sadomasochism, sadism and masochism (BDSM), polyamory, fetishism, amputee devotion, role play, body modification, sexual surrogacy and a number of other activities (Reynolds, 2007). Kink has been documented throughout the history of clinical work and even prior to that. Similar to homosexuality, it has been put into the Diagnostic and Statistical Manual (4<sup>th</sup> ed., text revision, American Psychiatric Association, 2000) used by mental health practitioners. Although the *DSM IV-TR* qualifies these diagnoses as causing clinically significant distress or impairment, practitioners may diagnose individuals simply because they practice kink. As an extension of this clinical pathology, the general population stigmatizes those that engage in kink, viewing them as mentally ill or unhealthy (Newmarh, 2010).

Despite this stigmatization by the population at large, it is widespread in cultures worldwide. In the U.S. and Europe, 5-10% of the population report engaging in BDSM (Gross, 2006). Bondage is the practice of using restraints, such as rope or handcuffs. Domination and submission involve plays with power, in which one partner submits to the demands of the other. Sadomasochism involves the use of pain to create sexual pleasure; sadism implies getting pleasure from inflicting pain and masochism implies getting pleasure from experiencing pain.

One study demonstrated 39% of male respondents fantasized about tying up a sexual partner and 30% had rape fantasies (Federoff, 2008). A study in Canada showed that of 94 respondents, 14.9% had sexual humiliation fantasies (Federoff, 2008). In another study, 25% of respondents reported being aroused by a partner's bite (Gross, 2006). Recently, the novel *Fifty Shades of Grey* (James, 2011) has brought awareness of kink behaviors, specifically BDSM, into households around the world. The novels are frequently referenced in popular culture and read in book clubs (Williams, 2012).

As individuals begin engaging in BDSM, issues of shame and guilt may arise (Lawrence & Love-Crowell, 2008). This population is often stigmatized due to a belief that BDSM behaviors are deviant (Williams, 2009). In addition to this, people who engage in BDSM are at risk for legal issues, blackmail, infectious disease, and internalized stigma (Gross, 2006). Despite these risks, therapists and individuals engaging in BDSM report that the benefits outweigh the risks and often times the BDSM community facilitates a framework in which safety, consent, skill building, and enjoyment are high priorities (Lawrence & Love-Crowell, 2008; Newmarh, 2010).

This stigma and fear may contribute to the lack of research around those engaging in kink and the professional needs of individuals engaging in kink often go missed by practitioners due to client concerns of stigma (Hoff & Sprott, 2009). Social workers may be uncertain of the appropriateness of asking about kink behaviors during a sexual health history. They could also be concerned about their lack of knowledge or preparation to discuss kink with clients. Understanding the subjective experience of individuals engaging in kink could help professionals understand the variations, challenges, and benefits of kink. As there are working models for chemical dependency, depression, anxiety and other psychological phenomena, a working model

for the unique experiences of this community can promote a culturally-competent therapeutic relationship.

In this qualitative study, I asked practitioners working with individuals practicing kink to identify how their clients speak of their subjective experiences. I also asked them to identify the challenges and benefits of engaging in kink that clients have reported to their practitioners. Practitioners were asked for their perspective on the benefits and challenges of engaging in kink as well as the transferability of interpersonal skills from the practice of kink within a community to a person's non-kink life. This exploration can familiarize social workers with the culture, practice and experiences of clients engaging in kink as well as educate and prepare them to have discussions with their clients about kink.

## **Literature Review**

### **Sexual Health**

Adulthood is an under-acknowledged developmental stage; it includes the recognition, acceptance and expression of sexuality (Sharpe, 2003). Sexuality includes biological, psychosocial, behavioral, moral, and cultural components. These pieces of sexuality influence beliefs about acceptable sexual activity through the presence of sexual scripts (procreative, relational, or recreational). Although the World Health Organization recognizes sex as a basic human right, it does not identify "normal sexual activity" as this varies according to cultural beliefs (Bartlik, Rosenfelt, & Beaton, 2005). As a medical director and family practitioner, Sharpe (2003) identified sexuality as a part of being human and includes emotions for others and one's self. However, Sharpe did not explore pleasure and possible variables that can lead to pleasure, such as pleasure derived from participating in non-traditional sexual behaviors like kink. Sexual behaviors can be spoken or unspoken, may or may not include genital acts, may be

alone or with others, and are subjective (Sharpe 2003). Sexual desire implies energy or motivation to engage in sexual acts. This definition embodied non-traditional sexualities that may go against cultural norms and values.

Research reported that 63% of women and 52% of men who have undergone a sexual health assessment or sexual health history with a provider have reported sexual dysfunction (Nusbaum & Hamilton, 2002). Seventy-five percent of couples seeking marital therapy report sexual concerns, yet only 35% of primary-care medical providers and 24% of psychiatrists report engaging in a sexual health history (Nusbaum & Hamilton, 2002; Timm 2009). Providers report not taking sexual health histories due to embarrassment, feeling ill-prepared, a belief that sexual health is not relevant to presenting problems, and time constraints. However, sexual health can be indicative of mental illness, medication side-effects, sexual abuse, lifelong sexual functioning, happiness, life longevity, and overall health. Providers can assess sexual health by taking a sexual health history: the absence and treatment of STIs, HIV and reproductive disorders; control of fertility; avoidance of undesired pregnancies, sexual exploitation, oppression, and abuse; and pleasure and orgasm.

A sexual health history may be the first and only time when a client can disclose sexual health issues (Bartlik, Rosenfelt, & Beaton, 2005). Providers who engage in sexual health histories with clients hear more about sexual health issues (Nusbaum & Hamilton, 2002). Social workers have an opportunity to also hear about unique relationship dynamics that clients present in sessions (Timm, 2009). Sexual health histories present opportunities to provide risk management intervention with clients (Nusbaum & Hamilton, 2002). As individuals continue to progress into adulthood, they are less likely to have challenges with sexual development if they

are given education and opportunities to discuss their sexuality and changes in their sexual health (Sharpe, 2003).

Sexual health histories can bring up non-traditional sexual fantasies, urges, and behaviors, such as kink, during sessions. However, clients report feeling reluctant to discuss sexuality with providers due to a perceived discomfort in the provider and fear of a non-empathetic responses from the provider (Nusbaum & Hamilton, 2002). Complicating this problem further is the fact that there are few programs and limited resources to prepare providers for taking sexual health histories (Bartlik, Rosenfelt, & Beaton, 2005).

In order to alleviate these perceptions and fears, there are two recommended models of taking a sexual health history that reduce the stigma experienced by clients and increase their comfort: Permission, Limited Information, Specific Suggestions, and Intensive Therapy also known as the PLISSIT Model of Intervention for Sexual Problems (Timm, 2009); and a stepped model in which providers 1) Put the patient at ease; 2) Find out what the problem is; 3) Learn about the patient's sexual background and clinical history; and 4) Arrive at a plan to manage to problems (PLFA Tasks of a Sexual History) (Bartlik, Rosenfelt, & Beaton, 2005). These models can assist providers to alleviate shame and guilt, assess for risk, and determine if a referral to a sexual health specialist is appropriate. However, not all reports of non-traditional sexual fantasies, urges, and behaviors warrant a referral, and providers can be prepared to discuss sexual health issues, including kink, with their clients.

### **Clinical Identifications of Kink**

Kink is often identified synonymously with paraphilias in the *DSM IV-TR*. The *DSM IV-TR* defines paraphilias as recurrent, intense, sexually-arousing fantasies, urges, or behaviors that involve non-human objects, suffering, humiliation, children, or non-consenting

persons. Paraphilias can be obligatory or episodic within sexual fantasies, urges and behaviors. The DSM IV-TR identifies seven current paraphilias:

- exhibitionism – exposing one's genitals to non-consenting persons.
- fetishism – using nonliving objects for intense sexual fantasies, urges or behaviors.
- frotteurism – touching or rubbing against non-consenting persons.
- pedophilia – involving sexual activity with prepubescent children (13 or younger).
- sexual masochism - having intense sexual fantasies, urges or behaviors involving humiliation, suffering or being beaten.
- sexual sadism - having intense sexual fantasies, urges or behaviors about the psychological or physical suffering of others.
- transvestic fetishism – a heterosexual male having intense sexual fantasies, urges or behaviors involving cross-dressing.
- voyeurism – observing unsuspecting individuals who are naked, disrobing or engaging in sexual activity.
- paraphilia not otherwise specified – paraphilias that do not meet the criteria for other specific categories.

In order to be diagnosed, paraphilias must cause marked distress, interpersonal difficulty, or involve prepubescent children or non-consenting people (APA, 2000). However, practicing or fantasizing about kink does not mandate a diagnosis of a paraphilia. Fantasizing or engaging in kink is not pathological and some research has shown that individuals who do so are healthy and socially well-adjusted individuals (Williams, 2009). After a client discloses they engage in kink, further assessment can help the practitioner establish if the diagnosis is appropriate. However, social workers are not required to have training or clinical supervision specific to sexuality and

healthy sexual behaviors, which could increase the risk for misdiagnosing a healthy sexual fantasy or behavior as a paraphilia (Lawrence & Love-Crowell, 2008). In addition, sexual scripts (i.e. societal norms prescribing normative, or what constitutes normal, sexual behavior) influence a practitioner's sexual values as well as their comfort level discussing sexuality and sexual behaviors, increasing the risk for misdiagnosis (Lawrence & Love, 2008; Timm, 2009). Cultural and religious messages also define normalcy within sexuality and sexual behavior, further complicating the diagnosis of a paraphilia (*DSM IV-TR*).

Differentiating kink from a paraphilia is just one concern for social workers; the *DSM IV-TR* recommends that during the assessment of a paraphilia, professionals need to assess whether clients may be diagnosed with mental retardation, dementia, a personality change due to a general medical condition, substance intoxication, a manic episode, or schizophrenia instead of a paraphilia; sexual fantasies, urges or behaviors are symptomatic various mental illnesses. In addition to these disorders, practitioners are at risk of attributing the practice of kink with out-of-control sexual behavior, also referred to as sexual compulsivity, sexual impulsivity, hypersexuality, or sexual addiction, and may diagnose individuals with impulse-control disorder not otherwise specified (Bancroft & Vukadinovic, 2004). Self-injurious behaviors such as cutting, piercing or tattooing can be symptomatic of depression, borderline personality disorder, and eating disorders (*DSM IV-TR*), yet Myers (1992) found that some individuals report engaging in these behaviors explicitly for sexual pleasure. To further complicate matters, there is a lack of agreed upon terms for all kink behaviors in communities in which awareness is relevant (i.e. the medical, mental health, and kink communities); and some kink fantasies, urges, and behaviors fall outside of the awareness of all of these communities (Gross, 2006).

