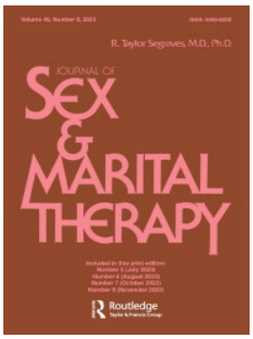

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Journal of Sex & Marital Therapy

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/usmt20

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To cite this article: Richard A. Sprott, Cara Herbitter, Patrick Grant, Charles Moser & Peggy J. Kleinplatz (2023) Clinical Guidelines for Working with Clients Involved in Kink, Journal of Sex & Marital Therapy, 49:8, 978-995, DOI: 10.1080/0092623X.2023.2232801

To link to this article: https://doi.org/10.1080/0092623X.2023.2232801

Published online: 13 Jul 2023.

JOURNAL OF SEX & MARITAL THERAPY
2023, VOL. 49, NO. 8, 978–995
https://doi.org/10.1080/0092623X.2023.2232801

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RESEARCH ARTICLE

Clinical Guidelines for Working with Clients Involved in Kink

Richard A. Sprott[a], Cara Herbitter[b,c], Patrick Grant[d], Charles Moser[e] and Peggy J. Kleinplatz[f]

[a]Human Development and Women's Studies, California State University, East Bay, CA, USA; [b]School of Medicine, Veteran Affairs Boston Healthcare System Boston University, West Roxbury, MA, USA; [c]Department of Psychiatry, Boston University Chobanian & Avedisian School of Medicine, Boston, MA, US; [d]Clinical Psychology, Michael E. Debakey Veterans Affairs Medical Center, USA; [e]Diverse Sexualities Research and Education Institute (DSREI.org), San Francisco, CA, USA; [f]Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada

ABSTRACT

People involved in kink (BDSM or fetish) subcultures often encounter stigma and bias in healthcare settings or when seeking psychotherapy. Such individuals typically encounter well-meaning clinicians who are not prepared to provide culturally competent care or who have not recognized their own biases. Over a two-year period, a team of 20 experienced clinicians and researchers created clinical practice guidelines for working with people involved with kink, incorporating an extensive literature review and documentation of clinical expertise. This article summarizes the guidelines and discusses relevant issues facing clinicians and their clients, as well as implications for clinical practice, research and training.

Dominant cultural mores stigmatize an array of sexual and relationship styles, identities, orientations, behaviors, and interests. The purpose of this article is to introduce and summarize a new set of guidelines to assist clinicians to provide culturally competent care for clients who identify with or practice kink. Over a two-year period, a team of 20 experienced clinicians and researchers created these clinical practice guidelines for working with people involved with kink, incorporating an extensive literature review and documentation of clinical expertise. In this paper, we define *kink* as Bondage/Discipline, Dominance/Submission, Sadism/Masochism (BDSM) and Fetish practices. We recognize that there is a sizable overlap between kink and CNM, including open marriages, non-exclusive relationships, and polyamory. Although this paper is not focused specifically on CNM, some of the same principles apply (Vaughan & Burnes, 2022).

Estimates of the prevalence of individuals involved with kink vary depending on how the population is sampled, how *kink* is operationalized, and whether it is interest/fantasy, behavior, or identity that is measured. In terms of fantasies, approximately 45–60% of the general public report having fantasies that incorporate dominance and submission (Joyal, Cossette, & Lapierre, 2015; Jozifkova, 2018), and approximately 30% report having fantasies that involve whipping or spanking (Herbenick et al., 2017; Joyal et al., 2015). In terms of behavior, approximately 10–12% of the general population has engaged in kink behaviors at some point in their lives (Janus & Janus, 1993; Joyal & Carpentier, 2017; Masters, Johnson, Kolodny, & Bergen, 1995). A smaller percentage of the population build identities and participate in kink subculture activities on a regular basis (Sprott & Berkey, 2015).

CONTACT Richard A. Sprott richard.sprott@csueastbay.edu Department of Human Development and Women's Studies, Mieklejohn Hall 3069, California State University, East Bay, 25800 Carlos Bee Boulevard, Hayward, CA 94542, USA

How are we to conceptualize of interests in kink? Some scholars argue that kink is serious leisure, others argue that kink identities resemble or actually constitute a form of sexual orientation (Newmahr, 2010; Sprott & Williams, 2019). There have been limited systematic attempts to measure the prevalence of kink identities in the general population. Based on the size and number of social clubs, advocacy organizations, community events, and participation in social media platforms, it is estimated that 1–2% of the general population holds an identity centered on kink (Sprott & Berkey, 2015). A study that examined a representative sample of the Belgian population ($n = 1{,}027$) found that nearly half (46.8%) of the participants had engaged in BDSM-related activities at least once in their lifetimes, 12.5% had engaged on a regular basis, and 7.6% had identified as "BDSM practitioners" (Holvoet et al., 2017).

Some surveys have asked kink-identified participants about a variety of behaviors in order to gauge the prevalence of kink activities. Such studies usually ask whether the participants have engaged in particular activities (e.g., flogging, use of restraints). Although the lists of activities are lengthy, they still provide only a partial picture of the variety of behaviors that could be labeled potentially as kinky (Joyal & Carpentier, 2017; Rehor, 2015; Rehor & Schiffman, 2022; Richters et al., 2003; Sandnabba, Santtila, Alison, & Nordling, 2002).

Mental health and kink sexualities

There is substantial research on whether kink fantasies and interests or involvement in kink behaviors constitute mental disorders, indicate symptoms of other mental disorders, or suggest vulnerability to other mental disorders. Among representative samples, Richter and colleagues (2008) found that Australian males (but not females)[1] who reported kink behavior showed significantly less neuroticism on the Big Five personality scales than the general population. Wismeijer and van Assen (2013) found less neuroticism for both men and women among a self-selected, non-representative sample. Cross and Matheson (2006) conducted a study comparing 93 self-identified sadomasochism (SM)-involved participants and 61 non-SM participants, administering several measures of psychopathology, feminist attitudes, and escapism, to test several theoretical proposals concerning kink behavior or interests. They found no differences between the SM and non-SM groups on measures of psychopathology, measures of anti-feminist beliefs, or escapism. Connolly (2006) conducted a study of 132 self-identified BDSM practitioners, using a battery of seven commonly used self-report measures of psychopathology. BDSM participants scored in the normal range for depression, PTSD and borderline and paranoia symptoms. There was some indication of lower anxiety than in the general population; Connolly did find higher levels of dissociative symptoms and narcissism. She noted that dissociative symptoms were not clearly related to any specific type of psychopathology in the study (Connolly, 2006); narcissism measures may include personality strengths and/or pathology but overall, the findings did not find psychopathology at higher levels than in the general population.

The hypothesis that BDSM interests or behaviors result from childhood abuse or trauma can be found in many theories and studies in psychology and psychiatry (e.g., Abrams, Chronos, & Grdinic, 2022; Abrams, Milisavljević, & Šoškić, 2019). In a study of 186 SM practitioners in Finland, Nordling, Sandnabba, and Santtila (2000) found that 7.9% of male and 22.7% of the female participants had childhood sexual abuse histories, which they reported as higher than the national prevalence in Finland. However, the national prevalence data were based on the findings of Sariola and Uutela (1994), a sample of 15–16-year-old adolescents ($n = 7{,}349$), which raises some questions about the appropriateness of this comparison, given the difference in sample size. A later meta-analysis of the prevalence of child sexual abuse found rates comparable to those found by Nordling et al. (2000), Pereda, Guilera, Forns, and Gomez-Benito (2009). In contrast, The Australian Study of Health and Relationships (ASHR) examined psychological distress and sexual functioning in a national, representative sample in 2001–2002. This study found that 2% of sexually active men and 1.4% of sexually active women had engaged in BDSM

activities within the past year, and found no difference in past sexual abuse history, or levels of psychological distress (Richters et al., 2008). Results from the 2016 National Kink Health Survey (Randall & Sprott, 2022, unpublished), which included questions about Adverse Childhood Events (ACEs), found that 9.6% of a sample of 980 kink-identified participants had high ACE scores, indicating elements of childhood neglect, emotional abuse, physical abuse, or sexual abuse. The national prevalence for high ACE scores is approximately 16% (Centers for Disease Control and Prevention, 2019). These studies find no strong empirical evidence to support the notion that kink interests and behaviors represent a response to trauma or abuse (de Neef, Coppens, Huys, & Morrens, 2019).

