COUNSELLORS' REFLECTIONS ON HARM IN BDSM PAIN PLAY:
CONTAINING AND MAINTAINING CLIENTS

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ABSTRACT

People who participate in BDSM (bondage/discipline, Dominance/submission, and sadism/masochism) activities have reported some instances of stigmatization and ethical violations from mental health care providers (e.g., Bezrreh, Weinberg & Edgar, 2012; Kolmes, Stock, & Moser, 2006). However, the literature pertaining to counsellor's understandings of clients who participate in BDSM is limited to a handful of studies (e.g., Garrott, 2008; Kelsey, Stiles, Spiller, & Diekhoff, 2013; Kolmes, et al., 2006; Lawrence & Love-Crowell, 2008). Given the potential for ethical violations, such as breach of confidentiality (Canadian Psychological Association [CPA], 2017), when kink play is interpreted as bodily harm (Garrott, 2008) this topic warrants more attention. From the few studies investigating counsellors' views of BDSM-oriented clients, pain play has surfaced as one particular area of contention (Garrott, 2008). However, it has not been explored sufficiently due to both a general lack of inquiry specific to pain play and a reluctance of participants to discuss this sensitive topic in-depth (Garrott, 2008). This research examined how counsellors understood *harm* (CPA, 2017) in need of therapeutic remediation as well as *serious harm* (CPA, 2017) in need of reporting for clients who participate in pain play. This study was designed to specifically elicit counsellors' understandings about particular painful activities using vignettes as well as to recruit counsellors using an anonymous, online platform in an effort to facilitate participant comfort in voicing opinions on sensitive topics. One global theme, *containing and maintaining the individual*, and six supporting organizing themes were generated: *bodily integrity*, *selfhood*, *presence of consent*, *social connectedness*, *mental health and healing*, and *threat and safety are vague.* The findings from this project contributed to this budding area of literature, deepening the description of harm and health as understood by counsellors and, hopefully, contributing to discussions of ethics while working with this sexual minority population.

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CHAPTER ONE: INTRODUCTION

Mental health professionals are bound to ethical standards which place the welfare of clients in the forefront of their decision making (Canadian Counseling and Psychotherapy Association [CCPA], 2007; CPA, 2017). Respect for the dignity and self-determination of all persons, regardless of sexual orientation or other personal characteristics and preferences, is highly valued in performing counselling and psychotherapy (CCPA, 2007; CPA, 2017). Confidentiality of information acquired by a counsellor (CCPA, 2007) or psychologist (CPA, 2017) through work with clients is also given the utmost of importance. However, the Canadian Psychological Association (2017) code of ethics also specifies that the risk of serious harm to self or others, such as death by suicide or homicide, necessitates a breaking of rights to self-determination and confidentiality (CPA, 2017). Similarly, the Canadian Counselling and Psychotherapy Association (2007) code of ethics allows for the breaking of confidentiality to prevent "clear and imminent danger to the client or others" (p. 7). Psychologists are to regard both psychological and physical dimensions of harm, however, of particular import in the context of this study are the aspects of harm determined by "physical safety, comfort, pain, and injury" (CPA, 2017, p. 17). Indeed, "imminent serious bodily harm" (CPA, 2017, p. 22) to oneself or others is designated as a legitimate reason to intervene and break confidentiality. While exceptions to the CPA and CCPA codes are designed to protect the best interests of clients and society, what constitutes "imminent serious bodily harm" (CPA, 2017, p. 17) or "imminent danger" (CCPA, 2007; p. 7), other than impending suicide or murder (CPA, 2017), is left open to professionals' interpretations. It is therefore necessary to understand how mental health professionals define harm for their clients.

One area that can complicate the notion of harm is found within the practice of kink activities. Kink can be used to describe a number of non-mainstream sexual practices, but for this project, it will be used to describe the activities of bondage/discipline, Dominance/submission, and sadism/masochism (BDSM; Bezreh, Weinberg, & Edgar, 2012; Connolly, 2006). The acronym BDSM is an umbrella term for a variety of related sexual and/or sensual activities. While these practices are undertaken consensually for the sexual, sensual, and/or emotional benefit of all parties, to those who are unfamiliar or unsympathetic with these behaviours they may appear to constitute overt harm or abuse (e.g., Garrott, 2008; Kolmes, et al., 2006). Seemingly antithetically to consensual pleasure, BDSM play often features actions which might

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be interpreted as painful and violent; for example, spanking, whipping, hitting, cutting, and breath play, among other activities (Newmahr, 2010a; Newmahr, 2010b; Nichols, 2006). The scenario of a BDSM disclosure in therapy, represents a potential quandary for mental health professionals. Is this activity harmful? Or *at what point* does this activity become harmful to a client? Does the motivation for engaging in this activity indicate a problem? Do such clients retain the rights to full self-determination and confidentiality or does the professional act to intervene somehow? Depending on the acuity of a psychotherapists' risk/benefit analysis (CPA, 2017), knowledge of the BDSM subculture, and their conceptualizations of harm, this scenario could play out a variety of ways for the client. Namely, it is possible for the client to be affirmed in their actions and identity, genuinely helped with issues tangentially or directly related to their BDSM participation, or negatively impacted by stigma from a therapist (e.g Hoff & Sprott, 2009; Kolmes et al., 2006). The latter outcome is, unfortunately, documented in BDSM practitioners' accounts of insensitivity from individual counsellors (e.g., Kolmes, et al., 2006; Hoff & Sprott, 2009) and in the social and legal ramifications of court proceedings informed by biased forensic psychologists (Bezreh, et al. ,2012; Hoff & Sprott, 2009; Klein & Moser, 2006). It is therefore possible for a mental health professional to cause more harm than is prevented through uncritical understandings of harm and of harm reporting.

Breeches of rights due to misinterpretations do not occur because BDSM is inherently wrong, but because of the historical and cultural constructions/discourses of (un)healthy expressions of sexuality. Early psychiatric theorists, such as Freud (1938) and Krafft-Ebing (1892), asserted that sadomasochism was indicative of underlying pathology; a *perversion* of the normal sex drive (Weinberg, 2006). The discourse of pathology echoed strongly into the 1970's and 80's through clinical case studies focused on *deviant* sexual desires, their roots in abuse, and potential treatments such as shock aversion therapy and anti-androgen medications (e.g., Money, 1987; Pinard & Lamontagne, 1976). It was not until 1980 and 1994 that sexually sadistic and sexual masochistic urges, respectively, were no longer considered inherently disordered by the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association [APA], 1980; 1994). At these times, proof of some dysfunction accompanying the sadistic or masochistic urges was added as a requisite criterion for the diagnoses. Today, sexual sadism and masochism remain hotly contested diagnostic categories (e.g., Klein & Moser, 2006; Krueger, 2010a, 2010b).

Due to their history of being understood as a consequence of immorality and sickness, sexual sadism is still linked in the forensic literature with murder and rape (e.g., Aylwin, Reddon, & Burke, 2005; Worling, 2013). This connection of sadomasochism to sickness and to violent crime is made regardless of noted problems with the application of diagnostic labels, flaws in research, and untenable findings to support the linkage between them (Aylwin et al., 2005; Quinsey, Chaplin, & Upfold, 1984; Worling, 2013). Criminality remains an attribute of sadomasochism in legal discourse, and it remains technically illegal to consent to bodily harm that no reasonable person would consent to, that is, harm that holds no cultural value (Greene, 2001; R. v. R.D.W., 2006) and is more than transient and trifling (Criminal Code, 1985). Allowing teens to consent to football related head injuries but inhibiting consenting parties from spanking each other too hard represents the constructed conflation of non-normative sexuality with sickness and criminality (Moser & Kleinplatz, 2006). It also represents marginalization and policing of bodily sovereignty for sexual minorities and transgressive identities (Attias, 2004).

Despite current research supporting a depathologized, neutral concept of BDSM play (Connolly, 2006; Taylor & Ussher, 2001; Wismeijer & van Assen, 2013), BDSM-identified individuals still face discrimination within a psychotherapeutic context and society at large (Bezreh et al., 2012; Hoff & Sprott, 2009; Kolmes et al., 2006). Due to the medicalized and criminalized history of *deviant* sexual practices, some mental health professionals may unknowingly pathologize clients partaking in BDSM (Bettinger, 2003), likely committing microaggressions, which subtly reveal negative views of clients' sexuality (Shelton & Delgado-Romero, 2011). Likewise, depictions of BDSM in the media, while gaining an eager audience, have been criticized as upholding hegemonic pathological views of BDSM, thereby replicating the sickness discourses within a distanced and exotic package for the consumer (Weiss, 2006). Many scholars have likened the status of the BDSM community today with the gay, lesbian, bisexual, and transgender (GLBT; e.g., Nichols, 2006) community in the 1970's in that while mental health professionals' attitudes seem to be moving away from overt discrimination (Kelsey, et al., 2013; Kolmes et al., 2006; Nichols, 2006), remnants of the past exist in modern times.

Research investigating mental health professionals' current stances on clients who engage in BDSM warrants some cautious optimism. Several studies have revealed empathetic responses to BDSM-identified clients, acknowledgment of the harm caused by shaming and pathologizing

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BDSM, and the existence of psychotherapists with specific expertise in navigating subculture-specific obstacles and successes (Bettinger, 2003; Garrott, 2008; Kolmes et al., 2006; Lawrence & Love-Crowell, 2008; Nichols, 2006). This indicates at least some acceptance and understanding of BDSM practice within the mental healthcare realm. However, a large minority of psychotherapists in one large scale study (Kelsey et al., 2013) were unsure about the healthiness of BDSM, those who practiced it, and whether they should target the BDSM in treatment. One specific area that remains especially controversial is that of pain play. A sizeable minority of psychotherapists in one study displayed revulsion and concern for the mental health of clients who engaged in painful activities; whereas they generally accepted the potential for legitimate meanings found in power role-play (Garrott, 2008). Some of these psychotherapists seemed to struggle to balance value-neutrality and prevention of physical harm.

While preventing harm and advocating for clients' self-determination are both admirable goals, there are potentially serious consequences of misjudging harm to a client in a BDSM context, for example, if the perceived harm is deemed by a counsellor to be grievous enough to break confidentiality (CPA, 2017; Kolmes et al., 2006). It seems as though a well-intentioned group of therapists, possibly a minority of them, have substantial difficulty with BDSM and pain play (Garrott, 2008; Kelsey et al., 2013). Therefore, in order to address mental health professional's level of comfort, or discomfort, with this topic, it is pertinent to investigate counsellors' understandings of harm in the context of BDSM pain play.

Even within BDSM communities, where pain is often an integral component of scenes, many people wish to distance themselves from the idea of it. Namely, even within these and similar communities, pain is seen as inherently aversive (Newmahr, 2010a; Plante, 2006) and, when it is used, is often denied being part of the experience, or constructed as serving a different purpose outside of itself. The experience of pain can be talked about without acknowledging one's experience as painful by framing the experience in different terms, such as a part of a power dynamic, a sacrifice, an investment, or as a sensation transformed into pleasure (Newmahr, 2010a). This notion of pain as something inherently aversive, and possibly stigmatizing, is far reaching, taking root not only in the mental health professional community, but also communities which frequently participate in activities which could be understood as *painful*.

The context of BDSM pain play will provide a unique setting in which to examine mental health professionals' concepts of harm for counselling clients. Expanding upon the previous literature investigating therapist beliefs about BDSM (Kelsey et al., 2013) and doing successful therapeutic work with kinky clients (e.g., Kolmes, et al., 2006) as well as managing value conflicts (Garrott, 2008) in working with BDSM-identified clients, this study endeavored to more fully investigate counsellors' interpretations of the notion of harm. Thematic analysis (Braun & Clarke, 2006) was used to explore pertinent themes in counsellors' understandings.

Researcher Interest, Beliefs, and Biases

The stakes I hold lay equally in the foci of this research project, as both a BDSM-identified individual and as a future mental health professional. Both facets of my identity inform each other and this project, as do my identities as an academic researcher and artist. My interest in the current inquiry came from an intersection of all of these identities where an intrigue in the social negotiation of mental health, taboo, and transgression has formed.

Having identified myself with a non-mainstream subculture, I entered the project knowing that I may hold values and assumptions that may differ from some participants. For example, at least theoretically, I tend towards a valuation of a radical body autonomy over the valuation of a prescriptive outline of appropriate ways in which one may use their body. Inherent in this is also a valuation of individualism and personal choice. I also hold the belief that BDSM is usually not harmful, but rather that people who engage in these practices get something they deem valuable out of it. I embarked on this project because of my interest in how these activities are evaluated – and often, stigmatized - by various parties. I suppose that some of my experiences having belonged to this category have also instilled in me some apprehension or mistrust for dominant culture. This has likely provoked emotions and biases in me that are averse to *normality*. Indeed, an interesting tension exists for me between fear of danger from normative-culture rejection and a desire to be set apart from it; between not wanting to be called a *freak*, derogatorily, by opinionated strangers, and yet adopting the meaning of that term subversively. This, I would suspect, is not an uncommon dilemma.

Another aspect of myself that builds on this normative-non-normative concept and informs the current project is my identity as an artist – the job of which, it could be argued, is to portray and present for scrutiny. In other words, I desire to continually examine and challenge both my own views and those held by the status quo. I value reflexivity and the induction of controversy in

the name of developing social discourses. I believe that inspiring reflection upon such is a necessary, and sometimes devious, endeavor. Indeed, some of the BDSM-awareness activities designed by Barker (2005) are designed to furtively bring to light the inconsistencies in people's unquestioned cultural assumptions. I am pulled towards examining these boundaries which have been drawn and seemingly forgotten, such as that between normative and non-normative sexualities. So, as I may balk at evidence contradicting my own beliefs, or relish in any devious upsetting of the status quo that may ensue in some small way from this project, I tried to acknowledge and bracket off my counter-culture preconceptions in my work here through reflective journaling and discussion with my supervisor.

As an academic and student of a mental health profession, I have developed yet another set of assumptions and values, some of which are congruent and some of which are in competition with those discussed above. Namely, the literature review I have completed somewhat supports my inclination towards a distrust of hegemony, thus partially feeding my bias. I have also, during the course of my training and professional activities, witnessed some comments first hand from mental health professionals indicating a sense of BDSM as inherently harmful or indicative of pathology. Although I disagree with those sentiments, I also feel responsible to uphold ethical standards in the counselling field and to serve my clients professionally; notions of which are inherently grounded in mainstream cultural conceptualizations of health and harm. This creates an interesting dilemma for me. I at once care very deeply about the wellbeing of clients, and yet have difficulty with the idea that I, or any other, should be the author of their concept of *wellbeing*. I imagine that my idealism could easily break down when I personally feel strong concern for a client or when it conflicts with ethical principles. Indeed, in my limited experience in counselling practice, I see how my two disparate desires, to both challenge the normophilic status quo and to successfully integrate into a professional collective, is something that I will need to address and harness for myself in my future practice.

This precarious act of identification with, while also distancing from, a mainstream and professional group undoubtedly carries impact for how I will work with my participants, who are members of that group. The dilemma here is that while I also care very deeply for the wellbeing of my participants and for the profession, as a whole, this group in some ways represents the majority culture that I *want* to question and that I may hold biases against. Somewhat

paradoxically, I am quite interested in how other professionals navigate the murky waters of harm in order to inform my own practice.

While writing this section, it became apparent to me that my words may be construed as villainizing those with the authority over, or adherence to, dominant culture. This is, in fact, something I have accused myself of, although I do not believe that is the ultimate message here. I acknowledge that a researcher's and clinician's role is to maintain an ethos of openness and, although I may have espoused a somewhat suspicious and interrogative tone, it was exposed in an effort to overcome such a position. In the words of Guba and Lincoln (1994), in a study using a constructivist paradigm, "hiding the inquirer's intent is destructive of the aim of uncovering and improving constructions" (p. 115). I recognize that ultimately, my desire to deconstruct social norms is pluripotent, and here I hope to use it in the service of gaining legitimacy and appropriate access to care for a minority group (a notion which is problematic in that the very core of a subculture is that is varies from the norm, and thus, depends on it for its own existence). However, I will not allow myself to aim for this at the expense of the legitimacy and safety of those representing the majority. To do so would not only contradict my training and ethics as a researcher and counsellor, but also to become the thing that I most resist.

