Cultural Competency with BDSM & Kink-Identified Clients

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Guidelines for Today's Presentation:

- This is a learning space – Please ask questions here (as opposed to asking your clients later)
- Assume the best from other participants
- Step up/Step Back
- "Oops" & "Ouch"
- Speak from your own experience
- Observe the confidentiality of those who speak in this space today
- Don't "yuck" someone else's "yum"
- Take care of yourself

What is “BDSM”?

- BDSM refers to behaviors, which may be sexual or erotic in nature, which encompass one or more of the following elements:
- B - bondage
- D - discipline (or sometimes domination)
- S - sadism
- M - masochism

Practitioners of BDSM often refer to the act of engaging in these behaviors as “play”, and to their orientation toward BDSM as a “lifestyle”.

What is “Kink”?

“Kink” is an identity, which is used to convey one’s association with or orientation toward non-normative sexuality or sexual behaviors.

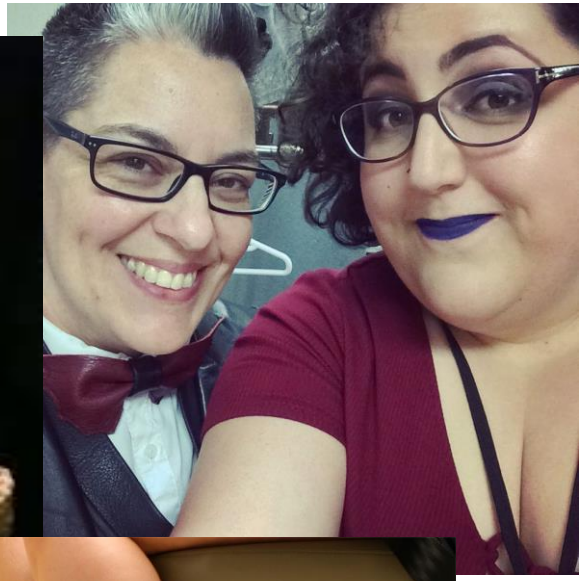
Clients may refer to themselves, sexual behaviors, or objects as being “kinky”, often (but not exclusively) as shorthand for BDSM.

Terms associated with BDSM & Kink

- **Dominant/submissive**
- **M/s or Master/slave**
- **Top/bottom**
- **Daddy or Mommy /boy or girl**
- **Play Partners**
- **Primal or Predator/prey**
- **Leather identities**
- **Animal identities, including puppies, kitties, ponies and their Handlers**
- **Leather families or houses**
- **Fetish**
- **Scene**
- **Play space or dungeon**
- **Sensation play**
- **Service**
- **Edging**
- **Impact Play, spanking, caning, slapping, flogging**
- **Shibari/Kinbaku/rope or other bondage or restriction**
- **Cutting, piercing, knife play or other blood play**
- **Fire play, cupping, branding, wax**
- **Electrical play, e-stim, violet wand**
- **Humiliation/degradation**
- **Identity Play**
- **Breath play, choking**
- **Psychological play**
- **Medical play**
- **Exhibition/voyeurism**
- **Scatological play**
- **Consensual non-consent**

Media depictions of BDSM practitioners/Kink-identified people:

Real, actual human beings who practice BDSM or are kink-identified:



As Providers, why is it important to know about BDSM and Kink?

- 2016 *Journal of Sex Research* study:
  - 1/3 of surveyed adults participated at least once in BDSM behavior
  - 1/2 indicated interest in at least one category of paraphilic behavior (DSM)
- Other studies indicate the prevalence of "kinky fantasies" could be as high as 64%
- BDSM practitioners and kink-identified people represent a subset of the LGBTQ population and may experience increased marginalization, as a "minority of a minority", which impacts health outcomes.
- LGBTQ relationships are less frequently supported by majority norm already, therefore there may be more freedom to explore additional sexual interests
- Fear of rejection, mandatory reporting, and prosecution is common in LGBTQ, and BDSM/kink communities. A survey of kink-identified women revealed at only 38% felt comfortable disclosing their identity to their provider.

As Providers, why is it important to know about BDSM & Kink?

- LGBTQ community may choose BDSM behaviors and kink-identities as a part of rejection of traditional social and institutional norms/expectations.
- Most providers lack tools/knowledge to assist.
- Provider could cause harm to client.
- *The codes of ethics for National Association of Social Workers, American Psychological Association, American Psychiatric Association, American Counseling Association, etc. all state that providers should obtain training to become competent or refer to a provider who is. How many people know a provider who would be competent in this topic?*

Possible barriers faced by BDSM & kink-identified clients:

- Coming out/Disclosure
- Increase in risk factors for health/economic disparity
- Stigma - disapproval of friends, family, society
- Legal ramifications
- Guilt/Shame
- Concerns about accessing information on safety and reputable BDSM technique
- Concerns about abuse, exploitation, or predation, especially in situations involving power dynamic
- Need for high level of emotional and physical self-awareness
- Concerns about accessing "aftercare" and medical care due to BDSM activities
- Physical sexual health concerns (pregnancy, sexually transmitted infections, injury)
- Emotional/mental health concerns (experiencing new/existing trauma)
- Alienation from some LGBTQ and more normative communities
- Talking about issues/problems within BDSM lifestyle giving detractors "ammunition"
- **Finding competent health and mental healthcare providers**

So, why would someone choose to participate in BDSM?