Evidence of stigma in society and mental healthcare

Although peer-reviewed research on discrimination experienced by kink-identified people remains nascent, the evidence available from both the scientific literature and advocacy group reports suggest that kink-practitioners confront stigma and discrimination in multiple arenas (e.g., Kolmes et al., 2006; Wright, 2008; Yost, 2010). The National Coalition for Sexual Freedom (NCSF), an advocacy organization for individuals involved in BDSM or CNM, has conducted surveys of kink-involved individuals reporting their experiences of violence and discrimination. The 2008 survey ($N = 3{,}058$) found that a quarter of the sample (26%; 804 of the 2,995 who responded to this question) reported discrimination (Wright, 2008). Of particular relevance, more than one in ten (11%) had experienced discrimination from a health professional, a category that included mental health providers. This type of widespread stigma, including but not limited to experiences in healthcare, can be conceptualized as minority stress (Meyer, 2003). Although the negative effects of this stigma have not been well-documented, there is evidence of elevated suicide risk among NCSF members (Cramer et al., 2017) and an association between internalized stigma and suicidality among BDSM practitioners (Roush et al., 2017).

A handful of studies have focused on stigma in mental healthcare and its impact on clients involved in kink. In one study of kink-involved individuals who sought care from mental health professionals ($n = 175$), respondents described the types of bias they experienced personally or learned about from others. The types of bias reported ranged from practitioners pathologizing kink and even requiring clients to discontinue their kink activities to be in therapy, to placing the burden on clients to educate the professionals (Kolmes et al., 2006). In a qualitative study, Hoff and Sprott (2009) found that biased therapy experiences affected the therapy process negatively, resulting in patient non-disclosure, negative interactions in which therapists over or under-emphasized BDSM, and even termination.

Lack of disclosure statement may belie actual frequency

Given the number of people who fantasize about or engage in kink, or identify with kink, it is important to note that many people do not disclose involvement in kink to their therapists. Several factors can affect whether clients choose to disclose or come out to therapists regarding a marginalized identity when that is not visible. In an interview study with 38 gay-identified men, Cain (1991) noted that respondents often concealed their identities as gay men because they felt the disclosure was not relevant, wanted to honor the wishes of a significant other to maintain secrecy or privacy, or were concerned that disclosure would have negative repercussions. This last motivation is an example of anticipated stigma: Patients often do not disclose their sexual practices to healthcare providers out of fear of being judged negatively or rejected (Klitzman & Greenberg, 2002; Waldura, Arora, Randall, Farala, & Sprott, 2016). Approximately 25–30% of clients who practice kink will not disclose this, even after a lengthy time in therapy (Sprott & Benoit Hadcock, 2018). In a survey of 175 kink-identified people, Kolmes et al. (2006) reported that 65.1% had disclosed their interests in BDSM. Respondents reported two main

reasons for nondisclosure: either they were not aware of their BDSM interests at the time, or they regarded their BDSM practices as irrelevant for the concerns that brought them into therapy. Anticipated stigma was reported by 4.6% of the sample at some point in their relationships with their therapists.

Because of this lack of disclosure, mental health professionals are likely to assume that the number of people engaged in kink is lower than it actually is. This assumption is reinforced by several factors: (1) this aspect of sexuality is rarely covered in graduate or clinical training (Kelsey, Stiles, Spiller, & Diekhoff, 2013); (2) the anticipated stigma on the part of people involved in kink leads to lack of disclosure (Waldura et al., 2016); (3) past negative experiences with therapists or counselors who pathologize kink or fail to perform a comprehensive sexual assessment (Sprott, Randall, Smith, & Woo, 2021).

Clinical practice and kink sexualities

Although there are very few studies of the therapy experiences of clients/patients involved in kink, the existing studies do suggest a few possible trends. Kink is often not a central issue in therapy, but often simply another factor to which a therapist should attend when relevant (Lawrence & Love-Crowell, 2008). Concerns around stigmatizing responses from therapists may affect whether clients choose to disclose their kink involvement. Kolmes et al. (2006) found that 75% of respondents in their survey reported that the concerns that brought them into therapy did not pertain to their kink interests, while 23% thought that their kink interests were related or tangentially related to their presenting issue. Of note, 35% of respondents never disclosed their kink interests or activities to their therapists. Hoff and Sprott (2009) conducted a content analysis of interviews with 32 heterosexual couples who engaged in kink activities regarding their experiences in therapy. Five therapy dynamics pertaining to disclosure of kink interests were identified: termination of therapy (by therapist or client); prejudicial statements on the part of the therapist but no termination of therapy; neutral reactions by therapists to disclosure; knowledgeable interactions on the part of the therapist after disclosure; and clients not disclosing kink at all. The study participants were asked what advice they might have for psychotherapists who work with clients involved in kink. A common theme was to recommend that psychotherapists should treat BDSM sexuality as one of several factors to address in therapy.

Lawrence and Love-Crowell (2008) interviewed 14 therapists who had experience working with kink-identified clients. Results suggested that kink was typically not a central issue in therapy and that therapists often approached working with kink-identified clients as a cultural competence issue. Kelsey et al. (2013) conducted a survey of therapists' attitudes and experiences with clients involved in kink ($N = 766$). Over three-quarters (76%) had treated at least one client involved in kink, but only 48% believed they had competence in this area. Nearly two-thirds (64%) of the therapists reported no training on kink in their graduate education, and therapists with no training about kink had less accepting attitudes. Helfer (2022) surveyed 326 therapists about their graduate education training and current attitudes regarding kink and found that, while the sample had generally somewhat positive attitudes toward kink, those participants who had taken human sexuality courses during their graduate education (51%) indicated higher perceived competency in working with kink. However, only 28% of those who took human sexuality courses reported that the coursework included information specific to kink, and this group had significantly higher perceived competency than those whose human sexuality coursework did not include information about kink.

Taken together, the evidence suggests that there is a need for culturally competent therapy for kink-identified practitioners. People often have concerns, questions and sometimes distress about these fantasies or behaviors. The lack of training and education in the mental health fields about the full range of human sexualities, and the stigma attached to kink sexualities, can result in ineffective care, and in some cases, harm from mental health professionals.

Kink clinical practice guidelines project

The Kink Clinical Practice Guidelines were developed in an iterative process from 2018 to 2020, incorporating a comprehensive literature review, initial drafting of guidelines and reflection. This process was followed by feedback from stakeholders (educators, clinicians, researchers and BDSM advocacy groups) and then further refinement of revisions. The initial Guidelines text was based on an article published in 2004 in *Contemporary Sexuality*, the American Association of Sexuality Educators, Counselors and Therapists (AASECT) newsletter, that presented a first attempt at specific clinical practice guidelines for working with BDSM clients (Kleinplatz & Moser, 2004). Model practice guidelines were also consulted for developing the initial text: The APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (2015); the APA Guidelines for Psychotherapy with Lesbian, Gay, & Bisexual Clients (2011); the APA Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality (2017); the APA Guidelines for Psychological Practice with Girls and Women (2007); and the APA Guidelines for Psychological Practice with Older Adults (2014). Practice guidelines from other professional organizations, such as NASW and ACA, were consulted as well. The complete Guidelines (Kink Clinical Practice Guidelines Project, 2019) are available at www.kinkguidelines.com.

Guidelines

The guidelines are summarized in Table 1. The guidelines are organized into four areas: (1) Foundational Knowledge, Skills, and Attitudes; (2) Life-Span Developmental Issues; (3) Assessment and Intervention; (4) Professional Education, Training, and Community Care. Each area is described briefly and includes several sub-areas that each relate to one or more of the guidelines. In the discussion below the guidelines are discussed thematically rather than individually, and they appear outside of the original numerical order. The original order from the community release of the guidelines is noted below for consistency.

Area 1: Foundational knowledge, skills and attitudes (Guidelines 1–9)

This area provides an overview of the key foundational skills providers should strive to demonstrate when working with kink clients. These approaches may be considered essential for all providers, as any provider may encounter kink clients. This area includes fundamentals such as developing a basic understanding of kink identity from an affirmative lens, recognizing that kink can promote personal growth, how other identities may shape how kink is expressed, and understanding the impact of societal stigma.

