
Clinical Practice Guidelines for Working with People with Kink Interests

DECEMBER 2019

Developed by the
Kink Clinical Practice
Guidelines Project
kinkguidelines.com



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Clinical Practice Guidelines for Working with People with Kink Interests:

Kink Clinical Practice Guidelines Project

Citation:

Kink Clinical Practice Guidelines Project. (2019). *Clinical Practice Guidelines for Working with People with Kink Interests*. Retrieved from <https://www.kinkguidelines.com>

Purpose

There are people who are involved in a range of sexual, erotic, or intimate behaviors and relationships that are commonly understood as *kinky*. We conceptualize *kink* as sexual identities, erotic behaviors, sexual interests and fantasies, relationship identities, relationship orientations, and relationship structures between consenting adults not accepted by the dominant culture. We specifically include BDSM (Bondage/Discipline, Dominance/Submission, Sadism/Masochism), Leather, and Fetish as important parts of the umbrella term of *kink*.

The lack of training and education about kink sexualities and the stigma attached to these interests have resulted in a lack of culturally competent treatment of this oppressed group. The gap calls for the clinical fields to address this unmet need as part of professional ethics and responsibility.

Clinical practice guidelines assist healthcare practitioners by identifying high quality services and desirable professional practices. The *Clinical Practice Guidelines for Working with People with Kink Interests* (hereafter referred to as “Kink Clinical Practice Guidelines”) are intended to outline the knowledge, skills, and attitudes important for providing culturally competent care to the population of people who are involved in kink, both kink-identified patients and those involved in kink who do not adopt that identity.

Clinical practice guidelines are recommendations, not mandatory requirements. The Kink Clinical Practice Guidelines are not standards of care, nor should they be used to exclude any healthcare provider from practicing in a particular area. The Kink Clinical Practice Guidelines are proposed to improve the care, and minimize harm to the kink community, an underserved and vulnerable population.

Cultural and Professional Context for Developing these Practice Guidelines

Over the past 10 years, there has been an acceleration of professional and popular cultural discussion and exploration of sexual, gender, and relationship diversity, including kink sexuality. Within the past five years, there has been a proliferation of workshops and training programs to educate counselors and therapists about kink sexuality and the clinical issues that arise in serving this part of the population. More research than ever is being published on different aspects of kink sexuality, the stigma around kink sexuality, and issues of health and well-being for people who practice kink. And because of an increase in images and stories in popular culture that address kink, there are more people disclosing their interests and fantasies, and more people

actively exploring kink sexuality - leading to more clients and their partners who need to address questions and issues in the context of counseling and therapy.

Given both the increase in empirical studies and more openness by healthcare professions to address the needs of kink-interested people, we feel that this is a propitious time to consolidate and deepen our collective understanding of good practice in providing therapy for this part of the population.

Process of Developing these Practice Guidelines

The Kink Clinical Practice Guidelines were developed in an iterative process, incorporating a comprehensive literature review, text construction, reflection, and feedback from various stakeholders across several rounds. The idea of developing these Kink Clinical Practice Guidelines first emerged at the 2010 Alternative Sexualities Conference (now known as the Multiplicity of The Erotic Conference) in San Francisco, CA. The closing plenary of the 2012 conference was entitled “Creating Clinical Practice Guidelines for Work with the Kink Community: First Steps.” In October 2016, an initial team came together to outline the process and the principles that would guide the work. In January 2017, two teams were formed: the Text subgroup and the Stakeholders Engagement subgroup. The Text subgroup worked on the initial draft and incorporated feedback into the text as the guidelines were developed. The Stakeholders Engagement subgroup worked to communicate with professionals and community members, gathered feedback from stakeholders, and found opportunities to present and

disseminate drafts of the guidelines. The interactions between the subgroups in developing the guidelines was an iterative process, covering the time period of January 2017 to August 2019.

The initial text was based on an article published in 2004 in *Contemporary Sexuality*, the AASECT newsletter, by Peggy J. Kleinplatz and Charles Moser, that presented specific clinical practice guidelines for working with BDSM clients (Kleinplatz & Moser, 2004). Model practice guidelines were also consulted for 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 Kink Clinical Practice Guidelines are meant to be a “living document” - there will be reviews, updates, new voices and new research incorporated into the Guidelines on a regular, periodic basis going forward. Given this intention, we invite people to provide feedback by going to www.kinkguidelines.com

Clinical Practice Guidelines for Working with People with Kink Interests

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.

Kink is used as an umbrella term to address a wide range of atypical sexual, erotic, pleasurable, fun, intimate, and/or self-expressive interests and behaviors (Kleinplatz & Moser, 2006; Simula, 2019). The range of interests and behaviors includes eroticizing intense sensations (including but not limited to pain), eroticizing interpersonal power dynamics and differences, enduring fascination and arousal with specific sensory stimuli including specific body parts or inanimate objects (fetish), enacting role play for arousal, exploration or playful excitement, and erotic or arousing activities that may induce heightened or altered states of consciousness.

Approximately 45-60% of people in the general population report having fantasies that involve some aspects of dominance and submission (Joyal et al. 2014; Jozifkova, 2018), and approximately 30% have fantasies that involve whipping or spanking (Joyal et al. 2014, Herbenick et al. 2017). In terms of behavior, it is estimated that approximately 10% of the general population has engaged in kink behaviors at some point in their lives (Janus & Janus, 1993; Joyal & Carpentier, 2016; Masters et al. 1995). Although there are very few 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 may be that 1-2% of the general population holds an identity centered on their kink sexuality (Sprott & Berkey, 2015). A recent study that examined a representative sample of the Belgian population (n=1,027) found that 46.8% of the participants had engaged in BDSM-related activities at least once in their lifetime, and 12.5% had engaged in a regular basis. In addition, 7.6% had identified as “BDSM practitioners” - that is, what clinicians and researchers might call having a kink identity (Holvoet, et al. 2017). In a nationally representative probability survey conducted in the United States in 2015 (n=2,021), Herbenick et al. (2017) found that 21.1% of participants had included bondage in their sexual behaviors; 31.9% had engaged in spanking; and 15.0% had playfully whipped or been whipped over the course of their lifetime.

Some survey studies have asked individuals about kink-related activities they've engaged in, yet these surveys do not fully capture the behaviors that can be defined as kinky (Joyal & Carpentier, 2016; Rehor, 2015; Richters, et al., 2003; Sandnabba et al., 2002). Common activities include spanking, slapping, restraints/bondage, blindfolds, using dildoes, hair-pulling, biting, scratching, and master/slave role-playing (Rehor, 2015; Sandnabba et al, 2002). The very large range of possible kink activities highlights the need for increasing kink awareness among clinicians, to avoid confusion, rejection, or invalidation that can interfere with a therapeutic alliance.

Given the large range of interests and activities that are recognized as “kinky” by the organized kink community, and by individuals in discussing their own sexual interests and behaviors, the clinician should be aware that (a) the term “kinky” may or may not be used by a client or patient to label or categorize their erotic interests or identities; and (b) if the term is

used, it may have an idiosyncratic meaning or be used by the individual client or patient. Hence, it is important for the clinician to proactively explore the relationship between erotic activity and the language used by the client. The clinician should refrain from any assumptions about any label used by clients and patients to describe their interests or 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.

A basic principle of clinical work is practicing within the domain of knowledge and scope of training that enables clinical work to be effective and ethical. Given the limited knowledge that we have of kink, and human sexuality in general, we recognize that questions of competence and scope of practice become relevant in most, if not all, encounters between clients and healthcare providers. Awareness of professional competence and scope of practice are an essential foundation for the rest of the clinical practice guidelines. These guidelines highlight the need for clinicians to check their understanding and knowledge of kink before working with these issues in a clinical setting.

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.

There is a large body of research on whether erotic fantasies and inclinations, or involvement in kink behaviors or practices are related to mental disorders. Among representative samples, Richter et al. (2008) showed that Australian males (but not females) who endorsed kinky behavior showed significantly less neuroticism on the Big Five personality characteristics than the general population. Wismeijer & van Assen (2013) found less neuroticism for both males and females among a self-selected sample. Cross & 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 for kink behavior or interests. Their findings indicated no differences between the kink and non-kink groups on multiple 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: the MMPI-2, MCMI-III, the Trauma Symptom Inventory, the Post Traumatic Stress Disorder Scale, the Multiscale Dissociation Inventory, the BDI-II, and the BAI. Participants tested in the normal range for depression; some indication of lower anxiety than the general population; within the normal range for PTSD; higher levels of dissociative symptoms but not DID; and higher levels of narcissism, but within the normal range for borderline and paranoia symptoms. Connolly (2006) noted that dissociative symptoms were

not clearly related to any specific psychopathology in the study; and that scores on narcissism measures may include personality strengths as well as personality pathology.