### **Kink Stigma**



Beyond the pathology of kink, there are number of other ways kink is stigmatized. Media can sensationalize instances of violent sexual crimes; however, sexual violence is a normal part of sexual fantasy. In one anonymous survey, researchers found that of a sample of college students, 51% of males reported they would rape a woman if they believed they could get away with it; 25% of male and female respondents reported they believed women would enjoy being raped if no one knew about it (Federoff, 2008). Other studies (as referenced in Federoff, 2008), have reported that 39% of respondents reported fantasizing about tying up a partner, 30% reported fantasizing about raping a partner, 33% of respondents had rape fantasies, and 14.9% had humiliation fantasies. In all of these studies, respondents did not have sexual offense histories. Despite this evidence that violent sexual fantasies exist for numerous individuals, media portrayals in a way where kink is congruent with sexual violence despite practices of consent and safety.

At the same time and for much the same reason, the population at large often associates perpetrators of violent sexual crimes with kink, specifically BDSM (Federoff, 2008). Yet, there currently is no research to support the assertion that engaging in BDSM is a risk factor for perpetrating violent sexual crimes. Although behaviors that resemble or are practiced in BDSM may be present in violent sexual crimes, consent has not been a part of the interactions, violating the rules and norms of current kink communities (Newmahr, 2010; Yost, 2010). Practitioners also report that differentiating physical and sexual abuse from healthy kink is not difficult if the practitioner demonstrates cultural competence through education on kink practices, understanding of kink identity issues, and knowing dynamics of kink relationships and communities (Lawrence & Love-Crowell, 2008).

Because of this spurious association between violence and consensual kink, early views of kink were primarily viewed as non-consensual and eroticized as such (Newmarh, 2010). Research, however, has shown that individuals who engage in BDSM seek partners with clearly defined limits (Gross, 2006). This is done to differentiate themselves from rapists and sexual abusers and to reduce the risk for legal issues. Frequent discussions, high priorities, and educational components of kink communities focus on obtaining consent, communicating limits, negotiating an emotional and physical safety plan, building kink skills, discussing health concerns, and addressing the risk for blood-borne pathogens (Newmarh, 2010; Williams, 2009). The BDSM community defines the importance of consent and safety to their members through two acronyms: Safe, Sane and Consensual (SSC) and Risk Aware Consensual Kink (RACK) (Williams, 2009).

Given the continued stigma of kink, kink activities are often closeted and people who engage in kink are often at risk of having this closet used against them. Some individuals who engage in kink may not disclose their behaviors due to concerns of fear and alienation from loved ones, the non-kink community, or professionals. Individuals may even hide their identity or participation in kink behaviors (Stiles & Clark, 2011). People practicing kink are also at risk for civil suits, criminal charges, child custody issues, blackmail, physical injury, blood-borne illnesses, sexual assault or rape, and interpersonal values conflicts (Gross, 2006). The National Coalition for Sexual Freedom's Violence and Discrimination Survey found that of over 3058 respondents who reported engaging in kink, 37.5% had experienced discrimination, harassment, or violence (2008). Stiles and Clark (2011) suggest that keeping one's kink behaviors a secret can create emotional and mental health challenges but can reduce the risk for harm, enhance the excitement of the kink experience, and promote a sense of belonging within the kink community.

This stigma also operates in mental health settings. Hoff and Sprott (2009) found that of 231 clients in therapy who practiced BDSM, 118 of them experienced incidents of biased or inadequate care in which they experienced stigma or there was an unnecessary focus on kink within sessions. Within the study, clients reported positive, neutral and negative responses from clinicians in regards to their disclosure of engaging in kink. Some individuals reported neutral and positive responses from their providers and this led to client feelings of comfort and safety. If the client experienced stigma, this led to future non-disclosure to the provider around other challenging issues or termination from therapy.

Although the kink community identifies a wide range of activities that produce rewards, there is also a wide array of feelings that may emerge before, during, or after a kink encounter. Some individuals engaging in kink may experience shame and guilt (Lawrence & Love-Crowell, 2008). Internalized stigma may emerge due to the perception that kink is deviant (Stiles & Clark, 2011). Clients also report concerns of being pathologized due to their kink behaviors (Newmarh, 2010). However, kink is not often the presenting issue when an individual works with a therapist (Lawrence & Love-Crowell, 2008). Relationship concerns are often the primary presenting issue. Individuals engaging in kink may also present concerns of disclosure, vulnerability, and intimacy (Hoff & Sprott, 2008)

Therefore, even if social workers continue to promote access to mental health services for all populations, there are limited efforts to provide and assist this large, non-traditional sexual community with culturally-sensitive services. Again, it is the experiences of stigma that create barriers to accessing mental health services for individuals engaging in kink (Hoff & Sprott, 2009). Yost (2010) identified four primary sources of kink stigma: Judeo-Christian values which identify norms of monogamy and heterosexuality; feminism which identifies the power

imbalances of kink as sexual violence; psychiatry which identifies kink as a mental illness; and links of kink to violence and crime. This stigma can be felt by clients in therapy/counseling sessions through inaccurate diagnoses of behaviors, challenges to information gathering and observations in sessions, labeling, and negative assumptions (Hoff & Sprott, 2009).

In response to kink stigma, Guy Baldwin, a practitioner based in Los Angeles, began a Kink Aware Professionals (KAP) list so that individuals engaging in kink would be able to receive services from non-stigmatizing professionals, and practitioners could network and consult with one another to enhance their cultural-competence (NCSF, 2011). Initially started to address the mental health needs of the kink community, the KAP list now includes medical and legal professionals to address currently identified vulnerabilities of the kink community. This list allows perspective clients to identify culturally-competent professionals who can provide clients with the opportunity to explore issues unrelated to kink without jumping to the conclusion that their kink behaviors are the primary issue (Lawrence & Love-Crowell, 2008). They can also assist them to explore and understand their kink fantasies, urges, and behaviors, and determine if clinical distress is due to stigma or feelings of guilt and shame, or if a paraphilia diagnosis is appropriate.

In moving beyond the stigma of kink, research actually suggests that clients who engage in kink have numerous strengths, and kink can lead to self-actualization, enhance self-expression, promote empowerment and self-efficacy, bring about a renewal and regeneration of self, create an emotional catharsis or sexual pleasure, or be used to overcome traumatic experiences (Newmahr, 2010). The number of KAPs, however, is limited and not all clients have a KAP available in their area. Expanding this network will provide clients an opportunity

to access mental health services with a decreased risk of stigma.

### **The Kink Experience**

Anecdotally, reports show that engaging in kink is rewarding. Newmarh (2010) found that kink communities are accepting of numerous practices. This may be in part due to the challenge of finding partners or spaces in which to practice kink activities. For some, they feel sexual pleasure when they engage in kink (Newmarh, 2010). In a previous, unpublished pilot study, I found that some individuals reported intense emotions, feelings of enhanced partner intimacy, a cathartic release, and were able to process traumas from their past (Appendix C). Interestingly enough, I found that the activities a person chose to engage in facilitated certain types of outcomes (i.e. sexual pleasure, cathartic release, etc.). The kink community identifies a number of practices: bondage - restraining a partner physically or psychologically, domination and submission - power exchange between individuals, sadism - pleasure derived from the physical or psychological suffering of others, masochism - pleasure derived from physical or psychological suffering, polyamory - multiple sexual and/or relational partners, fetishism - pleasure derived from nonhuman objects, amputee devotion, role play - pretending or acting to be someone other than one's self, body modification - piercing, tattooing or cutting, sexual surrogacy, impact play - striking another person or being struck by another person, and many other activities.

In all of these activities, consent is a complex issue for those engaging in kink - the level, frequency and intentions of a particular encounter or relationship are currently identified by the kink community as important to discuss with partners (Lawrence & Love-Crowell, 2008). Some individuals who engage in kink have brief encounters, or "play", while others engage in 24/7 kink relationships. Negotiating consent for the varying degrees of participation and frequency

can involve specific, moment-by-moment consent or generalized consent. Those who do not continue to establish consent can negatively impact their status and participation within their kink community (Newmarh, 2010).

Research suggests that kink is actually part of a healthy sexuality spectrum (Gross, 2006). Dominance and submission are also considered to be normal within current traditional sexual activity. Frequency of kink encounters varies according to individuals' preferences and relationships – for some it is part of every encounter they have and for others it is occasional occurrence. Kink can be a source of serious leisure for some individuals, connecting them to others, enhancing their friendships and social skills, and strengthening their identities (Newmahr, 2010, Williams, 2009). It is, for them, a source of fun and play, an endorphin rush, an escape from daily routines, a source of freedom, or even a spiritual experience (Williams, 2009). Some individuals report that they feel safe, or at “home”, when practicing kink because they become part of a community (Newmahr, 2010).

Although sadism, masochism and sadomasochism (SM) are classified as sexual disorders, research suggests that not all kink encounters are sexual (*DSM IV-TR*; Gross, 2006; Newmahr, 2010). For example, spankings tend to be frequently associated with sexual interaction where SM activities may lead to ecstatic or cathartic, not sexual, experiences. Newmahr (2010) and Williams (2009) explored similarities between engaging in serious leisure activities, such as kayaking or mountain climbing, and BDSM, noting that they shared outcome qualities: they help individuals feel empowered, they help establish an identity or integrate fragmented identities, they leave them feeling regenerated, they create a sense of belonging, or they help them overcome traumatic experiences.

### **Limited Research**

There is limited research of individuals engaging in kink behaviors. Due to stigma or fear of legal issues, individuals who engage in kink may not report their behaviors or volunteer for research studies. Of the studies that do exist, data collection has primarily relied on accessing established kink communities in which sexual encounters were a part of the community or Internet sites that sexualized kink. Individuals who engage in non-sexual kink may not be a part of these forums. Also, individuals who have been rejected from these communities due to not following established norms may not be represented in the existing samplings.

There is limited literature on the subjective experience of those engaging in kink. New models and theories of the subjective experience could help practitioners engage in culturally-competent practice, reduce experiences of pathology and stigma, increase diagnostic accuracy, and utilize potentially helpful interventions. With models and theories, practitioners could more accurately assess safety and help clients practice behaviors that feel healthy to them.

The purpose of this study was to learn of the benefits and challenges of engaging in kink that clients report to their clinicians. In addition to this, clinicians were asked to report if their clients experienced different outcomes from different kink practices and the internal processes that occurred that led to these various outcomes. Clinicians were asked to identify potential challenges and benefits to their clients who engage in kink. Finally, clinicians were asked to identify if there is any transferability of skills for those who engage in kink from the client's kink environment to their non-kink life.

### **Conceptual Framework**

#### **U.S. Work Ethic**

United States culture places value on working and as a result, leisure time is limited to non-work hours. This can make leisure one of the most rewarding ways for an individual to

spend their time. With the advent of the eight-hour work day, individuals spend time outside of work engaging in leisure activity such as eating, volunteering, engaging in the arts, or playing sports. Participating in leisure activities can be an important part of an individual's life and be an important source for life satisfaction. In fact, leisure activities may be one of the most valuable parts of one's life (Stebbins, 2011). Despite its value, typically leisure has been viewed as casual and unnecessary as a result of the U.S. value of employment. However, engaging in leisure activities is a means for some individuals to feel healed, refreshed, or satisfied with their lives (Stebbins, 2001). Leisure can be of great importance to individuals who experience stress, pressure or anxiety as a result of work.