Rather, I aimed to undertake this research with the acknowledgement of my internal personal debates and biases to the extent feasible. The first step of bracketing has been to make my assumptions prior to conducting the study (outlined above) known to myself and to my audience. I have also kept reflections on the research design in an Audit Trail (Appendix A). Through the rest of the research process I also kept a reflexivity journal (Appendix B), in which I explored and questioned my decisions on data collection and analysis. While analyzing the data, I also took breaks from the data to allow ideas to percolate and to revisit it with a freshened, naïve perspective. In sum, I strove to not project my assumptions and biases onto my participants and to reflect upon them as I designed the study materials and interpreted the data. Yet, I recognize that I am also inherently a part of the knowledge constructed here (Guba & Lincoln, 1994; Morrow, 2007).

Statement of Purpose

Previous literature has indicated stigma around BDSM in general, and around painful activities especially (e.g., Garrott, 2008). It has also noted psychotherapists' potential ethical blunders and discomfort in working with BDSM clients, especially when clients are involved in

activities that may be understood as causing pain (e.g., Garrott, 2008; Kolmes et al., 2006). In this context, psychotherapists may feel a desire to both protect the client from harm and to allow the client freedom (Garrott, 2008). What harm means for different therapists, however, varies and can be highly impacted by the presence of pain and the experience of the counsellor, such that less painful activities and more counsellor experience working with the kink community is related to less concern for clients (Garrott, 2008; Lawrence & Love-Crowell, 2008). The current study aimed to expand upon these previous findings by further exploring the question of how psychotherapists understand and define *harm* and *serious harm*, or reportable harm, in the context of clients' BDSM pain play.

The results of this study have potential implications for ethical clinical practice, but also promise to extend beyond the realm of psychology. Specifically, the findings from this study may inform and empower counsellors and counsellor-educators who are engaging with culturally responsive ideas of harm for BDSM-identified clients as well as help foster an atmosphere of understanding for kinky individuals in therapy. Additionally, this research may ultimately impact understandings of this complex phenomenon held by other professionals working in helping roles, in law, or in society at large.

Explanation of Terms

BDSM. An umbrella term for a variety of related activities that involve consensual bondage/discipline, Dominance/submission, and sadism/masochism (Bezreh, et al., 2012; Connolly, 2006). Bondage involves restraining someone, such as by tying with rope, while discipline involves giving commands and applying consequences (Miller & Devon, 1995). Dominance and submission involve a consensual power exchange, where (at least) one partner agrees to obey (at least) one other partner, and in return the partner(s) in charge agree to care for and respect the limits and desires of the submitting partner(s; Miller & Devon, 1995). Sadism and masochism involve deriving pleasure from giving or receiving pain or humiliation, respectively (Miller & Devon, 1995).

Edge play. Play that pushes up to or beyond the edges of someone's limits and/or carries a high amount of emotional or physical risk (Lee, Klement, Sagarin, 2015; Miller & Devon, 1995). An example of psychological edge play might be someone agreeing to let a partner give them away to other partners as a "sex toy" (Miller & Devon, 2015, p 188) because they want to engage with their personal limits around promiscuity. This could be considered edge play for

some people because of the potential for emotional reactions to occur despite pre-negotiation (Miller & Devon, 2015). An example of physical edge play is breath control play, where the breath is restricted (Lee, Klement, Sagarin, 2015). Breath play is controversial within the scene and commonly considered a type of edge play due to the medical risks involved (Lee, Klement, Sagarin, 2015).

Harm. According to the CPA ethical guidelines (2017), harm is determined in terms of any physical or psychological detriment and is implied, by the use of qualifiers such as "serious harm" (p. 7), to be on a scale of severity. Since harms may range in severity, the term harm, will be used in this study to indicate that which is of less immediate concern than reportable harm, but still in need of remediation. For example, therapists may perceive BDSM activity as problematic and misguidedly refocus treatment goals to eliminate the clients' activities (Kolmes et al., 2006), but not see it as serious enough to warrant disclosure of confidential information.

Kink. In a general context kink can be used to describe a variety of non-mainstream ("Kinky", n.d.) sexual appetites, but in this paper it will primarily refer to BDSM or similar desires and behaviours, as kink is a common term used to denote BDSM (Bezreh, et al., 2012; Nichols, 2006; Pitagora, 2016b).

Play. A noun or verb used to describe a BDSM interaction (Newmahr, 2010b).

Person who participates in BDSM. Person first language is used where feasible to describe people who engage in BDSM activities. However, for clarity and stylistic concerns, other terms are also used interchangeably in this document. The majority of people who responded to Kolmes and colleagues' (2006) study self-identified with the terms "BDSM" and "kinky" (p. 310). Therefore, with the knowledge that various people may relate differently to BDSM, identifying as a BDSM practitioner, simply engaging in it as an activity, and/or having an orientation (Kolmes, et al., 2006), the identifiers used in this document to refer to such people will include BDSM and kinky. The following terms are used interchangeably to describe this diverse group of people that share participation in BDSM activities: BDSMer (BDSMer, 2017), BDSM-identified individual/client (Kolmes, Stock, & Moser, 2006), Kinkster ("Kinkster", 2014), and kinky person/client (Kolmes, et al., 2006; Nichols, 2006).

Counsellor/psychotherapist/therapist/mental health professional. Counsellors and psychotherapists have professional and ethical relationships with clients (CCPA, 2017). They use their knowledge and skills to facilitate change for clients in response to a variety of client needs

(CCPA, 2017). Not all counsellors and psychotherapists are regulated (CCPA, 2017), however, and so in the context of this study, these terms will be used interchangeably and operationalized to include only professionals who are registered, licensed, or certified with some sort of professional body and who also have experience counselling clients.

Safeword. A clearly designated word, or signal, that is used to stop or slow down BDSM play (Nichols, 2006; Safeword, 2014). For example, in the stoplight system, "yellow" might indicate the need to tone down the intensity while "red" might mean the player wants the scene to stop for any reason (Safeword, 2014).

SM. Short for sadomasochism (e.g., Taylor & Ussher, 2001; Wright, 2006) or sadism/masochism (Nichols, 2006).

Scene. Refers to periods of play involving any combination of BDSM elements and play (Newmahr, 2010a; Newmahr, 2010b; Nichols, 2006). They are, ideally, negotiated and structured around players' desires and limits and halted when a safe word is uttered or indicated (Cross & Matheson, 2006; Safeword, 2014; Taylor & Ussher, 2001).

Serious harm. Abbreviated from the wording in the CPA (2016) ethical guidelines, "imminent serious bodily harm," (p. 17) serious harm will be conceptualized, as it is in the CPA guidelines, as harm that warrants reports of confidential information in order to intervene to preclude the harm. Because, as outlined by the CPA, psychological factors are integral to reportable harm (e.g., suicidal and homicidal ideation), and because a main purpose of this study is to understand the decision whether to report, I have chosen to indicate only the seriousness of the harm and leave out the situation of the harm (e.g., "bodily").

Vanilla. Refers to mainstream sexuality and sexual acts (Newmahr, 2010b; Nichols, 2006; Pitagora, 2016b; Stiles & Clarke, 2011).

Overview of Thesis

The literature relevant to BDSM in history, will be described in Chapter Two. This chapter reviews the conceptualizations of Sadism and Masochism as problems of morality, sickness, and criminality (e.g., Krafft-Ebbing, 1892; Freud, 1938). Psychiatric literature from the 19th century (e.g., Krafft-Ebbing, 1892; Freud, 1938) to modern times (e.g., Richters, De Visser, Rissel, Grulich, & Smith, 2008) is discussed, as well as current laws relevant to the topic of bodily harm (e.g., Attias, 2004). This chapter outlines the journey from a predominantly negative historical view of sadomasochism, to a moderately favourable one in contemporary thought.

Current literature regarding mental health professionals (e.g., Kelsey et al., 2013) will also be discussed. The second chapter will close with a brief summary and the rationale for this research.

Chapter three outlines the rationale for working with a qualitative paradigm. It discusses the paradigmatic assumptions adopted for this study and analytic strategy to be used, which is thematic analysis (Braun & Clark, 2006). My role as a researcher, the participant recruitment methods, as well as the data generation and analysis methods are discussed in relation to their compatibility with thematic analysis. Constructs which are useful for evaluating qualitative research studies and ethical considerations are discussed.

Chapter four presents the results of the thematic data analysis. One global theme, *containing and maintaining the individual*, was generated. Six organizing themes supporting the global theme were generated: *bodily integrity*, *selfhood*, *presence of consent*, *social connectedness*, *mental health and healing*, and *threat and safety are vague*.

Chapter five discusses the results in relation to the literature. This chapter also discusses the strengths and limitations of this research, future directions for research, and implications for counselling.

CHAPTER TWO: LITERATURE REVIEW

Chapter two outlines the historical and current literature on the topic of BDSM practitioners and the societal interpretations of them. I start by describing some historical psychiatric conceptualizations of sadomasochism, beginning from the nineteenth century, and then discuss the relationship between BDSM and the law. Situating a review of the current psychological literature against the historical perspectives, I then describe and critique the modern trend towards depathologization of BDSM. I discuss mental health professionals' responses to BDSM and BDSM identified-individuals, including commonly held pathologizing and depathologization narratives along with their caveats and critiques. This section concludes with a rationale for this study.

Historical Perspectives of SM: Perversions of the Sexual Aim

Sadism and masochism, or the enjoyment of giving and receiving pain, respectively (APA, 2013; Freud, 1938; Krafft-Ebing, 1892), have been present in some form since ancient times. Depictions of erotic flagellation and spanking date back to at least 490 B. C. (Steingräber, 2006). However, despite its ubiquity throughout time, sadomasochism has had a long history of theoretical scrutiny. As contemporary philosopher Scott Stewart (2012) reasons, understandings of the purposes of sexuality - and the corollary perversions, including sadomasochism - have their roots in Western teleological philosophy, dating back to Plato and Aristotle. The teleological explanation of sex, can be understood to mean reproduction, rendering other goals for sex to be invalid and perverted from its natural goal. This line of thinking, which Stewart (2012) deems *prescriptive* rather than "a *description* of the way in which people actually behave" (para. 5) has permeated much subsequent theorizing on sex and perversions of it.

Not unlike the stance taken today, sadism and masochism were considered immoral, pathological, and criminal but yet were allowed partial legitimacy within predetermined limits during the latter part of the 19th and earlier part of the 20th centuries. Early psychiatric understandings of sexual activity, sadism and masochism included, were situated within a morality-immorality discourse. According to Rubin (2010), at this time the shift from the "Christian morality of serving a higher purpose" (p. 773) to "modern morality of self-fulfillment" (p. 778), a shift that continues to this day, was beginning to take place. These teleological and religious themes are prevalent in early psychiatric writings on the morality, sanity, and legality of sex.

Krafft-Ebing (1892), a physician working in forensic settings, had great influence during the nineteenth century. During his era, sex was regarded as moral and healthy only if it was for the purpose of reproduction. Krafft-Ebing regarded this kind of regulation of sex as a normal sexual instinct which must be guided by Christian ethics. According to Rubin (2010), the Christian morality cast out earthly and sensual pleasures in favour of heeding divine commandments towards salvation. Thus, pleasure was only regarded as moral if it was for a purpose (Krafft, Ebing, 1892). In terms of what would now be termed BDSM-type pleasures, Krafft-Ebing (1892) took the view that flagellation could denigrate from the purpose of procreation such that the ecstatic experience of pain was no longer used as preparation for intercourse, thus becoming a diversion from reproduction. In this view, sexual pain could be justified as moral if it served the purpose of aiding procreative sex. The famous psychiatrist, Freud, espoused ideals similar to Krafft-Ebing's, but the telos shifted slightly from spiritual to biological aims.

Freud (1938), while less religiously moral in his intonation, clearly assumed the prevailing ethics of his time. He also had a tremendous impact during the nineteenth and twentieth centuries, further solidifying the teleological understanding of sex and perversions. He too considered sex to be a driving animal force imparted upon people to continue the species and, thus, the *natural* goal of the sexual force was to induce a reproductive sexual union (Freud; 1938). For both Freud (1938) and Krafft-Ebing (1982), any sex that occurred outside of this aim was considered immoral, deviant, and perverse from its higher aim of reproducing offspring. This conceptualization of immoral and abnormal sex was nearly all encompassing; among others, acts such as masturbation, oral sex, anal sex, same-sex sex, sadomasochistic sex, bestiality, and pedophilia were condemned uniformly by the argument for the intended purpose of the genitalia and sex drive. However, Freud's condemnation of perversions was more scientific in tone, emphasizing the animality intended to continue the species; a natural animal drive, rather than cultivation of a spiritual purpose.

Sadism and masochism, specifically, were said to degenerate from this intended purpose through an exaggeration of innate feminine and masculine sexual impulses (Freud, 1938; Krafft-Ebing, 1892) which are also tied to the aim of reproduction. According to both Freud (1938) and Krafft-Ebing (1892), men were designed to be aggressive in order to ensure their reproductive goals were met, while women were designed and socialized for the passive role in propagation

and to submit to male desires. To an extent, these were considered normal gender and sexual roles, however, if either masculine or feminine drives became inflamed, in either sex, sadism or masochism was said to occur. Thus, purportedly naturally existing gender, in addition to sex drives, became derailed from their intended procreative purpose.

Given that sadomasochism represented a deviance from the natural state, it was – and is still to this day – deemed necessary to explain the etiology and course of the perversion. For Krafft-Ebing (1892), this derailment could happen either through association of cruelty with lust, or more often, and severely, through genetic inheritance. While Krafft-Ebing acknowledged the considerable overlap between sadism and masochism within individuals, he viewed them as separated and yet complementary constructs. Freud (1938), however, considered sadism and masochism to be not two complimentary illnesses, but one in the same perversion manifested differently. Freud thought of sadism as the active form of the perversion, directed at external sexual objects, and masochism as the passive form of sadism, turned towards the self. While firmly placing sadism and masochism in the realm of illness, he noted that all people have the capability of sadism and it only becomes problematic if it is "an absolute attachment of the gratification of the subjection and maltreatment of the object" (Freud, 1938, p. 569), rather than merely a spur of the moment activity during normal, heterosexual, reproductive sex. In describing masochism, however, Freud takes a more pessimistic tone, saying that it is "further removed from the sexual goal than its opposite" (1938, p. 569). In Freud's eyes, because masochism is sadism further transformed and turned towards oneself, it represents a larger deviation from normal sexuality. In sum, sadism and masochism were deemed as perversions not of the action, but of the degenerated, derailed, psyche; perversions of the desire to procreate.

While the zeitgeist of the eighteen to nineteen hundreds was to frown upon all of these non-propagative sexual acts, some sadistic and masochistic acts could be deemed non-pathological if they were integrated into the "normal sexual aim" (Freud, 1938, p. 563). For example, Krafft-Ebing considered that "the not infrequent cases where individuals of very excitable sexual natures bite or scratch the companion in intercourse [fell] within physiological limits" (1892, p. 57). He also described "simple reflex flagellation" (Krafft-Ebing, 1892, p. 101) as a distinct physiological reflex that could not be helped, for example when boys became aroused from corporal punishments. Thus, he distinguished the enjoyment of biting, scratching, and whipping during sex - or enacted through happenstance - from enjoyment that is perverse,

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such as desiring the cruel acts in their own right. Freud (1938) also delineated acts of non-genital foreplay as a prelude to normal sex from a perversion of the same act that lingered too long and was not "rapidly passed" (p. 564) through towards the proper sexual aim. Freud (1938) distinguished the use of the term sadism to denote sexual assertiveness and impulsive sexual aggression from "absolute attachment of the gratification to the subjection and maltreatment of the sexual object" (p. 569). Thus, some sexually aggressive and passive acts were deemed non-pathological manifestations by virtue of the actors' gender-role-congruent motive to propagate the species.

In sum, social control over sexuality was expressed in the eighteen and nineteen hundreds through various means. Both gender and the intent to engage in procreative sex were factors to be considered when interpreting the normalcy or pathology of any sexual actions, including sadomasochistic ones. Transgressions of normal sexual and gender aims were deemed pathological. During most of the 19th and 20th centuries, however, it was the psyche, not necessarily the action, which was considered to be transgressive. This trend changes in psychological discourse of the late 1900's towards a focus on pathologization of the action.