An affirmative understanding of kink identity

Guideline 1: Clinicians understand that kink is used as an umbrella term for a wide range of consensual erotic or intimate behaviors, fantasies, relationships, and identities.
Guideline 3: Clinicians understand that kink fantasies, interests, behaviors, relationships and/or identities, by themselves, do not indicate the presence of psychopathology, a mental disorder or the inability of individuals to control their behavior.
Guideline 4: Clinicians understand that kink is not necessarily a response to trauma, including abuse.
Guideline 5: Clinicians recognize that kink intersects with other identities in ways that may shape how kink is expressed and experienced.
Guideline 8: Clinicians understand the centrality of consent and how it is managed in kink interactions and power-exchange relationships.

A definition of kink must be clarified to understand kink behaviors, practices, individuals, and relationships. Kink currently serves as an umbrella label that encompasses various niche

Table 1. Summary list of kink clinical practice guidelines.

Area 1: Foundational Knowledge, Skills and Attitudes (Guidelines 1–9)
Guideline 1: Clinicians understand that kink is used as an umbrella term for a wide range of consensual erotic or intimate behaviors, fantasies, relationships, and identities.
Guideline 2: Clinicians will be aware of their professional competence and scope of practice when working with clients who are exploring kink or who are kink-identified, and will consult, obtain supervision, and/or refer as appropriate to best serve their clients.
Guideline 3: Clinicians understand that kink fantasies, interests, behaviors, relationships and/or identities, by themselves, do not indicate the presence of psychopathology, a mental disorder or the inability of individuals to control their behavior.
Guideline 4: Clinicians understand that kink is not necessarily a response to trauma, including abuse.
Guideline 5: Clinicians recognize that kink intersects with other identities in ways that may shape how kink is expressed and experienced.
Guideline 6: Clinicians understand that kink may sometimes facilitate the exploration and expression of a range of gender, relationship, and sexuality interests and identities.
Guideline 7: Clinicians recognize how stigma, discrimination, and violence directed at people involved in kink can affect their health and well-being.
Guideline 8: Clinicians understand the centrality of consent and how it is managed in kink interactions and power-exchange relationships.
Guideline 9: Clinicians understand that kink experiences can lead to healing, personal growth, and empowerment.
Area 2: Life-Span Developmental Issues (Guidelines 10–13)
Guideline 10: Clinicians consider how generational differences can influence kink behaviors and identities.
Guideline 11: Clinicians understand that kink interests may be recognized at any age.
Guideline 12: Clinicians understand that there is a wide variety of family structures among kink-identified individuals.
Guideline 13: Clinicians do not assume that kink involvement has a negative effect on parenting.
Area 3: Assessment and Interventions (Guidelines 14–19)
Guideline 14: Clinicians do not assume that any concern arising in therapy is caused by kink.
Guideline 15: Clinicians understand that reparative or conversion therapies are unethical. Similarly, clinicians avoid attempts to eradicate consensual kink behaviors and identities.
Guideline 16: Clinicians understand that distress about kink may reflect internalized stigma, oppression, and negativity rather than evidence of a disorder.
Guideline 17: Clinicians should evaluate their own biases, values, attitudes, and feelings about kink and address how those can affect their interactions with clients on an ongoing basis.
Guideline 18: Clinicians understand that societal stereotypes about kink may affect the client's presentation in treatment and the process of therapy.
Guideline 19: Clinicians understand that intimate partner violence / domestic violence (IPV/DV) can co-exist with kink activities or relationships. Clinicians should ensure their assessments for IPV/DV are kink-informed.
Area 4: Professional Education, Training and Community Care (Guidelines 20–23)
Guideline 20: Clinicians strive to remain informed about the current scientific literature about kink and avoid misuse or misrepresentation of findings and methods.
Guideline 21: Clinicians support the development of professional education and training on kink-related issues.
Guideline 22: Clinicians make reasonable efforts to familiarize themselves with health, educational, and community resources relevant to clients who are exploring kink or who have a kink identity.
Guideline 23: Clinicians support social change to reduce stigma regarding kink.

pleasurable or erotic interests, behaviors, practices, relationships, and identities. Kink may include sexual arousal/pleasure from painful sensations and power dynamics, eroticizing body parts and inanimate objects (known to many as "fetish"), enacting or exaggerating erotic situations, and participating in erotic activities that involve intensifying or altering states of consciousness (e.g., "subspace", that is, one of many possible psychological states emerging during erotic peaks rather than drug-induced changes in mental state).

Many kink practitioners report combatting kink-related stigma on both personal and institutional levels (Nichols & Fedor, 2017; Sprott & Benoit Hadcock, 2018). Due to external stigma, some kink practitioners have internalized the belief that their kinky desires are evidence of psychopathology (Pillai-Friedman, Pollitt, & Castaldo, 2015). These beliefs may need to be clarified in therapy. It is imperative that clinicians engaging with kink practitioners be committed to affirming and uplifting their identities and behaviors.

Automatically classifying kink behaviors as psychopathology is an example of the institutional stigma experienced by many kink practitioners, which is one reason for the reluctance among many kink practitioners to disclose their identities to the psychotherapist (Pillai-Friedman et al., 2015). People of color, women, and gender diverse individuals may be told that their interests are politically incorrect, men may be told that their kink interests are sexist or even mask

impulses to rape. However, these commonly held negative beliefs about kink are not supported by the scientific literature.

Kink interests, for example, are commonly believed to stem from some experience of trauma. These beliefs have become so pervasive that some clinicians are inclined to explore trauma experiences before attending to the presenting complaint. Clinicians should understand that kink interests might not stem from or relate to any form of trauma or abuse (Hopkins et al., 2016; Nichols & Fedor, 2017). It is recommended that psychotherapy focus on goals other than resolving or "fixing" the kinky interests. Clients who request help with eliminating their kinky interests should be approached analogously to someone who requests the elimination of their same-sex interests.

The Australian Study of Health and Relationships, which investigated psychological distress in a nationally represented sample, found that 2% of sexually active men and 1.4% of sexually active women were involved in BDSM activities within the past year (Richters et al., 2008). When this cohort was compared to non-BDSM practitioners, no difference was found in history of past sexual abuse or reported levels of psychological distress (Richters et al., 2008). These and other studies empirically refute the idea that interest and participation in kink serve as responses to traumatic experiences (Cruz, 2016; Nichols & Fedor, 2017; Pillai-Friedman et al., 2015). Such findings are important for clinicians hoping to offer an affirming space to their kink clients. These data may assist kink clients who are struggling with stigma to reframe how they experience their identities and behaviors.

A kink-affirming approach encourages clients/patients to identify and to explore their interests in an informed and safe manner. This might include selective referrals to local or online kink support groups.

Understanding kink as part of healing and exploration

Guideline 6: Clinicians understand that kink may sometimes facilitate the exploration and expression of a range of gender, relationship, and sexuality interests and identities.
Guideline 9: Clinicians understand that kink experiences can lead to healing, personal growth, and empowerment.

Several studies have noted that non-heterosexual persons are more likely to report involvement in BDSM and kink than heterosexuals (Connolly, 2006; Cross & Matheson, 2006; Pitagora, 2016; Sprott & Benoit Hadcock, 2018; Waldura et al., 2016). It is unclear whether this indicates something about the dynamics and qualities of sexuality per se (van Anders, 2015), or if this phenomenon is a result of stigma processes affecting sexual minority and sexual majority populations differently (Damm et al., 2018). However, research highlights that kink allows for the exploration and expansion of sexuality and gender (Baker, 2018; Cruz, 2016, 2020; Sprott & Benoit Hadcock, 2018) and presents numerous examples of how heterosexual and non-heterosexual people alike have used kink practice to explore and perform gender and sexual identities to which they would not typically ascribe. Such practice has also been known to facilitate unions among communities that may not typically interact sexually, such as gay men with straight, cisgender women.

Clinical frameworks have frequently been developed and studied with cisgender, heterosexual, and White communities. Awareness and consideration of other cultural identities is necessary for meaningful and engaged treatment with a wide range of clients. Assessment and evaluation of all cultural influences is imperative for effective treatment. For example, there is a perpetuated stereotype that women of color involved in kink are often living with experiences of trauma. However, researchers have highlighted that there are intersectional identities that might benefit from kink exploration. For example, Cruz (2016) describes how Black women can engage in kink practices as an avenue for Black female empowerment. With broadened understanding, clinicians will be able to engage with intersectional kink populations with a nuanced stance that facilitates increased comfort around disclosure and psychological and emotional processing around kink.