### **Qualifying Leisure**

Robert Stebbins began to study leisure activities in 1973 when he began to observe amateur musicians and the culture surrounding them (Stebbins, 2001). He has published numerous articles about leisure activities and their importance in rehabilitation and institutionalization. He introduced the concept of qualifying leisure as casual, project-based, and serious. All of these classifications provide contentment and satisfaction. For people who experience major life change, such as disability due to an accident or medical condition, leisure can be a means to find purpose to life or even enhance the efficaciousness of rehabilitative treatment (Stebbins, 2008). Whether leisure is for rehabilitation or contentment, it ultimately is not coerced and is viewed as satisfying by those engaging in it.

The first type of leisure, casual leisure, is immediately rewarding and requires no special training (Stebbins, 2001). Satisfaction from casual leisure tends to be short-lived and does not lead to a feeling of life satisfaction. Casual leisure activities may include play, relaxation, passive entertainment, active entertainment, sociable conversation, sensory stimulation (sex,



eating, drinking, sight-seeing), casual volunteering, and pleasurable aerobic activity (Stebbins, 2001). This is the most commonly accessed type of leisure in U.S. culture due to an over-worked and heavily-stressed population. As a result of being easy to engage in, there is the risk of it becoming habitual. Due to the short-lived satisfaction, individuals only engaging in casual leisure may begin to feel a sense of purposelessness with life.

The second kind of leisure, project-based leisure, provides similar rewards to casual leisure in that they are short-lived and do not lead to a feeling of life-fulfillment (Stebbins, 2011). Project-based leisure may involve short-term projects such as putting on a show or performance, or organizing a fundraising event (Stebbins, 2001).

Serious leisure, the third form and in contrast to casual leisure and project-based leisure, can provide personal enrichment, enhanced self-esteem and self-awareness, and financial and social returns (Stebbins, 2011). It is long-lasting and means a lot to the participants. More so than casual or project-based leisure activities, serious leisure activities require larger amounts of mental or physical energy. Serious leisure engages its participants due to its complexity, which can increase feelings of non-work life satisfaction. It differs from paid-work in that the recovery time is limited if needed at all. Serious leisure promotes perseverance, provides potential career opportunities, involves special training and experience, develops and enhances self-image, and provides access to a social world and identity.

### **Kink as Serious Leisure**

Williams (2009) found that individuals who engage in kink used descriptors such as: fun, play, endorphin rush, escape from routine, freedom, and spiritual. He also found that individuals engaging in kink spent hours preparing and planning scenes and events, made toys and equipment for their practice, engaged in on-going learning and education, and had created their

own terminology, suggesting that kink communities are a subculture. Individuals who engage in kink often times do so within a community context (Newmarh, 2010). In one study, respondents stated that kink helped them powerfully connect with others and integrated their fragmented identities (Williams, 2009). Participants report feelings of satisfaction and life-fulfillment (Newmarh, 2010). Kink community members reported an enhanced self-image and that being a part of the community meant a lot to them. With these descriptors and established norms, kink fits within Stebbins' framework of serious leisure. I have chosen 'serious leisure' as the theoretical framework to apply to this study as it helps differentiate paraphilias from non-pathological kink and it assists in better understanding this social and sexual phenomenon in which kink communities promote kink as 'serious leisure'.

## **Methodology**

### **Research Design**

The purpose of this qualitative study was to learn about perceived challenges and benefits of participating in kink as well as to understand reported outcomes of participating in kink. Although there is research demonstrating the wide array of kink activities, there continues to be a lack of research exploring healthy kink behaviors. In a pilot study done by the researcher, the findings led to the creation of a theoretical model of the subjective experience of impact play, a specific type of kink involving physical impact to the body, as clients reported to a clinician. The model suggested that engaging in impact play (flogging, spanking, punching, hitting, kicking, etc.) can create experiences that are sexual and non-sexual, and lead to positive outcomes or results, similar to those kink experiences discussed by Williams (2009) through the conceptual framework of serious leisure.

For this study, participating clinicians who work with individuals who engage in kink were interviewed and asked to identify what are some of the benefits, challenges, and outcomes of engaging in kink reported to them by their clients. The clinicians were also asked to offer their opinions of the benefits, challenges, and outcomes as well as the transferability of skills from the kink community to non-kink related activities/communities. This offered a unique perspective: experiences as reported to the clinicians as well as the views and opinions of the clinicians on this often hidden population.

### **Population and Sample**

There were a total of eight interviews. Participants were recruited electronically from around the U.S. through National Coalition for Sexual Freedom's (NCSF) Kink Aware Professionals directory. Participants were listed on the Kink Aware Professionals directory through the NCSF, which identified them as kink-aware and prepared to work with clients who engage in kink. This sample was selected due to their unique, specialized access to those who engage in kink. The participants were selected at random by the researcher, and then contacted if they noted their licensure and the length of time they had been working with individuals who engage in kink in the KAP directory. All of the participants were licensed mental health practitioners and had been working with individuals who engage in kink for at least two years. All of the participants had identified as kink-aware or kink-knowledgeable on the NCSF KAP directory. NCSF has three tiers of kink aware providers:

- **Kink-Friendly:** open and non-judgmental of kink concepts and lifestyles, with general knowledge only.

- **Kink-Aware:** have specific knowledge of kink concepts and lifestyles, have researched and educated themselves in these areas. May have some previous experienced providing professional services to individuals with these interests.
- **Kink-Knowledgeable:** have previously provided professional services to multiple individuals in the lifestyle. Very experienced in kink concepts and lifestyle. (NCSF, 2011)

There were four rounds of recruitment: the first round, during which ten recruitment e-mail requests were sent out, six individuals responded to the request, and four engaged in interviews; the second round, during which five recruitment e-mail requests were sent out, of which one individual who was contacted had been recommended by another participant (snowball sample), were sent out and three people responded and engaged in interviews; the third round, during which seven recruitment e-mails were sent out, two individuals responded, and one individual engaged in an interview. Finally, two individuals were recruited at a Kink Aware Professionals networking group, of which one individual engaged in an interview.

Upon initial contact, the participants were informed of the purpose of the research study and the design of the study. The participants were informed that a refusal to participate in the study will in no way affect their relationship with the University of St. Thomas or St. Catherine's University. An offer to participate in the study was extended to the participant. If the participant agreed to be a part of the study, a date, time, and private location was established for the interview.

### **Protection of Human Participants**

This study was reviewed by the University of St. Thomas/St. Catherine University's Institutional Review Board (IRB) to ensure ethical treatment of participants. Upon approval of

the IRB, participants were recruited. After meeting in-person the consent form was reviewed, an assessment was performed to ensure participants understood the content of the consent form, and the participants were asked to sign a consent form. Participants that engaged in distance interviews via Skype were asked to mail back a copy of the consent form or sign the consent form electronically and e-mail the form to me. The participants were informed that if they refused to sign a consent form, they may withdraw from the study without any impact on their relationship with the University of St. Thomas or St. Catherine University. Participants were given a copy of the consent form to keep. Signed consent forms were scanned and stored on my personal computer, which is password protected and stored in a locked building. The signed consent forms were shredded immediately after being scanned electronically. The electronic forms will be destroyed by May 20th, 2014.

Participants were informed that they may feel discomfort while answering the interview questions. Participants were told they may withdraw from the study at any point before or during the interview. I reminded participants to refrain from providing any identifying information of their clients. In order to thank participants for their participation, a \$5.00 gift card was provided upon completion of the interview.

### **Data Collection**

Ten questions were developed based on the existing literature and the conceptual framework to elicit feedback about client experiences, challenges, benefits and practitioner opinions about kink. The interviews were one-on-one, audio-taped, and later transcribed. The question format was semi-structured (Berg, 2009). Participants who were not able to meet in-person were interviewed via Skype. None of the interviews were done via video conferencing to

further ensure the protection of participants. Skype audio interviews were recorded and later transcribed.

The interviews were recorded as an electronic audio file and stored on a password-protected personal computer. The audio recordings will be kept for one year and destroyed by May 20th, 2014. Interview transcriptions will be kept indefinitely, only to be used for educational or research purposes. I removed any particularly identifying information from the transcriptions.

### **Data Analysis**

The interviews were transcribed verbatim. A deductive approach was used to create questions based on the current literature about individuals engaging in kink (Berg, 2009). After transcription, descriptive phenomenology was coded in a line-by-line coding of the data. Upon completion of open coding, an inductive approach was used to identify themes, sub-themes, and latent themes that may emerge from the codes.

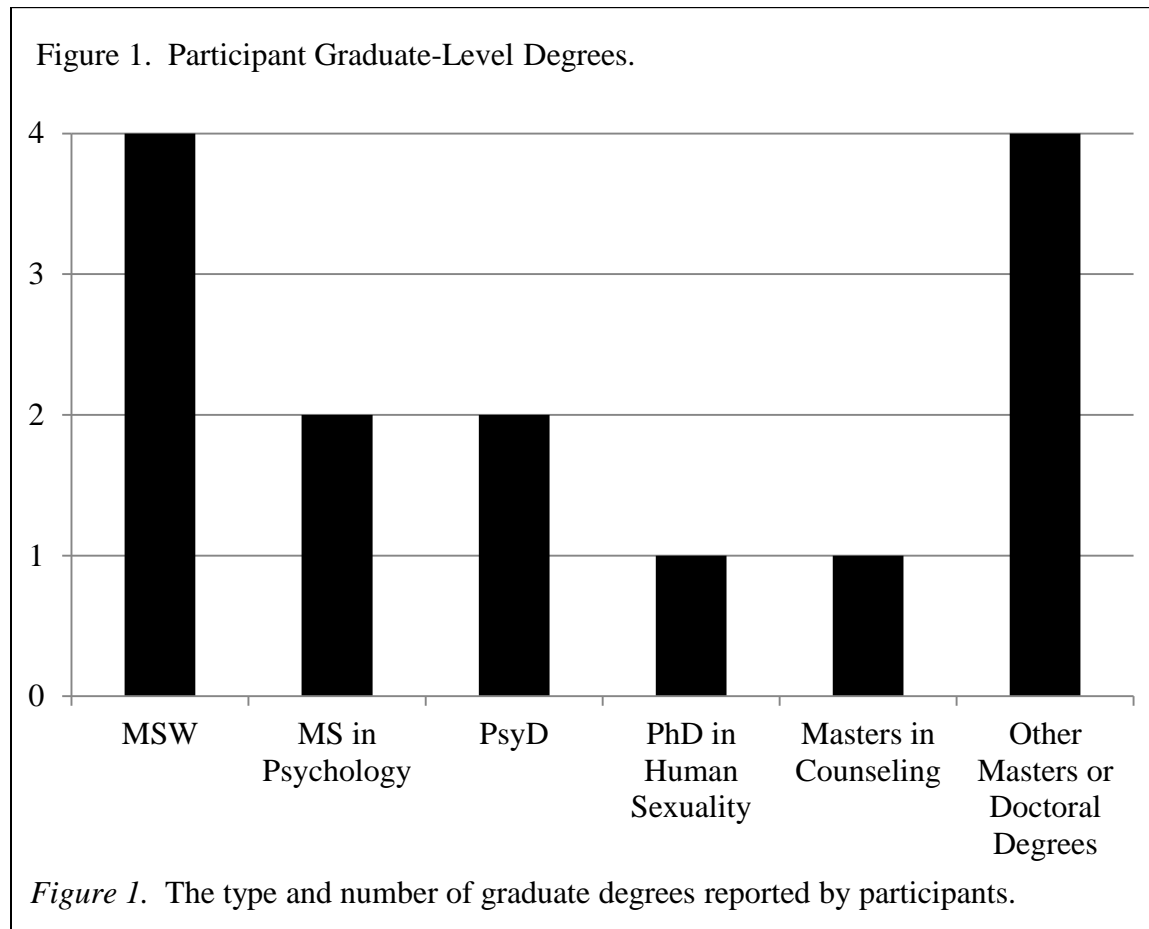
## **Findings**

### **Participant Data**

Of the individuals who participated in interviews (n=8), two identified as female and six identified as male. Participants were located in four different states, all in different regions of the United States.