Both the American Psychiatric Association's *Diagnostic and Statistical Manual - 5 (DSM-5)* and the World Health Organization's proposed *International Statistical Classification of Diseases and Related Health Problems - 11 (ICD - 11)* make clear that consensual kinky practices are not, in and of themselves evidence of psychopathology. They only merit clinical attention when clients report substantial subjective distress and/or impairment in work or life functions attributable to their sexuality. Kink practices would not ordinarily merit a diagnosis.

Dunkley & Brotto (2018) in an overview of clinical issues to consider when treating BDSM practitioners, noted specifically the need for clinicians to distinguish pathology from BDSM and to avoid making BDSM a central issue in therapy when it is peripheral to the client's presenting concerns.

Guideline 4: Clinicians understand that kink is not necessarily a response to trauma, including abuse.

The Australian Study of Health and Relationships (ASHR) examined psychological distress and sexual functioning in a national representative sample. This study found 2% of sexually active men and 1.4% of sexually active women had engaged in BDSM activities within the previous year, and found no difference in past sexual abuse history, or levels of psychological distress (Richters et al, 2008). In a study of 186 SM practitioners in Finland, Nordling et al. (2000) found that 7.9% of male participants had childhood sexual abuse histories, and 22.7% of female participants had childhood sexual abuse histories, and they noted that these levels were

higher than the national prevalence in Finland. Results from the 2016 National Kink Health Survey, which included questions about adverse childhood events (ACE scores), found that 9.6% of a sample of 980 kink-identified participants had high ACE scores, indicating a childhood that included elements of neglect, emotional abuse, physical abuse, or sexual abuse. The national prevalence for high ACE scores is approximately 15.8% (Merrick et al., 2018). There is little evidence to support the assertion that kink interests and behaviors are a response to trauma or abuse in most people with kink interests.

Is kink behavior a repetition compulsion? The concept of *repetition compulsion*, often articulated in psychoanalytic and psychosocial approaches but also used in cognitive-behavioral approaches to therapy, proposes that people will engage in repetitive behaviors, even if harmful, because the familiarity reinforces negative self-beliefs, or provides a sense of comfort and control in response to trauma, or protection from intimacy. Repetition compulsion may be a construct that is inappropriately applied to clients involved in kink, influenced by negative stereotypes of kink sexuality. Repetition compulsion presents a diagnostic challenge for clinicians in discerning whether or not a pattern of kink behavior and fantasies are a response to trauma or abuse, or whether they are healthy or even transformative (Kleinplatz, 2006). However, repetition can be part of an attempt at mastery or healing, through repetition and repair: “Consensual SMDS [somasochistic, dominant-submissive fantasies and behaviors] can form a particular kind of playground for this process by bringing the visceral (affective and physiological) elements of repetition into a symbolized play scene that is constructed with reparative goals in mind (which, as we have seen, cannot be extracted from the elements of repetition).” (Weille, 2002, p 143). Clinicians should be careful about the application of the construct of repetition compulsion in clinical work with kink-involved people. Even when kink

behaviors are determined to be a reaction to trauma, clinicians should explore their value to and impact on the client.

Guideline 5: Clinicians recognize that kink intersects with other identities in ways that may shape how kink is expressed and experienced.

There is a significant range of demographic and cultural diversity among people who are kink-involved. In part, this can be demonstrated by the presence of organized kink social and educational groups and networks in many nations such as China, India, Nigeria, Japan, Germany, Brazil, and Israel. While there is a preponderance of such organizations in Western, English-speaking nations, it is not limited to those cultures and countries. However, the vast majority of currently published empirical literature addressing kink sexualities focuses on White and middle-class populations (critiques of the current empirical literature: Damm et al. 2018; Sheff & Hammers, 2011; Bauer, 2016).

Several studies have noted that non-heterosexual people are more likely to report involvement in BDSM and kink (Cross & Matheson, 2006; Connolly, 2006; Pitagora, 2016; Waldura et al. 2016; Sprott & Benoit, 2017). 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 stigmatizing processes affecting sexual minorities and sexual majority populations differently (Damm et al, 2018). Similar observations about non-cisgender people have also been made clinically, although more work in this area is needed.

Historically, clinical frameworks have been normalized/standardized on cisgender, heterosexual, and White communities. Therefore, an awareness and a consideration of other

cultural identities is necessary for meaningful and engaged treatment. A continuous assessment and evaluation of the implications of all cultural influences is imperative to effective and culturally competent treatment.

Clinicians engaging with marginalized communities may unknowingly exclude some cultural and sociopolitical identities. Social and economic determinants, biases, inequities, and blind spots may create treatment barriers that impede achieving the client's desired outcomes. Clients are in a vulnerable position; the power dynamic between the client and clinician needs to be challenged and addressed. This allows space for the clinician to be in a humble position so as to hear the client's narrative and needs.

Little is available in the psychological literature about how kink behaviors and relationships differ across class, nationality, or racial/ethnic minority communities, nor are there any studies of how kink-related stigma processes might differ across different communities and cultures (Nerses, Kleinplatz & Moser, 2019). The field lacks basic information about diversity along these lines. More is known about gender and sexual orientation diversity as it relates to kink behaviors. However even in this area, the empirical database has yet to address questions beyond basic prevalence data. For example, although some studies suggest that having a lesbian, gay, bisexual, transgender, or queer identity might make it more likely that one discloses about kink sexuality, it is not clear whether this is a difference in likelihood to engage in kink, or a difference in comfort about "coming out" around another stigmatized sexual identity.

Guideline 6: Clinicians understand that kink may sometimes facilitate the exploration and expression of a range of gender, relationship, and sexuality interests and identities.

A number of studies have looked at the intersections of kink with gender, sexual orientation, and consensual non-monogamy. Sprott & Benoit (2017) in an interview study of 72 kink-identified individuals living in Northern California, suggested that for some individuals kink activities became a way to explore gender or sexual orientation; in the context of kink sexuality, individuals were allowed or encouraged to explore different gender identities, expressions (i.e., feminization or cross-dressing; role-playing scenarios), or sexual encounters with individuals of different sexes and genders. In an interview study of 50 self-identified dykes, trans people and queers from the United States and Western Europe, Bauer (2008) found that erotic roleplay included taking roles of other genders, leading to insights about the self and about gender as situated across race, class, and age. Simula & Sumerau (2017) noted how gender was used to negotiate BDSM activities, sometimes challenging culturally dominant discourses about gender but sometimes using and reproducing culturally dominant discourses in the pursuit of eroticizing power, in both in-depth interviews and in discussion board chats. Delisle et al. (2018) found that BDSM practitioners experienced sexual arousal and desire differently between BDSM contexts and non-BDSM sexual contexts, which may be related to how BDSM can facilitate exploration and expression of a range of sexuality interests. Pitagora (2016) noted that there are only a few studies of the intersections of kink and consensual non-monogamy (CNM), including polyamory, and in these few studies there is some indication that kink-identified people are more likely to identify as CNM; however, within the larger CNM population, the likelihood of people being kink-identified is no higher than in the monogamous population.

Cross-dressing, it should be noted, may be seen by some clients as a fetish or kink and as something that has a sexual or erotic element to it, but most people practice cross-dressing to relieve stress, or to challenge social norms and restrictions, or to explore gender in ways that are not sexual or erotic. Many cross-dressing people do not identify their interest or behavior as kinky, so clinicians should explore and ascertain the meaning of cross-dressing to the client, and not assume that the cross-dressing is associated with kink or fetish interests. Cross-dressing also generally relies on a binary view of gender which not all clients will share, and the term should not be applied to people unless they use this term themselves.

Guideline 7: Clinicians recognize how stigma, discrimination, and violence directed at people involved in kink can affect their health and well-being.