Clinicians should offer a supportive stance toward clients who report using kink as a tool for personal identity exploration and psychological growth. Kink-affirming therapists are able to engage clients/patients on how kink interacts with other areas of their lives. The clinician provides appropriate levels of encouragement for clients'/patients' development.

Providing stigma-informed care

Guideline 2: Clinicians will be aware of their professional competence and scope of practice when working with clients who are exploring kink or who are kink-identified, and will consult, obtain supervision, and/or refer as appropriate to best serve their clients.
Guideline 7: Clinicians recognize how stigma, discrimination, and violence directed at people involved in kink can affect their health and well-being.

Stigma has been associated with poorer mental and physical health outcomes in general and specifically, for other groups marginalized due to their sexual identities or practices (e.g., King et al., 2008; Lick, Durso, & Johnson, 2013). Limited research has been conducted to assess how minority stress and stigma might operate in the context of individuals involved in kink and potentially be relevant clinically (e.g., Cramer et al., 2017; Roush et al., 2017). However, given the significant discrimination faced by people involved in kink (see Wright, 2008), clinicians should include stigma and its effects within their case conceptualizations. Specifically, if clients present with ambivalence toward their kink identities, it will be important to assess whether this is the result of internalized stigma. It will be important to consider how stigma may be affecting individual and relationship well-being among clients involved in kink.

Given the context of minority stress and stigma experienced by many individuals exploring or involved in kink, it is important for therapists to seek out training to provide affirmative therapy. Due to the limited availability of training in routine graduate settings (Kelsey et al., 2013), it will likely require proactive efforts by clinicians to seek out such supplementary training and/or consultation. If providing affirmative therapy falls outside of one's scope of practice, it may be appropriate to make an appropriate referral if it is not feasible to seek out adequate training or consultation.

Area 2: Life-span developmental issues (Guidelines 10–13)

Certain developmental factors may affect clinical work with kink-involved or kink-identified people, including age of first awareness of kink interests, family of origin or chosen family issues and parenting. Kink can be expressed differently depending on age and generational cohort, including the age at which the individual began to explore kink. Acceptance of identities or lifestyles that are focused on kink may be challenging to families of origin, partners, friends, children, and larger family systems. Some kink identified individuals find support in chosen family and consensual relationship structures (e.g., leather families). Parenting may present unique challenges, given the absence of affirmative models, and there is very little empirical research on parenting among kink-identified people. The assumption that kink interests, behaviors or identities impair parenting in a way that is dangerous or detrimental to children has been a stereotype often used against kink-identified people in divorce or child custody proceedings (see Klein & Moser, 2006). Several guidelines attempt to address developmental areas of a person's life, affecting issues such as coming out, relationship dynamics, and family law.

Kink affirming therapy recognizes the importance of a sense of belonging to individuals' quality of life and sense of self and therefore supports multiple configurations and structures of families of choice.

Generational and lifespan issues

Guideline 10: Clinicians consider how generational differences can influence kink behaviors and identities.

Guideline 11: Clinicians understand that kink interests may be recognized at any age.

Research on people involved in kink, spanning the 1970s to the present, demonstrates generational shifts involving sources of information and education about kink (Sprott et al., 2019), but little change across generations in the age of awareness of kink interest (Holvoet et al., 2017; Moser & Levitt, 1987; Spengler, 1977). A study of a representative sample of the Belgian population found that 61.4% of people who indicated an interest in BDSM developed initial awareness of this interest prior to the age of 25. An earlier study conducted in the United States (primarily New York City and San Francisco) in the late 1970s found that 57% of a sample of 178 men reported their first kink experience before the age of 25 years. A 1977 study of among a sample of West German ($n = 237$) found that 77% first became aware of their kink interests before the age of 25 years (Spengler, 1977). However, although first awareness may tend to occur in late adolescence or emerging adulthood, some people have discovered or explored kink interests at later stages of life, whereas others have begun in childhood (Holvoet et al., 2017; Moser & Levitt, 1987; Spengler, 1977).

Family and parenting

Guideline 12: Clinicians understand that there is a wide variety of family structures among kink-identified individuals.

Guideline 13: Clinicians do not assume that kink involvement has a negative effect on parenting.

In considering family and parenting among kink communities, some have noted the creation of chosen families similar to those found among LGBTQ + populations (Hammack, Frost & Hughes, 2019). This includes a wide range of relationship and family structures, involving polyamory as well as more traditional family and relationship structures. Although there is a dearth of research on parenting among kink-identified people, there have been clear cases where people lost custody of children because kink was considered a mental illness or a character problem (Klein & Moser, 2006; Wright, 2014). More recently, changes to the Diagnostic and Statistical Manual of Mental Disorders (*DSM)* in its fifth edition (APA, 2013) and DSM-5-TR (APA, 2022), clarified that involvement in alternative sexualities like sadism, masochism or fetishism are not grounds for automatic diagnosis with a paraphilic disorder (Wright, 2018). Despite this change in the *DSM-5* and *DSM-5-TR*, clinicians who were trained on earlier versions of the *DSM* may nonetheless retain their biases regarding kink and parenting.

Kink affirming therapy supports clients'/patients' rights to parent, regardless of their sexualities.

Area 3: Assessment and interventions (Guidelines 14–19)

As noted in several reviews of the literature (e.g., Brown, Barker, & Rahman, 2020), a primary concern regarding assessment has been identifying mental disorders as an explanation for kink interests, behaviors and identities. In addition, given the societal stigma attached to kink interests and behaviors, clinicians need to consider the impact of internalized kink stigma, anticipated stigma, and experiences of discrimination and prejudice when assessing the mental health needs of people involved in kink. Research that has examined the therapy experiences of people involved in kink have also highlighted areas that are common pitfalls in the therapeutic process from the client's point of view (Dunkley & Brotto, 2018), such as overemphasizing BDSM involvement when irrelevant to the presenting concern.

Recognizing the impact of enacted and internalized stigma

Guideline 15: Clinicians understand that reparative or conversion therapies are unethical. Similarly, clinicians should avoid attempts to eradicate consensual kink behaviors and identities.

Guideline 16: Clinicians understand that distress about kink may reflect internalized stigma, oppression, and negativity rather than evidence of a disorder.
Guideline 17: Clinicians should evaluate their own biases, values, attitudes, and feelings about kink and address how those can affect their interactions with clients on an ongoing basis.
Guideline 18: Clinicians understand that societal stereotypes about kink may affect the client's presentation in treatment and the process of therapy.

Negative stereotypes about people involved in kink include unsubstantiated assertions, such as that the person is out of control, dangerous and anti-social (Turley, 2022). Equating BDSM between consenting adults as violence or abuse is a common theme when there is a negative stereotype. Part of viewing people involved in kink as suffering from mental disorders or problems includes assuming that such individuals are alone, isolated, and cannot function at higher levels of psychological maturity. Negative stereotypes also include messages that people who are interested in kink are hedonistic and narcissistic, which is why they indulge in these interests and behaviors. The negative messages about kink also often communicate that people involved in kink are easy to identify because of their anti-social, disordered and deviant interests and behaviors. We have little information on how extensively these negative stereotypes are shared in the general population (Stockwell, Walker, & Eshleman, 2010), nor on how many mental health providers hold onto specific stereotypes.

People who live with stigmatized sexualities can often internalize rejection or shaming messages from their cultural group, or experience acts of violence and aggression which lead to heightened distress—a key feature of sexual and gender minority stress (Hendricks & Testa, 2012; Meyer, 2003). This dynamic is well established empirically with LGBTQ populations (e.g., Lick et al., 2013; McConnell et al., 2018; White Hughto, Reisner, & Pachankis, 2015) and can be applied to conceptualizing the impact of stigma on individuals involved with kink. Some clinicians and kink community members use the phrase "internalized kink-phobia," as a parallel to internalized homophobia, to describe when individuals are distressed by their own interests and activities in kink. Clinicians should assess carefully as to whether heightened levels of distress are emerging from internalized stigma or from some other disorder that might be present rather than assuming automatically that kink per se causes psychopathology or disorder. It is possible that the pathology and the client's kink sexuality, or how it is expressed, have no relation; the kink might be the cause of the problem; or the problem has affected how the client's kink is expressed. It is possible that it could have elements of all three.