The Psychology of SM in the Late 1900's: The Pathology Debate

Reconfigurations of these historical teleological views of sexuality can be seen in more recent writings on sadomasochism during the late 1900's (e.g., Pinard & Lamontagne, 1976; Money, 1987). Up until the 1970's and 1980's, case studies of sadism and masochism (e.g., Pinard & Lamontagne, 1976; Money, 1987) continued to be published in a fashion similar to Krafft-Ebing (1892) and Freud (1938). Namely, these recent-past case studies (e.g., Pinard & Lamontagne, 1976; Money, 1987) still adopt a sickness perspective which often lacks a solid grounding both in patients' experiences and in empirical evidence. Essentially, some research at this time was still a proverbial witch hunt, with researchers looking for evidence to support their indoctrinated views of pathology as perversion of the *normal sexual aim*. While some researchers in the later 1900's began to produce de-pathologizing narratives, some would argue (Moser, 2016) that the teleological pathologized discourse still influences, many versions of the DSM (e.g., APA, 2013).

Early research blunders. Like Krafft-Ebing (1892) and Freud (1938), some of the case studies from the later 1900's engaged with theoretical etiological explanations for sadomasochism; however, again, they come from a theoretical perspective which is not grounded

in evidence. Money (1987), for example, recounts a case of a male masochist who enjoyed and celebrated flagellation. Contrary to this man's interpretation of his own activities as something celebratory, Money interprets the man's actions as a pathological reaction to childhood experiences of spanking and caning punishments in school. No evidence of what constitutes a normal desire is presented, but it is assumed, as in the past. The author chooses to outright disregard the subject's appeals to embrace and publicize the joys of spanking, opting for a stance dismissive of the man's phenomenological experiences of functioning in life. The author categorizes this man as suffering from a paraphilic "form of addiction… [which is] notoriously resistant to change by either punished as crimes or sexological disorders" (Money, 1987, p. 275). He concludes his article with a note on the most effective treatment methods for such a disease, which is chemical castration. Not only does the author conceptualize the case without taking into account the client's perspective on his own life, but he also fails to ground his interpretations in any empirical evidence, instead relying on theoretical conjecture. This interpretation of inherent pathology, while circumscribing sadomasochistic sexual activity even tighter than Krafft-Ebing's (1892) concessions for spanking would allow, echoes the notion of a normal versus perverted sex drive that can be seen throughout early psychiatric theories.

Other case studies of masochism from the late 1900's have been interpreted with an absence of etiological framework, adopting instead a flagrantly naturalized perspective of deviancy. Pinard and Lamontagne (1976), for example, simply described a case of male masochism in which the man desired to be slapped during sex, wear women's clothing, and masturbate to pornography. The treatment plan for this man involved shock therapy and step by step training in *normal* sexual intercourse; that is, intercourse that progresses from foreplay to penetrative sex without any hitting, cross dressing, masturbation, or pornography usage. For the man in this case, his presenting problems were substance abuse and relational problems due to his sexual interests, not the interests themselves. Clearly these authors held the stance that sexual deviancy was firstly, constituted by sex which involved anything other than transient foreplay and heterosexual penetrative sex, and secondly, the primary cause of his other social problems. It would have been hard for them to conceptualize that perhaps the cultural environment he was in was in fact a contributor to both the drinking and the relational problems. This position was also made abundantly clear by their sole reliance on literature that targeted the extinguishing of these

behaviours; not even a mention of theory was made, suggesting an unquestioning acceptance of the historically prevailing mores around genital sex (Pinard & Lamontagne, 1976).

Similar trends can be found in the interpretation of sadistic cases. One case study reported by Davison (1968) was on a young college man who was uninterested in "normal" (p. 85) sexual fantasies or activities. Instead, he had been interested in torturing women since about age 11, his typical fantasy being described as "a pretty girl tied to stakes on the ground and struggling tearfully to extricate herself" (p. 86). This was disturbing to the man and so he avoided intimacy and the idea of marriage. Having found some literature on sadism and the "poor prognosis" (Davison, 1968, p. 85) which accompanied it, the client was also concerned about his future planning. The therapist noted "…his concern over the gravity and implications of his problem seemed at least as disruptive as the problem itself" (Davison, 1986, p. 85). This seems to denote an understanding of the *problem* of sadism as social rather than inherent, however, this therapist- like those discussed above- still placed cause for change within the individual, rather than the level of acceptance from society. This therapist did, however, devote a whole session to countering the client's fears about being diseased - a caring and progressive action in relation to some of the other therapeutic techniques previously described for treating masochism. This comparatively light treatment for the sadist may have roots in Freud's theory that masochism is even farther than sadism from the sexual aim as well as the congruence of the male gender role with the active, or sadistic, role. However, this therapist's course of treatment still hinged upon a complete cessation of sadistic fantasies and a substitution of "normal" (Davison, 1968, p. 85) male sexuality.

It is evident that what is considered a normal sexuality by the therapist is culturally proscribed (Davison, 1968). Specifically, the man was given a masturbation regimen in which he was to wean himself off of sadistic fantasy. He was to do so by mentally pairing the sadistic fantasies with an undesirable thought (for example, a branding iron approaching his eyes whilst he viewed the struggling woman) while rewarding the development of *normal* fantasies, assisted by Playboy Magazine, with an orgasm. He was also taught the "social-sexual games" (Davison, 1968, p. 85) in which many men in society partake; such as mentally undressing women and engaging in "locker room talk" (Davison, 1968, p. 87). While the client was pleased with the way the therapy had abated his sadistic fantasies and allowed him to discover a newfound sexual attraction to what might now be called vanilla sex, he still desired to revisit his fantasies after

termination of therapy. The emphasis the therapist placed on normal sexuality constituting desirable sexuality is evident in his admonishment to the client "not to make any more 'premeditated' returns, rather to consolidate his gains in dating and other conventional heterosexual activities and interests," (Davison, 1968, p. 89). Thus, while the client was helped in some self-determined way to interact with potential partners, he was still encouraged by his therapist to conform to cultural standards and completely eradicate his fantasies for bondage and sexual torture.

Evidently many authors in the late twentieth century espoused beliefs about sexual behaviours that were rooted explicitly or implicitly in historic notions of correct sexualities, gender roles, and their complementary sexual pathologies (e.g., Davison, 1968; Pinard & Lamontagne, 1976; Money, 1987). The intensity of the chosen treatment methods used in during this time- hormonal therapies, aversion therapies, and conversion therapies (Money,1987; Pinard & Lamontagne, 1976) - in response to some relatively common fantasies, by today's standards (Joyal, Cossette, & Lapierre, 2015), attests to the abhorrence and deviancy with which SM acts were revered by mental health professionals during this relatively recent time period. Given the importance many authors have given to treating sadomasochism intensively and without question, it seems logical to conclude that the impact of previous moralistic and pathologizing understandings of yesteryear have cascaded through subsequent decades. However, the assumption of deviancy has seemingly become stronger in the more recent past, and even the slight allowances of sadomasochism as a precursor to genital sex provided by Freud (1938) and Krafft-Ebing (1892) have been abandoned by many in the later 1900's.

SM: an illness according to the DSM. The assumption of deviation and sickness by the psychological professions is evinced throughout the evolution of sadism and masochism in the APA's DSM. Sadism has evolved from a vague symptom of sociopathy (APA, 1952), back to a diagnosis of automatic deviance of the sexual aim (APA, 1968), to a paraphilia which is only diagnosable when it is the exclusive mode of sexual expression, results in bodily injury of a consenting partner, is done without the consent of a partner (APA, 1980), or the desire results in significant impairment in social or work life (APA, 1987, 1994, 2000, 2013). As noted above, 1980 was the first year that sadistic acts with a consensual partner were not automatically considered pathological - however the small allowance made for non-pathological sadism was only non-repeated and mild sadistic acts, much like Freud (1938) and Krafft-Ebing's (1892)

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allowances for spur of the moment sexual aggression. This seems to indicate that one is allowed to retain normalcy and enjoy sadistic acts, but only if the acts are driven by the body's ravenous desire to have procreative sex, rather than the mind's satisfaction in hurting one's partner.

The evolution of masochism in the DSM took a similar path to that of sadism. Masochism as a diagnosis evolved from part of generalized sexual deviation category (APA 1968), to a paraphilia characterized by either exclusivity in terms of sexual gratification or a simple acting out masochistic urges (APA, 1980), to a paraphilia marked by these same things, sometimes accompanied by distress or dysfunction (APA, 1987), to a paraphilia which required distress and dysfunction to be present for diagnosis (APA, 1994, 2000, 2013). The first year that acting out masochistic acts was not automatically considered a diagnosable paraphilia was 1994 (APA, 1994). While the general course of the DSM's initial automatic pathologization to an incremental allowance of consensual and functional enactments of urges rings true for both sadism and masochism, masochism took longer to accept as potentially non-pathological than sadism. The delay between when sadism and masochism started to become somewhat non-pathologized is reminiscent of Freud's (1938) notion of masochism being farther away from the normal sexual instinct than sadism. This might suggest that, masochism, being a perversion not only of the sexual aim, but also of the (presumably male) body's ravenous desire to hurt others, is seen as more passive and mentally based (and presumably female) and, therefore, less acceptable than the carnal, base, and active desire towards sadism which is intended to propagate the species. Apparently, psychological professionals have debated the distinction between acceptable and unacceptable sadomasochistic behaviours throughout the nineteenth and twentieth centuries.

This pattern of moral biases impacting therapeutic practice is reminiscent of the oft compared controversy surrounding psychotherapeutic correction of homosexuality (e.g., Nichols, 2006). Diagnosis of homosexuality, like sadism and masochism, was also included in the DSM, in some form or another, until the 1987 edition of the DSM (APA, 1987; Drescher, 2015). Moreover, treatments of homosexuality (Haldeman, 1994), like kinky sexual interests (e.g., Kolmes et al., 2006), is known today to be harmful to clients. Although psychotherapists had been trying to eradicate sadomasochistic behaviours in their clients, little empirical investigation on the topic, other than the aforementioned morality steeped case studies (e.g., Money, 1987), had taken place until the later twentieth century. And, when larger empirical studies of BDSM

practitioners began to emerge, a pathologizing and criminalizing lens was still apparent (Quinsey, Chapplin, & Upfold, 1984). A good proportion of the studies in the late twentieth century still sought to find confirmation of sadomasochism in pathologized populations or pathology in sadomasochistic populations (e.g., Quinsey et al., 1984). However, some studies conducted by researchers allied to the BDSM community also began to emerge around this time (e.g., Breslow, Evans, & Langley, 1985). The findings from both camps served to start shifting the psychological perspective towards BDSM practitioners, much how the clinical perspective on homosexuality has shifted over time (Haldeman, 1994; Nichols, 2006).

Moving away from a pathology paradigm. One such example of the perspective-shifting properties of research can be found in the forensic psychology arena. In the early 1980's, Quinsey, Chapplin, and Upfold (1984) set out to study male arousal patterns in incarcerated sexual offenders, nonsexual offenders, and a control male group. Although they found that sexual offenders were more aroused than the other groups in response to stories of rape and nonsexual violence, they were *surprised* to find no differences between the groups in arousal to BDSM themed vignettes. Clearly, these authors did not expect to find arousal to BDSM in a control population and they could not find evidence to link BDSM themes of spanking and bondage exclusively with a criminal population. Their anticipation is not unexpected given the assumption that violence is synonymous with BDSM. The version of the DSM current at the time of Quinsey and colleagues' (1984) study lumps consensual and non-consensual expressions of sadism under one diagnostic category (APA, 1980). Given the paucity of literature on a non-clinical population of BDSMers, it would have seemed natural at that time to hypothesize that regular people would not like BDSM while criminal people would. Their surprise at the findings illustrates the muddling of both social dysfunction and criminality with the sicknesses of sadism.

Around this time, depathologizing descriptive research outside of the forensic arena also began to be published. Studies conducted by Moser and Levitt (1987) and Breslow and colleagues (1985) examined the demographics and sexual activities of BDSM practitioners in the wider community. Both studies (Breslow et al., 1985; Moser & Levitt, 1987) found that their participants had a relatively high level of education, were not usually fixed in one role, incorporated their SM interests later in life, often engaged in a variety of behaviours that were both vanilla and SM oriented, and mostly did not have reservations about their sexuality. These findings from researchers allied with BDSM communities provided empirical evidence to

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complicate some of the previous reasoning around sadomasochism as a sickness and immorality that impacts sexual and daily functioning in society.

Although depathologizing research in a non-criminal population began to amass around this time (Breslow et al., 1985; Moser & Levitt, 1987), effectively sparking a shift in understanding about BDSM, criminality is still closely tied to the traditional notions of SM sexuality as immoral and sick (e.g., Attias, 2004). The following section will discuss the impact of moralizing and pathologizing BDSM on legal understandings.

Psychology, Morality, and State of the Law for Kinksters

Psychiatric and legal understandings are closely linked. Dymock (2012) pointed out that law looks to psychology and psychology-related disciplines to draw the line between reasonable and unreasonable people and actions. Congruent with the former exploration of morality and sexual functioning, Dymock (2012) also noted the moral discourse of procreativity surrounding laws regarding consent to BDSM activities. Specifically, Dymock observed that it is morally counterintuitive to harm oneself during a process that is deemed worthy only for propagation - a process in which you must be alive and well to see through. Rubin (2010) posited that modern morality is influenced by both the Christian ethic of a higher purpose and the ethics of self-fulfillment. The connection between procreative futurity is closely linked with the higher purpose of bearing children, but risking life for sex is also condemned by the morality of self-fulfillment. Rubin stated, "for the most part, life is to be preserved at nearly all costs; for individuals to fulfill themselves, it is generally necessary for them to be alive" (2010, p. 779). Thus, while pleasure as the purpose for future reproduction is not the main concern of the ethics of self-fulfillment, the future of self-preservation for continued pleasure is. Both discourses inform psychological understandings as well as the laws on what activities one may consent to have done to their body for pleasure.

Today it is still technically illegal to consent to bodily harm that is more than 'transient or trifling' if it has no cultural value (Criminal Code, 1985). Under current legal discourse, activities that intend or risk the alteration of body tissue, such as body piercings, cosmetic surgery, and sports have cultural value, but erotic or sensual activities which involve the possibility of lasting bodily harm do not (Attias, 2004; Dymock, 2012; Green, 2001; R. v. R.D.W., 2006). Dymock (2012) compared these laws to Freud's (1920/1955) concept of the pleasure principle which, if contradicted, indicates either the insanity of a person or the

monstrosity of their pleasure in actions which go beyond this principal. Indeed, criminalization of monstrous people and pleasure is illustrated in court cases.

There is indication that people who are kinky are incapacitated in a law setting. Attias (2004) noted that conservatives' efforts to delegitimize BDSM based on its violent connotations ironically allows for more violations of kinksters' rights. One case that he reviewed recounts the acquittal of a self-confessed rapist who assaulted a BDSM-identified woman. Attias reasoned that the implied justification for this ruling was that the woman was already perverted and therefore inviolable. Attias (2004) further argued that the consent of the perverted is both void for consensual acts while simultaneously uninfringeable for non-consensual acts. Taking away kinksters' right to consent under the guise of protecting them is comparable to the common medical practice of *risk managing* away patients' sexuality in mental health wards despite a lack of evidence of actions increasing safety (Dein, et al., 2016; Ruane, & Hayter, 2008). Ultimately, this policing of consent represents (ironically) legal authorities' desire to control people's sexual actions through punishment. This description of the legal views of complainant BDSMers suggests that their credibility as a person may be undermined in court. Effectively, they are so monstrous and sick that they are incapable of either consenting to or resisting sexual activities.