Minority Stress Theory and investigations of multiple minority stress have outlined the impact of stigma, prejudice and discrimination on the health of sexual minorities (Meyer & Frost, 2013; McConnell et al. 2018; Nerses, Kleinplatz & Moser, 2019). The stress of overt institutional discrimination; interpersonal hostility and rejection; violence; the clash in values between a stigmatized social group and the larger society; anticipated stigma; and the stress of concealment and information management, are sources of stress that affects physical and mental health beyond the stressors of everyday life.

The National Coalition for Sexual Freedom (NCSF) has documented cases of discrimination based on BDSM or kink disclosure, including from healthcare providers (NCSF, 2008). Cramer et al. (2017) reported findings that members of the NCSF were between two and three times

more likely to be at elevated suicide risk compared to college student and community-dwelling adult comparisons. Internalized stigma, shame and guilt were significant risk factors for elevated rates of suicidality in one sample of BDSM practitioners (Roush et al., 2017). Although not being formally recognized as a sexual minority by the CDC or NIH, there are clear empirical grounds for the clinician to approach the care of kink-oriented and kink-identified clients and patients in the same way they would approach the care of other sexual minorities.

Guideline 8: Clinicians understand the centrality of consent and how it is managed in kink interactions and power-exchange relationships.

In the 1970s when the kink subculture began to form social organizations, groups, and clubs that were more public-facing, there was a felt need to distinguish the practice of BDSM as distinct from psychopathology or criminality. The issue of consent became central to making these distinctions: consent is an informed, voluntary agreement by two or more people to engage in a particular activity or to enter into a relationship.

The first use of the phrase “safe, sane, and consensual” was in the 1983 mission statement of the Gay Male SM Activists (GMSMA) organization:

GMSMA is a not-for-profit organization of gay males in the New York City area who are seriously interested in safe, sane, and consensual S/M. Our purpose is to help create a more supportive S/M community for gay males, whether they desire a total lifestyle or an occasional adventure, whether they are just coming out into S/M or are long experienced. [as quoted in Stein, 2002].

Since then, this phrase and several alternative phrases have crystallized a community value on consent (Rodemaker, 2008; Barker, Iantaffi & Gupta, 2007; Kleinplatz & Moser, 2006).

Practices such as *safewords* or safe signals (to communicate a need to stop or slow down during a scene), *negotiation* of limits and desires before a scene, and *aftercare* (attending to physical and psychological needs after a scene) are cultural practices that help ensure and manage consent (Ortmann & Sprott, 2013). These practices recognize that consent is an ongoing process, rather than a one-time moment separate from the ensuing activity. Within 24/7 power or authority exchange relationships (such as Master/slave relationships), there are emphases on consent through the use of *contracts* (written agreements), *check-ins* (periodic review by those in relationship about the health of the relationship dynamic, including boundaries and limits), and the emphasis on *transparency* (clear and direct communication without holding anything back) as a valued practice to maintain a power or authority exchange (Baldwin, 2002; Shahbaz, in review). A therapist should be familiar with these terms, practices and community values in order to assess issues and adequacy of consent.

Guideline 9: Clinicians understand that kink experiences can lead to healing, personal growth, and empowerment.

Kink-identified individuals report that BDSM has been used to promote psychological or spiritual growth, healing, and transformation. Kink scenes and relationships have been used in conscious, creative, and life-affirming ways (whether on their own or as an adjunct to psychotherapy) with positive impacts on self-actualization, personal growth, and increased sense of empowerment and autonomy (Brizzi, in review; Califia, 2001; Easton, 2007; Kleinplatz, 2006; Newmahr, 2010; Ortmann, & Sprott, 2013; Sprott & Randall, in review).

Clinicians understand that kink behaviors per se are not signifiers of psychopathology (Bader, 1993; Morin, 1995). Because sexuality is linked to important aspects of the self-concept and identity, BDSM may be useful for personal growth and empowerment.

Clinicians should be open to supporting clients'/patients' attempts to use their sexuality as vehicles towards psychological growth. Some theoretical perspectives (Cowan, 1982; Easton, 2007; Hillman, 2004; Shahbaz & Chirinos, 2017; Shahbaz, in review) combined with clinical and empirical evidence suggest that clinicians recognize the value in helping clients create therapeutic sexual/erotic experiences (Brizzi, in review; Henkin, 2013; Kleinplatz, 2006; Sprott, & Randall, in review).

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

There are very few studies that have examined generational differences specific to kink or BDSM expression. Some clinicians report different patterns of kink identity acceptance and behavior among older and younger clients. It appears that emerging adults are coming out as kinky earlier in life than older cohorts. The impact of the Internet to facilitate the discovery of kink communities and supporting the exploration of kink sexual identity should not be underestimated.

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

A recent study of a representative sample of the Belgian population, collected in 2017 (n=1,027), found that 61.4% of people who had an interest in BDSM became aware of this interest before the age of 25, and 8% of the sample before the age of 15 (Holvoet, et al, 2017); 5.2% of this sample reported awareness before the age of 10 (Morrens, personal communication, November 2018). In a study of 244 Belgian participants on Fetlife (a social media site), 29.9% of the sample reported having their first thoughts or fantasies about BDSM at age 10 years or earlier (Morrens, personal communication, November 2018). In a study of 184 sadomasochistically oriented Finnish participants conducted in the late 1990s, 77.8% became aware of their interests before the age of 25; the median age of first awareness of kink interests was in the 18-20 age bracket, with 9.3% reporting interest awareness before the age of 10, and 5% reporting their first experience before the age of 10. According to Sandnabba et al. (1999) 21.8% had their first kink experience before the age of 18. The study also found that heterosexual men became aware of this sexual interest earlier than non-heterosexual men (Nordling et al, 2006). 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; 12% reported their first kink experience at the age of 10 or younger (Moser & Levitt, 1987). A 1977 study of a West Germany sample of men (n=237) found that 77% first became aware of their kink interests before the age of 25 years; 7% of the sample reported their first interest at age 10 or younger (Spengler, 1977). In a representative random-sample survey of the United States adult population in 2014-2015, 11.7% of men and 14.7 % of women had experienced bondage before the age of 25, and 9.2% of men

and 8.4% of women had experienced whipping or flogging before the age of 25 (Herbenick et al. 2017). Although these are exploratory studies, and are not uniform in how they measure or report early kink awareness, the results seem to suggest that 5-12% of the population are aware of their kink interests during early adolescence or emerging adulthood.

Given that the research literature examining the mental health status of kink-involved people finds no difference in psychological functioning or attachment patterns, one can draw the inference that these early explorations do not lead to mental health complications or disorders; however, there is no direct empirical investigation about the positive and negative effects of early exploration and discovery on the individual.

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

While there has been little research on the relationships of kink-identified individuals, there does seem to be a large part of the kink community that practices some form of consensual non-monogamy (CNM), whether open relationships or polyamorous networks. Rehor (2015), in an international survey of 1,580 kink-identified women collected in 2010-2011, reported that 39.91% were in polyamorous or open relationships, 4.63% were swingers, and 14.75% were in monogamous relationships. Carlstrom & Andersson (2019) reported that 58.9% of participants in their ethnographic study defined themselves as polyamorous or non-monogamous (17 out of 29 persons interviewed, in data collected in Sweden in 2012 and 2013). Their participants noted some common elements between BDSM and CNM: the value placed on clear negotiations of consent, explicit agreements about relationship dynamics and boundaries, the encouragement of

a permissive atmosphere when it comes to individual happiness and exploration, the priority placed on safety and communication, and conscious countercultural transgression of standard ways of adult relating. For some people, exploration of kink can lead to exploration of CNM as a way to facilitate their kink development. And often because BDSM can involve non-genital intimate interactions, involvement with other kink partners may be perceived as less threatening to primary committed relationships (Carlstrom & Andersson, 2019).

Some research has documented the phenomenon of *leather families* as a form of intentional, chosen families created by adult members of sexual and gender minority groups, often in the face of biological family rejection and marginalization in society (Bauer, 2010; Hammack, Frost & Hughes, 2018; Murphy & Bjorngaard, 2019; Pitagora, 2016). Leather families are a network of people that acknowledge and practice ongoing supportive relationships “while sharing the commonalities of the leather and kink scene” (Bannon, 2016, May 12). Some relationships in the network may include erotic or sexual connections, others not, and many of the relationships exhibit a hierarchical structure, with differences in power and authority depending on role identities relevant to kink (Green, 2007; Hammack, Frost & Hughes, 2018; Moser & Kleinplatz, 2007; Pitagora, 2016). As for prevalence, there are very few studies that inquire into how many people are members of leather families. Rehor (2015) reported that 11.35% of a sample of 1,383 kink-identified women chose being part of a “BDSM family” as their relationship status. Other than descriptive efforts, there is little research on the functions and dynamics of leather families. Clinicians should also be aware that leather families can involve persons who care for or have custody of minor children, children who are not involved in the leather family interactions but who can indirectly impact adult relationships within the leather family.