**Education and professional development.** All of the participants were licensed mental health practitioners and had been working with individuals who engage in kink for at least two years. Four of the participants had a masters of social work. Two participants had a masters in psychology and two had a doctorate in psychology. One participant had a masters in counseling and one had a doctorate in human sexuality. Other supplemental educational degrees included a

doctorate in oriental medicine, a masters in health sciences, a masters in chemistry, and a masters in massage therapy (Fig. 2, Page 28).



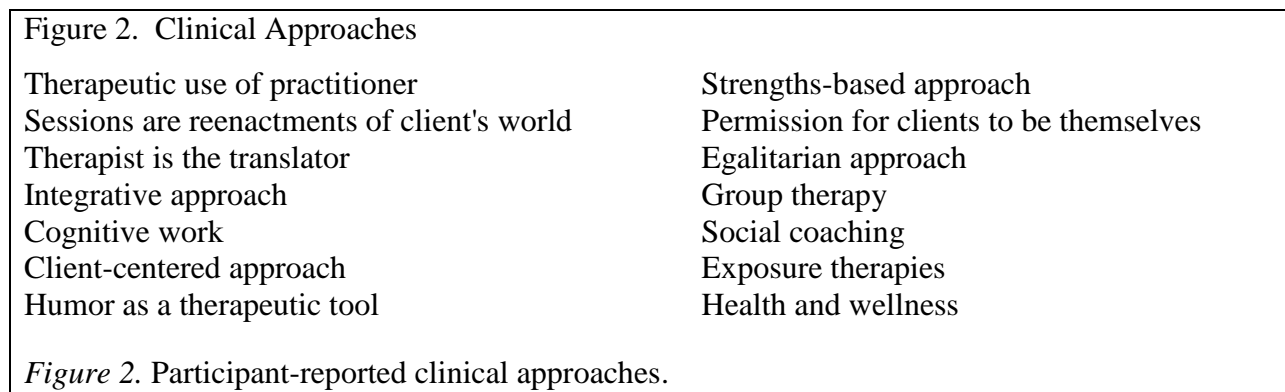
All of the respondents had additional training, skills and professional certifications to enhance their work in human sexuality. One participant had been certified through the American Association of Sexuality Educators, Counselors and Therapists (AASECT). One participant had engaged in post-doctoral education in human sexuality. All of the participants reported engaging in continuing education with a focus on human sexuality. To supplement their work, one participant reported becoming a certified Supreme Court Certified Family Mediator and another participant reported their bachelor's level education included conflict resolution.

**Clinical approach.** All of the participants were in private practice. In their interviews, two participants reported providing clinical supervision and two reported engaging in contract mental health work around human sexuality. One respondent reported owning and working at a multi-disciplinary organization focusing on health and wellness.

All of the respondents reported working with sexual or erotic minorities. This work seemed to be intentional in that the participants felt sexual/erotic minority communities were stigmatized. One practitioner defined individuals that may be considered sexual or erotic minorities:

*By erotic minorities I mean people who, generally speaking, are stigmatized or persecuted by institutions in society and by individuals. So this would be people who are not approved of by churches, universities, the government. That would be, basically, people of a minority orientation such as lesbians, bisexuals, and gay men. But most of my practice is [with] kinky people, swingers, sex workers, and porn industry professionals.*

There was no consistent clinical approach reported by the participants. All of the participants reported using clinical approaches centered on their clients' needs. All of the respondents reported using flexibility in the work they engaged in with their clients who engage in kink. (Fig. 2)



**Theoretical framework.** All of the respondents reported using the psychoanalytic paradigm in their private practice. Within their work, however, practitioners reported using



theoretical frameworks specific to their interests, which they have found to be successful in their work with clients. (Fig. 3, page 30)

Figure 3. Theoretical Frameworks

Jungian	Object Relations
Intersubjective Dynamic	Narrative Therapy
Humanistic Existentialist	Eriksonian Utilization
Psychoanalytic	Hypnotherapy
Relational Psychoanalytic	EMDR
Bowen Theory	Rogerian Positive Regard
Humanistic Existentialist	Gottman Theory
Buddhist	Keeney Theory
Psychodynamic	Gestalt Therapy

Figure 3. Participant-reported theoretical frameworks.

### Working with Individuals Who Engage in Kink

All of the participants reported that it is not common for individuals who engage in kink to come into therapy specifically to address their kink. They report clients are more likely to come in to address issues unrelated to their kink and chose to come to a Kink Aware Provider because they will not unnecessarily focus on their kink in the sessions.

*...often times people who engage in kink come to me because they have some other problem that's not really related to their kink. But they come to me because they know I'm not going to get distracted by that or try to blame whatever problem on that.*

When in sessions, participants utilized various methods to discern whether kink was an issue in their work with their clients.

**Clinical differentiation.** When asked how to differentiate healthy kink, problematic kink and a paraphilia, three of the respondents reported that identifying kink in this way implies a binary of right versus wrong; healthy and problematic are social constructs. Kink in of itself cannot be healthy or unhealthy, it just simply “is”, and values such as “healthy” and “problematic” are assigned by the client and by society.

*I don't really use the term healthy kink or unhealthy kink because I kind of think kink is neutral. I think any form of sexuality is really neutral so I don't look for healthy or unhealthy right off the bat because I feel that limits my vision of the person I'm sitting in front of.*

In order to become a Kink Aware Professional, providers electronically sign an agreement which states they believe kink can be a healthy sexual activity. This view seemed to be shared among all of the participants. One provider succinctly stated how he defines healthy kink:

*When it's within the consensus and there is no danger to health or safety, I consider it healthy kink.*

All of the participants reported that they let the client decide if their kink is problematic. Some of the signals of problematic kink participants had heard from their clients were distress, non-consensual acts, risk of physical harm, risk of psychological harm, and negative impact on interpersonal relationships. One participant noted that just because a client is identifying kink as problematic, it does not mean it is unhealthy; the client's view that their kink is unhealthy required further exploration to rule out personal sexual scripts formulated by external stigma as a cause for the distress specific to the kink.

*But the kink itself is not unhealthy. Let me put it to you this way. Sex does not have meaning. People give it meaning. It doesn't have its own inherent meaning. So kink can't inherently be anything. People have to give it whatever [meaning] it's got.*

Another participant stated that although he may identify behaviors that imply the kink is problematic, he is likely not to say that the kink is problematic and ultimately let the client make the decision as to whether the kink is problematic.

*What's problematic may be if there's a guy that's going to hookers and he's mortgaged his house and lost his job and his wife is leaving him. Maybe that's problematic and he doesn't see it as problematic. Maybe I'd tell him, but probably not.*

When asked how they differentiate problematic kink from a paraphilia, five participants reported they do not use *DSM IV-TR* diagnoses in their work. One participant felt the *DSM IV-TR* classifications were not based in science.

*I find the paraphilia section of the DSM problematic because it conflates a lot of sexual behavior that is consensual, non-consensual, that involves children, that involves adults. I find it to be a very sloppy, non-scientific section of what is a very non-scientific book. I really tend to steer away from that, while arguing for a revision of that section.*

Another participant reported that he felt the *DSM IV-TR* classifications created stigma for those who engage in kink.

*Paraphilia is a term I don't like, don't approve of, don't use. People say it's neutral. I don't think so. It sounds shaming as hell to me. Alongside love? What do you mean? That is really judgmental, I think. So, I don't use the term, even though it's still in the DSM IV.*

Of the three who reported using the paraphilia diagnoses from the *DSM IV-TR*, two participants reported educating their clients on the diagnostic criteria for a paraphilia and letting their clients decide if the diagnosis was necessary.

*One of the things I do is teach a lot of classes on how to spot a dangerous lover and show them the difference between domestic violence and BDSM and consent, and I give them lots of paraphernalia from the National Coalition for Sexual Freedom. I give them lots of resources and then we sit back and evaluate together. "What do you think this is? Is it a paraphilia? What's going on for you?" I try to make that [diagnosis] collaborative.*

The other reported that he did not diagnose clients, but instead translated problematic kink issues clients reported to him into categories that fit within the framework of the *DSM IV-TR* in order to bill insurance companies for the work he does with his clients.

*And I also interface with the insurance industry, which requires DSM diagnoses. So if there's a sexual behavior for a person that's a problem and clarifying specifically why it's a problem, then I might translate that problem into a category within the category system of the DSM.*

In order to accurately make these differentiations, the participants emphasized the need for professional development and personal awareness to practice with individuals who engage in kink.

**Enhancing Cultural-Competence.** When asked how practitioners could begin or improve their existing work with clients who engage in kink, five themes emerged in the participants' responses: client approach, practitioner self-awareness, referrals to kink aware professionals, clinical approach, and professional development.

***Client approach around experiences of kink.*** Participants expressed concern over some of their clients' previous experiences in therapy in which the client disclosed they engaged in kink; the clients' previous providers stigmatized and pathologized their clients.

*I had a client who came to me about six weeks ago who's [in his twenties], straight, [race], educated, high-functioning, and he's into shit [feces/scat play]. And he went to a kink-aware professional who advertises here in [redacted] as a sex therapist and she told him, "What you're doing is disgusting and it's dangerous and you have to stop. And if you continue to do it, I'll have to call a psychiatric emergency team and have you taken to a mental ward on a fifty-one fifty, where you'll be locked up for 48 hours. And, I think you need to go to a sex addicts group." That's awful. It's absolutely awful. And he came to me shaking, in tears, "You're not going to call a PET team on me, are you?" And I said, "absolutely not. There's nothing wrong with what you want to do. It's fine with me."*

One participant stated that understanding the diversity of sexual expression can help prevent intentional or unintentional stigmatization in sessions with clients.

*They need to know that human sexuality and relationships vary widely and they need to know that the same behavior for one person may be problematic and an expression of something going wrong and maybe an expression of health in another person and that the determination of whether something is a problem or not, more often than not, needs to lie with the position the person takes on their own life.*

Two participant recommended practitioners follow their clients' leads in discussions of kink – the client is the expert on their own life and will help the practitioner understand the reasoning behind disclosing kink behaviors in a session.