Continuing the notion of illegitimate pleasure punished by law, there are many court cases around consensual BDSM which *have no complainants* (e.g., R. v. R.D.W., 2006; Attias, 2004). Usually these cases only become problematic for individuals involved when some evidence of BDSM comes to the attention of an authority. For example: a video of a mock gay slave auction - a charity fundraiser - found by police that resulted in assault convictions for the participants (Attias, 2004); a mother's view of a teen girl's "unsightly" (para. 10) scarring left over from consensual cutting scenes with her boyfriend, resulting in the conviction of the young man (R. v. R.D.W., 2006); and the candid revelation of consensual BDSM between a couple in court to determine their parental fitness for a separate - and acquitted - reason, resulting in their limitation and loss of child custody (Klein & Moser, 2006). While some rulings have acknowledged that BDSM is not obscene, but normal and acceptable to Canadians (Perelle, 2004), it is evident by subsequent convictions of consensual BDSMers that, legally, kink still falls into a dark grey area influenced heavily by hegemonic understandings of the purpose and value of sex, pleasure, and consent. Cases against consensual BDSMers are not about

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determining the acquisition of consent, but about the nullification of a person's ability to consent and, consequently, the punishment of transgressive sexualities (Attias, 2004; Dymock, 2012).

Deconstructing the Moral Policing of the Sexual Body

To further illustrate the ironic policing of morally transgressive sexuality, consider the more extreme case of consensual lust murder, in which one consents to their own murder for pleasure (Downing, 2004). Downing (2004) stated that modern liberal views of sex advocate for tolerance of diversity so long as the condition of consent is adhered to. However, regardless of whether consent was given in a consensual lust murder scenario, it is voided on the basis that murder is beyond the reach of full and informed consent (Downing, 2004). However, voiding that consent in this case problematizes the prevailing "liberal logic" (Downing, 2004, p. 6), or, in the words of Rubin, "the modern morality of self-fulfillment" (2010, p. 778), which respects each individual's freedom to subjective aspirations and self-defined purpose to the extent that they are not impinging on others' right to the same. To experience killing or dying (Downing, 2004; Rubin, 2010), activities that risk killing or dying, such as erotic asphyxiation (Ernoul, Orsat, Mesu, Garre,& Richard-Devantoy, 2012) – and perhaps even just hurting (Dymock, 2012) – to enhance one's subjective experience, appears to have somehow become an illegitimate self-defined goal which one may not consent to, except under very specific and non-sexualized circumstances (Downing, 2004; Rubin, 2010). Rubin (2010), in a discussion on the prohibition of assisted suicide, offered that this failure of liberal logic is formed upon two notions: firstly, that death is counterintuitive to living a fulfilling life so long as there is future possibility of doing so, and, secondly, that vestigial characteristics from the Christian morality view suicide as ethically wrong. The result of this awkward moral merger is the paradox that suicide is legalized and viewed as an unfortunate event preventable by therapy, and yet assisted dying – whether it be euthanasia (Rubin, 2010) or lust murder (Downing, 2004) - is largely criminalized (Rubin, 2010). Thus, the doctor, partner, or other party which induces death becomes an abusive criminal and the death-seeker becomes an unfortunate, mentally sick person (Downing, 2004). Consensual lust murder, assisted suicide, and BDSM are, generally, distinct phenomena, but overlap in that they equally illustrate the presence of self-determined consent that is invalidated.

By constructing the death-seeker, and/or kinkster, as automatically mentally unwell, their personal choices can then be invalidated on the grounds that they are mentally unable to give free

and informed consent, by virtue of the choice of death itself (Downing, 2004), or perhaps, more often in the case of kink, minor tissue death itself. Downing described the policing of what people can and cannot consent to as "the 'paternalistic' answer… a moral absolutism that overrides the liberal notion of respect for plurality and individual will" (2004, p. 9). This is counterintuitive to the notion of personal choice touted as a tenet of liberal ethics because it assumes that some people, for example, professionals, "*just know better* than the people who consent to certain types of activity" (Downing, 2004, p. 4). Downing (2004) posited that the discomfort many face in this situation is not only with death, but with combining sexual pleasure and an act that is morally wrong (i.e. killing), and herein lies the modifier of liberal self-determination. The legal purpose of consent appears to be the protection of individuals against immoral violence, not only from others, but themselves as well, for anyone desiring and consenting to pain, injury, or death is, under most circumstances, unequivocally constructed as mentally sick.

The notion of violence is important here. If consent is not the thing in violation, then the law is protecting something else. If the case can be made that the people consenting to pain, injury, or death are not inherently psychologically ill – a notion which, in some ways, is supported by psychological literature (e.g., Richters et al., 2008) but apparently overlooked by law – then it follows that there must be something else that the law is protecting from violation. Byrne (2013) highlighted that the actual threat of BDSM is that it contradicts essentialist views of sexuality by revealing precisely the *un*naturalness of how power is constructed in society at large. Byrne argued that BDSM allows sexuality to be shown as the art of humans, as acts and desires that are *chosen* by active makers, rather than predetermined. BDSM play, through the incorporation of quotidian symbols and language to imitate, or even mock, the formations of power, reveals what is often invisible: all systems of power are constructed by humans, and thus, none exist naturally (Byrne, 2013). It seems, then, that the law not only protects individuals from themselves and others, it also protects itself from others which may want to pain, injure, or kill itself by rendering them invalid through sickness or criminality.

Further Confusion: BDSM or Abuse?

While consent to certain sadomasochistic activities is constrained by laws, there are times when an abuser hides behind the label of BDSM, further conflating the notions of BDSM and abuse. This is suspected to be the case in the high-profile Jian Ghomeshi trial (Kingston, 2014).

Jian Ghomeshi, a formerly beloved Canadian Broadcasting Corporation (CBC) talk show host, claimed to have had consensual BDSM relationships after past partners started coming forward with allegations of abuse. Despite multiple complainants outlining sexually abusive and unwanted treatment, he evaded conviction. Some posit this escape is linked to stardom, outward charisma and popularity, and a culture of ignorance to warning signs, such as to reports of sexual harassment within the CBC, in favour of keeping ratings (Kingston, 2014). While no convictions were laid, the public opinion has ultimately become one of disdain for Ghomeshi, but his use of the "kinky defense" (Grinberg, 2014, para. 7) could serve to bolster confusion around BDSM as abuse.

Another example that illustrates this conflation is that of a repeat sex offender who attempted to divert the blame incurred from his actions onto a background of BDSM experimentation (R. v. S, 2011). The accused claimed that a BDSM lifestyle made him unable to define appropriate boundaries, which included those around pedophilia and sexual assault. While the courts saw through his attempt to hide abuse behind the label of BDSM, the lawyers involved in the case described this convolution as "understandable given this environment," (R. v. S, 2011, para. 11) and were concerned about his past behaviour including "his history of interest in the BDSM lifestyle" (R. v. S, 2011, para. 12) in addition to the crimes he was being tried for. Given the BDSM community's heavy emphasis on consent prior to an activity and the use of safewords to withdraw consent during the activity (Beres & Macdonald, 2015; Klement, Sagarin, & Lee, 2016; Newmahr, 2010a; Pitagora, 2013), it seems erroneous to conclude, as the lawyers' comments indicate, that a BDSM environment would breed abuse. Regardless of the justice, or lack thereof, in cases where perpetrators attempt to hide behind the label of BDSM, the legal-political discourse surrounding them perpetuates and reinforces the belief in criminal associations with kink, rather than helping to delineate between consensual kink and assault. While no community, including the BDSM community, is exempt from abuse, perpetuation of BDSM as inherently abusive further marginalizes participants of BDSM who have been abused and attempt to seek assistance (Pitagora, 2016a).

Contemporary Psychological Interpretations

Given the lack of a clear link between sadomasochistic desires, pathology, and criminality as well as the moral paradigm shifting increasingly towards an ethic of self-fulfillment (Rubin, 2010), the majority of current literature has adopted a different focus (e.g.,

Richters et al., 2008). This section will discuss contemporary scholarly work which dispels some popular misconceptions about BDSM, reviews the work done on understanding the experiences of BDSM practitioners, draws attention to some of the ways in which BDSM remains contentious, and reviews the available literature on mental health care provider's perspectives on BDSM. This section will conclude with a rationale for the current study.

Non-Pathologizing Research Findings

Today, there is still a large body of work devoted to determining the relative psychological standing of BDSMers to control participants (e.g., Richters, De Visser, Rissel, Grulich, & Smith, 2008), however, these studies often set out with an openness towards providing evidence for the depathologization of BDSM, rather explicitly trying to find evidence of pathology.

Functioning of BDSM practitioners. One such study examining the relative psychological functioning of kinky populations was conducted by Richters, de Visser, Rissel, Grulich, and Smith (2008). Richters and colleagues conducted telephone interviews designed to collect self-report demographic, behavioural, and psychosocial information from a representative sample of nearly twenty thousand Australian adults. They found that 1 to 2 percent of people were involved in BDSM during the last year and that those people had experienced a wider array of sexual activities than the general population, for example, the use of toys or non-genital sex. They also found that, contrary to previously popular opinions, involvement in BDSM was not related to a variety of often purported psychological ills. Namely, participating in BDSM was not linked to having experienced past abuse, to unhappiness, anxiety, nor sexual dysfunction. Overall, their results corroborated the notion that BDSM behaviours, while participated in by a minority, exist on a spectrum of functional sexual activity. Indeed, other current studies indicate a favourable psychological profile of kinksters.

Another current large scale study of demographic and psychosocial information is consistent with the idea of kink as an activity engaged in by functioning individuals. Wismeijer and Van Assen (2013) collected personality, attachment style, rejection sensitivity, and subjective well-being ratings from 902 BDSMers and 434 control persons. In comparison to non-practitioners, BDSM practitioners have higher levels of communication skills, openness to experience, extraversion, subjective wellbeing, and less neuroticism. Overall, these recent studies

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stand in opposition to some historically rooted beliefs and myths that BDSM practice is the result of abuse and mental instability.

Sizeable prevalence of BDSM. The *unusualness* and *rarity* which has often been attributed to SM, as a paraphilic diagnosis (APA, 2013) and as a symptom of criminality (Aylwin et al., 2005), has also been challenged by current findings. Statistically speaking, some authors have found that 65% of women fantasized about being dominated, 52% fantasized about being tied up, and 36% fantasized about being whipped and spanked (Joyal, et al.,2015). Similar proportions of men also reported these sexual fantasies, however with a higher desire of dominating rather than being dominated. Although most women fantasized about submitting, about half did not wish for their fantasy to occur in real life. This pattern is similar to the pattern of occurrence for forceful sex, or rape, fantasies. About half of men and half or more of women fantasize about being forced to submit sexually to an aggressive lover, however it should be noted that this fantasy does not reflect the desire for *actual* rape (Hawley & Hensley, 2009; Strassberg, & Locker, 1998). This large proportion of people reporting BDSM type fantasies in Joyal and colleagues' (2015) study was discrepant from the smaller proportion of people, about 1 to 2 percent, that had reported partaking in BDSM activities in Richters and colleagues' (2008) study. This can be attributed to at least a few reasons; firstly, that fantasy is separate from the desire for that fantasy to materialize, secondly, that Richters and colleagues defined their BDSM group as those participating in the past year, likely underrepresenting the lifetime occurrence of BDSM practitioners, and thirdly, that not all people who participate in bondage, dominance, submission, and sadomasochistic activities identify themselves with BDSM (e.g., Plante, 2006). Overall these findings suggest that BDSM type desires - whether acted upon or identified as such- are far from uncommon and should not, in and of themselves, be treated as a sign of pathology or criminal tendencies.

Consent differentiates BDSM from abuse. As counterintuitive as it may seem to some, BDSM is, in fact, generally not connected to assault, but rather, to a strong adherence to consent obtainment. Traditionally, consent in heteronormative vanilla, or traditional mainstream, relationships is assumed rather than clearly asserted (Beres & Macdonald, 2015; Pitagora, 2013). The trend in BDSM culture stands in contrast to the assumption of sexual willingness, instead relying on the practice of clearly communicating desire and consent (Beres & Macdonald, 2015; Connolly, 2006; Taylor & Ussher, 2001). Processes such as pre-negotiating activities and the use

of safe words, used to withdraw consent during activities, are of paramount importance in BDSM interactions and distinguish consensual kink from abuse (Taylor & Ussher, 2001). Indeed, BDSMers construct a definition of their activities based in large part on mutuality and may ostracize those who violate others' consent (Beres & MacDonald, 2015; Cross & Matheson, 2006; Taylor & Ussher, 2001). For the heterosexual women interviewed in one study, the emphasis placed on consent obtainment in BDSM-oriented relationships provided a refreshing contrast to the lack of emphasis on explicit consent that they experienced in their previous vanilla relationships (Beres & MacDonald, 2015). Furthermore, the popular slogans *Safe, Sane, Consensual* (SSC; e.g., Pitagora, 2013) and *Risk Aware Consensual Kink* (RACK; e.g., Pitagora, 2013) stand as testaments to the importance given to consent in BDSM. Contrary to the popular misconception that any aggressive sexual acts are abusive and pathological, the general aura of the BDSM community is one which endorses consensuality and assertiveness.

Congruent with the valuation of consent, participating in BDSM is also linked to feminist beliefs. BDSM practitioners report significantly lower endorsement of benevolent sexism, rape myth acceptance, and victim blaming than adults in college and the general public (Klement, Sagarin, & Lee, 2016). Moreover, in women, being more sexually liberal, more sexually desirous, having less guilt about sex, and feeling more dominant and powerful is related to engaging in forced sex fantasies (Hawley & Hensley, 2009; Shulman & Horne, 2006). Indeed, it takes assertiveness for a female to break gender stereotypes and ask for erotic activities which are considered non-normative or dangerous (Dymock, 2012). On the whole, BDSM is often an arena for women to assert their desires and have them be respected; something that has not traditionally occurred in mainstream sexual practices. While there is evidence to suggest that BDSMers are functioning in their lives and obtain the consent of their partners, kink-negativity remains.

Remaining Kink-Negativity in Society, Psychology, and the DSM-V

Given that mental health professionals are part of a larger society, and therefore impacted by the prevailing social mores (e.g., Barker, 2007), attention to the norms and attitudes of contemporary popular culture is warranted (e.g., Weiss, 2006). Although BDSM has gained limited acceptance as a valid expression of desire in theory (e.g., Kelsey et al., 2013), its visage in the general population remains widely misunderstood (e.g., Weiss, 2006). Despite piquing public interest, BDSM-themed media is consumed as an exotic and distanced phenomenon

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(Weiss, 2006). Moreover, people who self-identified as "mainstream" (Stockwell, et al., 2010, p. 307), or not interested in BDSM, showed negative reactions to indicators of BDSM on an implicit measure of attitudes (Stockwell et al., 2010). From Weiss' (2006) perspective, BDSM is only accepted as something emotionally disturbed people do within an otherwise conventional sexuality; that is, a heteronormative, monogamous, and marriage-focused relationship. According to Weiss, this conditional and distanced reception does nothing to dismantle stereotypes regarding BDSM and actually further perpetuates hegemonic sexual norms. Since the general populous reacts both with intrigue and negativity, it is probable that some or many mental health professionals react in a similar way. Indeed, it appears that myths which alternate back and forth between professional and lay understandings, still circulate amongst some mental health care providers (e.g., Kelsey et al., 2013; Nichols, 2006).

   Misconceptions and misinterpretations. Some common misconceptions about BDSM that persist in mental health professions, despite contrary evidence, are described by Nichols (2006). Namely, BDSM can be misunderstood by professionals as abusive, exploitative, primarily about physical pain, addictive, self-destructive, a pathological result of past abuse, an avoidance of intimacy, and practiced separately from vanilla sex. For psychotherapists whose work is informed by these stereotypes, this can translate into countertransference issues such as revulsion and disgust in response to kinky clients. This kind of environment in mental health professionals' offices results in clients feeling the need for secrecy and concealment (Kolmes et al., 2006; Nichols, 2006).

   This is not always unwarranted caution, as there remains much discourse surrounding BDSM as a disordered set of behaviours in psychologically related fields. Both Sexual Sadism Disorder and Sexual Masochism Disorder currently reside in the "Paraphilic Disorders" section of the DSM -V. A paraphilia can be defined as "any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" (APA, 2013, p. 685). In this case, the paraphilic urge would either be arousal from the physical or psychological suffering of another person, in sadism, or the suffering of oneself through beating, binding, or humiliation in masochism. A paraphilia, however, is not considered a paraphilic *disorder* until the fantasies, urges, or behaviours have become "intense," (APA, 2013, p. 685), measured as greater than "normophilic" (APA, 2013, p. 685) sexual interests, or the search of satisfaction entails "personal harm or risk

of harm to others" (APA, 2013, p. 685), such as, in the case of sadism, acting without consent. Overall, the APA's (2013) continued valuation of normophilic, genital, procreative sex has perpetuated biases and prejudgments which have led to a reliance on non-evidence based reasoning in the diagnostic criteria for disorders of Sadism and Masochism.

