All Tied Up: Perceptions of BDSM and Kink for Mental Health Providers

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Abstract

Historically, there has been a question of whether or not BDSM/kink is linked to pathology. The biases and stigma towards BDSM and kink have shown to be detrimental with many BDSM- and kink-identified individuals not being out due to concerns regarding clinician beliefs. The current project broadly explored therapists' understanding and attitudes towards BDSM and kink through semi-structured interviews. From interviews with 10 practicing therapists, half of whom identified as kink-allied, responses to questions about BDSM and kink familiarity and experiences revealed themes of 1) lack of education; 2) communication, consent, and safety; and 3) trauma. This exploratory research allows us to gain an understanding of clinician BDSM and kink knowledge (or lack thereof), which can aid in our work towards normalization to enhance treatment effectiveness and allow therapists to provide more individualized care for their clients.

Keywords: qualitative, diversity, clinical ethics, mental health, sexuality

Introduction

Kink refers to unconventional sexual practices or desires. BDSM is an overarching term that refers to a spectrum of sexual behaviors and preferences that incorporate (B)ondage, (D)iscipline (or Domination), (S)adism (or submission), and (M)asochism. BDSM and kink are highly stigmatized amongst clinicians. Waldura and colleagues (2016) argued that it is crucial that therapists are educated on BDSM and kink because it can enhance treatment effectiveness and allow therapists to provide more individualized care for their clients. In a study of 115 therapy patients, they found that those who engage

with any form of kink have specific needs relating to their kink behaviors and would prefer to be out to their providers. However, many of these individuals are not out due to the fear of stigma and concerns regarding clinician beliefs (Waldura et al., 2016). Stigmatization has impacted many fronts, with parents who partake in SM being viewed as unfit due to their engagement (Yost, 2010). BDSM- and kink-informed therapists may better understand dynamics and therefore better diagnose patients and assess their safety. Due to the past DSM diagnosis categories of paraphilic disorders, including Sexual Sadism and Sexual Masochism, there has been a question of whether or not BDSM/kink is linked to pathology. Indeed, research has sought to analyze if sadomasochism meets the definition of the paraphilic diagnostic category, which in 2000 originally outlined a primary criterion of paraphilia as "generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's sex partner, or (3) children or other nonconsenting persons"(Diagnostic and Statistical Manual of Mental Disorders IV, p.566). The inclusion of Sexual Sadism Disorder and Sexual Masochism Disorder then created the misunderstanding that those who are sexual sadists or sexual masochists engage in non-consensual acts, which is not the case (Moser, 2005; Moser, 1999; Weinberg, Williams, & Moser, 1984). There are similar misconceptions about the overlap between paraphilias and pedophilia, although pedophilia is classified by the DSM-5 as a subset of paraphilias. Kink and BDSM, as referred to in this paper and more generally in the academic literature, refer to consensual acts (that is, excluding pedophilia and other forms of non-consensual sexual behavior). Non-distressing Sexual Sadism and Sexual Masochism are no longer deemed to be mental disorders according to the DSM-5 (American Psychological Association, 2013). In fact, a majority of kink and BDSM practitioners report perceiving positive impacts of kink on their experience of mental health, including in the areas of autonomy, positive relations with others, personal growth, and self-acceptance (Sprott & Randall, 2024). Therapists who are BDSM- and kink-friendly are often stigmatized as well. In a study that assessed the experiences of therapists who have worked with BDSM- or kink-involved clients, they felt they may need to be careful about how they advertise their therapy due to the shock that vanilla individuals (individuals who partake in or have interest in "conventional" sexual practices) would feel if they saw this (Lawrence et al., 2008). There is a need for better BDSM and kink sexuality training to ensure healthier client-

therapist relationships that address relevant clinical concerns (Dunkley, 2018). Further sexuality training that is not received through coursework could assist in stigma reduction and reflect better client outcomes (Miller et al., 2011). With this in mind, researchers focused on four research questions specifically developed to see how clinicians understand BDSM and kink in a clinical realm.

Research Questions

Research suggests that clinicians may not have experience with BDSM and kink dynamics in a clinical setting or in previous coursework. It is important to ask specific questions aimed towards assessing current BDSM and kink knowledge along with how this may impact clinician and client outcomes and relationships. The current exploratory study sought to gain insight into clinicians' knowledge, understanding, and familiarity with BDSM and kink in a clinical setting by addressing the following research questions:

1. How do clinicians understand BDSM and kink in a therapeutic setting?
2. What biases do clinicians hold regarding these communities/lifestyles?
3. What do clinicians see as the importance of being educated in these topics?
4. What role do clinicians think that identity plays in BDSM and kink?