Clinicians operate under a professional ethic that calls for supporting health and well-being for individual clients instead of enforcing society's agendas around sexuality or relationships. This ethic is part of the stance against reparative or conversion therapies, wherein the goal of therapy is to change or suppress a person's sexual orientation (Anton, 2010). Instead, clinicians are to focus on the stress of a mismatch between society's views and values versus the client's views and values, as well as the stress of living as a member of a stigmatized minority group with social exposure to rejection and violence.

It remains unclear whether kink could be considered a sexual orientation (Moser, 2016; Sprott & Williams, 2019). Therapeutic approaches attempting to change or suppress sexual orientation have been harmful to sexual and gender minority clients. Similarly, it is important to support a clinical approach that would avoid the harm to some clients who are kink-identified or kink-involved which is caused by trying to change their sexuality. It may be that through culturally informed therapeutic processes, clients may be invited to alter their kink practices to better align with their values if there is a mismatch identified by the clients. Clinicians may use harm reduction frameworks around kink behaviors that pose physical risks, but it is critical that clinicians not attempt to eradicate kink interests altogether.

Ongoing consultation and continuing education workshops around kink are vital to evaluating biases, values and attitudes, even for clinicians who have extensive experience working with kink communities. Several clinicians and researchers have noted different levels of knowledge or experience and have articulated these differences. Therapists may be seen as: "kink-friendly"

which refers to a minimal level of general knowledge about kink and openness to working with clients without automatically pathologizing kink behaviors or interests; "kink-aware" as a level where clinicians have specific knowledge of concepts and practices that are important to the kink subculture, and experience working with more than one or two kink-identified clients; and "kink-knowledgeable" which refers to a more advanced level of knowledge and affirmative care (Shahbaz & Chirinos, 2017). Sprott and Benoit Hadcock (2018) also noted that therapy with clients involved in kink can call for different levels of awareness or knowledge, depending on whether the presenting issues and treatment need to focus on specific kink interests, behaviors, identities or relationships as central to treatment or whether kink is peripheral to presenting issues and treatment.

Kink affirming care goes beyond being minimally aware of kink or even "value-free" to identifying and confronting clinical shortcomings.

Providing kink affirmative care that differentiates between Intimate Partner Violence (IPV) and kink

Guideline 14: Clinicians do not assume that any concern arising in therapy is caused by kink.
Guideline 19: Clinicians understand that intimate partner violence/domestic violence (IPV/DV) can co-exist with kink activities or relationships. Clinicians should ensure their assessments for IPV/DV are kink-informed.

It is a key clinical skill to distinguish abuse from consensual BDSM or power exchange interactions; however, it is also important for clinicians to be aware that intimate partner violence can occur within the context of kink activities or relationships (Pitagora, 2016). For example, in a large online survey of kink practitioners in 2012 ($n = 5{,}667$), 14.9% of respondents had a scene where a safeword or safe signal was ignored, and 30.1% had a pre-negotiated limit ignored or violated (Wright, Guerin, & Heaven, 2012). In about one-third of these incidents, the transgression was an accident, came from a miscommunication or was the result of a lack of knowledge and skills—but two-thirds involved abusive behavior (Wright, Stambaugh, & Cox, 2015). In a study of 146 self-identified slaves in 24/7 power exchange relationships, 27% had left a previous power exchange relationship because they felt unsafe, and about a third of this subgroup left due to concerns about risk of bodily harm or death (Dancer, Kleinplatz, & Moser, 2006). It is important to note that ignoring a safeword or safe signal, or enacting risky or reckless kink behavior, is not the equivalent of intimate partner violence, but the two can co-occur.

There are some challenges to the clinician in the discernment of IPV in kink activities or relationships. One factor is the anticipated stigma around kink: Given that society already views all consensual kink behaviors as inherently abusive, there might be fear and reluctance on the part of the target of abuse to report or discuss abuse within a kink relationship with a clinician or service provider. They may anticipate being blamed or dismissed (e.g., "you must have wanted that" or "you must have liked it"). They may fear that their reports will just confirm and intensify the stigma around kink, thereby confirming the viewpoint of the larger society, thus causing additional harm to their community.

Another factor is the ambiguity and confusion that can arise when someone is new to kink and just learning about safe, sane, and consensual kink. A case example is presented in Pitagora (2016, p. 2):

> It took time for A to recognize that he was emotionally abusing her, and it took even longer to realize that the physical abuse she received was likewise not aligned with the premise of a healthy, consensual D/s dynamic. The atmosphere of fear that she had initially enjoyed in the context of a consensual scene was pervading the relationship; actual fear and discomfort replaced the connection she had felt with him when they met, and were enforced without regard for her pleasure or consent. Eventually A was able to distinguish between BDSM interactions that were enjoyable, and those that she did not enjoy but tolerated out of confusion and denial.

This confusion, of course, can also occur for people with more experience and knowledge about kink. A clinician can consider some "red flags" when trying to identify abuse in the context of kink: issues of "bleed-through" when stress, anger, and frustration are expressed within BDSM; statements like "real slaves…" or "real Masters…" being used as justifications for certain problematic behaviors such as repeatedly pushing boundaries without discussion or negotiation or refusing to listen to a partner's fears or concerns; and restrictions on access to money, people, or safer-sex decisions (Nichols, 2006).

The most important point is that discernment of abuse needs to be evaluated in context, with a full picture of the kink dynamics involved and in light of the standards of safety and consent that have developed in the kink community. Simple screening questions about abuse are not likely to be helpful in the context of kink.

Kink affirming care offers screening that is conscious of the kink community's ideals of Safe, Sane and Consensual (SSC) or Risk Aware Consensual Kink (RACK) (Williams, Thomas, Prior, & Christensen, 2014) and which would thereby provide the type of discernment recommended by these Guidelines.

Area 4: Professional education, training and community care (Guidelines 20–23)

This area encompasses guidelines regarding the role of clinicians in pursuing relevant training and shaping the field to provide these opportunities on a more routine basis. This area also addresses more broadly the potential role of clinicians as agents of change to promote greater inclusivity. These changes will be critical to implementing the other guidelines and ensuring that the foundational skills are widespread among clinicians.

Commitment to continuing education

Guideline 20: Clinicians strive to remain informed about the current scientific literature about kink and avoid misuse or misrepresentation of findings and methods.

Guideline 22: Clinicians make reasonable efforts to familiarize themselves with health, educational, and community resources relevant to clients who are exploring kink or who have a kink identity.

Clinicians should demonstrate a commitment to professional training to insure nonjudgmental and culturally competent care for clients involved in kink. Given the lack of standardized training in sexual issues (Burnes, Singh, & Witherspoon, 2017; Miller & Byers, 2010) and the apparent lack of training on kink in particular (Kelsey et al., 2013), it is important for clinicians to seek out foundational information regarding clients involved in kink, such as *via* literature reviews and online training. For those who wish to provide more specialized care, it will be necessary to engage in more ongoing training as well as seeking out appropriate consultation. Clinicians should seek to familiarize themselves with community resources that can provide support to kink-identified clients, such as connecting clients to other community members. Community norms and terms are constantly evolving, so that even those who have significant experience working with clients involved with kink might benefit from ongoing training and resources produced by kink community educators and organizations (e.g., NCSF). Finally, it may be useful for clinicians to incorporate tenets from a cultural humility framework (Hook, Davis, Owen, & DeBlaere, 2017) to acknowledge the limits of their knowledge and their respect for clients' experiences.

Advocacy for change and education

Guideline 21: Clinicians support the development of professional education and training on kink-related issues.

Guideline 23: Clinicians support social change to reduce stigma regarding kink.

Clinicians seeking to affirm clients involved with kink must consider acting beyond their individual spheres to effect change on a more systemic level. For example, in addition to seeking to educate themselves, clinicians should also participate in larger advocacy efforts to increase undergraduate and graduate education in sexuality, inclusive of kink, as part of an ethical obligation to develop the field and increase effectiveness. Clinicians can also support continuing education opportunities, such as by demonstrating support for the inclusion of relevant proposals at professional conferences. Clinicians can also advocate for having stronger sexuality training requirements, inclusive of kink as a topic, in accreditation standards by regulatory bodies that assess and approve health professional curricula. Another avenue is to address standards for undergraduate and graduate curricula regarding psychology and sexuality so that they are inclusive of kink as a topic (Graham, Kirakosyan, Fox, & Ruvabalca, 2023).