Leather families and other types of intimate relationships found in kink subcultures often involve authority or power exchange, or consensual dominance, as part of the relationship. (Bauer, 2010; Hammack, Frost & Hughes, 2018). Consensual dominance “is any kind of intentional, mutually desired, mutually fulfilling exercise of power and control between partners.” (Fulmen, 2016, p. 1). A person takes on the role of leading, directing, deciding in relation to one or more other partners that concur with that leadership, direction, and decision-making. Often hierarchies of authority are established if there are more than two people in a relationship configuration.

The mix of power exchange, authority hierarchies, and consensual non-monogamies can create situations where a Dominant partner can have multiple sexual or kink relationships, but a submissive partner may not, or a situation where a submissive partner’s sexual encounters with others is controlled by the Dominant (but not the other way around). It is important for clinicians not to assume that this situation is a sign of intimate partner abuse. It is important to discern if the power imbalance is consensual and negotiated, and if the power differential around sexual encounters enhances or detracts from the health of the relationship and the people in it. In certain cases, clinicians might need to help negotiate interpersonal boundaries or discern personal values and needs around sexuality in power exchange relationships.

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

There is no evidence that parents who are kink-involved are in any way significantly different from parents who are not. Given the lack of evidence for kinky people having more

personality disorders, more psychopathology, and more insecure attachment patterns, there doesn't seem to be grounds for making the assumption that kink involvement has a negative effect on parenting. We note that there are no published studies documenting problems for children, or retrospective studies of adults, related to having kinky parents or caregivers.

How many kink-identified people are parenting or providing childcare? The Kink Health Survey 2016 asked the question "how many children do you care for or look after (even part time)?" 234 out of 1000 participants answered that they take care of at least one child, currently. More work needs to be done in terms of understanding the familial relationships and parenting situations of kink-identified people, but the Kink Health Survey and anecdotal evidence suggests that this is not a rare situation for clients.

Issues about child custody, on the other hand, are also not rare situations for kink-involved clients. Wright (2018) reported that between 2005 and 2017, NCSF was contacted by 808 parents regarding child custody hearings wherein their kink involvement had become an issue. In some of these cases, the DSM-IV-TR had been used by social workers and psychologists to diagnose a paraphilia, and judges denied custody on that basis - only 13-19% of parents retained custody or visitation rights out of the dozens of parents who contacted NCSF, depending on the year. NCSF noted that after the posting of proposed revisions to the DSM-5 in 2010, and the publication of the DSM-5 in 2013, which explicitly made clear that there was a distinction between consensual paraphilias and paraphilic disorders, the number of parents losing custody dropped precipitously. In 2015, only 3 parents had their custody removed, and only 5 parents lost custody in 2017 (Wright, 2018).

Klein & Moser (2006) reported on a child custody case, demonstrating in detail how bias against BDSM can work in custody cases. A forensic and clinical psychologist maintained that a

custodial parent and her current partner had sexual interest in children, when he discovered that the parent and her partner had an SM relationship. He diagnosed her with Sexual Masochism and her current partner with Sexual Sadism, based on the DSM-IV-TR. And although even following the criteria for diagnosis would preclude these diagnostic conclusions, he reported this to the judge, and referred to language in the DSM that proposed that *paraphilias generally increase in intensity over time* and that *people often develop multiple paraphilias*, including pedophilia. Hence, the psychologist recommended severe limitations on custody and visitation because of some possible future danger to the child. The assertions about increasing intensity and multiple paraphilias, which have very little empirical evidence to support them, have been used in cases to deny custody.

Given the empirical data on psychological functioning of kink-involved people, and the historical record of revoking child custody based on diagnoses of paraphilias alone, it is important that clinicians don't assume that kink involvement has a negative effect on parenting. Such assessments should be made on a case by case basis.

Guideline 14: Clinicians do not assume that any concern arising in therapy is caused by kink.

While there are very few studies of kink-involved clients' and patients' experience of therapy, the existing studies do suggest a few possible trends. Kolmes, Stock and Moser (2006) surveyed 175 clients in the early 2000s and found that 75% of the respondents reported that the issues which brought them into therapy were not related to their kink interests, while 23% thought that their kink interests were related or tangentially related to their presenting concern.

Of note is that 35% of the respondents never disclosed their kink interests or activities to their therapists. Hoff & Sprott (2009) conducted a content analysis of the interviews of 32 heterosexual couples who practiced kink activities and their experiences in therapy. The study found five therapy dynamics around the issue of disclosure of kink interests: 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 their kink sexuality at all. The study participants were asked about advice to psychotherapists for working with kink-involved clients, and a common theme was advice that psychotherapists should regard BDSM sexuality as one of several factors to consider in therapy, and to treat these factors as equal in importance. Lawrence & Love-Crowell (2008) interviewed 14 therapists who had experience working with kink-identified clients. Results suggested that kink was rarely a central issue in therapy, and that therapists often approached working with kink-identified clients as a cultural competence issue.

Studies on the mental health of kink-identified people have assessed personality disorders, attachment styles, and mental disorders such as depression or anxiety, etc. Part of the stigma around kink/BDSM sexuality is the unsubstantiated belief that these interests, fantasies or behaviors are the result of childhood abuse. The relation of child abuse to subsequent kink/BDSM behavior, and an examination of psychological health and functioning of kink-identified people, have been studied fairly extensively. Although a few studies have found some correlations between past childhood abuse and adult engagement in kink/BDSM practices (Hopkins et al. 2016; Nordling et al. 2000) or kink-identified individuals identifying prior childhood abuse as part of their narratives of kink sexuality (Yost & Hunter, 2012), a nationally

representative survey of Australians' sexual practices found no significant correlation between sexual abuse or coercion and BDSM participation (Richters et al. 2008). The preponderance of research finds little or no difference in psychological functioning and attachment styles when comparing those who engage in alternative sexualities with control samples (Cannon, 2009; Connolly, 2006; Cross & Matheson, 2006; Richters, et al. 2008; Wismeijer & van Assen, 2013).

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

Clinicians work under a professional ethic that calls for supporting the improvement of health and well-being for individual clients, not enforcing society's agendas around sexuality or relationships over the health of their clients. 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. Instead, clinicians are to focus on the stress of a mismatch between society's views and values and the person's views and values, the stress of living as a stigmatized minority with social exposure to rejection and violence.

It remains unclear at the moment whether or not kink could be considered a sexual orientation (Spratt & Williams, 2019). Two productive theoretical approaches to understanding kink are the leisure approach and the sexual orientation approach. Leisure studies examine meaningful activities that are freely chosen, intrinsically motivated, and that provide opportunities for people to experience positive emotions, stress release, adventure, and self-expression (Walker, Scott, and Stodolska, 2017). The sexual orientation approach examines kink

as an aspect of sexuality that involves enduring interests or attractions that are beyond the conscious control of a person. Moser (2016), in response to the retention of the concept of *orientation* in Sexual Configurations Theory (van Anders, 2015), discusses elements of sexuality entailed by the concept of orientation: (a) sexual attraction that is strong and persistent; (b) relative immutability / fluidity of sexual attraction or arousal that is beyond conscious control; (c) early onset, developmentally, in childhood or adolescence; (d) significant psychological consequences to denying, exploring, fulfilling or repressing sexual attraction and arousal; and (e) lifelong patterns of sexual attraction and arousal. Early evidence supports both leisure and orientation approaches to understanding kink, and in as much as kink could exhibit qualities like an orientation, then issues about reparative or conversion therapies might apply here. More work needs to be done, scientifically, but early indications support a clinical approach that would avoid the harm to some kink-identified or kink-involved clients that has been documented in therapeutic approaches attempting to change or suppress sexual orientation. It may be that through a culturally informed therapeutic process, a client may be invited to alter their kink practice to better align with their values, or a clinician may use a harm reduction framework around kink behaviors, but it is critical that clinicians not attempt to eradicate kink interests altogether.