Methods

Participants

Researchers recruited clinicians via Psychology Today (n=10) to participate in interviews held from December 2022 to April 2023. The sample size was determined by the ability to schedule interviews within the specified study period. These individuals all had public profiles and contact information that was publicly listed. Participants were practicing therapists who did either virtual or in-person individual sessions, and therefore location varied. Consistent with the qualitative research tradition of eliciting diverse responses, researchers identified individuals from various places in the U.S. There was an emphasis placed on ensuring individuals of all gender identities and sexualities were participating in this study. In searching for participants, researchers chose some who listed sex therapy or kink-allied work in their bios as well as those who had no link to these key terms. Of the 10 interviewed participants, 5 participants identified as kink-allied.

Procedures

IRB approval was received from Augustana College's board. Clinicians were scouted through Psychology Today by using related or unrelated terms to BDSM and kink. Related terminology included: kink-allied, sex therapy, sex positive, and BDSM. Unrelated terminology was chosen at

random from the general Psychology Today therapists' filters and included: faith, LGBTQ, trauma, and coping skills. Once researchers curated a list of different therapists, they reached out regarding the study and provided them with the next steps.

Potential participants were sent a recruitment email to the address listed on Psychology Today. Researchers interviewed 10 individuals but maintained a list of practitioners in case there were issues with recruitment. Once interest was confirmed, clinicians received an informed consent form that was sent prior to the interview via Google Forms. From there, semi-structured interviews were conducted. These interviews lasted approximately 30-45 minutes. Participants received a virtual Amazon gift card of $30 after the completion of their interview.

Interview Questions

The questions aimed to assess clinicians' attitudes and possible experiences discussing this topic in a therapeutic setting. The interview questions were chosen based on the pre-existing literature on BDSM and kink stigma in clinical settings and focused primarily on what knowledge various therapists already had prior to our interview. The questions were ordered specifically with the first questions on definition, personal experience, and formal education so that researchers could utilize this information and take it into account while performing their analyses. The overall goal was to strengthen our understanding of the experiences already had by therapists as well as their thoughts on BDSM and kink engagement alongside or due to that experience.

- How would you define the terms BDSM and kink?
- What is your experience with BDSM and kink?
- Have you worked with any clients in the BDSM and kink community?
- What education (if any) did you receive on BDSM and kink?
- How do you propose education on this topic could be shared with therapists?
- What are the challenges that come with discussing these topics in a therapeutic setting?
- Do you think it is important to engage in conversations regarding a client's BDSM and kink identity(s)? Why or why not?

Analysis

Inductive thematic analysis (Braun & Clarke, 2021) was used to identify, analyze, and report patterns in the data. All interviews were audio recorded and transcribed verbatim. Investigators 1) reviewed the transcripts and identified

potential codes, 2) generated the different codes into potential themes, and 3) systematically reviewed them to ensure that a name and a clear definition for each theme were identified. Researchers chose to manually code for themes due to the small sample size. The coding was conducted by a single author under the supervision of an experienced reviewer. Manually coding for themes included in-depth readings of the interview transcriptions by two coders several times while seeking commonalities among the interviews.

Results

From the interviews, three primary themes emerged: 1) lack of education; 2) communication, consent, and safety; and 3) trauma.

Lack of Education

Clinicians reported that there was a lack of formal education on BDSM and kink, even when they requested it. Indeed, the lack of education was the most frequently occurring theme. Upon being asked about their training on alternative sexualities, many suggested that they not ever introduced to them at all. Indeed, a majority of the clinicians' knowledge on this topic was self-taught. Clinicians expressed that they would turn to their clients for information regarding their lifestyle/practices or use internet search engines as a means of learning more. Furthermore, clinicians were unable to confidently provide definitions for the terms BDSM and kink.

> *"There was nothing in undergrad or grad school. Nothing in any of my internships either. So yeah, I was not- I was very ill-prepared for that. Luckily my curiosity helped me out."-Kink-allied clinician*

> *"If we do not know that identity and so for example, I've had clients come in there may have tie-like marks on their wrist. And so of course, if I am aware of that already know that is something that they partake in. It rules out the idea that many therapists who are not aware of that language of what's happening, you're gonna maybe consider the safety concern or different bruises and marks are also done, I did, there's cutting and there's like pleasure with different needles and all that."- Kink-allied clinician*

> *"Kink? Because I don't know what that is…And I have no idea how I know the term BDSM. "- Non-kink-allied clinician*

> *" I did all that in the 90s. So that that wasn't a thing, then. Maybe? Probably it's been around, I did not*

get any education on it." -Non-kink-allied clinician

"*So it was usually through we would have like different special topics, like presentations or like, students would bring, like a special topic article, or like a topic in itself, that we would cover and discuss as a class. And I think that that was something that was brought a couple of times during the course of like a special topics conversation. But no, like formal coursework around it."-Kink-allied clinician*