- Differences in sexual interest
- Sexual novelty
- Affinity or connection to a group/community
- Accessibility, accommodation, and a variety of skill levels for those with body differences, and disabilities.
- Creation of Chosen Family
- Sexual excitement and/or fulfillment
- Opportunities for healing physical and emotional trauma
- Self-exploration
- Inability, unavailability, or disinterest from primary sexual partner
- They identify with the sexual liberation movement and reject sexual normativity
- Escapism, stress-reduction, or coping
- Pain management/relief
- Participation in sexual economy
- Personal growth, achievement, or discipline.
- **Born this way!**

But isn't this mental illness?

- Sexual dysfunction and related treatments are focused upon disorders related to pain, arousal, or an impairment of functioning, HOWEVER, all are predicated upon **client distress**. If your client is enthusiastic about their BDSM practice, this does not meet criteria for sexual dysfunction.
- The DSM 5 outlines eight specific paraphilic disorders, including voyeuristic, exhibitionistic, frotteuristic, sexual masochism, sexual sadism, pedophilic, fetishistic and transvestitic*. The primary function of these diagnoses is forensic, meaning that there is legal implication for the client (and potentially for the clinician, in terms of liability). In addition to criteria related to atypical sexual interest, there is also a harm component.
  Currently, there is no diagnosis in the DSM 5 to indicate atypical, nonpathological sexuality.

How might you help a client who is experiencing distress about their sexual interests, or sexual behaviors?

*How do you harm someone with gender? No, really, how? If you know, please tell us.

But isn't this abuse/self-harm?

- Abuse occurs without consent. BDSM behaviors are consensual. Although consent can take many forms, it is vital to BDSM practice. Practitioners should take care to identify that all client sexual behavior, including BDSM, is consensual (otherwise it isn't sex, right?).
- Clients sometimes make choices that are not in their best interests, or that result in physical or emotional harm, or other negative consequences. Like other behaviors, BDSM activity can be viewed through a lens of self-determination. Practitioners can support kink-identified clients through the use of BDSM-informed psychoeducation and harm-reduction tools.
- Multiple frameworks exist within the BDSM community to address risk awareness and harm reduction. Ex, S. S. C. and R. A. C. K.

Practice with BDSM and Kink-identified Clients

Inclusive assessment, negotiation, and treatment.

Inclusive Assessments:

- **This starts with your forms!**
  - Open questions about relationship(s)and sexuality
  - No "Are you sexually active? Y/N" questions!
  - Questions that do not assume monogamy from your clients help elicit BDSM disclosure
- **During assessment, ask the right questions**
  - Open-ended questions/statements:
    - *"Tell me about your relationships."*
    - *"Tell me about your sex life."*
    - *"Tell me about your sexual history."*
    - *"What does sex look like for you?"*
  - Specific, inclusive questions:
    - *"Do you use toys or other items during sex?"*
    - *"Do you participate in (x behavior)? With whom?"*

Helping Clients practice BDSM safely:

- Assist clients in negotiating, and creating relationship contracts and agreements, which outline harm-reduction measures, such as “safewords”. Renegotiate as needed.

- Normalize client behaviors and thoughts, as you would with other identities and sexualities.

- Advocate for individual clients who are facing discrimination and stigma, as well as for sexual freedom, generally.

- Assist clients in building coping skills, particularly emotional-regulation and self-care.

Helping Clients practice BDSM safely:

- Assess client(s) for power imbalances, and how this is played out in their day-to-day lives and sexual behaviors.
- Encourage explicit and clear communication.
- Help clients determine what is important about their sexuality and to and identify their sexual needs.
- Explore topics related to trust, vulnerability, self-esteem and consent.
- Encourage clients to educate themselves about risks and safe techniques

Treatment of Kink-identified clients:

- Signs that BDSM behaviors may be unhealthy:
  - One partner feels pressured into activities
  - Safewords are ignored, or agreements are frequently violated
  - There is (non-consensual) physical violence or emotional abuse
  - The client is experiencing guilt or shame related to BDSM behaviors
  - Negotiation is absent or there is a lack of boundaries
  - One person's needs or feelings are consistently ignored or unmet
  - Evidence of untreated mental or physical health concerns
  - There is (non-consensual) exploitation or coercion

Treatment of Kink-identified clients:

What makes a BDSM practice healthy?