*It doesn't matter what I understand about daddy/boy or master/slave relationships. It matters what my patient believes about daddy/boy or master/slave relationships and I have no knowledge of that until I understand that person's narrative and understand that person.*

If a client feels safe enough to disclose their kink to a practitioner, participants suggested issues of counter-transference may emerge, so having an understanding of oneself is important in this kind of work.

***Practitioner self-awareness.*** One participant reported the importance of understanding why people may engage in kink; this understanding can assist with empathy in their work with clients who engage in kink. This can help them be open to new experiences in their professional work.

*But I think they have to have their values clear and they have to have a professional understanding. They have to have their own professional understanding of why anyone, whether the average person or average client, would choose this type of sexuality.*

Five of the eight respondents reported engaging in kink, themselves. Two of the participants felt clinicians should engage in kink themselves and participation in kink is necessary in order to successfully work with individuals who engage in kink.

*I think, the most important thing is that they shouldn't see them [kinky clients] unless they're kinky, and I say that all the time.*

One participant took the opposite stance of this when he stated that practitioners who identify as kinky should not go to kink events as this would cross professional boundaries and prevent them from working with the kink community due to pre-existing relationships.

*I don't feel that I can go to play parties, or to conventions, or conferences where people are doing workshops and having parties after hours and so forth. Not because it would be wrong or I could be criminally indicted as not adhering to professional standards but probably because I'm going to run into clients, or who-would-be clients, except for the fact that they met me at an event and therefore I can't ever help them.*

Although a practitioner may identify as kinky, one participant felt that this did not qualify a practitioner to work with the kink population.

*For instance, I'm a member of the kink community but I'm also a lesbian. Just because I'm a lesbian doesn't make me think that I'm qualified to work with the LGBT community. So, I went and got extra training on working with the LGBT community. When I decided to work with the kink community, I sought out a sex therapist who's been trained and done this work for thirty years, and I mentored under him for a long time to learn more.*

Another participant stated that working with the kink community and being kinky oneself present numerous professional challenges, and awareness of personal and professional boundaries is very important.

*So I've chosen the mostly cautious way. I've made some pronouncements public, like being on those lists and saying that I view this positively, that's some risk, and it used to be a big risk, but now it's small risk. But participating in the community is a much bigger risk.*

Blurring boundaries can be important and helpful in working with individuals who engage in kink, according to another participant; the participant takes field trips with their clients to kink events and is available to coach them around communication, finding partners, negotiation, and identifying community experts.

*But our relationship is very egalitarian, which blurs a little bit of that boundary line. But we stay within appropriate boundaries, in the sense that we don't have sex with clients and things like that. But, I have chaperoned my clients to a kink party to be able to be there to offer advice, to answer questions, in fact all sorts of things.*

**Referrals to kink aware professionals.** According to participants, not all providers can or need to work with individuals who engage in kink. Human sexuality issues can be complex, according to the respondents, so being aware that there are specialists can be very helpful to practitioners and clients. By referring clients to specialists, they can prevent stigmatizing this vulnerable population and as a result will be practicing in an effective and therapeutic way.

*There are going to be some clinicians who are going to need to say, "You know, I just can't talk to you about BDSM because I'm uncomfortable with it and I don't know enough about it and I need to help you find a resource that will be helpful to you." I think that's fair to do. It's good to do.*

Respondents mentioned accessing the Kink Aware Professionals directory through the NCSF as these individuals are self-identifying as kink aware and are prepared to work with clients who engage in kink.

*It's nice that they [a referring organization] knew there was someone out there they could ask. So the fact that the NCSF has the kink friendly confirming list, was great.*

One participant expressed concern over the use of the directory as it is self-reporting; KAP providers may not actually be kink-aware or have any expertise to some of the complexities that may arise in sessions. By being on the KAP provider list, they are in fact putting the client at risk for harm. Individuals on this directory may be aware the kink exists, what it may look like, and the context it may occur within, they may have participated in kink, or they may be part of a long-standing kink community.

*In a place like [redacted] where I live, we have lots of kinky therapists here now, and it's very disturbing to me that non-kinky people advertise on kinky websites, such as the Kink Aware Professionals, that they're kink-aware when they're not.*

Another participant explained the variations in self-identification of the KAP directory. He felt professionals referring to providers on the directory should be aware of what these differentiations mean.

*I think, for me, the Kink Aware Professionals directory has these 3 arbitrary levels that people get to select for themselves: kink-friendly, kink-aware, and kink-knowledgeable. Kink-friendly is just being ok hearing stuff and not putting people down for it. It's sort of a general positive attitude. Kink-aware means you know something more about the structure and organization and activities. You may know a lot about specific fetishes and activities. And kink-knowledgeable, I have a different definition of that than what NCSF does because they fudge on it, and let anyone define themselves as knowledgeable, and to have people get knowledgeable through book learning.*

The ultimate goal of referrals thematically focused on the prevention of kinky clients experiencing external stigma within therapy sessions. This stigma may be intentional or

unintentional, but regardless of intent, the clinical approach plays a major role in client experiences of stigma.

*Clinical approach with clients who engage in kink.* Participants reported kink stigma clinically can emerge through morality, pathology, and quick judgments. One participant suggested that being comfortable with discomfort can help resolve counter-transference that may emerge in regards to disclosures of kink. In addition to this, awareness of one's clinical paradigm is important when working with clients who engage in kink. Five of the participants felt the organic paradigm, of which the *DSM IV-TR* is the foundation of, stigmatizes clients and therefore should not be used. Two of the participants felt that working from a sex addiction model, an extension of the organic paradigm, is not going to be helpful in working with clients who engage in kink and stigmatize their kink behaviors.

*Take the strictures of professional groups like [redacted] which I'm a member [of] and [redacted] but even on list-servs, I get e-mails demonstrating gross ignorance of a lot of sexual issues. I think, "How can this be?" So even taking [redacted] standards too seriously and what are they calling it now... but they still operate mainly on the addiction model.*

Respondents reported that building the therapeutic alliance was a very important approach in working with clients who engage in kink. This can be done by normalizing kink, using a sex-positive framework in making statements or asking questions of to clients, emphasizing sex is not something to be feared, being non-judgmental, practicing empathy, understanding the uniqueness of each client situation, and approaching the uniqueness of each client situations with a sense of curiosity without being exploitive or voyeuristic.

Respondents identified that often times, internal stigma can emerge in sessions with clients who engage in kink. Having skills in addressing internalized kink-phobia can be an important part of therapy with clients who engage in kink.



*So I think just thoughtfulness and sensitivity around that internalized stigma and a sort of grace to when it comes to working with it. I think that's the most important piece.*

Another clinical task can be engaging in a risk assessment. However, this involves knowledge of what can be included in certain kink behaviors, as well as understanding a client's particular needs such as the risk for physical or psychological harm. Risk assessment should be done, keeping in mind the level of expertise that client has with their particular kink.

*And I asked him if he knew about parasites. And every shit [feces] person I've ever seen in my office, they all know about it. I used to feel like it was my duty to warn them that this is a dangerous sexual activity. But now I don't feel that way because I've seen over and over and over and over and over, these scat boys, they research it. They know what medications to take before engaging in the play. They know all about it.*

One participant suggested that bringing up harm reduction skills, leveling, or identifying psychological patterns that involve risk with clients can sometimes be interpreted as stigmatizing by the client. This practitioner suggested that having a strong therapeutic alliance can help alleviate this.

*And there are times I need to challenge my clients on what they're doing and the first thing they're going to throw back at me is that I'm shaming them or that I'm just confirming that this is a fucked up aspect of themselves or whatever. And so if I can anticipate that and be sensitive to it and make sure that that person and me, that we have a sufficient bond so that the relationship has enough trust built that they can actually challenge themselves to consider what they're doing, I think that's when there's actually going to be movement.*

Ultimately, remaining focused on the client, using supervision, and engaging in on-going professional development were viewed by participants as ways to enhance and refine skills used within clinical approaches used with clients who engage in kink.

***Professional development to enhance kink cultural competence.*** Participants reported that a number of their clients engage in kink within a community context. Complex dynamics and issues of communication can make working with this group challenging. The identification of people who engage in kink as a group is important; cultural-competency education can

address micro (i.e. interpersonal relationships), mezzo (i.e. finding community), and macro issues (i.e. legal issues). However, most mental health degree programs offer little to no education on counseling around issues of sexuality, let alone issues of the kink community. One participant felt that this lack of education on addressing all of these tiers of work with clients highlights a gap in mental health education. One participant said:

*But there's nothing built into the curriculum that I'm aware of. They talk about diversity. Ethical standards talk about diversity but through what means. How do people gain that confidence? So then there ought to be courses that can go further into particular aspects of sexuality and then that might be elective, but there's a required course on sexuality, period, using recent research material.*

Another participant suggested that students can take advantage of independent learning opportunities through existing coursework by including sexuality into issues of mental health.

*As grad students we have so many opportunities to do research through papers. It's taking those opportunities to learn more. Talk to people, that's another great way.*

Participants recommended taking advantage of continuing education courses through accredited organizations, although this may be difficult due to the lack of sexuality-specific courses being offered to mental health providers. Professional membership or certification offer mental health practitioners access to research and resources specific to sexuality, further exposing them to various theories, methodologies, findings, and treatments to working with challenging issues that may arise in sessions with clients.

### **Challenges to Engaging in Kink**

Participants reported the challenges they had heard from clients in sessions as well as some of their beliefs and opinions on the challenges individuals engaging in kink face at this time.

**Client reported challenges to engaging in kink.** Five primary thematic areas arose in the interviews when participants were asked about challenges to engaging in kink: internal

stigma, external stigma, kink community issues, interpersonal issues, and risk of harm. Other challenges were identified that fell outside of the thematic areas, however.

*Internal stigma.* All of the respondents discussed their clients feeling internalized stigma at times when they engaged in their kink, especially those new to their kink, or “kink babies” as one participant named them. This internalized stigma expressed itself as shame, guilt, sex-negativity or a fear of being abnormal in sessions.

*For instance, the slave that I was talking about, he has gotten into so much shame about his sexuality in general through shame about his preferences and the things that turn him on... a lot of kink clients have a lot of resistance to making those connections because they think that means there's something dysfunctional about their likes, about their preferences.*

*External stigma.* Several participants stated that their clients had experienced external messages that lead to internalized stigma.

*The term micro-aggressions is coming to mind, so all of the subtle ways in which the dominant story is reinforced in media, news, the way people talk about the questions people ask, reinforce to people what “normal” is, that devalue or other-ize the experiences that are not with the dominant understanding.*

These micro-aggressions included discriminatory policy or laws that impact a kinky person's employment, housing, or family. Despite the dissolution of sodomy laws, participants reported hearing about fear of legal recourse as a result of participating in kink. One participant obtained certification to challenge external stigma within legal settings and to be a resource to her clients in instances where external stigma may lead to legal action.