" I'm thinking of like, a law and order episode, okay. And it was like, I'm trying to, like, put it together. I think it was like, somebody who had, like, they got into the world of BDSM. And like, the detectives, like, got into the world of BDSM. And there was somebody who was like, murdered, who was like involved in the BDSM world. I don't even know there was a long time ago that I'd seen this. But yeah, that's what's coming to mind. And I don't think that it was like, I feel like there was a sense of, like, Oh, this is like, like there was a sense of judgment from the detectives."-Non-kink-allied clinician

Communication, Consent, and Safety

Clinicians described their understanding of BDSM and kink to be associated with higher levels of partner communication, consent, and safety. Clinicians reported that their experiences with this population were different from traditional sexuality clientele because of the large emphasis placed on being proactive and outright with desires and limits. Clinicians expressed that those in the community or lifestyle used safe words. Safe words are code words that are used by a person expressing their general wellbeing. This word gives any partner(s) the state of the person, which allows them to stop or take any necessary steps to ensure that physical or emotional damage is not done. It is the case that safe words are a primary part of the community's principles, and many will not engage in any form of dynamic or play without having an established safe word. Clinicians were not familiar with this form of communication on consent outside of BDSM and kink clientele.

"The biggest takeaway for myself was just like, there's so much consent going on, why don't we do this everywhere else in life, not just inside of sex? And outside of that, just the safety measures that they

were taking…"-Non-kink-allied clinician

"...consent is one of the most important things in in the BDSM community and knowing what your limits are and having that trust for individuals. So just I guess being able to teach someone and get that information that they're okay to say yes, they're okay to say no. Or if they're allowed to have those choices, for sure."-Kink-allied clinician

" I personally, absolutely love, love, love working with the BDSM and kink culture, just with his these individuals in particular, because, again, consent is so heavy, and we're able to focus on boundaries and respect and self-love and being able to talk about, hey, if we are engaging in, in some pretty intense BDSM in that someone could get hurt, someone could get injured. That's really important for people to know, what are their limitations? How do we verbalize and vocalize those concerns? How do we advocate? How do we first identify and then advocate for our needs, and be able to really take care of ourselves afterwards?" -Kink-allied clinician

Trauma

Clinicians expressed that they have personal or therapeutic experience with understanding BDSM and kink as relating to trauma. Several clinicians explained that they had clients who partake in BDSM and kink who have severe trauma from abuse. Clinicians questioned if their interest in BDSM and kink was related to trauma because of their interests and how they correlate to their unmet needs or traumatic life events. There was a primary concern regarding a client's intention in partaking in BDSM and kink, as they were unsure if it was being done as a negative expression, such as a form of punishment, pain, or reliving toxicity. Additionally, clinicians reported that they felt that their own personal experiences with BDSM and kink were connected to past traumatic and abusive experiences.

"I think it's important for folks to understand their intention behind their sexual desires…I tended to lean towards a certain type of kink. You know, after I started exploring it, it became reliving certain things that felt very safe and comfortable. It wasn't necessarily healthy."-Kink-allied clinician

> *"I mean, depending on for example, if a client of mine was…um had severe bipolar disorder, and if they were in a severe manic phase, they were more willing to participate in like risky sex and that kind of situation." -Non-kink-allied clinician*

> *"It's understanding the roots of the desires, you know, is it for pleasure? Is it for reliving, you know, an unsafe experience? Does that make sense?"-Kink-allied clinician*

> *"And then I imagine that could be in BDSM. Like, will, you know, what sexual trauma do ALL TIED UP 12 you have versus something like this, that you're sort of seeking this out? And I think that's something that you just have to be really careful of, you know, it's really limiting."-Non-kink-allied clinician*

Discussion

Due to prior DSM edition definitions that outlined Sexual Sadism and Sexual Masochism as paraphilic, there have been perpetuated biases that can impact the clinical realm. In research done by Ansara (2019), they outlined five of the clinicians' common misconceptions about BDSM/kink. They included the notions that BDSM/kink is inherently abusive and causes trauma, that involvement in BDSM/kink is caused by past trauma, that BDSM/kink are less meaningful than non-BDSM/kink relationships, BDSM/kink is not clinically relevant to discuss in therapy, and finally that BDSM/kink relationships indicate a different kind of lifestyle completely out of the "typical" mold. Research has not seen credible evidence that BDSM and kink engagement are related to early age abuse or trauma (Coppens et al., 2019; Ansara, 2019). Rather, literature supports the idea that BDSM and kink identity development follows a developmental path unrelated to adverse experiences (Coppens et al. 2019, Ansara 2019). Extensive research has outlined the emotional benefits of engaging in BDSM and kink, with many reports of it being healing in nature (Sprott & Randall,2024; Ansara, 2019). Furthermore, the significance of BDSM and kink relationships and dynamics can be seen through ceremonies of union that exist in the community (Turley, 2018; Ansara, 2019).