Guideline 16: Clinicians understand that distress about kink may reflect internalized stigma, oppression, and negativity rather than evidence of a disorder.

People who live with stigmatized sexualities can often internalize rejecting or shaming messages from their cultural group, or experience acts of violence and aggression from others who reject them, and this leads to heightened distress - a key feature of minority stress. This dynamic is well established empirically with LGBTQ populations. We do not see any aspect of kink that could put kink outside the models addressing sexual minority stress. Some clinicians and people in the kink community talk about internalized kink-phobia, parallel to internalized homophobia, to describe when individuals are distressed by their own interests and activities in kink.

In addition, distress about kink may be related to kink interest discrepancies in intimate relationships. In the 2016 Kink Health Survey, 24.98% of kink-identified participants had a partner who was not kinky, and 23.77% had a partner with different kinks than their own - and about 10% of those with kink interest discrepancies were distressed "a lot" by these discrepancies (Vilkin & Sprott, 2019).

In LGBTQ psychology, it is understood that health disparities, such as elevated levels of depression, anxiety, issues with addiction or substance use, and suicidality are not symptoms of sexual and gender diversity as a pathology but responses of individuals and communities under significant stress and pressure. The same model applies here.

Clinicians should make a careful assessment as to whether heightened levels of distress are coming from internalized stigma, or from some other disorder that might be present, and not automatically assume that kink itself causes psychopathology or 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.

Clinicians are trained to examine their own biases, values, and attitudes on conditions or situations that are stigmatized by the dominant culture, in order to provide effective and ethical care. The APA *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*, Guideline #2, states:

Psychologists aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, and/or formulations based on limited knowledge about individuals and communities (APA, 2017).

The NASW *Standards and Indicators for Cultural Competence in Social Work Practice*, states in Standard 2: Self Awareness:

Social workers shall demonstrate an appreciation of their own cultural identities and those of others. Social workers must also be aware of their own privilege and power and must acknowledge the impact of this privilege and power in their work with and on behalf of clients. Social workers will also demonstrate cultural humility and sensitivity to the dynamics of power and privilege in all areas of social work. (NASW, 2015).

Ongoing consultation and continuing education around kink are vital to evaluating biases, values and attitudes, even for clinicians with extensive experience working with kink communities. Because kink covers a wide range of sexual and erotic interests, including some rare fetishes and scenes, even experienced clinicians can encounter client situations that they have no experience or little knowledge about. The extensiveness of kink means that clinicians can be at different levels of awareness or knowledge. Several clinicians and researchers have noted these different levels and articulated the differences: “kink-friendly” as 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” as a more advanced level of knowledge and affirmative care (NCSF, 2019; Shahbaz & Chirinos, 2017). Spratt et al. also noted that therapy with kink-involved clients 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 (Spratt et al., 2017).

In addressing this clinical guideline, it is crucial that clinicians examine whether or not they are expecting or depending on the client to educate the clinician about their kink. It is not appropriate for clinicians to rely on their clients for their education about kink. The clinician should seek out continuing education opportunities, engage in self-directed learning, and initiate consultation proactively. Depending on the client can derail therapy (Hoff & Spratt, 2009; Kolmes, Stock & Moser, 2006).

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 assertions such as the person is out of control, dangerous, and anti-social. Equating consensual BDSM between adults as violence or abuse is common. Part of seeing kink-involved people as suffering from a mental disorder or problem includes assuming that kinksters 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 spot because of their anti-social, disordered and deviant interests and behaviors. We have little information on how extensive these negative stereotypes are shared in the general population, nor on how many mental health providers hold onto specific stereotypes. However, there is clear anecdotal evidence and community conversation about clinicians holding negative stereotypes of people interested in kink.

If a person interested or involved in kink has internalized these messages, or if their close friends and family members hold these negative stereotypes, this may impact the treatment and process of therapy. Internalizing negative messages and beliefs lowers self-esteem, increases risks of depression or substance use, and can increase suicidality in some cases. The mental health provider will need to assess for these risks in an ongoing manner while addressing presenting concerns and problems. Internalizing negative beliefs about kink may also lead the patient or client to remain closeted and to conceal their kink interests or behaviors. Even if a patient or client discloses these interests or behaviors, they may continue to conceal from

intimate partners, family, and friends, creating difficulties in asking for support about other matters, including presenting concerns or problems that are unrelated to kink.

Clinicians should seek out ongoing consultation and/or supervision around internalized negative stereotypes about kink, and seek out continuing education training when opportunities arise. Learning about disclosure, concealment, closet dynamics, and addressing internalized transphobia or homophobia will also give tools for addressing internalized negative stereotypes about 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.

While it is a key clinical skill to discern abuse from consensual BDSM and consensual power exchange interactions, it is also important for clinicians to know that intimate partner violence can occur within the context of kink activities or kink relationships (Pitagora, 2015). For example, in a large online survey 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 cause was an accident, a miscommunication or lack of knowledge and skills - but two-thirds involved abusive behavior (Wright, Stambaugh & Cox, 2015). In a study of 146 slaves in 24/7 power exchange relationships, 27% left a previous power exchange relationship because they felt unsafe, and

about a third of this subgroup left due to risk of bodily harm or death (Dancer, Kleinplatz & Moser, 2006).

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 sees 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. They may anticipate being blamed or dismissed (“you must have wanted that” or “you must have liked it”). They may fear that their report will just confirm and intensify the stigma around kink, confirming the viewpoint of the larger society, thus causing 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 (2015):

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. (Pitagora, 2015, p. 2)

This confusion, of course, can also happen for people with more experience and knowledge about kink. A clinician can consider some “red flags” when trying to discern 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 troubling 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.

There are resources for the clinician at the National Coalition for Sexual Freedom; the website allows for the download of information about their Consent Counts campaign, and NCSF’s *Got Consent for Kink* brochure, and NCSF’s *Got Consent for Non-Monogamy* brochure. These contain some guidance for clinicians.

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 has developed in the kink community. Simple screening questions about abuse are not likely to be helpful in the context of kink.

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

While research highlights that continuing education assists in building clinical competency on an array of issues, literature also suggests that continuing education on topics of sexuality is highly underutilized by clinicians in the field. Many clinicians have been noted to receive little to no education on issues that center around sexuality; and those who elect to engage in continuing education find themselves acquiring knowledge that is focused mainly on topics such as sexual violence, infection prevention, and sexual dysfunction (Miller & Byers, 2010). Such norms can impact treatment, as clinicians with less sexually affirming education have reported feeling less

confident to introduce or address sexual practices, such as kink, in the therapeutic space (Miller & Byers, 2009).

Clinicians working with kinky clients and the kink community should consider guidelines of competence and nonmaleficence similar to those outlined by the American Psychological Association (§2.01 Competence (b)(c)(e), 2017) and the National Association of Social Workers (NASW, 2015). A foundational understanding of kink is essential for the effective and culturally humble implementation of treatment to kinky clients. Clinicians planning to provide services to kinky clients should therefore seek and obtain knowledge about kink practice and the kink community through ongoing training, experience, literature review, consultation, and supervision. Knowledge and findings obtained by clinicians should never be misused or misrepresented; should be disseminated as necessary for the well-being of the client and in congruence with the client's treatment goals; and should be used as a supplement, and never a replacement, to the client's own experiences. In emerging areas of kink that are generally understudied, and where resources for continued training are scarce or do not exist, clinicians should take reasonable action to ensure the cultural humility of their work with clients (such as creating an affirming and harm preventive space by focusing on clients' individual experiences and using said experiences to be informed about both the client, and the client's practices).

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

Kelsey et al. (2013) conducted a survey of therapists' attitudes and experiences with kink-involved clients (n=766). They found that 76% had treated at least one kink-involved client, but

only 48% thought they had competence in this area. In addition, 64% of the therapists reported no training on kink sexuality during their graduate education; therapists with no training about kink had less accepting attitudes.

Given the history of the mental health fields in addressing kink sexuality or interests, and the low level of human sexuality training in the field in comparison to the needs of the general population, it is important that clinicians support the development of training and resources to address kink-related issues in their professions. Clinicians as professionals have an ethical responsibility to develop their field and increase the effectiveness of their work with clients, and this includes addressing kink interests and kink involvement as part of professional education and continuing education and training as clinicians. There is abundant evidence from the clinical professionals and from the kink communities that kink-involved people are asking for clinicians to be better trained (Dunkley & Brotto, 2018; Hoff & Sprott, 2009; Kelsey et al, 2013; Kolmes, Stock & Moser, 2006).