Similarly, in addition to affirming individual clients, kink affirming clinicians can also be part of larger efforts to destigmatize kink and point out inadvertent stigmatizing of kink within their spheres of influence. For example, they can include kink within their areas of interest in therapist listings, joining the Kink Aware Professionals List (http://www.ncsfreedom.org/key-programs/kink-aware-professionals-59776), or presenting relevant workshops at professional conferences.

Recommendations for research and training

Several recommendations for clinical training and research practice emerge from the clinical guidelines and are discussed in depth below.

Trainings recommendations

We recommend utilizing these guidelines in the context of training to familiarize undergraduates, graduate students, interns and postdoctoral candidates and practicing clinicians with best practices for serving clients who engage in kink. This type of training can occur as standalone training with a focus on kink, but also should be incorporated more broadly into trainings on addressing stigma toward other marginalized groups. Currently, trainings about stigma to marginalized groups typically focus on more recognized issues of sexual diversity in the context of sexual orientation, but do not attend to kink as another important facet of human sexuality that may be associated with stigma and marginalization. For those who are interested in more advanced training and consultation, we encourage the creation of peer consultation groups with clinicians who are more experienced in working with this population.

We recommend that training providers take responsibility for their own education while collaborating with advocacy organizations for the kink community to understand their perspectives. Notably, seeking out training is one way that practitioners can take responsibility for educating themselves rather than placing the burden on their clients involved in kink. Trainees are to engage in a dynamic process of development rather than striving to achieve a static end goal of "competence." This type of approach invites providers to recognize and take responsibility for their growth edges as an ongoing process.

Research recommendations

In reviewing the literature that supports the guidelines for working with people involved in kink, we note several areas where more research is needed. How do people's identities around kink develop, and how does that affect their relationships or their health? What are the issues and challenges around identifying and addressing intimate partner violence in the context of BDSM or kink relationships? How do people use kink or BDSM for addressing past trauma or injury, and for personal growth and self-actualization?

There are research areas that are specific to clinical practice that need to be incorporated, as well. What is entailed in becoming kink-affirmative in clinical practice? What kinds of training practices are effective in reducing bias among clinicians, when it comes to kink interests, behaviors or identities? Are measures and scales used in general clinical research valid for use with a kink-identified population? For example, are measures of relationship functioning valid and reliable for people whose relationships are built around kink/BDSM behaviors and identities? Are the standard screening inventories for intimate partner violence reliable and valid for use with a kink-identified population?

We also need to identify how minority stress is experienced by people involved in kink. How is anti-kink stigma similar, or different, from other sexuality-related stigma? How does the legal status of kink behavior affect the evaluation of kink behavior?

Answering these questions would further the effectiveness of clinical work with a kink-involved population, and refine the clinical guidelines discussed in this paper.

Conclusion

The therapeutic process is often conceptualized as a "voyeuristic" engagement in which the therapist is studying the client objectively. This often contributes to the perpetuating of unbalanced power dynamics in treatment and can influence how clients present their identities in the therapeutic space (Berendt, 2017). In order to protect against this dynamic, therapists should be intentional about understanding the explicit and implicit factors that may influence feelings of stigmatization in their clients. It is incumbent on the therapist to uncover personally held stigma and biases toward kink culture that may have an adverse impact on the therapeutic process. For example, therapists should explore their own reactions to accounts of kink interests, fantasies, behaviors and relationships. Such introspection will also assist the therapist in understanding whether working on kink issues, or with practitioners of kink, is within their scope of practice.

The field is moving in a direction of greater recognition of the particular needs and challenges which kink-involved individuals bring to sex and marital/relationship therapy. The American Psychological Association's recently revised *Guidelines for Psychological Practice with Sexual Minority People* (2021) affirms the importance of developing knowledge of and recognizing the impact of stigma on kink behavior and relationships for clinicians serving the broader sexual minority population (see Guideline 9 and Guideline 10). Continuing education trainings are now being offered more frequently, and research on kink has grown. The greater recognition calls for some type of agreement in the field about minimum, standard competencies for working with clients who engage in kink. We hope the *Clinical Practice Guidelines for Working with People with Kink Interests* helps in coming to that agreement in the field, for the sake of the health and well-being of this sexual minority group.

Author note

This manuscript represents original work but is adapted from a longer version of Guidelines that are publicly available: https://www.kinkguidelines.com/the-guidelines.

Note

1. Some studies used gender classifications that do not reflect the full range of gender identities, or who have noted gender diversity but due to low frequencies, did not report on findings relevant to gender diverse or transgender people. We have kept to the language of the original research reports to represent accurately the reported findings.

Acknowledgements

We wish to thank the 20 members of the Kink Guidelines Project team for their work over the course of two years to produce the clinical guidelines discussed in this paper.

Disclosure statement

The authors report there are no competing interests to declare.

Funding

CH is supported by the Office of Academic Affiliations, US Department of Veteran Affairs. The view(s) expressed herein are those of the authors and do not reflect the official policy or position of the affiliations, the Department of Veterans Affairs, or the U.S. Government.

ORCID

Cara Herbitter http://orcid.org/0000-0002-5019-0442
Charles Moser http://orcid.org/0000-0002-5120-6362
Peggy J. Kleinplatz http://orcid.org/0000-0003-0886-4869

References

Abrams, M., Chronos, A., & Grdinic, M. M. (2022). Childhood abuse and sadomasochism: New insights. *Sexologies*, *31*(3), 240–259. doi:10.1016/j.sexol.2021.10.004

Abrams, M., Milisavljević, M., & Šoškić, A. (2019). Childhood abuse: Differential gender effects on mental health and sexuality, *Sexologies*, *28*(4), e89–e96. doi:10.1016/j.sexol.2019.07.002

American Psychological Association. (2007). Guidelines for psychological practice with girls and women. *American Psychologist*, *62*(9). 949–979. doi:10/1037/0003-066X.62.9.949

American Psychological Association. (2011). Guidelines for psychological practice with lesbian, gay and bisexual clients. Office on Sexual Orientation and Gender Diversity. Retrieved from https://www.apa.org/pi/lgbt/resources/guidelines

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Press.

American Psychological Association. (2014). Guidelines for psychological practice with older adults. *American Psychologist*, *69*(1), 34–65. doi:10.1037/a0035063

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist*, *70*(9), 832–864. doi:10.1037/a0039906

American Psychological Association. (2017). Multicultural guidelines: An ecological approach to context, identity, and intersectionality. Retrieved from http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2021). *Guidelines for psychological practice with sexual minority persons*. Retrieved from www.apa.org/about/policy/psychological-practice-sexual-minority-persons.pdf

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text revision). Arlington, VA: American Psychiatric Press.

Anton, B. S. (2010). Proceedings of the American Psychological Association for the legislative year 2009: Minutes of the annual meeting of the Council of Representatives and minutes of the meetings of the Board of Directors. *American Psychologist*, *65*, 385–475. doi:10.1037/a0019553

Baker, A. C. (2018). Sacred kink: Finding psychological meaning at the intersection of BDSM and spiritual experience. *Sexual and Relationship Therapy*, *33*(4), 440–453. https://www.tandfonline.com/ doi:10.1080/14681994.2016.1205185

Berendt, R. (2017). Gestalt therapist as self: The role of the therapist as a self in the therapeutic relationship. *Gestalt Journal of Australia and New Zealand*, *14*(1), 93–108.