The current study opens the opportunity for more exploratory work that highlights key themes from clinicians themselves; this allows us to gain further perspective moving forward.

To review the initial research questions, there are several ways in which clinicians understand BDSM and kink in a therapeutic setting, though these hold both positive and negative connotations. Some clinicians felt that they were ill-informed on how BDSM and kink exist in a therapeutic setting, while others informed themselves on how to understand the coexistence of therapy and BDSM/kink. Clinicians in this study felt that further education on BDSM and kink would be helpful to them and acknowledged that much of their prior knowledge on BDSM and kink came from clients themselves or from self-exploration. When considering clinician biases, the primary two included communication, safety, and consent, as well as trauma. The contradictory nature between these two themes lent themselves to understanding biases towards BDSM and kink in a unique manner; the theme of communication, safety, and consent highlighted the positive connotations, while the trauma theme brought in negative connotations. Finally, while clinicians were asked about BDSM/kink identity in their interviews, it did not present itself as a primary theme; rather, it was expressed mainly when discussing trauma.

The argument made by Waldura and colleagues (2016) that therapists should be educated on BDSM and kink because it can enhance treatment effectiveness and allow therapists to provide more individualized care for their clients was mentioned throughout the interviews we conducted. Additionally, the themes of lack of education and trauma suggest that there are many misconceptions that have been present in clinical settings. These misconceptions ignore literature that notes that kink and BDSM practitioners report positive impacts of kink on their experience of mental health (Sprott & Randall, 2024). This, paired with the prior findings that BDSM and kink practitioners have specific needs relating to their kink behaviors and would prefer to be out to their providers, makes this current study relevant as it is important to furthering and strengthening clinician BDSM and kink knowledge.

Limitations and Future Directions

This exploratory study had a small sample size, which meant that there was a limited geographic reach within participants. However, the small sample size is not entirely atypical. Braun and Clarke's (2013) guidelines suggested that an appropriate sample size for a small interview project is between six and ten participants, as this allows for theme identification without an overflow of data. Theoretical saturation is another commonly recognized qualitative approach, which is marked by investigating until no further themes are emerging, thus suggesting meaningful data. With this approach,

studies have reported theoretical saturation after as few as 6 interviews (Isman et al., 2013). Therefore, while the sample size was limited, it remains consistent with established qualitative research standards. Additionally, a more diverse range of clinicians would be beneficial moving forward. Due to financial and temporal constraints, a wide clinician range was not achieved.

The continuation of education on BDSM and kink is of utmost importance. Clinicians suggested that continuing education programs, workshops, and undergraduate or graduate classes could be helpful for ensuring that there are resources that they can look to for information on the subject. This, combined with prior literature on various kinds of cultural competence training having positive outcomes for mental health providers, suggests that a format like this could be of benefit to educate on more specific topics such as BDSM and kink (Chu, 2022). The current study did not address BDSM and kink practitioners' identity in a large enough capacity and should therefore be considered moving forward in work done on BDSM and kink identity narratives. Identity narratives may give insight into how clinicians can educate themselves on BDSM and kink practitioners and practices as a whole. Future research should aim to create a model for education surrounding BDSM and kink that can be utilized by professionals to assist in reducing stigma surrounding BDSM and kink practitioners. A model for education on BDSM and kink could be beneficial in assessing the effectiveness of workshops and other training that are provided as well.

Conclusions

This exploratory research allows us to better assess future steps needed to work towards BDSM and kink normalization to enhance treatment effectiveness and allow therapists to provide more individualized care for their clients. Establishing a strong relationship with a mental health clinician has shown positive outcomes for individuals, specifically when it comes to seeking future care (Schuller, 2020). For this reason, clinicians and clients could benefit from BDSM and kink education. It is interesting to note that, concerningly, practitioners expressed a large emphasis on consent for those in BDSM and kink, but not as much of an emphasis for those in vanilla or traditional dynamics. Regardless of this acknowledgment, clinicians viewed BDSM and kink as more "risky" forms of sex that seemingly stem from trauma. With these findings in mind, the lack of education must be addressed, as this contributes to the misconceptions and lack of understanding of this subject. Additional

research should continue to explore these issues and utilize them as a starting place for further exploration.

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