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.

It is particularly important for clinicians to be familiar with community resources for their kink-involved clients. The National Coalition for Sexual Freedom has documented discrimination by healthcare providers against kinky people (NCSF, 2008), so it is extremely helpful to identify providers who are kink-knowledgeable and kink-positive. The stigmatized

nature of kink makes access to organizations that support and educate BDSM practitioners essential to their mental health. Such community organizations can guide newcomers to kink, as well as provide opportunities for social networking and affiliation. Especially in places outside large urban areas, kinky people may be isolated from each other, and knowing where to go to meet others with similar interests can be vital to reduce feelings of alienation and loneliness. In short, receiving unbiased healthcare, and being connected to kink-identified community organizations and venues contributes significantly to the mental health of kinky clients, and so clinicians should consider familiarity with providers and community groups to be a vital part of therapy. Some resources for further investigation of community and educational resources are available in the Resource section at the end of this document.

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

‘Minority stress’ is a major causal factor in mental health problems for all sexual minorities. While we do not have hard data on how social stigma affects BDSM practitioners specifically, we can surmise its impact from the research on minority stress and gay, lesbian and bisexual populations. For example, Hatzenbuehler et al (2010) found significant increases in a variety of mental health disorders among gay, lesbian, and bisexual people living in states that enacted bans of same sex marriage after these bans were passed, while LGB people living in states that did not enact bans experienced no such increase in psychiatric comorbidity. This kind of data makes clear the direct impact that social change can have on sexual and gender diverse people. While most psychotherapists will not themselves become activists, clinicians can support efforts to

address harm and improve health in the venues where they have a voice. For example, clinicians can join the Kink Aware Professionals list (see Resources section), can identify as kink-positive in the profiles they post on referral sites like Psychology Today, they can present informational workshops at professional events which they attend, and they can educate other professionals, formally or informally, in their community. These efforts will help reduce the stigma associated with BDSM and thereby provide mental health benefits to the larger population of kinky people, beyond the clients in the clinicians own practice.

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Resources for Clinicians

Websites

The Network / La Red

<http://tnlr.org/en/>

National Coalition for Sexual Freedom (NCSF)

<http://www.ncsfreedom.org>

The Alternative Sexualities Health Research Alliance (TASHRA)

<https://www.tashra.org>

Community-Academic Consortium for Research on Alternative Sexualities (CARAS)

<https://www.carasresearch.org>

Kink Knowledgeable

<http://training.kinkknowledgeable.com>

Diverse Sexualities Research and Education Institute

<https://dsrei.org>

Multiplicity of the Erotic Conference (MOTE)

<https://www.mote-con.org>

Kink Aware Professionals (KAP)

<http://www.ncsfreedom.org/key-programs/kink-aware-professionals-59776>

Books

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Team Members of Kink Guidelines Project

Braden Berkey, PsyD

Braden Berkey, Psy.D., CSE (pronouns he/him/his) is a licensed clinical psychologist and an AASECT Certified Sexuality Educator. He completed his doctoral work at Wright State University in Dayton, Ohio and earned a certification in Nonprofit Management through the College of Urban Planning and Public Affairs at the University of Illinois at Chicago. He has held positions in private practice, university counseling, managed care and community health care settings. Dr. Berkey is an Associate Professor in the Clinical Psy.D. Program at the Chicago School of Professional Psychology where he teaches courses on diversity, ethics, sexuality and gender. Braden previously served as the Director of Behavioral Health and Social Services at Howard Brown Health Center and he was the founding director of the Sexual Orientation and Gender Identity Institute at Center on Halsted. In 2011 he created Projects Advancing Sexual Diversity. For over thirty years his private practice has focused on serving sexual minorities and those impacted with HIV/AIDS. He has been a consultant with the Department of Medicine at the University of Chicago, contributing to projects on shared decision making between health care providers and LGBT patient populations. He currently serves on the Legal Counsel for Health Justice Board of Directors.

Recognizing the unique clinical dilemmas faced by providers within the leather community, Dr. Berkey created the Kink-Identified Clinicians Discussion Group at International Mr. Leather (IML) eighteen years ago. It became apparent in these group meetings that clinical guidelines for work with non-traditional sexualities was critical. Professional connections forged there laid the foundation for national conferences and the guidelines project. Braden currently works with valued colleagues to produce the Multiplicity of the Erotic (MOTE) Conference.
bberkey@thechicagoschool.edu

Peter Chirinos

Peter Chirinos is president of Capital Counseling Services, LLC, where he provides online professional coaching, counseling and supervision as well as expert legal consultations on alternative sexualities including BDSM and kink. Together with his wife and partner, Caroline Shahbaz, he co-authored “Becoming a Kink Aware Therapist” (Routledge 2016), the first academic text instructing clinical best practices in working with kink and BDSM involved clients. He also cofounded and is the president of Kink Knowledgeable which is the first completely online accredited eLearning training academy to teach and mentor psychotherapists

in developing their skills, knowledge and competency in being able to work with clients who practice BDSM.

Peter's professional experience in the field of behavioral health began in 1993 and continued after earning a graduate degree in Mental Health Counseling from Gallaudet University, class of 1999. In addition, he has worked administratively and clinically in varied capacities, ranging from community-based services agencies, in-patient and out-patient drug and alcohol treatment facilities, and emergency medical service response teams as well as a level-one trauma emergency department.

Peter's professional interests and research currently include but are not limited to male bisexuality and Queer studies as well as socio-political and gender influences on conceptualization and clinical implementation of male victims of intimate partner violence.

Personally, Peter identifies as a bisexual, cis-gender male in an ethically, conscious and consensually non-monogamous mixed orientation relationship.

Shadeen Francis, LMFT

Shadeen Francis, LMFT is a licensed marriage and family therapist, professor, and author specializing in sex therapy and social justice. She has been featured as a relationship expert on several major media platforms (including 6abc, NBC, CBC, the New York Times, and Fox), and speaks internationally on topics like sexual self-esteem, intimacy, and relationship negotiation. Shadeen's belief is that the world is built on the strengths of communities. This worldview has propelled her to focus on underserved populations: ethnic and cultural minorities, the kinky/poly/queer communities, and victims of economic hardship. Her work allows people of all backgrounds to improve their relationships and live in peace and pleasure.

Patrick Grant, MA, MPH

Patrick Grant, MA, MPH is a fourth year Doctor of Clinical Psychology (PsyD.) candidate at LaSalle University, whose interests include examining the intersections of sexual health, mental wellness, an religiosity among Black sexual and gender minorities. As a sexual health educator in St. Louis, MO, Grant worked to promote sexual wellness among young Black men who identified as gay, bisexual, and queer; as well as among individuals of varying sexual identities with cognitive disabilities. As a sexual health educator in Philadelphia, PA, Grant collaborated with self-identifying Black LGBT youth to develop a teen pregnancy prevention curriculum for sexual minority emerging adults.

A podcaster, presenter, and group facilitator, Grant has provided an array of domestic and international presentations. His liberation focused workshops, such as “We Should All Be ‘Finger in the Bootyhole Ass Bitches,’” has afforded him the opportunity to engage with audiences in Chicago, IL, St. Thomas, and Cape Town, South Africa. His recent published works have focused on the ethnographic and autoethnographic study of Black same sex attracted men; and have examined various topics related to this cohort, such as the availability of truly sexually liberating spaces for Black queer men in metropolitan areas. Grant is currently working on his dissertation, which will center on Black queer men’s experiences with internalized homonegativity. In his downtime, Grant enjoys food, wine, and singing.

Laura Jacobs, LCSW-R

As a Trans and GenderQueer-identified psychotherapist, activist, writer, and public speaker in the NYC area working with transgender and gender nonbinary, LGBTQ+, and sexual/gender diversity issues, Laura Jacobs is a firm believer in body autonomy as a fundamental human right and that gender and sexuality are arenas of the human experience through which we can explore identity, relationships, power, intimacy, cultural constructs, and even existential questions of meaning.

Laura Jacobs works toward helping others and propagating this message on multiple levels: micro in private practice, mezzo and macro through activism and speaking.