- Consent
- Self-awareness
- Communication
- Honesty
- Boundaries
- Trust
- Commitment
- Respect
- Freedom
- Egalitarianism/Equality

Considerations Regarding Practice:

- Lack of research of best practices/evidence-based practice
- Lack of diversity in the limited research available
- No one-size fits all for people in BDSM relationships
- There is no consensus about the “best way” to practice BDSM, even among the community itself
- When seeing multiple clients who are in relationships, do not assume their problems are directly related to their BDSM – at the same time, do not assume it isn’t!

Anyone here willing to share their own experiences working with clients in BDSM/Kink relationships?

Managing Internal Bias:

- Culture designates heteronormative/cis/pro-creative/genital-based/monogamous/non-transactional sexuality as “normal”, “good”, or “healthy”
- Therapists should monitor themselves (sexuality, religious beliefs, personal relationship history, etc.) so as not to provoke prejudices
- Monitor “microaggressions,” both verbal and non-verbal during a session
- Likening BDSM to abuse and kink-identified people to abusers or victims
- Assuming people who participate in BDSM have histories of sexual abuse
- Believing BDSM and kink are “anti-feminist”
- Assuming this is a “phase” or that someone’s participating in BDSM because it is “trendy”
- Making assumptions about what BDSM looks like for your client

Clinicians do not have to be kink-identified themselves to effectively assist clients who practice BDSM, but they must be non-judgmental and accepting of a range of sexual behaviors and identities.

Case study #1:

- Mary is a 47 year old white cis woman who is in a monogamous marriage with her partner, Rae. Mary and Rae have been exploring BDSM together for 6 months, including attending some community events with their friends. Mary identifies as submissive and has expressed enthusiasm about including impact play (spanking) into her sex life with her wife. Lately, however, Mary reports that she is feeling embarrassed about their dynamic, especially after has Rae "swatted her on the butt a few times" outside of the bedroom – once in front of friends, once at the grocery store, and in other public places. Mary reports that she is feeling very conflicted. She and Rae were having "the best sex of their lives", but she has avoided sex with her partner this week, and is considering telling Rae she doesn't want to participate in BDSM activities any longer. Mary tells you she is particularly concerned about her 12 yr old daughter seeing this behavior and the message it sends about "allowing a partner to hit you".

Case study #2:

- Jeff is a 45 yr old black cis man who identifies as same-gender-loving. He has been seeing you for two years to cope with his HIV diagnosis and depression. Jeff reports that he is "starting to get back out there" and date again, and has been hooking up with a few guys on Grindr. Jeff tell you that he has been exploring BDSM and power exchange with one of the men, and that he feels that this is a "safe alternative to sex", since he is not engaging in anal penetration. Jeff is wondering if he must disclose his HIV status to other play partners in the future, since "there is no penetration".

Case study #3

- Colin is a 33 year old black transgender man. He and his girlfriend Leesa both receive primary care from the LGBTQ health center where you work. Colin and Leesa discovered that they had a mutual interest in choking and breath play after attending a party at a local kink club, and decided to give it a try. Colin reports mild breathing difficulty and trouble swallowing after engaging in repeated sessions of breath play. Leesa and Colin are both enjoying their new hobby, but Leesa insisted that Colin come to see you because she is concerned that Colin is starting to have some side effects from the play. Colin insists that he is ok, and can tolerate more intense play, and that a small woman like Leesa “isn’t capable of seriously hurting [him]”.

Case study #4

- Aryn is a 22 year old white transgender man who has been seeing you for 3 years in your youth clinic. He is in a 6 month relationship with an older cis gay man, and has shared with you that they engage in BDSM. One day, Aryn comes to clinic unexpectedly, and asks to see you. Aryn tells you that last night, his partner ignored their safe word during a scene, and penetrated Aryn without his consent. Aryn verbalizes that he “just needed to vent” and doesn’t want to “do anything about it”. As you talk further, Aryn expresses concern about being kicked out if he “starts a fight”, and tells you that he doesn’t have money to stay elsewhere because his partner “is in charge of” Aryn’s paycheck. Aryn becomes very short with you and accuses you of trying to “mess things up” with the “only man who has ever cared” about him.

Questions?

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Hyperlinks for photos of "real, actual human beings"

- https://seattlemeninleather.org/the-seattle-leather-daddy-and-daddys-boy-contest/
- https://www.flickr.com/photos/dapperq/5818566840
- http://www.internationalbearbash.com/event-schedule/
- https://topsy.one/hashtag.php?q=IMsBB
- https://leatherati.com/time-out-of-time-5594e31f9dc8
- www.thekinktank.com

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