*They have to be kept a secret except for those of us who are out and open because of child custody things. And, in fact, that's one of the things I do, is go and testify in court, in divorce cases to say that, “Just because he spanks her ass in the bedroom doesn't mean he's going to spank the children.”*

*Kink community issues.* One participant stated that as a result of fear and shame, clients have been less likely to seek out a kink community. Participants stated that in urban areas,

finding kink community is not difficult for their clients, but in rural areas it is a primary challenge. Another participant stated that kink communities have experienced external stigma which impacts their decision to be visible. This has made them difficult to be found, even if a client decides to seek one out.

Similar to other communities, a participant stated clients felt that within some kink communities, politics, socio-politics, lack of structure, or poor leadership can make joining a kink community unappealing.

*Finding it [community] is very hard, even for those that are in it. Finding a healthy way to live in it [is difficult], when usually these very small groups are full of political in-fighting back-fighting, unfair tactics, and egotistic putdowns. You know, it's a really poor situation.*

A participant stated that joining a kink community can also be unappealing for individuals if they fear they may be “outed” by joining. There is a risk they may be recognized within their community or if they are seen attending kink community events.

*Interpersonal issues.* If a client chooses to join a kink community, one participant stated some clients experience difficulty creating meaningful relationships and meeting new people due to the client's challenges with social skills. Participants reported hearing from their clients that communication issues led to difficulty in arriving at shared meaning and consent for a kink scene with a potential partner. According to one participant, the kink community is the primary way for individuals to enhance skills specific to their kink. The kink community is also a way for individuals to find partners who are skilled and trust-worthy.

Participants also stated that their clients experience a fragmentation in their life through selective disclosures – they tell some people in their life they are kinky, but not others. According to one participant, this fragmentation is a bigger challenge if a client does not want to disclose to a primary partner or primary partners. Another participant reported that a client

decided to disclose to a partner that they were kink-oriented, but found out that the partner was non-kink oriented. This orientation-difference led to some challenging relationship dynamics and outcomes for the client. One participant stated that certain kink relationship dynamics created dyadic uncertainty or an end to the relationship.

*Well I think some people have the challenge of making their mixed marriage last. You know, people who have been married for twenty years... and one of them is kinky, and they just want to come out and be kinky. So there's a values conflict - that it's not ok with their partner. And I've actually seen a couple cases where they've divorced.*

Another participant stated that due to the level of trust and the intensity of the experiences from kink, ending those relationships can be very difficult for clients and their kink community.

*One of the challenges is that the kink community is very incestuous and quite small. So you'll be getting involved with somebody and all of the sudden break up with somebody and then all of the sudden now they've got to run into them all over the place at all of their activities.*

*Risk of harm.* Participants reported that some of their clients had experienced injury due to engaging in kink, both physical and emotional harm. Two participants reported discussing the risk of infections specific to certain kink activities and exposure to body fluids, but found that most of their clients knew the risks for infections.

One practitioner stated that she has found a high risk for suicide, and even suicide completion, in people when a long-term kinky partnership is ended.

*...but one of the things, probably most common, is that there's a very high suicide attempt rate and a very deep, dark depression that occurs when lifestyle people break up. Their relationships tend to be a lot more intimate and a lot more intense. It just gets really bad. In fact, we've had several people in the community over here commit suicide during breaks of those relationships.*

*Other challenges to engaging in kink.* One participant stated that sexual dysfunction in a kink scene had been reported to him numerous times. Another participant reported that a client

had expected a kink scene to feel sexual and it did not. This led the client to discover that kink is not sexual for them and sexual kink experiences are not universal.

*Participant beliefs and opinions of challenges to engaging in kink.* Four primary thematic areas arose in the interviews surrounding the opinions and beliefs of the practitioners along with several other issues that can arise for individuals that engage in kink: internal stigma, external stigma, kinky community issues, and interpersonal issues. These themes strongly reflect what was reported to the clinicians by their clients. However, there were additional clinical insights beyond those reflected to the participants by their clients

*Internal stigma.* Most of the participants reported internal stigma, enacted through expressions of shame and guilt, were common amongst their clients. One participant believed it was the primary reason clients come to therapy for kink-related issues. According to participants, this internal stigma led to an un-integrated self, living an unauthentic life, and prevented them from acting on their kink desires. One participant felt that reenacting any stigma can lead a client to internalize kink stigma even deeper into their psyche.

*You know I think that internalized stigma piece is the most relevant challenge because that sort of infects everything. It affects one's ability to go after what they want, to really look at their behavior in a curious way instead of a shaming way. I don't know if you're getting the impression that I deal with a lot of shame, but that is what comes up so much. So much shame and worry that what they're doing is wrong somehow.*

*External stigma.* Three respondents felt that external stigma appeared in sessions for participants around fears of losing employment and legal recourse in instances of divorce or child custody. It led to a sense of secrecy about their kink identity.

Participants also felt that the mental health and medical communities were partially at fault for external stigma by pathologizing kink behaviors.

*Well again, because we're conflated in this big red book that's medical, legal, and moral, it's influenced by a lot more than science, the DSM, and not many actual lay-people*

*know this, but kink is equated with pedophilia; it gets conflated with antisocial personality disorder.*

*Kink community issues.* One participant discussed the rigidity of the kink community being problematic at times.

*They might see themselves as rebels or outcasts in a proud way, in a very affirmative way. But ask them to bend or break some of the rules they have about themselves and some of the ways they categorize other people and they have real difficulty. In other words, you'll rarely see people who really, I think in a broad historical and social sense, break the rules who none-the-less amongst themselves are unbelievably fastidious and rigid about the rules.*

Another participant also stated that stigma exists within the kink communities themselves. The community can create a binary, deeming certain kink behaviors as good and others as bad.

*And so how do you protect yourself, even in that community... there's homophobia in the gay community and lesbian community; there's bi-phobia within the bi community; there's gender phobia within the transgender community; and I think there's kink phobia within the kink community – my kink is good, yours is not.*

*Interpersonal issues.* Participants reported issues for clients if they chose not to come out as kink to their partner, which they felt eventually lead to cheating on a partner or feelings of isolation. Within relationships where both partners are kink-oriented, power dynamics can be a great source of strain, according to some of the participants. Participants also reported intimate partner relationship issues when clients were rigid with boundaries, had boundaries that were not established, had overall inequality in a dyadic relationship which created an unwanted power differential, were not able to cope with power dynamics, or were not willing to engage in power exchange with their partners through the use of kink.

One participant emphasized internal difficulty when ending kink relationships – clients lack social support and are not able to express everything they have lost (i.e. a dominant partner

that tells them what to do, so they lose their motivation to take action); and they have lost part of their identity in addition to their partner (i.e. I cannot be a submissive without a dominant).

One participant reported issues of partners using kink manipulatively if the kink relationship ends.

*I've seen very ugly break-ups where people have been engaged in consensual behavior then out of anger will, due to a messy break-up, say, "Oh, I never consented to that," or, "You pushed my boundaries in December of 2003." Well that may or may not be true... why are we hearing about it now in this heated break-up?*

*Other challenges.* The risk for emotional and physical harm was expressed by one participant. Another participant stated she engaged in grief work quite often with her clients who engage in kink. One participant expressed concern over boundaries between a client's kink life and non-kink life.

*Well, the challenge is, I believe for the majority of my clients whose sexual personae involve these behaviors, is for them to decide where does play begin. Where does the basic work of life, the working aspects of life end, and where does play begin?*

Despite all of the challenges that individuals who engage in kink could potentially encounter, the benefits seem to outweigh the cons according to the participants.

### **Benefits to Engaging in Kink**

Participants were asked to report any benefits to participating in kink that they had heard from clients in sessions. They were also asked to share their opinions and beliefs about the benefits to engaging in kink.

*Client reported benefits to engaging in kink.* Three thematic areas emerged in the interviews around client reported benefits: physical benefits, psychological benefits, and interpersonal benefits.

*Physical benefits.* The primary benefit participants reported was pleasure. Often, they specified sexual pleasure, however this was not consistent with all of the participant. Two



participants reported the intensity of the physical experience being the primary benefit for their client. One participant felt that lacking sexual pleasure and experiences of pain negated the benefit. Another participant reported that wearing fetish clothing was a source of pleasure and enjoyment. He suggested wearing fetish clothing connected wearers to their historical roots. Another participant reported that some people who engage in kink experience feelings of safety and security while engaging in their specific kink (i.e. engaging in bondage led to feelings of safety and security). Kink was even reported to one participant as a way to manage chronic pain.

*Some of them have used kink to self-soothe and pain management and have been drug-free from prescription medications through the use of kink.*

*Psychological benefits.* Participants reported their clients felt the primary benefits were a sense of relief and liberation. Engaging in kink assisted clients to integrate their multiple identities within their own lives. One participant reported she had seen clients use kink to manage mental health symptoms; engaging in kink, reduced the severity of the client's mental health symptoms. Power exchange was also a way for a client to manage mental health symptoms.

*I've had multiple clients with borderline personality disorder able to resolve 80-90% of symptoms through the use of power exchange dynamics and techniques. I've had a lot of clients with post-traumatic stress disorder that have benefited and really healed through the use of kink in a lot of ways.*

Kink also was a source of empowerment and enjoyment. The exploration of kink allowed clients to explore fear, address body-image issues, resolve sexuality issues, and foster a sense of safety and security. Three participants reported kink provided their clients a sense of transcendence or spirituality.

*So some of them have that kind of outcome or result where they came because it got them hard or got them wet - that's why they came to kink. But after they got their fourth or fifth flogging they realize, "Oh my God, there's a transcendence to be had here that I never*

*even dreamed of. I don't even care about the orgasm anymore. I want this out of body experience."*

*Interpersonal benefits.* Seven of the eight participants reported that kink had enhanced interpersonal communication and intimate partner relationships among their clients; specifically, clients were able to find partners who also engage in kink.

*Well I would say that most of my clients who talk about it will say that the benefits are primarily the fact that they can have a very intense experience with another person and exceed certain limits, or tempt certain limits, of pain, or wounding, making a sense of closeness, and as a result, find a deepening of trust with the other person or people - that they were able to surrender safely.*

Two of the participants reported their clients had reported they were able to establish a sense of community.

*Also, along with accepting yourself and so forth, it's the same as gay people coming out to themselves and their community -it's finally allowing them self to be, to know, and be involved with people like them. A big, big benefit. A new circle of friends...*

***Participant beliefs and opinions of benefits to engaging in kink.*** A participant suggested that benefits are going to be subjective and if U.S. culture were more sex-positive, there may not be so many challenges to engaging in kink; benefits would really be the only consideration to engaging in kink in this practitioner's belief. Overall, three thematic areas emerged around the benefits to engaging in kink from the perspective of the participants: physical benefits, psychological benefits, and interpersonal benefits. These benefits seemed to reflect those benefits reported by clients. However, there were additional clinical insights identified by the participants that had not been reflected to them by their clients.

*Physical benefits.* One practitioner indicated that kink is a way to explore basic, human, aggressive impulses. He identified and normalized human aggression and designated kink as a safe way to explore that aggression.