Brown, A., Barker, E. D., & Rahman, Q. (2020). A systematic scoping review of the prevalence, etiological, psychological, and interpersonal factors associated with BDSM. *Journal of Sex Research*, *57*(6), 781–811. doi:10.1080/00224499.2019.1665619

Burnes, T., Singh, A. A., & Witherspoon, R. G. (2017). Graduate counseling psychology training in sex and sexuality: An exploratory analysis. *The Counseling Psychologist*, *45*(4), 504–527. doi:10.1177/0011000017714765

Centers for Disease Control and Prevention. (2019). Adverse childhood experiences (ACEs): Preventing early trauma to improve adult health. https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf

Connolly, P. H. (2006). Psychological functioning of bondage/domination/sado-masochism (BDSM) practitioners. *Journal of Psychology & Human Sexuality*, *18*(1), 79–120. https://www.tandfonline.com/ doi:10.1300/J056v18n01_05

Cramer, R. J., Mandracchia, J., Gemberling, T. M., Holley, S. R., Wright, S., Moody, K., & Nobles, M. R. (2017). Can need for affect and sexuality differentiate suicide risk in three community samples? *Journal of Social and Clinical Psychology*, *36*(8), 704–722. doi:10.1521/jscp.2017.36.8.704

Cross, P. A., & Matheson, K. (2006). Understanding sadomasochism: An empirical examination of four perspectives. *Journal of Homosexuality*, *50*(2–3), 133–166. doi:10.1300/J082v50n02_07

Cruz, A. (2016). *The color of kink: Black women, BDSM, and pornography*. New York: NYU Press.

Cruz, A. (2020). Not a moment too soon: A juncture of BDSM and race. *Sexualities*, *2020*, 1–6. doi:10.1177/1363460720979309

Damm, C. Dentato, M. P. & Busch, N. (2018). Unravelling intersecting identities: Understanding the lives of people who practice BDSM. *Psychology & Sexuality*, *9*(1), 21–37. doi:10.1080/19419899.2017.1410854.

Dancer, P. L., Kleinplatz, P. J., & Moser, C. (2006). 24/7 SM slavery. *Journal of Homosexuality*, *50*(2–3), 81–101. doi:10.1300/J082v50n02_05

de Neef, N. D., Coppens, V., Huys, W., & Morrens, M. (2019). Bondage-discipline, dominance-submission and sadomasochism (BDSM) from an integrative biopsychosocial perspective: A systematic review. *Sexual medicine*, *7*(2), 129–144. https://www.sciencedirect.com/science/article/pii/S2050116119300285 doi:10.1016/j.esxm.2019.02.002

Dunkley, C. R., & Brotto, L. A. (2018). Clinical considerations in treating BDSM practitioners: A review. *Journal of Sex & Marital Therapy*, *44*(7), 701–712. doi:10.1080/0092623x.2018.1451792

Graham, B. C., Kirakosyan, T. M., Fox, J. A., & Ruvabalca, M. (2023). Examining representations of BDSM in undergraduate human sexuality textbooks. *The Power of BDSM: Play, Communities, and Consent in the 21st Century*, 165.

Hammack, P., Frost, D., & Hughes, S. (2019). Queer intimacies: A new paradigm for the study of relationship diversity. *Journal of Sex Research*, *56*(4-5), 556–592. doi:10.1080/00224499.2018.1531281

Helfer, E. (2022). *A kink in the system: Assessing the impact of Master's level human sexuality education on mental health practitioners' attitudes and perceived competency working with kink-involved clients* [unpublished doctoral dissertation]. Modern Sex Therapy Institute.

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model. *Professional Psychology*, *43*(5), 460–467. doi:10.1037/a0029597

Herbenick, D., Bowling, J., Fu, T. J., Dodge, B., Guerra-Reyes, L., & Sanders, S. (2017). Sexual diversity in the United States: Results from a nationally representative probability sample of adult women and men. *PLoS One*, *12*(7), e0181198. doi:10.1371/journal.pone.0181198

Hoff, G., & Sprott, R. A. (2009). Therapy experiences of clients with BDSM sexualities: Listening to a stigmatized sexuality. *Electronic Journal of Human Sexuality*, *12*(9), 30. http://mail.ejhs.org/Volume12/bdsm.htm

Holvoet, L., Huys, W., Coppens, V., Seeuws, J., Goethals, K., & Morrens, M. (2017). Fifty Shades of Belgian Gray: The prevalence of BDSM-related fantasies and activities in the general population. *The Journal of Sexual Medicine*, *14*(9), 1152–1159. doi:10.1016/j.jsxm.2017.07.003

Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy*. Washington, DC: American Psychological Association.

Hopkins, T. A., Brawner, C. A., Meyer, M., Zawilinski, L., Carnes, P. J., & Green, B. A. (2016). MMPI-2 correlates of sadomasochism in a sexual addiction sample: Contrasting and [sic] men and women, *Sexual Addiction & Compulsivity*, *23*(1), 114–140. doi:10.1080/10720162.2015.1095137

Janus, S. S., & Janus, C. L. (1993). The Janus report on sexual behavior. New York: John Wiley & Sons. https://psycnet.apa.org/record/1993-97237-000

Joyal, C. C., & Carpentier, J. (2017). The prevalence of paraphilic interests and behaviors in the general population: A provincial survey. *The journal of sex research*, *54*(2), 161–171. https://www.tandfonline.com/ doi:10.1080/00224499.2016.1139034

Joyal, C. C., Cossette, A., & Lapierre, V. (2015). What exactly is an unusual sexual fantasy. *The Journal of Sexual Medicine*, *12*(2), 328–340. https://www.sciencedirect.com/science/article/pii/S1743609515309449 doi:10.1111/jsm.12734

Jozifkova, E. (2018). Sexual arousal by dominance and submissiveness in the general population: How many, how strongly, and why. *Deviant Behavior*, *39*(9), 1229–1236. https://www.tandfonline.com/ doi:10.1080/01639625.2017.1410607

Kelsey, K., Stiles, B. L., Spiller, L. & Diekhoff, G. M. (2013). Assessment of therapists' attitudes towards BDSM. *Psychology & Sexuality*, *4*(3), 255–267. doi:10.1080/19419899.2012.655255

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, *8*, 70. doi:10.1186/1471-244X-8-70

Kink Clinical Practice Guidelines Project. (2019). *Clinical practice guidelines for working with people with kink interests*. Retrieved from https://www.kinkguidelines.com

Klein, M. & Moser, C. (2006). SM (sadomasochistic) interests as an issue in a child custody proceeding. *Journal of Homosexuality*, *50*:2, 233–242. doi:10.1300/J082v50n02_11

Kleinplatz, P. J., & Moser, C. (2004). Toward clinical guidelines for working with BDSM clients. *Contemporary Sexuality*, *38*(6), 1–4.

Klitzman, R. L., & Greenberg, J. D. (2002). Patterns of communication between gay and lesbian patients and their health care providers. *Journal of homosexuality*, *42*(4), 65–75. doi:10.7916/d8-2wz0-2b85/download