Because of this reasoning, the DSM definitions, by design, can present a danger of over-diagnosis of functional kinksters. Firstly, the a. criterion, of "intense" (APA, 2013, p. 685) sadomasochistic desires, or those which outweigh normophilic desires, is flawed in the assumption that BDSM is both undesirable or deviant as well as is rare or unusual. This valuation of SM has clear roots in the teleological understanding of sex which, as Stewart (2012) noted, is philosophically a "perfectionist account of normophilic sexual desire" (para. 6) rather than descriptive of real behaviours. Indeed, the rarity of SM has been disproved by evidence showing that these desires are quite widespread (e.g., Joyal et al., 2015). Although criterion a. is only sufficient for a paraphilia, not yet a paraphilic *disorder,* even this classification of SM as an abnormal sexual desire begets more stigma. Secondly, the b. criterion of clinically significant distress in social, occupational, or other areas of functioning seems oblivious of social climate. In a climate of secrecy, shame, and misconceptions about BDSM, the social, occupational, and personal distress due to stigma make this criterion of "personal harm" (APA, 2013 p. 685) an inevitable consequence for at least some BDSM practitioners who have internalized this interpretation of themselves. Thus, these current paraphilic diagnoses are something akin to yesteryear's diagnosis of ego dystonic homosexuality (Nichols, 2006). Thirdly, the inclusion of non-consent as a potential aspect of the b. criterion for Sexual Sadism Disorder, both perpetuates the notion that SM is done as a violence and conflates criminality with (purported) sexual deviancy. This failure to acknowledge current research and social stigma has consequences for the application of the diagnoses, including overpathologizing, or just plain pathologizing, kink practitioners.

BDSM normalization and the pleasure-pain dichotomy. In response to the pathologizing tone of the DSM and popular myths about BDSM, a depathologizing discourse has begun to form. BDSM activities are often constructed as quite understandable from a mainstream perspective. Some reasons outlined for participating in these activities are that it is simply fun, mutually pleasurable, and they keep sex interesting beyond the usual sexual acts (Hébert, & Weaver, 2015; Nichols, 2006). Some participate in BDSM for the emotional release, confidence

boosting effects, and for psychological healing (Hébert, & Weaver, 2014; Hébert, & Weaver, 2015; Lindemann, 2011; Newmahr, 2010b; Nichols, 2006). Relationally, engaging in BDSM is also said to enhance intimacy, communication, and trust, even for those in asexual partnerships (Hébert, & Weaver, 2015; Nichols, 2006; Sloan; 2015). Moreover, some people find BDSM to be a spiritual experience (Nichols, 2006). As researchers and counsellors paid attention to the phenomenology of BDSM, the fulfillment of physical, emotional, relational, and spiritual needs came to be understood as a common ground between alternative and mainstream sexualities and sensualities.

This functions in the current psychological literature as a normalizing interpretation of kink. However, as Weiss (2006) highlighted, "by offering acceptance or understanding only insofar as BDSM sexuality conforms to the ideological categories of normal/not-SM or not normal/pathological SM, these representations do not challenge the systems of privilege and power currently governing sexuality" (p. 120). This type of acceptance discourse runs the risk of creating a *good BDSM citizen*, like the "good gay citizen" (Allison, 2000 p. 2) who is often constructed using notions of masculinity that reinforce the current patriarchal hierarchy, rather than challenging it. Indeed, the negotiation of BDSMers as acceptable has also *relied on the dominant discourse* of pleasure and sexuality precisely to defend itself *from the dominant discourse* of pleasure and sexuality.

While kink is becoming somewhat acceptable as an activity or lifestyle from some academic perspectives, it is being normalized and made acceptable in a way that still reinforces widely recognizable, life-affirming pleasure. As Dymock (2012) noted, desiring pain for pain's sake represents the ultimate infringement on procreation, because any threat to a parent's life during sex affronts the purpose of that, ostensibly, reproductive act. Here Dymock associates the desire for pain with a potential threat to life, rendering such desire as a doorway to self-destruction. While dominance and submission themes are becoming more accepted in psychological literature, pain is still somewhat of a taboo in the psychological community (Garrott, 2008), although it is often used by BDSMers in a context of power exchange (Newmahr, 2010). To some extent, this understanding of pain as inherently negative is even present within the BDSM community itself (Newmahr, 2010a).

One study looking at the ways in which those who use pain play understood pain revealed that many constructed pain as something still inherently negative (Newmahr, 2010a).

Newmahr (2010a) entered a sadomasochistic community in the United States as an ethnographic researcher, attending workshops, parties, socials, political events, and even participating in BDSM scenes. During this time, she collected field notes and, after establishing herself in the community, conducted interviews with BDSMers from this club. The interviews focused on the participants' life history as well as on BDSM-related topics. She found that although participants talked about their identities in terms of power exchange, for example *tops*, *bottoms*, or *switches*, as opposed to *sadists* and *masochists,* pain also had a central role in many BDSM scenes. For these participants, pain was firmly anchored in the social context of power and the carnal experience of pain was used to reinforce and add authenticity to the power dynamic. Newmahr gives the example of spilling blood in a cutting scene; she interprets this painful activity as "[testifying] to [the top's] ability and willingness to wound [the bottom], and to his mortality," (Newmahr, 2010a, p. 396). Although pain is clearly embraced as one essential aspect of consensual power exchange in this community, the experience of it was navigated in varying ways, many of which utilized an understanding of pain that is hegemonically pain-avoidant.

Namely, pain was often not actually described as a painful experience by BDSMers, but instead, was negotiated as something else (Newmarh, 2010a). The first understanding of pain described by Newmahr (2010a) was that it was transformed into or perceived as a pleasurable sensation. The second and third constructions of pain were that it was either something to endure as a sacrifice to a partner, or to endure for a sense of personal accomplishment. Similar to sports endurance, the pain is a necessary evil in order to achieve some other aim. While the first construction sidesteps the notion of pain altogether, the second and third constructions suggest a view of hurting as something to put up with rather than to enjoy. The fourth, and most transgressive, understanding of pain was endorsed by only a minority of pain players who held a view of pain such that it was pleasurable *as a painful* experience. She termed these four categories "transformed pain," "sacrificial pain," "investment pain," and "autotelic pain" (Newmahr, 2010a, p. 397). Essentially, even when pain is an integral component to BDSM play, it is more often discursively negotiated in relation to power, rather than as an embodied sensation. Newmahr attributes this resistance to pain as a reflection of the wider societal conception of pain as a negative, medicalized, pathologized experience, such that the power exchange often accompanying pain is given privilege over the experience of receiving or inflicting pain.

Another example of kink players distancing themselves from the association of pain can be found in a study focused on a group devoted to sexual spanking, an activity which is often construed as a type of BDSM play and as an activity that may hurt. Plante (2006) found that this group of "spanking purist[s]" (p. 76) strove to differentiate themselves from a desire for pain and the *real* sadomasochists. Plante interpreted this groups' constructions as an effort to distance themselves from the stigma of BDSM and normalize their spanking activities.

Essentially, BDSM normalization within both professional and kink circles often still draws from the very foundations that were once used to condemn kink: the dichotomy of good and bad (Dymock, 2012). Normalizing efforts now position healthy BDSM on the *right* side of the health-sickness, morality-criminality, and pleasure-pain dichotomies rather than transgressing these dichotomies entirely. Given the prevalence of this notion in psychological discourse and ethics, it is, admittedly, effectively reproduced in much of the above literature review, although not unproblematically. Regardless of some formation of normalizing and de-pathologizing discourses, disclosure of one's interest in BDSM remains personally and politically charged.

BDSM disclosure remains formidable. While some BDSMers prefer to keep their kink secretive as a way to enhance their sense of subcultural identity (Stiles & Clark, 2011), many people who would like to disclose feel that it is fraught with stigma and discrimination, in both a general and therapeutic context. In a general context, many BDSM practitioners believe they need to conceal their identity to all but a select group of people in order to protect themselves and those that they love (Stiles & Clark, 2011). Similarly, in a therapeutic context, a sizable proportion of psychotherapy clients are fearful of disclosing their BDSM practice to their counsellor (e.g., Hoff & Sprott, 2009). Although many BDSM clients bring unrelated issues to therapy (e.g., Nichols, 2006), the fear of judgement and internalized shame pose very real risks to not only the therapeutic relationship but also the client (Kolmes, et al., 2006; Nichols, 2006). Indeed, although many clients do end up disclosing their involvement in BDSM to their counsellor or psychotherapist, regardless of its relation to presenting concerns (Kolmes, et al., 2006), their reluctance to disclose is well founded in the very tangible impact that discrimination can have.

People who disclose their BDSM practice can face consequences in all aspects of their lives (e.g., Bezreh, et al., 2012; Hoff & Sprott, 2009; Klein & Moser, 2006; Nichols, 2006). There are the looming possibilities of social rejection from family, friends, partners, or

workplaces (Bezreh, et al., 2012; Nichols, 2006), biased custody battles or abuse allegations (Klein & Moser, 2006), judgement from one's psychotherapist (Bezreh, et al., 2012; Hoff & Sprott, 2009; Kolmes, 2006), having to educate one's psychotherapist (Kolmes, et al., 2006), feeling the need to terminate therapy (Kolmes, et al., 2006), or even having therapy terminated for them solely due to the outcome of their BDSM disclosure (Kolmes, et al., 2006). While keeping one's BDSM participation a secret can vary from a positive to negative experience (Stiles & Clark, 2011), it is clear that fear and apprehension surrounding disclosure are very real to some BDSMers.

Psychotherapists' Reactions to Kinky Clients: Apprehension… And Acceptance?

The few recent studies investigating psychotherapists' views of BDSM lend some credence to the findings of clients' fears about disclosure (e.g., Garrott, 2008). Specifically, even while well-meaning, psychotherapists are often uncertain about how to interpret BDSM behaviours (Kelsey, et al., 2013). Those unfamiliar or uncomfortable with BDSM seem to face more challenges, such as value conflicts and countertransference (e.g., Garrott, 2008; Nichols, 2006), while working with this population than those who are more experienced and at ease (e.g., Garrott, 2008; Lawrence & Love-Crowell, 2008). Indeed, some professionals who are comfortable working with a BDSM population express concern over their clients' stories about previous therapists being unaccepting or judgmental (Garrott, 2008; Lawrence & Love-Crowell, 2008). Studies that elicit information from both inexperienced and kink-aware professionals confirm that clients face stigma that extends from the greater society (e.g., Stockwell, et al., 2010) and into the therapeutic realm (e.g., Garrott, 2008; Kelsey et al., 2013).

Desire and need for education. Although many counsellors serve kinky clients, not all feel prepared to take on work with this population. Kelsey and colleagues (2013) conducted an anonymous, quantitative internet survey asking a general population of licensed mental health professionals about their attitudes towards BDSM. Seven hundred and sixty-six professionals responded to questions eliciting their own demographic data and the opinions they hold in terms of the healthiness of BDSM, associated problems, beliefs about the people who practice it, and treatment planning implications. Results indicated that, while 76% of counsellors had treated a client who participated in BDSM, only 48% felt equipped to work with such clients. The general trend was towards a growing acceptance of BDSM, with 67% of professionals endorsing the thought that BDSM can be part of a healthy long-term relationship and 70% disagreeing that

BDSM interests should be eliminated through therapy. Kelsey and colleagues concluded that, counter to the anticipated widely held pathologizing attitudes, as reflected in such studies as Kolmes and colleagues' (2006), "the majority of clinicians did not universally equate these unconventional activities with individual psychopathology or dysfunctional relationships" (Kelsey, et al., 2013, p. 262). However, about 20% to 50% of psychotherapists were still unsure about whether BDSM could be a part of a healthy relationship, whether to target the BDSM behaviours for treatment, and whether it could be conducted by someone who was mentally healthy. While Kelsey and colleagues did acknowledge a need for better counsellor education, the implication of their conclusion – that the majority of clinicians did not outright condemn BDSM as pathological and therefore the outlook is optimistic - presents as somewhat premature considering the large proportion of counsellors displaying uncertainty. This proportion of counsellors who were unsure about how to respond, or who responded disapprovingly, leaves clients at a high likelihood of encountering unethical care.

Moreover, there may be differences between clinicians' endorsements of generic statements, such as "sexual masochism can be practised in healthy ways" (Kelsey et al., 2013, p. 260) and their understandings as applied to real clinical cases. Although a counsellor may endorse such a statement (in fact, 52% and 13% of Kelsey and colleagues' participants agreed and strongly agreed, respectively), it remains uncertain what exactly clinicians consider to be healthy masochism, as well as how that conceptualization impacts their reaction to and treatment of real clients. Indeed, while the counsellors in Garrott's (2008) study rated numerically that they held liberal attitudes towards sex, in discussion of sexuality, they displayed more discomfort and avoidance. The level of clinicians' comfort with and understanding of masochism (and BDSM more generally) is left uncertain, especially given that only 48% of Kelsey and colleagues' clinicians felt they were competent in this area. In essence, although many counsellors may hold ideals that are permitting of BDSM, they may or may not have the skills that allow them to act accordingly. Given that most psychotherapists were generally open to the possibility that BDSM could be healthy, it is likely that most do not maliciously attack their kinky clients, but instead are unaware of and unfamiliar with BDSM culture and the misjudgments they make in therapy with them.

Many other authors have also noted the need for self-reflection and confrontation of biases in their suggestions for working with kinky clients to prevent personal biases from

inhibiting therapy (Barker, 2005; Bettinger, 2003; Nichols, 2006). Indeed, psychotherapists who work with sexual minorities may not even know that they are committing microaggressions, or subtle forms of assault, insult, or invalidation (Shelton & Delgado-Romero, 2011). However, these subtle messages can cause clients to feel powerless, angry, manipulated, misunderstood, and like they have to hold back information about themselves in order to get help. Thus, microaggressive acts may be committed by well-meaning therapists, but regardless of intention, may have a negative impact on therapy.

Indeed, the microaggressions committed by counsellors working with the BDSM population are similar to those in lesbian, gay, and bisexual (LGB; Shelton et al., 2011) populations. Some examples of microaggressions experienced by LGB therapy clients include the counsellor assuming that the client's sexual orientation is a cause of the problem, making stereotypical assumptions, expressing heteronormative bias, and assuming that LGB people need psychotherapy (Shelton et al., 2011). Similarly, Kolmes and colleagues' (2006) internet survey indicated that both BDSM-identified psychotherapy clients and psychotherapists believed behaviours such as considering BDSM to be unhealthy and requiring the client to give it up for therapy, assuming an interest in BDSM was a result of past abuse, and asking - or needing - the client to exclusively educate them would be harmful to clients. The general trends between these two sexual minority groups are centered on counsellor stereotyping, adoption of a normophilic bias, and believing the client's sexuality is to be remediated. Even if well-intentioned, given the uncertainty of some psychotherapists working with kinky clients (e.g., Kelsey et al., 2013), a lack of knowledge and awareness of on the part of the psychotherapists seems to be a plausible contributor towards kinky clients reports of dissatisfaction with psychotherapists (e.g., Kolmes at al., 2006).

Competence. The importance of obtaining cultural competence and openness is a theme across more studies of therapists, as well as clients. Kolmes and colleagues (2006) surveyed both therapists and clients about therapy experiences. While they described their therapist sample as too small to meaningfully interpret in detail, they did briefly discuss the views of the 17 general practice psychotherapists who did respond, although a detailed qualitative analysis was missed. These professionals indicated that they thought it would be helpful to clients to be well-informed about BDSM culture, avoiding the pitfall of assuming all kink is being used in a healthy way, being able to ask questions, normalizing towards kink while not focusing on it when

inappropriate, and being open minded. The clients surveyed suggested, similarly, that helpful therapist stances should be towards normalization, helping the clients in overcoming shame and stigma, reflecting upon their own values, and having a good knowledge and understanding of BDSM in order to discriminate healthy from unhealthy uses of the activities. Although broad thematic categories were produced in this study, they were not fleshed out with examples of participants' words, leading to an impoverished understanding of these categories. For example, the speech around what constitutes a healthy or unhealthy use of BDSM is not presented in detail. Overall, Kolmes and colleagues' (2006) findings contributed to the description of competent practice with clients and concurs with subsequent literature. Kink-aware therapists in a study two years later also noted that the usual presenting concerns of kinky clients were rarely directly related to BDSM, but instead were often surrounding the associated shame and guilt or co-existing mental health concerns (Lawrence & Love-Crowell, 2008). In sum, the crux of therapists' recounts of successful work with kinky clients is having knowledge of BDSM as a basis for critical judgement around issues of diagnosis, treatment, and boundaries.