*And I also think it's a very safe way, socially, for us to explore our aggressive impulses which, like power, we collectively have decided to pretend don't exist in us. It exists in other people, but we don't have it. And that's a real fallacy. I think we all have aggressive impulses and BDSM is a great way to explore, safely, expressing aggression in a contained way. Where else does it go if we don't have that...if we don't allow ourselves to have that?*

*Psychological benefits.* Multiple participants reported kink had been used to assist with self-actualization; it allowed individuals to resolve conflict of the self and the kinky-self; and it helped individuals cope with stigma. This self-actualization can bring about a perception of happiness. Clients have demonstrated self-assuredness, self-awareness, and self-enrichment. Participants felt clients nurtured their authentic selves.

Participants also reported kink assisting their clients with a sense of confidence. Some clients seemed more confident as a result of engaging in kink, while some ended up with an enhanced body-image, or a sense of self-liberation. One participant felt this would increase her client's ability to take healthy risks in their lives, demonstrating a comfort with vulnerability.

Finally, participants found that clients were able to process trauma, using kink as the therapeutic tool.

*I've seen some clients who have a history of abuse use kink behavior, particularly impact play, in a controlled environment, and this is rather controversial, to transcend past trauma and integrate that wounded child or wounded teenager with an adult who is engaging in consensual behavior.*

One participant reported that although he had seen this occur, he found that it was just as likely to just recreate trauma and do nothing to assist with processing trauma.

*Yeah, that's called in sexology "triumph over trauma." However you're going to see just as much pathological reenactment of trauma where there's no triumph over it as you will triumph over trauma. So yeah, I don't see that as a huge benefit.*

Another participant suggested that through intentional negotiation, trauma can be processed but clinical exploration is important.

*I had a client who was abused brutally by one of his parents, mostly through spanking and whipping, and with his girlfriend he very much wanted to experience this sensation but couldn't without shutting down emotionally and physically. And in our work, they decided they wanted to use spanking and whipping and ass-sensation as a way to increase the pleasure in their sex life... but also as a way to heal his past, non-consensual, and abusive history, by having this experience of impact play in the present, in a controlled environment, with someone he loved, knowing he could say the safe word at any time. I should also say that his parent didn't allow him to make any noise when he was getting disciplined. His partner and I encouraged him to scream and yell and swear and say whatever he wanted to so there was that cathartic experience. So I've seen kink be used be a healing tool for people who are suffering.*

*Interpersonal benefits.* Participants reported that individuals who engage in kink and are able to find a relatable kink-community end up feeling a sense of belonging. Through the use of community, participants reported that their clients are able to practice communication skills, work on obtaining consent, and negotiating boundaries.

*And escaping the judgment and sense of self that's reflected by society is really hard to come up against, unless you have a lot of really healthy people around you who are also saying, "Hey, I've been through this, and this is who I am, and I survived discriminatory behavior. I've lived through my parents not talking to me. I've lived through partners who thought I was sick. And I'm hopeful, and I'm not ashamed, and you can be here, too."*

One participant felt that kink is also a form of protest against sex-negativity. This form of protest can lead to a sense of empowerment. This would be aligned with the views of another participant who felt that sex-positivity within over-arching culture decreases physical and mental health issues.

### **The Experience of Engaging in Kink**

*Physical sensations.* All of the participants stated that their clients have some form of physical sensation associated with engaging in kink and that was a primary reason clients engaged in kink. Physical sensations evoked pleasure and pain. The pleasure was sometimes sexual, sometimes just physical pleasure similar to that experienced in serious leisure activities

such as marathon running, and sometimes both, according to participants. One participant stated that she had heard that exchanging power dynamics elicited sexual pleasure.

In some instances, pain was regarded by clients as a positive outcome and they ended up having an attraction to it. Other times, the pain caused harm as a result of crossing physical boundaries. Crossing physical boundaries can occur when engaging in kink, according to one participant, and this highlights a need to educate those choosing to engage in kink about safety issues.

*Psychological and social experiences.* When asked what clients receive from engaging in kink, participants felt that exploring power dynamics was one of the primary reasons their clients engaged in kink; it allowed them to experience and acknowledge power differentials in a safe way. One participant suggested that playing with power dynamics can be one of the attractions to kink. Another participant stated that kink is a way to strengthen an identity within a power differential as well as give perspective to a power dynamic the person engaging in kink may not be familiar with in their daily life.

At times, participants had heard about negative outcomes, emotions or experiences around kink experiences. One participant had heard that engaging in kink elicited fear in one client and found that engaging in kink was a struggle. Clients had reported a fear of losing a primary partner upon disclosing their desire to engage in kink. Other clients have had difficulty finding a kink community to participate in and learn from. One participant felt that they witnessed a client reenact harmful psychological patterns from their childhood.

Overall, participants felt that engaging in kink resulted in client empowerment. One participant stated that kink allowed their clients to express themselves, build assertiveness skills,

and strengthened negotiation skills. Kink allowed some clients to access parts of themselves they may not have otherwise accessed, such as spiritual transcendence.

*All of that is wide open to the unlimited area of human creativity. But I think the benefit is that they see themselves not only operating in society, you know they hold down the same jobs that other people hold down and parent children and do everything everyone else does and yet they have this medium in their life that allows them to really surrender, really alter their consciousness and I don't mean with drugs or alcohol.*

With this empowerment and sense of community, respondents reported consistently that individuals who engage in kink can feel safe. They can learn skills to promote a safer kink scene from other community members. Participation in the community builds strengthens the individual's sense of self and challenges internal and external stigma. Finding this community can help improve the mental well-being of an individual.

### **Discussion**

Eight mental health practitioners were interviewed to assess the challenges and benefits to engaging in kink, as well as to explore effective practice with individuals who engage in kink. Although qualitative studies have explored therapy experiences of those engaging in kink, and practitioner experiences of working with people who engage in kink this research explored some of the reasons, challenges, benefits, and outcomes for people who choose to engage in kink (Hoff & Sprott, 2009; Lawrence & Love-Crowell, 2008; Myers, 1992; Newmahr, 2010; Yost, 2010).

#### **Kink as Leisure**

This data suggest that some individual who engage in kink fit within Stebbins' (2001) definition of serious leisure, and they find personal enrichment, enhanced self-esteem and self-awareness, and financial and social returns; kink is in all parts of their life. According to the data, individuals who experience kink as serious leisure can experience a physical or spiritual transcendence. Contrary to this, some individuals engage in kink in ways that resemble casual

and project-based leisure – they are not immersed within kink culture and find the benefit of kink is primarily sexual or physical pleasure. Although not all kink is experienced as serious leisure, this data suggest that each person who engages in kink experiences it uniquely; in order to accurately understand their clients' experiences, clinicians can assess whether a client's experience of kink is casual, project-based, or serious leisure; this can assist them to minimize assumptions they may make about their clients or potentially help them avoid unnecessarily focusing on kink when working with clients who engage in kink.

### **Education**

All of the participants had a masters-level degree or higher in mental health; one participant had a doctorate in human sexuality and another had completed post-doctoral work focusing on human sexuality. Participants utilized various clinical approaches in their work, originating from diverse theoretical frameworks. This multi-disciplinary sample suggests that regardless of the educational track a mental health practitioner may take in their professional development, human sexuality can be, and often times is, a part of mental health work. The data suggests educational settings for aspiring clinicians lack preparatory course work to prepare them for discussions regarding human sexuality, yet education was the primary resource incredibly suggested by the participants for enhancing awareness and understanding of human sexuality; it is important in providing culturally-competent care around sexuality, especially with sexual minorities such as the kink community. This disregard of kink cultural-competency may be in part due to educational institutions being hesitant to address challenging issues surrounding sexuality, specifically kink, due to Yost's (2010) four primary sources of kink stigma: Judeo-Christian values, feminism, psychiatry/pathology, and views of kink as violence/crime. Yet with 63% of woman and 52% of men reporting sexual health issues when asked by a provider and 5-

10% of individuals reporting engaging in kink, it may not be ethical to avoid providing culturally-competent education to aspiring clinicians for much longer (Gross, 2006; Nusbaum & Hamilton, 2002).

### **Engaging in Best Practices**

The participants reported that often times, clients did not come into sessions to work on kink-specific issues; rather they came for similar reasons that the general population may enter therapy – mental health concerns, interpersonal relationship issues, grief and loss, etc. Due to the variety of kink activities and the reasons clients have accessed mental health services, eclectic clinical approaches may be beneficial to address the plethora of clinical issues that may emerge in sessions. Further research may demonstrate the effectiveness of using particular interventions (i.e. CBT, narrative therapy, etc.) with the kink population versus the non-kink population due to the specific challenges around stigma, a primary challenge identified by the participants for those who engage in kink.

Social workers are likely to encounter an individual who engages in kink, even though their client may not have disclosed to them that they are engaging in kink. According to NASW (2008), social workers should be engaging in culturally-competent best-practices, backed by research; Nusbaum & Hamilton (2002) high-light the importance of taking a sexual health history. More so, participants in this study encouraged mental health practitioners to not only further their own sex education and personal awareness regarding human sexuality, but also to read research about kink, take continuing education courses focusing on kink, or even engage in kink themselves, to enhance their ability to empathize with their clients. This suggests that, regardless of the profession, continuing education can include elements of building competency



around sexual sub-groups that is based on research and enhances practitioner skills to reduce the risk for stigma within mental health practice.

Professional conferences, one-day institutes, and comprehensive agencies with sexual health programming provide opportunities for professional development within the area of human sexuality and kink. Regardless of the source, ongoing education can prepare clinicians to address issues specific to the kink population. Continuing education can help practitioners understand complex relationship dynamics, health considerations, safety considerations, co-occurring mental health issues, and the diversity of sexual activity that may exist, reducing the risk for stigma within clinical practice. All of this can lead to culturally-competent, ethical social work practice.

### **Boundaries**

The broader literature suggested that confusing clinical boundaries can emerge if a practitioner engages in kink and also works with the kink community, and that is supported by this research (Lawrence & Love-Crowell, 2008). Boundaries were presented as an important clinical consideration by the participants within this study. However, the boundaries were not consistent among the participants – some participants refused to participate in the kink community, some actively participated in the community, and one participant even accompanied their clients to kink events. This blurring of boundaries resembles situations in other professional fields, such as drug and alcohol counselors bringing their clients at Alcoholics Anonymous meetings, or case managers bringing their clients to the food shelf or medical appointments. Blurring boundaries while maintaining ethical practice may lead to unique, helpful experiences for clients, meeting them where they are at in the work they are doing with

the clinician. Supervision and consultation can assist practitioners maintain ethical practice if they choose to blur boundaries within their clinical practice.

### **Stigma**

Individuals who engage in kink experience stigma from various sources in their lives: from the mental health and medical communities, the legal system, family, friends, and themselves (NCSF, 2011). Participants from the study suggested joining with the client to determine whether or not they experience benefits and distress from engaging in kink and to further the discussion by exploring some of the reasons for the perceived benefits and distress, whether they be pleasure, an enhanced sense of self, feelings of shame and guilt (i.e. internal stigma), interpersonal relationship or community dissonance with their kink behaviors (i.e. external stigma), or behaviors that may be non-consensual and harmful to others (i.e. paraphilia).