Kolmes, K., Stock, W., & Moser, C. (2006). Investigating bias in psychotherapy with BDSM clients. *Journal of homosexuality*, *50*(2-3), 301–324. doi:10.1300/J082v50n02_15. 16803769.
Lawrence, A. A., & Love-Crowell, J. (2008). Psychotherapists' experience with clients who engage in consensual sadomasochism: A qualitative study. *J Sex Marital Ther*, *34*(1), 67–85. doi:10.1080/00926230701620936
Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority stress and physical health among sexual minorities. *Perspectives on Psychological Science*, *8*(5), 521–548. doi:10.1177/1745691613497965
Masters, W. H., Johnson, V. E., Kolodny, R. C., & Bergen, M. B. (1995). *Human sexuality*. New York: HarperCollins College Publishers.
McConnell, E. A., Janulis, P., Phillips II, G. Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity*, *5*(1), 1–12. doi:10.1037/sgd0000265
Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychol Bull*, *129*(5), 674–697. doi:10.1037/0033-2909.129.5.674
Miller, S. A., & Byers, E. S. (2010). Psychologists' sexual education and training in graduate school. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, *42*(2), 93. doi:10.1037/a0018571
Moser, C. (2016). Defining sexual orientation. *Archives of Sexual Behavior*, *45*(3) 505–508. doi:10.1007/s10508-015-0625-y
Moser, C., & Levitt, E. E. (1987). An exploratory-descriptive study of a sadomasochistically oriented sample. *Journal of Sex Research*, *23*(3), 322–337. https://www.tandfonline.com/ doi:10.1080/00224498709551370
Newmahr, S. (2010). Rethinking kink: Sadomasochism as serious leisure. *Qualitative Sociology*, *33*, 313–331. doi:10.1007/s11133-010-9158-9
Nichols, M. (2006). Psychotherapeutic issues with "kinky" clients: Clinical problems, yours and theirs. *Journal of Homosexuality*, *50*(2–3), 281–300. doi:10.1300/J082v50n02_14
Nichols, M., & Fedor, J. P. (2017). *Treating sexual problems in clients who practice "Kink"* (Z. D. Peterson (Ed.), (pp. 420–434)). Chichester, UK: John Wiley & Sons, Ltd. doi:10.1002/9781118510384.ch26
Nordling, N., Sandnabba, N. K., & Santtila, P. (2000). The prevalence and effects of self-reported childhood sexual abuse among sadomasochistically oriented males and females. *Journal of Child Sexual Abuse*, *9*(1), 53–63. doi:10.1300/J070v09n01_04
Pereda, N., Guilera, G., Forns, M., & Gomez-Benito, J. (2009). The prevalence of child sexual abuse in community and student simples: A meta-analysis. *Clinical Psychological Review*, *29*(4), 328–338. doi:10.1016/j.cpr.2009.02.007
Pillai-Friedman, S., Pollitt, J. L., & Castaldo, A. (2015). Becoming kink-aware - a necessity for sexuality professionals. *Sexual and Relationship Therapy*, *30*(2), 196–210. doi:10.1080/14681994.2014.975681
Pitagora, D. (2016). Intimate partner violence in sadomasochistic relationships. *Sexual and Relationship Therapy*, *31*(1), 95–108. doi:10.1080/14681994.2015.1102219.
Randall, A., and Sprott, R. A. (2022). *Adverse childhood events among kink-identified adults* [unpublished manuscript]. The Alternative Sexualities Health Research Alliance. www.tashra.org
Rehor, J. (2015). Sensual, erotic, and sexual behaviors of women from the "kink" community. *Archives of Sexual Behavior*, *44*, 825–836. doi:10.1007/s10508-015-0524-2
Rehor, J., & Schiffman, J. (2022). *Women and kink: Relationships, reasons, and stories*. Milton Park: Routledge.
Richters, J., de Visser, R. O., Rissel, C. E., Grulich, A. E., & Smith, A. M. (2008). Demographic and psychosocial features of participants in bondage and discipline, "sadomasochism" or dominance and submission (BDSM): Data from a national survey. *The Journal of Sexual Medicine*, *5*(7), 1660–1668. doi:10.1111/j.1743-6109.2008.00795.x
Richters, J., Grulich, A. E., de Visser, R. O., Smith, A. M., & Rissel, C. E. (2003). Sex in Australia: Autoerotic, esoteric and other sexual practices engaged in by a representative sample of adults. *Australian and New Zealand Journal of Public Healthh*, *27*(2), 180–190. doi:10.1111/j.1467-842x.2003.tb00806.x
Roush, J. F., Brown, S. L., Mitchell, S. M., & Cukrowicz, K. C. (2017). Shame, guilt, and suicide ideation among bondage and discipline, dominance and submission, and sadomasochism practitioners: Examining the role of the interpersonal theory of suicide. Suicide and Life-*Threatening Behavior*, *47*(2), 129–141. https://psycnet.apa.org/ doi:10.1111/sltb.12267
Sandnabba, N. K., Santtila, P., Alison, L., & Nordling, N. (2002). Demographics, sexual behaviour, family background and abuse experiences of practitioners of sadomasochistic sex: A review of recent research. *Sexual and relationship Therapy*, *17*(1), 39–55. https://www.tandfonline.com/ doi:10.1080/14681990220108018
Sariola, H., & Uutela, A. (1994). The prevalence of child sexual abuse in Finland. *Child Abuse & Neglect*, *18*(10), 827–835. doi:10.1016/0145-2134(94)90062-0
Shahbaz, C., & Chirinos, P. (2017). *Becoming a kink aware therapist*. Milton Park: Routledge.
Spengler, A. (1977). Manifest sadomasochism of males: Results of an empirical study. *Archives of Sexual Behavior*, *6*, 441–456. https://link.springer.com/article/ doi:10.1007/BF01541150
Sprott, R. Meeker, C., & O'Brien, M. (2019). Kink community education: Experiential learning and communities of practice. *Journal of Positive Sexuality*, *5*(2), 1–6.
Sprott, R. A., & Benoit Hadcock, B. (2018). Bisexuality, pansexuality, queer identity, and kink identity. *Sexual and Relationship Therapy*, *33*(1–2), 214–232. doi:10.1080/14681994.2017.1347616

Sprott, R. A., & Berkey, B. (2015). At the intersection of sexual orientation and alternative sexualities: Issues raised by Fifty Shades of Grey. *Psychology of Sexual Orientation and Gender Diversity*, *2*(4), 506–507. doi:10.1037/sgd0000150

Sprott, R. A., Randall, A. R., Smith, K., & Woo, L. (2021). Rates of injury and healthcare utilization for kink-identified patients. *Journal of Sexual Medicine*, *18*(10), 1721–1734.

Sprott, R. A., & Williams, D. J. (2019). Is BDSM a sexual orientation or serious leisure? *Current Sexual Health Reports*, *11*, 75–78. doi:10.1007/s11930-019-00195-x

Stockwell, F. M. J., Walker, D. J., & Eshleman, J. W. (2010). Measures of implicit and explicit attitudes toward mainstream and BDSM sexual terms using the IRAP and questionnaire with BDSM/fetish and student participants. *The Psychological Record*, *47*(2), 129–141. https://link.springer.com/article/ doi:10.1007/BF03395709

Turley, E. L. (2022). Unperverting the perverse: Sacrificing transgression for normalised acceptance in the BDSM subculture. *Sexualities*, 1–19. doi:10.1177/13634607221132727

van Anders, S. M. (2015). Beyond sexual orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory. *Archives of Sexual Behavior, 44*(5), 1177–1213. doi:10.1007/s10508-015-0490-8.

Vaughan, M. D., & Burnes, T. R. (2022). *The handbook of consensual non-monogamy: Affirming mental health practice*. Lanham: Rowman & Littlefield.

Waldura, J., Arora, I., Randall, A., Farala, J. P., & Sprott, R. A. (2016). 50 Shades of stigma: Exploring the healthcare experiences of kink-oriented patients. *The Journal of Sexual Medicine*, *13*(12), 1918–1929. doi:10.1016/j.jsxm.2016.09.019

White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, *147*(Supplement C), 222–231. doi:10.1016/j.socscimed.2015.11.010

Williams, D. J., Thomas, J. N., Prior, E. E., & Christensen, M. C. (2014). From "SSC" and "RACK" to the "4Cs": Introducing a new framework for negotiating BDSM participation. *Electronic Journal of Human Sexuality*, *17*, 1–10. www.ejhs.org

Wismeijer, A. A., & van Assen, M. A. (2013). Psychological characteristics of BDSM practitioners. *J Sex Med*, *10*(8), 1943–1952. doi:10.1111/jsm.12192

Wright, S. (2008). *Second national survey of violence & discrimination against sexual minorities*. National Coalition for Sexual Freedom. https://secureservercdn.net/198.71.233.68/9xj.1d5.myftpupload.com/wp-content/uploads/2019/12/Violence-Discrimination-Against-Sexual-Minorities-Survey.pdf

Wright, S. (2014). Kinky parents and child custody: The effect of the DSM-5 differentiation between the paraphilias and the paraphilic disorders. *Archives of Sexual Behavior*, *43*(7), 1257–1258. doi:10.1007/s10508-013-0250-6

Wright, S. (2018). De-pathologization of consensual BDSM. *The Journal of Sexual Medicine*, *15*(5), 622–624. doi:10.1016/j.jsxm.2018.02.018

Wright, S., Guerin, J., & Heaven, C. (2012). *NCSF Consent Counts Survey*. Retrieved from https://ncsfreedom.org/images/stories/pdfs/Consent%20Counts/CC_Docs_New_011513/cons ent%20survey%20analysis.pdf

Wright, S., Stambaugh, R. J., & Cox, D. (2015). Consent violations survey. *Retrieved from National Coalition for Sexual Freedom.* https://www. ncsfreedom. org/keyprograms/consent-counts-64083/consentcounts-44979.

Yost, M. R. (2010). Development and validation of the attitudes about sadomasochism scale. *Journal of Sex Research*, *47*(1), 79–91. doi:10.1080/00224490902999286.