While it seems that most therapists who feel success navigating work with BDSM-identified clients do so through activities basic to competent practice, for psychotherapists who are biased or do not have a knowledge base about BDSM to draw from, this process may become complicated. Indeed, the psychotherapists in Garrott's (2008) study who were more comfortable with BDSM reported better rapport with their kinky clients than those who were uncomfortable. And the kink-aware, expert psychotherapists in Lawrence and Love-Crowell's (2008) study felt better prepared to handle situations in which they had to use discerning judgement about BDSM activities. Namely, they did not believe they had difficulty teasing apart BDSM from abusive relationships, however, they postulated that those clinicians who are unfamiliar with BDSM may have trouble discerning the two. It seems very likely that clinicians new to or uncomfortable working with this population may have difficulty relating to clients and teasing apart abuse from play.

Variable constructions of harm. Another particular notion that seems to be a direct link to therapist uncertainty when interpreting BDSM behaviours is that of harm. Specifically, self-harm has, for some professionals, become an extremely generalized concept to include any "socially unacceptable, intentional alteration or destruction of body tissue without conscious suicidal intent" (Croyle & Waltz, 2007, p. 332). This definition of self-harm can include acts

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such as nail or scab picking (Croyle & Waltz, 2007) and could easily translate into many BDSM behaviours becoming classified as self-harm, simply by virtue of social stigma. Moreover, some have conceptualized self-harm as also composed of actions which are done in a "self-punishing way" (Turp, 1999, p. 318), regardless of whether they are generally culturally acceptable (Turp, 2002). For Turp (2002), imperfect but normal self-care rests on the opposite side of a spectrum of self-harm. Turp (2002) also posited that these activities need not be active, such as cutting, but may also be made by omissions of self-care activities, such as by failing to seek medical help. The self-harm, or possibly self-punishment, referred to by Turp (1999, 2002) is always described as an act done (or omitted) towards the body, for example, flagellation, body piercing, smoking, too much or too little exercise, overworking oneself to exhaustion (Turp, 2002). Thus, self-harm can essentially be taken to mean any kind of bodily tissue interference, situated in the context of one's intent, at either the behest of one's own action, or inaction.

This all-inclusive definition of self-harm as defined by bodily tissue destruction, especially culturally unsanctioned destruction of body tissue, is in keeping with the legalistic and moralistic values forbidding socially undesirable permanent tissue damage (Criminal Code, 1985; Green, 2001; R. v. R.D.W., 2006). Indeed, the notion of self-harm is intertwined with ethical mores; the current clinical perspective on self-harming behaviours described by Florides (2015) as a "moral panic" (p. 133). This way of conceptualizing self-harm is of special concern in the therapeutic context as it couches almost any alteration of body tissue into a category of behaviours which are easily pathologized and, thus, ethically concerning to mental health care professionals.

Given these interpretations of self-harm, it is left unclear whether self-harm denotes simply unsanctioned tissue destruction without an intent to self-destruct, or whether the function of the behaviour within the person's relation to the self is taken into account. For counsellors, implementing the definitions of self-harm available may prove to be perplexing when bodily safety is, or is *seemingly*, placed in danger or disregard. Combined with the persistent myth that BDSM is self-destructive (Nichols, 2006), this notion of harm as constituting destruction of bodily tissue likely interacts with and complicates some psychotherapists' interpretations of BDSM.

Indeed, there is evidence of this struggle in counsellors' differing perspectives of BDSM. In a study looking at how counsellors' values and beliefs about sexuality influenced work with

BDSM-identified clients, Garrott (2008) interviewed and surveyed ten counsellors of varying training backgrounds. This sample was comprised of psychologists, social workers, and interns of the same disciplines in Massachusetts who had previously worked with BDSM-identified clients. Participants were interviewed and surveyed regarding their values, views of BDSM, and views of sexuality in general. Overall, the major theme generated in response to working with kinky clients was in their desire to prevent harm while remaining value-neutral. While the sample adopted a generally sexually liberal stance in terms of their values, their views of BDSM were rated as less liberal (Garrott, 2008). The majority of the sample was generally rejecting of blatantly pathologizing theories of sadomasochism, for example, "a sexual sadist is also likely to be violent in non-sexual contexts" (Garrott, 2008, p. 75). However, given that the sample was so liberal and, as Garrott notes, comfortable with participating in her study due to either relational proximity with the researcher or knowledge about the topic of study, a further investigation of a wider array of counsellors' beliefs is warranted. The current study aimed to fill this gap by reaching participants anonymously, so that more conservative members of counselling professions can feel comfortable coming forward with their opinions.

Although some of the psychotherapists in Garrott's (2008) study also adopted a liberal stance towards painful BDSM behaviours, a proportion of these otherwise generally sexually liberal counsellors displayed some level of difficulty accepting that others may participate in these activities healthily (Garrott, 2008). This was especially the case for activities that were painful, rather than some of the "lighter… kind of erotic" (Garrott, 2008, p. 78) BDSM play. In fact, one participant who was particularly disquieted by the idea, even used the terms "self-harm" and "self-injury" (Garrot, 2008, p. 78) to describe painful BDSM activities. Another participant also described her interpretation of actions that risked pain or potential injury as "almost traumatizing" (Garrott, 2008, p. 78). It is evident that a sizable minority of counsellors encountered strong emotional reactions to BDSMers and their activities that were linked to the value of harm prevention.

Navigating cases that inspired these value conflicts presented the counsellors with challenges to overcome. Many of the counsellors in Garrott's study (2008) noted that consultation was a resource in these cases of value conflict, both helping them to gain a better understanding of BDSM and of their own values. However, some of the counsellors in this sample either did not feel that other professionals would be knowledgeable enough to consult

with or found that their supervisors were not willing to engage in case consultation around topics related to BDSM. Some of the counsellors also had not engaged in much case research of their own due to various reasons, such as a perception that they knew enough to work with the client or a lack of readily available, appropriate resources. Garrott noted that the literature contains some support for either a pathologizing or depathologizing view of BDSM, and therefore clinicians are left to make their own judgements about it. Indeed, her participants often felt isolated in navigating these cases and when counsellors could engage in consultation or find other appropriate resources to consult, it was helpful to them. Clearly, these psychotherapists faced challenges in unpacking cultural notions of harm and of sexuality, but when they were able to, they perceived working more effectively with BDSM-identified clients.

However, while many of these psychotherapists were increasingly comfortable with the dominance and submission aspect of BDSM, a proportion of therapists remained quite uneasy when faced with pain (Garrott, 2008). Both the psychotherapists who were most uncomfortable and comfortable with the idea of pain held the value of harm prevention, but expressed this value in different ways (Garrott, 2008). Those who were uncomfortable with pain seemed to equate the prevention of harm to the prevention of physical harm and the enactment of healthy BDSM to the intactness of tissue, thereby rendering the lighter kinds of play more palatable to them. The psychotherapists who were more comfortable with BDSM activities, however, held a more nuanced view of harm. While still endorsing the value of harm prevention and health maintenance, the BDSM-comfortable psychotherapists were less concerned with the intensity of play and more with such things as how the BDSM play functioned in the clients' life and how stigma could shame clients and hinder their self-acceptance. Therefore, these therapists were less concerned with the level of pain used in the play and more focused on the functioning of it in their life. They were more likely to see intense play as requiring proper education in order to control risk rather than eradication in order to prevent any possible risk. The comfortable psychotherapists also noted their concern for others in the field whom they have seen pass judgement towards sexual minorities, suggesting either that the prejudgment of kinky clients may be more endemic than represented in research samples, or that the behaviour they see in a minority of fellow counsellors is simply of notable concern to them (Garrott, 2008).

Another study that solicited the perspectives of counsellors who were knowledgeable in working with a BDSM population, evinced a similar view on intensity of play. Lawrence and

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Love-Crowell (2008) conducted a qualitative investigation of the experiences of psychotherapists who had worked with kinky clients. Similar to the more nuanced views of harm in the context of BDSM reported by the comfortable counsellors in Garrott's (2008) study, the kink-aware professionals interviewed by Lawrence and Love-Crowell (2008) did not often feel a need to be concerned for the safety of BDSM-practicing clients. This stands in contrast to the views of the kink-uncomfortable counsellors in Garrott's (2008) study. In fact, these experienced psychotherapists stated that countertransference issues surrounding sex and power were akin to any other therapeutic work, suggesting that work with kinky clients felt quite similar to work with any other clients. It is possible that their decreased alarm and increased comfort is due to both their experience in working with multitudes of kinky clients as well as personal experience, as many of the professionals in Lawrence and Love-Crowell's (2008) sample identified as part of the BDSM community. Congruent to the kink-comfortable therapists in Garrott's (2008) study, the themes that the psychotherapists in Lawrence and Love-Crowell's (2008) sample brought up around working successfully with kinky clients were to obtain comfort with the topics and cultural competence through a variety of means, including education, consultation, and experience.

Given that novice therapists trended towards a simplistic delineation of harmful BDSM play as marked by tissue destruction (Garrott, 2008), it follows that clinicians naive to or repulsed by BDSM may struggle to differentiate bodily harm from bodily play. Thus, unlike previous studies (e.g., Garrot, 2008; Lawrence & Love-Crowell, 2008), the current study will include in its purview the opinions of counsellors who have not yet worked with clients who participate in BDSM. This should be a useful addition to the literature given that 76% of counsellors report working with a kinky client (Kelsey, et al., 2013) and it is likely that those who have not yet worked with these clients will eventually encounter them. Psychotherapists' understandings of bodily harm are an especially important aspect of working with BDSM clients, given the moral and legalistic circumscriptions, and accompanying ethical obligations, which carry the possibility to induce harm reporting and outing the client.

Summary and Rationale

Due to the perpetuation of historical understandings claiming inherent pathology, criminality, and immorality in those who breech sexual norms by participating in BDSM practices, people who practice such continue to encounter stigma and discrimination (e.g.,

Kolmes et al., 2006). While investigations of clients' experiences in psychotherapy have indicated a need for more responsive care from some mental health care providers (e.g., Kolmes et al., 2006), very few investigations have examined psychotherapists' understandings of these encounters (e.g., Garrott, 2008; Kelsey et al., 2013; Lawrence & Love-Crowell, 2008). Those studies that have investigated psychotherapists' understandings of BDSM-identified clients have shown some empathic and culturally sensitive responses to kinky clients; however, inadequate care and therapist misunderstandings still exist (Bettinger, 2003; Garrott, 2008; Kolmes et al., 2006; Nichols, 2006). Many counsellors will encounter clients who participate in BDSM, regardless of their preparedness to work with them (Kelsey et al., 2013). Given that those unfamiliar with BDSM are more likely to feel underprepared to work with these clients- and possibly to provide inappropriate care to them (Garrott, 2008) - a fuller understanding of their concepts about BDSM play is warranted in order to tailor appropriate counsellor-training. Therefore, this study sought participation from counsellors with a variety of experience, including those who have not yet worked with BDSM clients.

One area that remains an especially significant potential ethical challenge for mental health counsellors is that of pain play. Pain play seems to be a point of personal and ethical importance to many psychotherapists (Garrott, 2008). Mental health professionals must balance considerations of value neutrality with prevention of harm, meanings of which can vary (Garrott, 2008). While these are both admirable goals, due to the serious consequences of misjudging or misconstruing harm to a client in a BDSM context, even if well-intentioned, it is important to further investigate psychotherapists' understandings of harm in the context of BDSM pain play.

Pillai-Friedman and colleagues (2015) noted that while most professionals who deal with sexuality are open minded and eager to help, desiring to be helpful is simply not enough preparation to work with topics which are rife with taboos, such as kink. Many authors advocate for the development of specific training programs and guidelines for kink-awareness (Barker, 2005; Bezreh, et al., 2012; Ford & Hendrick, 2003; Kolmes, Stock, & Moser, 2006; Pillai-Friedman, et al., 2015). Indeed, there is evidence of openness in counsellors, but, even so, it is coupled with uncertainty and apprehension (e.g., Kelsey et al., 2013). In order to support the creation and delivery of such guidelines and training programs, it is necessary to build on previous studies which have opened up the discussion about mental health professionals' understandings of clients' use of pain in BDSM.

This study will add to the budding literature describing mental health professionals' understandings of kinky clients. Most notably, it will build upon Garrott's (2008) findings regarding psychotherapists' value conflict between harm prevention and preserving client autonomy in BDSM. Garrott noted that her participants were reluctant to talk about specific sexual activities, often referring to them in vague terms. Garrott also noted that many counsellors who participated in her study already felt comfortable with the subject matter and so she recommended that an online study be used to reach counsellors with more diverse attitudes towards BDSM. This study will heed Garrott's (2008) advice to improve upon her methodology by recruiting counsellors online. Additionally, it will prompt participants with vignettes, which should also improve upon the previous methodologies used in that it will provide an ease of discussion for participants and elicit their reasoning about more specific activities; to help ascertain what activities and circumstances are understood as destructive of body tissue or life functioning. It will also pay special attention to the some of the heavier types of play, which are most liable to be labeled problematic (Garrott, 2008). By utilizing vignettes that may stress counsellors' delineations of harm and ethical practice, it is hoped that this study will spark further conversations about harm and steer this discussion towards their understandings of harm reporting in this context. Thus, the primary focus of this study was to investigate personal and professional understanding of clients' actions which may be viewed as painful and/or harmful. The main research question guiding this inquiry was how do psychotherapists understand *harm* and *serious reportable harm* in the context of clients' BDSM pain play? The findings from this research will contribute to the growing literature on counselling sexual minority clients as well as potentially impact psychotherapist training programs and ethical guidelines.

CHAPTER THREE: METHODOLOGY

This chapter summarizes my rationale for using qualitative inquiry, my role as a researcher, and how I used thematic analysis to analyze the data. This section also outlines who the participants were, how they were recruited, and how their data were generated.

Qualitative Inquiry

Qualitative methodologies are suitable for describing people's experiences as they can be illustrated through language or other human artifacts (Polkinghorne, 2005). Through a conduit of communication, which is usually language, a qualitative researcher aims to enter the lifeworld of a study's participants (Polkinghorne, 2005). A researcher aims to understand how participants make sense of, give meaning to, live, undergo, and accomplish the experiences of their particular lifeworlds (Polkinghorne, 2005). In the current study, I aimed to gain access to the lifeworlds of mental health professionals as they made sense of BDSM-identified clients who engage in painful activities as well as their instincts regarding the conceptualization of and ethical decision-making for such clients.

Paradigm

A paradigm is a basic set of assumptions, or theoretical framework, that informs a study and a researcher's actions within that study (Guba & Lincoln, 1994; Morrow, 2007). Essentially, a paradigm is one of many lenses that may be chosen by a researcher to look through when interpreting data. The present research was informed by an interpretivist-constructivist paradigm which holds a relativist ontology (Guba & Lincoln, 1994; Morrow, 2007). That is, this paradigm holds that multiple realities are created, exist, and change through co-construction, or co-interpretation of experiences (Guba & Lincoln, 1994; Morrow, 2007). Given the interpretative ontology, a transactional and subjective epistemology follows (Guba & Lincoln, 1994). Transactional epistemology assumes that a researcher has their own reality and, as such, is also a part of the co-construction of the data explored in the study (Guba & Lincoln, 1994; Morrow, 2007); that narratives are generated in response to the research context and are not merely waiting to be found as artifacts are in an archeological dig. It is not the artifact or language itself that is under study, nor the participants words themselves, but the meaning that can be interpreted from the language left behind. This conveyance of meaning, from a participant through their words, requires a receiver to interpret and create their own meaning of the message. The interpretation of the present data was, therefore, a responsibility of myself as a researcher

and remains a responsibility of the current or future readers of the research report. The findings of a study can be interpreted as a co-creation, rather than a mirror image of experience (Morrow, 2007). Congruent with the selected paradigm, my own personal reality and biases were reflected upon throughout the research process, as recommended by Tobin and Begley (2004; see Researcher Interests, Beliefs, and Biases section above; see Appendix B).