Most of the participants reported not using the *DSM IV-TR* paraphilic disorders, stating that diagnoses are shaming and promote stigma. A meta-analysis of research done on each paraphilic disorder, as well as a synopsis of each of the studies' strengths and limitations, may either promote more use of the *DSM IV-TR* diagnoses by practitioners or challenge their inclusion in their current form. This meta-analysis may help social workers increase their diagnostic accuracy when working with individuals who engage in kink (Lawrence & Love-Crowell, 2008).

Regardless of the theoretical frameworks and clinical approaches used by mental health practitioners, this study suggests that it is important to assess, discuss and explore stigma with clients in sessions if they report engaging in kink. This data suggest that external kink stigma is a primary source of internal kink stigma, which can lead to serious mental health issues. To challenge this stigma, social workers can empathize with the psychic pain stigma causes,

normalize kink behaviors, relieve guilt and shame, challenge the dominant sex-negative narrative, and advocate against sex-negativity within their communities.

**Benefits.** According to participants of this study, individuals who receive culturally-competent, sex-positive treatment in therapy reported fewer or resolved physical and mental health issues. They experience both sexual and non-sexual pleasure as a result of engaging in kink. Individuals engaging in kink reported to the participants of this study enhanced interpersonal relationships and strengthened self-esteem, in line with the definition of Stebbins' (2001) serious leisure theory, all of which were suggested in the research of Newmahr (2010). Participants also reported that kink has been used as a way to transcend life, evoking spirituality, sometimes referred to as "space" by individuals who engage in kink (i.e. sub-space, head-space).

This perceived sense of wellness can be further enhanced by finding a kink community that is structured and organized. This research suggests structurally-organized kink communities with strong leadership provide individuals with multiple learning opportunities around safety, interpersonal dynamics, and kink-specific skills, consistent with existing research (Newmahr, 2010). According to participants in this study, these skills are translated into their non-kink lives, ultimately enhancing their non-kink interpersonal relationships. Participating in this kind of community was also suggested in this study as a way to reduce internalized stigma – specifically feeling the need to hide one's kink behaviors or identity (Stiles & Clark, 2011). These findings support the theory that kink can be viewed as a serious leisure activity but clinicians should assess with their clients what level of involvement they engage in with their kink (Williams, 2009). By viewing kink as leisure, social workers can challenge their personal narratives of kink and be supportive in an attempt to reduce stigma and seek out the strengths within their clients' experiences of engaging in kink. Based on the data from this study, social

workers may be able to strategize with kink-oriented clients on the use of kink to process and triumph over trauma, or to manage physical and mental health symptoms.

### **Strengths and Limitations**

The participants recruited for this study were listed on the NCSF's Kink Aware Provider (KAP) Directory; therefore generalizability should be made with caution. In order to become a KAP, the provider must agree to a set of values in which kink is viewed as an acceptable, healthy behavior. This bias directly influences the applicability to the general mental health provider population.

The participants of this study have access to a population that may regularly discuss kink within sessions with them. The detailed insight gained from the participants may be invaluable for general practitioners as they encounter individuals who engage in kink within their realm of practice. These participants provided insight which can assist practitioners minimize the risk for stigma and also increase diagnostic accuracy.

The sample consisted of mental health providers and it is uncommon for individuals to access mental health services unless they are having challenging issues. Responses, beliefs, and opinion from the participant's clients may not be universal across the kink-practicing population. This may also negatively or positively skew the beliefs and opinions held by the mental health practitioners.

The questions and themes for the study came out of existing literature. In order to reduce bias, the questions were reviewed by a committee that has experience working with clients presenting with sexual health issues. Upon completion of this review, the questions were reviewed by the University of St. Thomas/St. Catherine University IRB and no changes were recommended.

The information gathered in this research is a strong addition to a limited body of kink-related research. Although some themes of the challenges and benefits to engaging in kink were consistent with the existing literature, new themes did emerge and can increase clinical considerations. Also, this study identified outcomes and gains from participating in kink, enhancing the ability for practitioners to understand a person's decision to engage in kink behaviors. The data collected in this study was gathered from practitioners around the United States, increasing its generalizability.

However, all of the participants were practicing in urban settings, and only one participant had practiced in a non-major metropolitan area. Participation from practitioners in suburban or rural areas could have exposed a unique set of challenges differing from those who have more access in urban settings.

### **Suggestions for Future Research**

The term kink was a very broad focus for this study. Participants commented on the difficulty of answering the questions of the unique challenges, benefits, and outcomes as each kink activity may function differently for the individual and the community. Future research could explore the unique barriers and benefits to specific kink activities as well as give practitioners some insight into why their clients may choose to engage in a specific kink.

This research was done from the perspective of mental health practitioners and provided the dual insights of benefits, challenges, and outcomes of engaging in kink. The practitioners were able to identify mental health themes present within the kink community. However, future research could explore the perceived benefits, challenges and outcomes directly from those who engage in kink. Their perspectives could provide further insight into the theory of kink as leisure, sexual pleasure, or something else not yet identified.

Future research could explore the organization and structure of kink communities, the differences between new and long-term communities, and what have been some of their challenges and successes. These communities seem to create rules and norms that impact the practice of kink. Understanding their structure and the logic to their rules and norms may assist practitioners in their interpersonal skills-building work with their clients.

The kink community faces numerous challenges and barriers to engaging in their serious leisure. External stigma, internal stigma, community issues, and interpersonal issues all emerged within the data. However, the triumph over some of these challenges shows the strength of this community and demonstrates to social workers that participating in kink can enhance one's self-worth and be a source of empowerment.

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### **Appendix A: Consent Form**

**Project Name:** Increasing Clinicians' Understandings of Kink

**University of St. Thomas IRB Tracking Number:** 411438-1

The purpose of this qualitative study is to learn about perceived challenges and benefits of participating in kink as well as to understand reported outcomes of participating in kink from the perspective of practicing mental health clinicians who identify themselves as working with this group. The term "kink" includes bondage, domination, submission, sadomasochism, sadism and masochism (BDSM), polyamory, fetishism, amputee devotion, role play, body modification, sexual surrogacy and a number of other activities. Although there is research demonstrating the wide array of kink activities, there continues to be a lack of research exploring healthy kink behaviors. Therapists who work with individuals who engage in kink will be interviewed and asked to identify what are some of the benefits, challenges, and outcomes of engaging in kink, from their perspective. The therapists will also be asked to offer their opinions of the benefits, challenges, and outcomes as well as the transferability of skills from the kink community to non-kink related activities/communities.

You are invited to participate in this research. You were selected because you are listed as a licensed mental health professional on the Kink Aware Professional Directory through the National Coalition of Sexual Freedom and you have worked with clients who engage in kink for at least two years.

The purpose of this study is to learn of the perceived benefits, challenges, and outcomes of engaging in kink. Clinicians will be asked to report both their perceptions as well as the perceptions of their clients. No client identifying information will be requested (i.e. practitioners will not be asked to reflect on specific cases). Information gathered in this study will be used to create a potential, beginning framework for clinicians to utilize when working with clients who engage in kink.

You will be asked ten interview questions by the researcher. The interview will last 30 minutes to an hour but may be longer or shorter depending on your responses to the questions. The interview will be audio recorded and later transcribed by the researcher solely for the purpose of data analysis. The data may be used in future research.

You may experience discomfort when answering the questions. If you need to stop the interview and withdraw from the study, you may do so at any time during the interview. You may also contact the researcher and ask that your interview, or a portion of your interview, not be used up to one week following the interview. Withdrawing from the study will in no way affect your relationship with the University of St. Thomas/St. Catherine University or with the School of Social Work.

You will receive the \$5 Starbucks gift card upon completion of the interview. If you are not available for an in-person interview, the gift card will be mailed to you within 2 business days of the interview to an address of your choice. No record of this address will be kept.

Signed consent forms will be scanned and stored on a flash drive, which will be password protected and stored in a locked box at the researcher's home. The signed consent forms will be shredded immediately after being scanned electronically. The electronic forms will be kept for 7 years after the interview and destroyed no later than June 1, 2020.

Face-to-face interviews will be audio recorded. Long distance interviews will take place over Skype. Interviews via Skype will not be video recorded but instead audio recorded with an electronic audio recorder. Audio recordings will be kept until June 1, 2014, upon which they will be destroyed. The audio recording will be transcribed with any particular identifying information redacted.

Should you decide to withdraw from this study, data collected about you will not be used.

If you have any questions, you may contact the researcher, Richard Laska, at 651-235-4396 or via e-mail at [lask4494@stthomas.edu](mailto:lask4494@stthomas.edu). You may also contact the Research Advisor, David Roseborough, PhD, at 651-962-5804. If you have any concerns, you may also contact the St. Thomas IRB at 651-962-5341.

I have read the above information. My questions have been answered to my satisfaction and I am at least 18 years old. I consent to participate in this study.

### **Appendix B: Interview Questions**

I want to start by learning about you and your work with clients that engage in kink.

- 1) Please explain your education and profession/current position.
- 2) Do you have an area of focus, theoretical framework, or clinical approach in the work that you do with clients?
- 3) What are some of the ways you differentiate healthy kink, problematic kink, or a paraphilia?

Now, I'd like to talk about your clients' experiences of engaging in kink.

- 4) What are some of the descriptive words your clients use when they talk about engaging in kink?
- 5) What are some of the outcomes/results of kink experiences that clients have reported to you? (Prompts: Arousal/pleasure/orgasm? Intense physical experience? Finding community? Exploring power dynamics? Processing trauma? Emotional catharsis?)
- 6) Have any of your clients reported any challenges to engaging in kink? If so, what are some of the challenges they have reported to you? (Prompts: Legal issues? Family/partner issues? Disclosing? Values conflicts? Costs? Finding/participating in community?)
- 7) Have any of your clients reported any benefits to engaging in kink? If so, what are some of the benefits they have reported to you? (Prompts: Building relationships? Reconciling authentic self? Pleasure? Expertise?)

Finally, I'd like to talk about some of your views and impressions about your clients' experiences of engaging in kink.

- 8) In your opinion, what do you see as some of the challenges for your clients to engaging in kink? (Prompts: Consent? Stigma? Legal issues? Religious beliefs? Power dynamics? Pathology?)
- 9) In your opinion, what do you see as some of the benefits for your clients to engaging in kink? (Prompts: Transferability of skills? Processing trauma? Other?)
- 10) What do clinicians need to know to be helpful to their clients who engage in kink?

**Appendix C: Pilot Study – The Subjective Experience of Impact Play**

Previous research by the author led to the creation of a theoretical model of the subjective experience of impact play, a specific type of kink involving physical impact to the body, as clients reported to a clinician. The model suggested that engaging in impact play (flogging, spanking, punching, hitting, kicking, etc.) can create experiences that are sexual and non-sexual, as discussed through the conceptual framework of serious leisure. Outcomes reported to the clinician that participated in the pilot study included a catharsis or emotional release, sexual satisfaction, physical satisfaction, endorphin release, or a combination of these. In some instances, individuals reported they had been able to process trauma they had experienced. Others had reported an enhanced sense of intimacy with their partner.

Figure 1. The Subjective Experience of Impact Play