Currently Laura Jacobs serves as Chair of the Board of Directors for the Callen-Lorde Community Health Center whose mission is to provide high quality, compassionate healthcare to LGBTQ+ and other marginalized populations of New York City regardless of ability to pay. Laura also has spoken in the media on NPR, MSNBC, NBC News Online, SiriusXM, CBS News, in The New York Times and The Huffington Post, and has educated countless therapists and allies through public speaking at organizations, conferences, and universities.

Laura Jacobs is the recipient of the 2017 Dorothy Kartashovich Award by the Community Health Center Association of New York State, "In recognition of your dedication and advocacy to ensure high-quality health care for all", and of a 2018 Gay City News Impact Award.

"‘You’re In The Wrong Bathroom!’ and 20 Other Myths and Misconceptions About Transgender and Gender Nonconforming People”, a book co-authored with Laura Erickson-Schroth, was published in May 2017 by Beacon Press.

As Lawrence Jacobs. Laura worked as a musician, composer, photographer, and less glamorous corporate middle management.

Carrie Jameson, LCPC

Carrie Jameson welcomes people of all orientations, identities, and relationships, including heterosexual, LGBTQIA, POC, fetish, kink and alternative relationships (such as consensual non-monogamy, swinging, and polyamory) and those who are working through issues related to sexuality.

Ms. Jameson also helps people who have survived traumas, either recent or past. Traumatic experiences can affect relationships, moods (being anxious, irritable or angry, feeling sad or fearful), and daily living including eating, sleeping and self-care. Therapy can help you access the power that comes with healing trauma, find peace and meaning, as well as enrich your relationships.

Life may feel like uncharted waters, if you are not sure of where you are, where you are going, or even where you want to be. Underlying these experiences may be feelings of not belonging, being broken, not worthy (of success, love, peace), or fear of being abandoned or left. Together we can explore what belonging and/or self-worth means and the kind of life you want to be living. Therapy can heal wounds, create more rewarding relationships (with self and others), help you to accept yourself, while appreciating that you are a constantly changing being.

Ruby Johnson, LCSW

Ruby Bouie Johnson is a clinical social worker and sex therapist who has 16 years of experience in a variety of behavioral health settings. Currently, she is private practice in Plano, Texas.

Over the last 5 years, Ruby has been specializing in kinky, polyamorous, and open relationships as well as sexually- and gender-fluid clients. Ruby has a strong family and group theoretical and intervention skill set. She is able to work with triads, quads, and polycules with power dynamics and communication problems.

Ruby has published in various journals and in the African American Encyclopedia on Criminology, she has presented at Kinky Kollege, Consent Summit, Association of Black Sexologists and Clinicians, American Association of Sex Educators, Counselors, and Therapists, and recently, she awarded the AASECT 2018 Professional Excellence Award. Ruby has been featured in Playboy Magazine and Women's Health and interviewed on Cunnig Minx, Dawn Serra, Living a Sex Positive Life, and Inner Hoe Uprising podcasts.

Ms. Johnson authored the forward for Kevin Patterson's inaugural book, Love's Not Colorblind. Previously, Ms. Johnson was a contributor for Huffington Post. Currently, she is on faculty for the Kink Knowledgeable Program, and serves on the board for the National Coalition for Sexual Freedom. Ruby is the CEO, Founder, and organizer for PolyDallas Millennium LLC. Ruby has a hub of information at www.blacksexgeek.net or www.facebook.com/blacksexgeek

Peggy J. Kleinplatz, PhD

Peggy J. Kleinplatz, Ph.D. is Professor of Medicine, and Director of Sex and Couples Therapy Training at the University of Ottawa, Canada. She is AASECT Certified as a Sexuality Educator and Consultant and as a Diplomate and Supervisor of Sex Therapy. Kleinplatz has edited four books, including *Sadomasochism: Powerful Pleasures* with Charles Moser, Ph.D., M.D. and notably *New Directions in Sex Therapy: Innovations and Alternatives*, (Routledge, 2nd Edition), winner of the AASECT 2013 Book Award. In 2015, Kleinplatz received the AASECT Professional Standard of Excellence Award. Her clinical work focuses on eroticism and transformation. Her current research focuses on optimal sexual experience, with a particular interest in sexual health in the elderly, disabled and marginalized populations. Her research team is currently conducting clinical trials on “curing” low desire by creating optimal erotic intimacy (see optimalsexualexperiences.com).

Audriannah Levine-Ward, PsyD

Dr. Levine received her MA and Doctorate in clinical psychology from Wright Institute in Berkeley, CA. Currently, she approaches her work with a Narrative theory lens while also integrating empirically validated treatments including; CBT, DBT and Mindfulness. Dr. Levine utilizes Feminist, Social- Justice and Trauma- Informed theories in order to allow the individual to access and express their most authentic self while in treatment.

Prior to working at Bayside Marin, Dr. Levine completed her pre-doctoral hours working for UCSF/ ZSFG Trauma Recovery Center in the psychosocial medicine training program. There she worked with survivors of religion and gender- based persecution, refugees and trauma survivors living in San Francisco.\

Dr. Levine has 5 years of experience in the mental health field working predominantly with women, the LGBT community, people of color, and those in pursuit of sobriety.

In addition to working in the addiction and recovery field, Dr. Levine specializes in working in the areas of sexual orientation, gender transition, alternative sexuality, sex work, trauma and sexuality, trauma, culture, race, social class, homelessness, body positivity and personal empowerment.

In addition to working as a residential treatment therapist, Dr. Levine works as a consultant, providing education and consultation to psychologists and psychology trainees. Dr. Levine works as an educator, providing lectures to community based organizations, psychology students and private groups. She provides consultation and education in the areas of sex, sexuality,

alternative sexualities, trauma, trauma and sexuality, the LGBTQ community, and working with Trans and Transitioning individuals.

Dr. Levine believes that therapy begins with human to human connection and can be used as a safe space to empower the individual to make change.

Aida Manduley, LCSW

Aida Manduley is an award-winning Latinx activist, international presenter, and trauma-focused clinician known for big earrings and building bridges. Born and raised in Puerto Rico, they hold a Bachelor's in Gender and Sexuality Studies from Brown University and a Master's in Social Work from Boston University. With a dedication to community accountability processes and a liberation health framework, they center anti-oppression and resilience in their work. As a Boston-based clinician, they primarily serve communities marginalized due to gender, sexuality, and race—shaking up the landscape of mental health with specialties in trauma, pleasure, gerontology, and alternative relationship paradigms.

From The New York Times to The Rainbow Times, Mx. Manduley has been interviewed by a variety of media outlets for over a decade of work, and they're a frequent presenter across North America. Mx. Manduley is also known for launching Rhode Island's first Sexual Health Education and Advocacy Program housed at a domestic violence agency in 2011, which included groundbreaking data-collection on LGBTQ domestic violence and building the infrastructure to provide on-site HIV testing. Past projects include crisis-response with victims of sexual assault, consulting with state departments on LGBTQ health, and leadership on a number of national and regional coalitions on HIV & STI prevention, sexuality education, and anti-violence.

You can find out more about their work and the organizations they innovate with at www.aidamanduley.com or by following them on Facebook (bit.ly/FBaida), Instagram ([@aidamanduley](https://www.instagram.com/aidamanduley)), and Twitter ([@neuronbomb](https://twitter.com/neuronbomb)). As one of the queer and trans people of color in this workgroup, they are dedicated to bringing on more voices from these communities onto the project.

Lori Michels, LMFT, CST

Lori Michels has an extensive history working with the LGBT, Kink/BDSM communities in understanding safe and consensual practice. Her previous experience drew her into the therapy field and is a license psychotherapist and certified sex therapist. Currently, Lori has a private practice in Connecticut, at the The Center for Intimacy and Sex Therapy, with a focus in alternative sexualities.