Thematic Analysis

Given the constructivist-interpretative theoretical paradigm, a methodology that emphasizes constructed meaning and interpretation of such meaning followed. Thematic analysis is a flexible analytic approach which is compatible with these assumptions (Braun & Clarke, 2006). It is concerned with describing and interpreting repeated meanings that are considered to be important from across participants' responses (Braun & Clarke, 2006). In this study, thematic analysis was used to answer the research question: how do psychotherapists understand *harm* and *serious harm* in the context of clients' BDSM pain play? Special emphasis was also placed on how these understandings informed treatment decisions.

As described by Braun and Clarke (2006), thematic analysis is an adaptable method of data analysis which required me to make some choices about how the methodology was to be carried out. The first decision Braun and Clarke outlined concerns how prevalent a theme must be in order to be counted as such. As there are no clear-cut rules for deriving themes, themes were considered, in this study, based on the relevance to the research question rather than on their numerical occurrence. While themes relevant to the research question were reported regardless of quantified prevalence, the number of speakers who articulated a given theme within their accounts was reported in order to enhance transferability, as discussed in detail below (e.g., Tobin & Begley, 2004). The second decision Braun and Clarke (2006) outlined concerns the codes and themes that are attended to. One may choose to engage with all possible themes or to focus on themes specifically related to the research question. This analysis focused on the aspects of the data which related to the research question. The third decision outlined by Braun and Clarke regards the level of the themes identified: semantic or latent. This study focused mainly on latent themes, which went beyond the surface of participants' words, instead exploring the underlying meanings of participants' accounts.

Participant Recruitment

As the current study sought to explore mental health care providers' understandings of clients who participate in BDSM, it was necessary for participants to be mental health care professionals who provide counselling. For the purpose of this study, a mental health care professional was defined as someone who has met formalized training requirements (for registration, certification, or licensure) in providing psychotherapeutic services to clients and who has provided such services. Participants were also required to be over 18 years of age due to the content of the study. For the current project, a range of 10-15 respondents was sought and data collection was ceased at 15 responses. No criterion for past experience with BDSM-identified clients was used in this study. By virtue of their professional status, counsellors were considered able to represent their professional understandings and experiences in response to the vignettes (which are discussed in a subsequent section). Moreover, because the question of harm in the context of BDSM is one that any counsellor may have to answer, all psychotherapists' responses were thought to be able to provide valuable information for the research question.

The University of Saskatchewan's Behavioural Sciences Research Ethics Board granted ethical approval for this study on July 18th, 2017 (BEH 17-262). After approval was received, advertising of the study commenced via several avenues. Advertisements were placed on websites geared towards counsellors, including relevant online forums (Appendix C), the Saskatchewan Association for Social Workers' website, and the Canadian Psychological Association's website (Appendix D). Additionally, a mail out advertisement was sent to the member directory of the Alberta College of Social Workers (Appendix E) and a recruitment letter (Appendix F) was sent to the member directories of both the Psychological Association of Saskatchewan and the Psychological Association of Prince Edward Island. My personal contacts were also invited to participate in and/or share the study with others (Appendix F). A reminder letter (Appendix G) was also sent to invited personal contacts about 2 weeks after the initial letter, as follow-up emails have been shown to increase clinician response rates for online surveys (Dykema, Jones, Piche, & Stevenson, 2013).

Data Generation

Data Generation Instrument

The data set for a thematic analysis may take the form of transcribed interviews or focus groups, but they may also take the form of a written text (Braun & Clark, 2006). Participants

may also be asked to respond to vignettes as a method of data generation (e.g., Veldhuizen, Horselenberg, Landström, Granhag, & Koppen, 2017). For this study, an open-ended online questionnaire (Appendix H), which included space to respond to vignettes, was used to facilitate a written account of participants' understandings.

The questionnaire (Appendix H) was hosted on Surveymonkey.com. The host site was selected for its ease of use for researcher and participants, its financial accessibility, as well as its ability to collect data ethically and anonymously. Given the previously demonstrated relationship of some demographic variables to therapists' views of BDSM, such as age (Kelsey, et al., 2013), general demographics were collected to describe the respondents and inform my interpretation. The questions, vignettes, and accompanying prompts, were designed to facilitate participant's narratives and exploration of meanings (Larkin & Thompson, 2012; Appendix H). Overall, the survey questionnaire had several categories of questions, namely: demographics, reactions to BDSM-identified client vignettes and activities, and discussion of previous experience and knowledge about BDSM in relation to their current understandings.

The survey was set up to collect data anonymously, without collecting identifying demographics or IP addresses. For various reasons, some professionals may be too uncomfortable to talk about this topic having their professional or personal identity attached to it, in any degree. Therefore, anonymous online data generation was employed to help participants feel comfortable freely expressing their thoughts on this potentially controversial topic. Garrott (2008) also found that only those counsellors who were already comfortable with either talking to the researcher or about BDSM volunteered for her study and suggested using an online platform to reach a more representative and diverse participant base. Although participants in this study were not required to be representative or diverse, it was a goal of the study to include any counsellors who either have, or might one day encounter, kinky clients. Thus, an anonymous platform was used in an effort to increase participants' comfort in contributing their thoughts, regardless of the emotional valence to or experience with kinky clients.

The vignettes were included for a few reasons that centered around the benefits of allowing the participation of any counsellor, regardless of prior experience with kinky clients. Firstly, any therapist may encounter a BDSM-identified client, and so, in addition to any previous experience with BDSM-identified clients, responses to these vignettes were aimed at gleaning valuable insight into the initial processing of a simulated kinky client encounter. There

is a significant likelihood of counsellors encountering a kinky client (Kelsey, et al., 2013) and so there is merit in giving a platform to clinicians such as these. Secondly, although many psychotherapists will come into contact with kinky clients at some point in their career (Kelsey, et al., 2013), the perspective of psychotherapists who have little experience working with BDSM-identified clients have not been explored in depth, but primarily through initial statistical inquiry (Kelsey et al., 2013). The vignettes provided an opportunity for counsellors who had not yet encountered a kinky client to share their thoughts in this study. Thirdly, the vignettes were designed with the aim of prompting specific and in-depth discussion aligning with the research objectives. Garrott (2008) noted that her participants did not enter into detailed discussion around BDSM behaviours, and so, it was hoped that providing example activities through the vignettes would generate more detailed discussion than previously recounted in the literature. And finally, obtaining responses in this manner allowed me to obtain access to relevant and informed responses within the scope of a master's level project.

The client vignettes were created using information gleaned from the literature review and from people I have known, combined with my own sadomasochistic imagination. Feedback on the vignettes was sought from colleagues and minor adjustments were made prior to launching the survey. Generally, all clients in the vignettes (Appendix H) are likely to be interpreted as heterosexual, monogamous persons in a coupled pairing. Although the BDSM community, at least as it appears in the populations that are accessed by researchers (mainly public dungeons), may have more people who identify as LGB and who have sex with people outside of a traditional partnership than the general population (Cross & Matheson, 2006; Richters et al., 2008), both LGB (Shelton et al.,2011) and non-traditional relationship patterns (Graham, 2014; Pitagora, 2016b), are also stigmatized. Within the scope of this study, the goal was primarily to look at the understandings of the stigmatized practice of pain play, and so only vignettes that included only the minority characteristic of BDSM were included. However, future studies should investigate counsellors' responses to people who occupy the intersections of these and other minority demographic groups. All vignettes were also developed to reflect that clients usually present in therapy with an issue that is not directly related to their BDSM (Kolmes et al., 2006; Lawrence & Love-Crowell, 2008; Nichols, 2006). The vignettes were not intended to necessarily be statistically representative of the BDSM population, at least as it is studied which

is mainly within formal clubs (e.g., Newmahr, 2010b), but they were intended to be plausible cases that a counsellor may encounter, in order to stimulate discussion.

Alex vignette. The Alex vignette, specifically, was designed with the knowledge that role playing with power is a common activity in BDSM (Nichols, 2006) and that pain play is often interpreted within a power dynamic (Newmahr, 2010a). It is usually documented that piercing play, which Alex engages in addition to impact play, is done with sterile disposable needles meant for such purpose (Barker, 2005; Powell, 2010), however I am aware of a handful of people who have used other household items, staples included, to produce a desired effect. Thus, being stapled, while perhaps less commonly documented and perhaps less endorsed by the BDSM community, is a plausible situation that a counsellor may encounter. Although this study was primarily geared towards counsellors' examination of physical pain, psychological pain or humiliation, which is also engaged in by sadomasochists (Nichols, 2006; Powell, 2010), is also made evident in this scenario via his receipt of verbal derogation.

Alex reenacting his stressful workplace scenario is a plausible role play endeavor, as one possible benefit of BDSM play is the healing of negative past experiences through confronting them within the safety of the relationship (Nichols, 2006). Alex also alludes to escaping the stresses of the world and having a psychological tension release, which are other reported benefits of BDSM (Hébert & Weaver, 2015; Powell, 2010; Sagarin et al., 2009). This vignette also explicitly mentioned acts of aftercare, in which the BDSM players re-orient themselves to the non-BDSM world after a scene through such acts as talking or cuddling (Sagarin, Culter, Cutler, Lawler-Sagarin, & Matuszewich, 2009).

Sara vignette. In the Sara vignette, Sara was aware of her desires since early on, but she suppressed and hid them to meet social standards, which may occur with this population (Nichols, 2006). Sometimes after beginning to engage in the suppressed activities, people then begin "making up for lost time" (Nichols, 2006, p. 284), which might account for Sara's excitation at finding a partner and trying out many new techniques. Sara also noted guilt and shame about her sexuality, which is a common issue for BDSM-identified clients seen in the counselling office (Lawrence & Love-Crowel, 2007; Nichols, 2006). She also notes fear about her sadism being found out by her loved ones, which is another experience for many BDSM practitioners, even if they have come to accept themselves (Bezreh et al., 2012).

Mary vignette. The Mary vignette was loosely based on two cases. One case was of a polyamorous woman with depression and anxiety reported by Graham (2014). The vignette in the current study shared details with Graham's case study in that both clients engaged in self-harm behaviours and incorporated similar activities into sex in ways that replaced their self-harm. This vignette was also similar in that they had both experienced pathologizing counsellors. Graham's client previously experienced a therapist who had admonished her polyamorous orientation, subsequently leading her to question herself and withdraw from the polyamorous community, to eventually seek support from a more sensitive therapist. Mary, similarly, experienced a counsellor that pathologized her sexual activity and sought out a new therapist. The second case informing the vignette of Mary, reported by Nichols (2006), was of a woman with borderline personality disorder who was also a masochist. Nichols' client informs the conceptualization of Mary in that she also participated in BDSM pain activities for pleasure or as an enactment of self-loathing which partially eased her psychological discomfort.

Mary's situation with her previous counsellor was also developed based on the knowledge that some therapists make continuation of treatment conditional upon the client giving up BDSM activities (Kolmes et al., 2006; Nichols, 2006), that some professionals have difficulty distinguishing between BDSM and abuse (Nichols, 2006), and they may have difficulty distinguishing BDSM from self-harm (Garrott, 2008). Some of Mary's motives for engaging in BDSM – namely, a spiritual dimension to the activity, enhanced sexual enjoyment, and closeness with Jeff - are some of the many common motives as documented by Nichols (2006) and others (e.g., Sagarin, et al., 2009; Powell, 2010).

The survey question asking participants to respond to different techniques of inducing pain was not an exhaustive list. Indeed, BDSM behaviours and tastes vary widely, "limited only by the participants' imagination" (Powell, 2010, p. 77) and so a variety of behaviours were included for the purpose of eliciting discussion. Namely, the following were included based, semi-randomly, on their citations in the professional and lay literature:

- Biting (Ando, Rowen, & Shindel, 2014; Nichols, 2006);
- spanking, whipping, and caning (Newmahr, 2010b; Powell, 2010);
- paddling and using riding crops (Latches, n.d.; Weiss, 2011);
- abrading the skin (Latches, n.d.);
- punching (Newmahr, 2010b);

- hitting (Nichols, 2006; Newmahr, 2010b);

- slapping (Ando, et al., 2014);

- applying stinging nettles ("Urtication," n.d.);

- testicle kicking ("Cock and ball torture", n.d.);

- piercing (Ando, et al., 2014; Powell, 2010);

- cutting (Ando, et al., 2014; Newmahr, 2010a; Newmahr, 2010b; Powell, 2010);

- scratching (Newmahr, 2010b);

- branding (Ando, et al., 2014; Powell, 2010);

- dripping hot wax onto the skin (Latches, n.d.);

- pinching (Newmahr, 2010a);

- clamping (Newmahr, 2010a; Powell, 2010); and

- electrical shocks (Ando, et al., 2014; Powell, 2010).

Data Generation Procedure

Upon opening the survey link, participants saw a consent screen (Appendix I). If they consented to continue, they were instructed to indicate their consent by proceeding to the next page. They then were asked to fill out a demographic questionnaire. Before proceeding to the open-ended questions, they saw a message requesting them to provide detailed responses when answering the subsequent items (Appendix H). The questions and vignettes were displayed with prompts of possible things to write about (e.g., "How do you immediately react - viscerally, emotionally, cognitively - to this vignette?"). Participants typed their responses into comment boxes below each question or vignette. On the final page of the survey, participants saw a debriefing screen (Appendix H) thanking them for their participation, explaining more about the study, providing further resources, and asking them to make a final decision about whether or not they would like to submit their responses for analysis. Generally, participants spent about 20 to 60 minutes completing the survey.

<div align="center">

Data Analysis

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The submitted typed responses were used for analysis. In conducting the analysis, the following iterative steps, outlined by Braun and Clarke (2006), were used. In the first step of analysis, I familiarized myself with the data through repeatedly reading over the data and searching for potential patterns of meaning. During this first step, jot notes of thoughts about and potential codes were kept.

In the second step, I produced preliminary codes for the data. As discussed above, only codes related in some way to the research question were considered. However, heeding the advice of Braun and Clarke, all data were attended to for meanings and codes which had any potential relevance to the research question: "code for as many potential themes/patterns as possible… you never know what might be interesting later" (2006, p. 89). Both the issues brought forth in the text data and the research question were considered when creating a coding framework, but primarily the coding was around the issues of harm, safety, and how counsellors described appropriate treatment responses (Attride-Stirling, 2001). Data were coded in Microsoft Word by using the comments function. Once coded, extracts were reviewed and then transferred to Microsoft Excel so that they could be easily collated into a chart of codes. During revision of codes, Attride-Stirling's (2001) advice, to screen codes such that they are "not interchangeable or redundant; and they should also be limited in scope and focus explicitly on the object of analysis, in order to avoid coding every single sentence in the original text" (p. 391) was heeded. When revised, some codes were removed due to redundancy or lack of evidence. For example, the code for therapist determined treatment due to lack of evidence.

The third step was to produce potential themes from the codes. This involved combining codes into preliminary broader meaning categories, or themes and subthemes. To start this process, I assigned each code with a brief description then arranged them into lists with semantically similar codes to form broader meaning categories. These were arranged into visual webs depicting the potential overarching themes and subthemes. Attride-Sterling's (2001) concept of thematic networks was used to aid the creation of themes. Namely, initial codes were arranged into *basic themes*, collated into *organizing themes*, and those were, in turn, organized by *global themes.* Initial codes became themes, subthemes, or were removed at this stage, for example, the initial code of consent was actually split into several different aspects of consent and the presence of consent was then promoted to the level of an organizing theme. At the conclusion of this stage, the possible themes and subthemes were added to the Microsoft Excel spreadsheet of collated data extracts such that the supporting coded data extracts were arranged together with their assigned subtheme (or organizing theme) and theme (or global theme).