Charles Moser, MD

Charles Moser, PhD, MD received his PhD in Human Sexuality from the Institute for Advanced Study of Human Sexuality in San Francisco in 1979. He received his MD from Hahnemann University (now Drexel University) in Philadelphia in 1991. He is also a Licensed Clinical Social Worker in California and maintained a private psychotherapy practice specializing in the treatment of sexual concerns prior to his medical career. He is board certified in Internal Medicine by the American Board of Internal Medicine and HIV Medicine by American Academy of HIV Medicine. He is a Fellow of the European Committee of Sexual Medicine (FECSM). He is President of Diverse Sexualities Research and Education Institute, a 501(c)(3) charity, <https://dsrei.org> He maintains a private practice specializing in Sexual Medicine (the sexual aspects of medical concerns and the medical aspects of sexual concerns). He has authored or co-authored over 70 scientific papers or books. His complete CV can be accessed at <http://docx2.com/>

Margaret Nichols, PhD

Margaret Nichols, Ph.D. is a psychologist, AASECT Certified Sex Therapy Supervisor, and WPATH Certified GEI Provider. She is the founder and first Executive Director of the Institute for Personal Growth, a psychotherapy organization in New Jersey specializing in sex therapy and other clinical work with the sex and gender diverse community. Dr. Nichols currently works independently through Nichols Counseling and Psychotherapy in Jersey City. She is an international speaker on LGBTQ issues and author of many articles and papers on LGBTQ sexuality and mental health issues. Current projects include her work as a new Board Member of AASECT and Chair of the Public Relations, Media, and Advocacy Committee, and the development of a certification program for transgender mental health through Modern Sex Therapy Institutes.. She is the author of the forthcoming book from Routledge Press titled “Gender Expansive Kids, Polyamorous Couples, and Mostly Heterosexual Men: A Modern Therapist’s Guide to the LGBTQ+ Community.” Her main areas of focus now are transgender care and working with the ‘+’ in ‘LGBTQ+’, such as people involved kink and/or consensual nonmonogamy. She identifies as queer, which is shorthand for pansexual lesbian mother who is kinky and nonmonogamous.

Emily Prior, MA

Emily E. Prior is the Executive Director for the Center for Positive Sexuality. Since 1996 she has been teaching formal and informal classes about a variety of sexuality-related topics including Gender, Deviance, Relationships and Family, and Feminism. She is an adjunct

professor at several colleges and universities, has over a dozen publications, and has presented at conferences around the U.S. She is frequently interviewed about her research, the Center, and positive sexuality in general. She also won the Vern Bullough Award for research. To contact Emily, please email at emily@positivesexuality.org.

Anna Randall, DHS, LCSW, MPH

Anna Randall, MSW, DHS, MPH is a psychotherapist, sex therapist and sex researcher in the San Francisco Bay Area. In her robust private practice, she has the honor of supporting sexual explorers as they courageously find their way toward more juicy, authentic and self-determined lives. Her goal is to provide a safe and judgment-free space to talk about sexuality in all its flavors and expressions, including our vast fantasies, desires, urges and behaviors. She is passionate about helping partnerships stay curious, increase their teamwork and learn ways to move from pain and disconnection back to safety and connection.

She is a nationally known researcher and educator on sexual interests and expressions that are out of the mainstream and the non-traditional relationship structures that are often misunderstood and stigmatized. When she is not crunching data from some new research project, she trains therapists and other healthcare professionals to deliver competent, compassionate and knowledgeable care to sexual minorities.

Caroline Shahbaz

Caroline Shahbaz is the CEO of [Kink Knowledgeable](#), a comprehensive online academy combining extensive APA approved continued education courses with coaching and clinical supervision aimed at mental health professionals looking to move from being kink-aware towards being kink knowledgeable.

Ms Shahbaz' background is in clinical psychology (in Australia) and she identifies as a Jungian, depth and liberation psychologist. She draws on a unique cross cultural, international perspective on kink and BDSM dynamics, communities and practices. She is driven to end the othering, stigmatization and pathologizing of people who practice BDSM by professionals through psychopathological misinformation, and kinkophobia about BDSM and MS dynamics. To this end, Peter Chirinos and Caroline Shahbaz wrote *Becoming a Kink-Aware Therapist* published by Routledge; the first of its kind aimed at mental health professionals.

She feels called to the intersectionality of individual, social, and political spheres in which our personal, collective professional and institutional consciousness needs to step up and shine a light on what needs to change. She is passionate to serve the professional community, collectively reframe professional and training standards for defining what constitutes clinical

best practice on how to practice with clients who are kink identified or practice BDSM. This has profound implications for our profession going forward in terms of research initiatives as well as training in the area of kink and BDSM.

Richard A. Sprott, PhD

Richard Sprott received his Ph.D. in Developmental Psychology from UC Berkeley in 1994. His early work was on social and language development in early childhood. He is currently directing research projects focused on identity development and health/well-being in people who express alternative sexualities and non-traditional relationships, with a special emphasis on kink/BDSM sexuality, and polyamory or consensual non-monogamy. He is also co-chair of the Children, Youth and Families Committee of the Society for the Psychology of Sexual Orientation and Gender Diversity (APA Division 44). All of these efforts highlight the ways in which stigma, prejudice, minority dynamics, health, language, identity development and community development all intersect and affect each other. Richard currently teaches courses in the Department of Human Development and Women's Studies at California State University, East Bay and graduate level courses at various universities in the Bay Area, including UC Berkeley, the California Institute of Integral Studies, and Holy Names University.

Shane'a Thomas, LICSW, M.Ed

Shane'a Thomas, LICSW, M.Ed. (he/she pronouns) is a Senior Lecturer for the University of Southern California's Suzanne Dworak-Peck School of Social Work's Virtual Academic Center, as well as a Youth Psychotherapist at Whitman-Walker Health in Washington D.C. Clinically and educationally, he commits time toward supporting LGBTQI youth and those affected by HIV/AIDS through trauma-focused care, as well as training social workers, educators and service providers around building safer therapeutic, service, and educational spaces for clients and students, especially those working and existing in communities who are underserved, are Black and people of color, and/or LGBTQI folks. She is an Advisory Board Member to the National Queer and Trans Therapists of Color Network. Thomas is proud alumnus of Virginia Tech, Howard University, and Widener University holding a Bachelors of Science in Psychology, a Masters of Social Work degree with a concentration of Direct Services (Families and Children), and a Masters in Education with a concentration in Human Sexuality Studies, as well as an Advanced Certificate in Human Sexuality Studies, respectively. Thomas is currently working towards an Ed.D. in Organizational Change and Leadership through the University of Southern California's Rossier's School of Education.

DJ Williams

DJ Williams is the past Director of Research for the Center for Positive Sexuality in Los Angeles and current Associate Professor of Sociology, Social Work, and Criminology at Idaho State University. His education includes M.S. and M.S.W. degrees from the University of Utah, and a Ph.D. and postdoctoral research fellowship from the University of Alberta.

He is a multidisciplinary social and behavioral scientist with a focus on deviance as leisure experience, and his scholarship intersects sexology, leisure science, and criminology and forensic behavioral science. Specifically, his academic work has focused on topics such as BDSM and alternative sexualities, self-identified vampires, gambling in prisons and jails, sexual crime, and (more recently) serial and mass homicide. Dr. Williams has given numerous research presentations at national and international conferences in the United States, Canada, New Zealand, and the United Kingdom; and his work has appeared in dozens of academic books and journals, including *Journal of Sexual Medicine*, *Sexualities*, *Leisure Sciences*, *Deviant Behavior*, *Journal of Forensic Psychiatry & Psychology*, *Social Work*, *Critical Criminology*, *International Journal of Comparative Criminology & Offender Therapy*, and *Journal of Forensic Sciences*.

His research has also been featured in hundreds of media outlets across the world. He has served as an editorial board member for multiple academic journals and have been an invited guest reviewer for 20 others. In 2015, Dr. Williams cofounded (with Emily Prior) the online *Journal of Positive Sexuality*.

Susan Wright

Susan Wright founded the National Coalition for Sexual Freedom in 1997, and currently serve as Spokesperson and Director of Incident Reporting & Response. She has presented at over a hundred professional organizations, universities, service agencies and community groups on consent, discrimination against consenting adults, and sexuality & the media.

Ms. Wright chaired the successful DSM-5 Revision Project which helped result in the consensual paraphilias being delineated from Paraphilic Disorders in 2013. She also coordinated the SM Policy Reform Project for the National Organization for Women (NOW) that replaced the Delineation of Lesbian Rights with one that embraced diversity of sexual behaviors at the national conference in 1999.

She has also conducted six surveys on discrimination and violence against BDSM practitioners; consent practices and attitudes; and the mental and physical health of BDSM and non-monogamy practitioners.

Her research has been published in the Archives of Sexual Behavior, Journal of Sexual Medicine, Journal of Behavioral Health Services & Research, International Journal of Social Psychiatry, Journal of Trauma and Dissociation and Journal of Homosexuality.
www.ncsfreedom.org