The fourth step involved revisiting and revising the themes. Reviewing of this nature was done by reviewing the collated coded extracts to ensure that they formed a cohesive theme. When the extracts were cohesive within the candidate themes, the themes themselves were

examined for the fit between the entire data set or, as Braun and Clarke (2006) stated, the "validity" (p. 91) of the themes in relation to the entire data set. This was done by rereading the entre data set and seeing how the themes related to it. At this point, any data that had been overlooked was coded and added to the relevant theme or themes. The thematic map was revised by adjustments in coding and themes until it was suitably fitting in relation to the data set.

The fifth step was to name and define the essential features of the themes that were to be written into the final report. Data extracts within each theme were organized into a narrative account of the themes and the scope of themes themselves was described.

The sixth and final step was to produce the narrative report on the themes relative to the research question. The final report was written with sufficient, but not repetitive, extracts to illustrate each theme. This report is located in the Results section, Chapter Four, of this thesis.

Trustworthiness

Research has traditionally been conducted using positivist paradigms which attempt to lay claim to an external truth (Guba & Lincoln, 1994). Correspondingly, the positivist notion of *rigor* includes *reliability*, *validity*, and *objectivity* (Sandelowski, 1986, 1993) as evaluative concepts. Given that this study adopted a non-positivist paradigm, the alternate concept of *trustworthiness* was used to evaluate the quality of this study (Guba & Lincoln, 1994; Haverkamp, 2005; Sandelowski, 2993). Sandelowski (1993) presented the idea of trustworthiness as basically a process of having made the research practices visible and auditable. She claimed that the exact method used was less important than the faithfulness to the ethos of qualitative work. Haverkamp (2005) also stressed the relational aspect of trustworthiness such that a researcher must keep in mind the relationships and responsibilities they have with regard to participants and readers. Thus, underpinning the notion of trustworthy qualitative research is a commitment to examine the relation of the research to theory and the scientific process, participants, the researcher, and readers. The concept of trustworthiness (Guba & Lincoln, 1994) includes such criteria as *credibility*, *transferability*, *dependability*, and *confirmability*. The concepts, processes, and ethical considerations that were used to ensure the trustworthiness of the current study are outlined in the following sections.

Credibility

Credibility in qualitative research is likened to internal validity in quantitative research. Qualitative research is considered credible when it produces faithful accounts of people's

experiences (Sandelowski, 1986). The accounts and interpretations produced by the research must also help readers to understand and recognize the phenomenon after having consumed the research report (Sandelowski, 1986). The credibility is enriched when a researcher's relationship to participants' experiences is explicated (Sandelowski, 1986). Being close, as a researcher, to the experiences of the participants is both a threat and a boon to credibility. On one side, researchers may have difficulty differentiating their experiences from that of the participants, but on the other side, they have more direct access into the participants' experiences. To assure this research is credible, I deliberately engaged in reflection on how I was impacted by and how I impacted the research (Sandelowski, 1986).

Debriefing with the research supervisor was also used to ensure credibility. Emerging themes and interpretations were discussed with the knowledge that disagreement between interpretations did not necessarily invalidate either account. Conferences were used simply to enhance my constructions and interpretations, rather than a way to *confirm accuracy* (Sandelowski, 1993; Tobin & Begley, 2004). Discussion of themes also helped me to elucidate and confront my own position and assumptions during the research process (Shenton, 2004). These meetings also served as an opportunity for me to gain insight into any ethical or technical dilemmas that occurred during the course of the research (Shenton, 2004).

Transferability

Transferability is compared to external validity in that it is concerned with generalizing the results of the study (Tobin & Begley, 2004). Qualitative research, however, does not use sampling or other methods that attempt to obtain a representative, and purportedly, externally generalizable result (Sandelowski, 1986; Smith, 2009). Instead, qualitative studies seek out participants who are *a* representative of a *particular* group (Sandelowski, 1986; Smith et al., 2009). Non-positivist research also sets out to describe *particular* truths which are constructed by people in contexts and which are malleable (Guba & Lincoln, 1994; Sandelowski, 1993). These assumptions and aims are, instead, focused on subjective accounts which change over time and situation and are also impacted by the interpreter, making the results necessarily variable (Guba & Lincoln, 1994; Sandelowski, 1993). Within those representatives, many valid and different realities may exist, and so, transferability in qualitative inquiry is focused on the descriptions of the particular which allow readers to judge for themselves how transferable those particular experiences are to other people in other contexts (Shenton, 2004). Sandelowski (1993) noted that

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different stories told by participants, or by researchers, are not necessarily an indication of unreliability, but are a function of the inherent nature of storytelling and meaning-making- the very subject that non-positivist methodologies attempt to explore and describe.

Sandelowski (1986) identified three paths to achieving transferability in qualitative research. First, a researcher must establish the position of all subjects within the larger group they represent. Shenton (2004) recommends including as many contextual factors as possible in the description of the participants and contexts of the study. Thus, demographic and contextual information was reported as fully as ethically feasible. Second, Sandelowski (1986) identified that researchers must establish the typicality or atypicality of responses reported with respect to their lives, that is, with respect to their behaviours, feelings, experiences. Therefore, experiences from the contrived context of this study, as well those derived from actual counselling practice, were explored. Thirdly, in a researcher's conclusions, they must avoid over-patterning data to look as though they contain all of the information neatly and representatively. I made every attempt to preserve variation in responses in my reporting of the results because, ultimately, the results must be understood within particular contexts (Shenton, 2004).

Dependability

Dependability is a construct similar to reliability in that it is concerned with repeatability (Shenton, 2004; Tobin & Begley, 2004). However, given the embracing of multiple truths in many qualitative frameworks, it is not the result that is supposed to be repeatable, but rather the methods. One may accomplish dependability in a study by keeping documentation of data and decisions such that others, namely, researchers and readers, may audit the process and discern whether the research was carried out properly (Shenton, 2004; Tobin & Begley, 2004). According to Shenton (2004), one may achieve dependability in a study by having sections of the research report clearly devoted to the research design and implementation, details of data gathering, and reflecting upon the project and its effectiveness. Tobin and Begley (2004) recommend keeping a reflexivity journal of a researcher's self-critical thoughts on the research process (Appendix B). In this journal, I explored and questioned my decisions during data collection and analysis. For example, documenting reasoning about ethical dilemmas during the research process. While analyzing the data, I also took breaks from the data to allow ideas to percolate and to revisit them with a freshened perspective. I wrote a lot of entries to do with ponderings on consent, death, transgression, normalization, pain, rights, and other topics, as well

potential themes. I also adopted the stance of the naïve inquirer when I perceived that I was biased in some way. For example, questioning my own understandings of what harm might be constituted by. In sum, the current research strove to meet dependability criteria via a detailed methodology section, the auditable decision-making trail (outlined in the following section), as well as a reflexivity journal for the research process (Appendix A and Appendix B).

Confirmability

Confirmability is compared with objectivity and it is concerned with ensuring the interpretations are grounded in the data rather than in the researchers' preferences (Tobin & Begley, 2004). This can be assured by having a researcher explicate their own biases and limitations in their decision-making processes about the research design and their interpretations. One may discuss, also, initial themes that were decidedly discarded. The format used for an audit trail, complete with reflective commentary and detailed methodological descriptions, can be found in Appendix A. As an example of how it was used, the completed audit trail documents that that two different thematic maps were discarded in favour of the third. Shenton (2004) describes an audit trail as often consisting of two diagrams depicting decisions regarding the research design and the data, and thus, such diagrams were used (Appendix A).

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Ethical Considerations

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As per the University of Saskatchewan's research requirements, an ethics application was submitted to the Behavioural Ethics Review Board for approval. Informed consent, confidentiality, and internet-based research ethics are discussed in some detail in the following sections.

Informed Consent

Informed consent was obtained from participants before they completed the online questionnaire. The specific content of the consent page can be found in Appendix I. Overall, the consent screen informed participants of my contact information and that of my supervisor, the participation criteria, purpose of the study, procedure of the study, funding received for the project, the voluntary nature of their participation and right to withdraw, the potential risks and benefits of participation, information regarding confidentiality of their data, the way their data were to be used and disseminated, and notification of ethics board approval.

Because the topic of BDSM is sensitive for some, the risk of feeling uncomfortable while answering questions was outlined in the informed consent page. Participants were also informed

of their right to leave any answer box blank (Appendix I). Counselling resources were not provided due to the likely geographical variability of participants contacted over the internet. Seeking counselling, if needed, to deal with emotions brought up by participating in this study was, however, encouraged.

Confidentiality

The information generated from the surveys was collected anonymously. I configured the survey to collect respondents' information such that there were no identifying details that could be used to connect participants to their survey answers. Participants were instructed to not provide any identifying details when responding and no one did. Thus, no extra editing with pseudonyms to protect identities was needed. Random alphabetical pseudonyms were chosen for each participant (Long & Jenkins, 2010). Other information that may be used to identify participants, such as uncommon or identifiable demographic data or particular wording of quotations, was omitted, changed, or reported aggregately as needed to protect participants' confidentiality. This was only necessary to protect online identities of commenters leaving messages on the online forum advertisements, as is discussed in the *online community-based ethics* section below. Limits of confidentiality associated with the online, SurveyMonkey platform were outlined in detail on the consent screen (Appendix I). The limitations included the location of the SurveyMonkey servers being in the United States and the fact that the Patriot Act may allow authorities to gain access to an internet service provider's (i.e. SurveyMonkey) records. A link to SurveyMonkey's privacy and security statements was provided in the consent information. These links described that a record of participants' IP addresses and their survey responses were maintained, but not in connection to each other. Participants were informed of the potential that both their IP address and their survey responses may be made known to authorities, but not in connection.

Aside from the confidentiality limits of the location of the SurveyMonkey servers, upon which the data is stored, I also took precautions to keep my SurveyMonkey account login sufficiently complicated and private to prevent unauthorized access to the collected responses. When I downloaded a copy of the participants' responses, they were transmitted from the site to my computer over a secure connection (Secure Sockets Layer, or SSL connection) which is the same protection which banks use to transmit private information over the internet. This connection is the default method which SurveyMonkey uses. I kept a copy of the responses

stored on my password protected cabinet storage on PAWS, in a password protected document. Only myself and my supervisor had access to the responses in full.

Confidentiality was also attended to during the recruitment process. When I invited my personal contacts via email, I took care to send invites out individually, such that no other addresses were visible to other potential participants.

The procedure for destruction of the raw data will be as follows. For a minimum period of 5 years after the completion of the thesis, a password-protected copy of the data will be stored on a flash drive and kept in a locked filing cabinet by the research supervisor. After this time period has elapsed, this data will be permanently deleted by the supervisor. Immediately following the completion of the thesis, and transit of the raw data files to the research supervisor, the responses stored on the SurveyMonkey servers will be deleted by requesting this action after the completion of the Master's thesis. This action alone will not immediately permanently delete the data from the servers and a copy will remain available to reinstate for a period of approximately 12 months. At this time, I will also use a file shredding program to delete the files stored on cabinet containing the raw data.

Online Community-Based Ethics

Special consideration was given to the internet-based recruitment done through online forums. Namely, as per the online-community code of conduct, permission from each forum was obtained to post the advertisement before posting. Once posted, I soon realized that people (using anonymous usernames) could post public responses to the ad. This created an ethical dilemma for me regarding whether or not to respond on this platform. I decided to respond to the remarks as if someone had said them via email or in-person, as the online forum had a conversational aspect and I thought that it would have been disrespectful to ask community members to consider taking the survey and yet not contribute back to the community. Roberts (2015) stated that the benefits and harms to an online community must be considered, and a researcher must establish credibility within a community. By attempting to meaningfully participate in the forum discussion, I was aiming to accomplish these things. However, some of the feedback posted as comments were quite critical of my survey design. I also learned that critical feedback of online surveys is not unique to this study (see Van Selm & Jankowski, 2006). Through discussion with the research supervisor, it was decided that the criticisms could be taken into account, but they

did not warrant overhaul of the study. In fact, these unanticipated comments even constituted *paradata*, or data that are produced as a byproduct of data collection (Dykema, 2013).

Using online forum data, or in this case, online forum paradata, presents another set of ethical questions (Roberts, 2015). Although these forums were publicly accessible, and thus, the usage of such data do not technically require ethical review, enacting relational ethics complicates the notion that the use of such data is inherently ethical (Roberts, 2015). Firstly, the issue of the forum site as a public versus private space is still contentious (Roberts, 2015) and the commenters in this case, while they knew that they were commenting to a researcher about a research study, they did not explicitly know that their comments might be analyzed as part of the research. In fact, I did not know this initially either. As well, online pseudonyms may need to be protected, as they may have developed reputations within the forum community (Roberts, 2015). Online forum quotations may also be searchable and, hence, present the issue of privacy for the commenters (Roberts, 2015). I believed that the forum comments were informative, and so, an ethical way of incorporating the paradata was sought.

I reasoned that, while it would be technically ethical to use the paradata as found online, additional measures were necessary to further protect the commenters. Regarding the issue of public versus private space, the particular forum in question was publicly available. There was no promise of privacy and no passwords or accounts were required to access the content. Thus, it seemed reasonable that this data could be used as public data. However, none gave informed consent for their comments to be analyzed. They did, however, give feedback on the study and recruitment. It could reasonably be expected that a researcher would incorporate this feedback in some way into their research report, as comments from colleagues or reviewers might. Although not ideal to bypass informed consent, the data were still publicly accessible and obtained in a way that was relatively transparent (i.e., I was known as a researcher). Given the lack of responses that I received on my reply comments, it was also unlikely that informed consent could be meaningfully sought through the forum. Given this scenario, it was concluded that extra precautions taken to protect commenters would constitute a relatively safe and ethical option to use the paradata. Since some of the comments that constituted the paradata were quite hostile, they may or may not have reflected favourably on the commenters' online identities. Thus, I did not use forum pseudonyms, nor direct quotations in this paper. Instead, the meaning of the forum posts was discussed in a summarized form, so as to prevent traceability of quotes (Roberts,

2015). To further prevent traceability, the name of the forum in question has also been removed from this thesis as I found it possible to find the quotes through searching the forum for the advertisement title (however, this information was not readily available using a more general search engine). In sum, the five comments that constituted paradata are discussed in aggregate summary in relation to the results and/or limitations sections below.

CHAPTER FOUR: RESULTS

This chapter presents the counsellors who participated in the study and summarizes the themes generated from their responses. The results section will first introduce the participants and their demographics. To reiterate some of the ethical precautions outlined above, all names that appear below are pseudonyms. Participants' quotations are edited for clarity (e.g., small typos are removed) and paradata are summarized, rather than quoted, to protect confidentiality. Any paradata responses are aggregately referred to using the name *Commenter*. This section then outlines the themes that were generated using the thematic analysis guidelines of Braun and Clarke (2006) and Attride-Stirling's (2001) concept of thematic maps. The thematic maps are structured into global, organizing, and basic themes. The generated themes are illustrated with supporting extracts from participants' accounts. This section concludes with a summary of the results.

Participants

Fifteen participants submitted survey responses for analysis. For succinctness, and easy reference, their pseudonyms and demographics are broken into two tables. Table 4.1 presents the Canadian participants while Table 4.2 presents the American participants. One participant, Blair, declined to report any demographics and so they are not included in either table. Overall, most of the respondents held a masters' degree in social work or some area of counselling and identified as female. The participants identified myriad practice settings, ranging from private practice to practice in public centers, as well as a wide range of ages (27 to 74) and years of counselling experience (from 1 to 45+ years). Additionally, they reported very diverse theoretical orientations.

How Counsellors Understood Harm in the Context of BDSM Pain Play

The current study sought to explore how counsellors understood the concept of harm requiring therapeutic remediation, and serious harm requiring prevention or immediate response, in the context of BDSM pain play activities. The analysis of participants' responses resulted in the generation of one global theme, containing and maintaining an individual, and six organizing themes which supported the global theme: bodily integrity, selfhood, presence of consent, social connectedness, mental health and healing, and threat and safety are vague. These themes as well as the multiple basic themes, a third level of theme which support the organizing themes, are outlined in Table 4.3.

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Table 4.1

Canadian Participants' Pseudonyms and Demographics

Participant	Degree	Credential	Age	Gender	Location	Practice setting	Years of practice	Theoretical orientation
Adrian	Masters in theological studies in Pastoral Counselling	Registered	51	Fluid	Ontario	Private	25	Trauma-informed, sensorimotor, psychodynamic
Ivey	M. Ed.	Registered	27	Female	Western Canada	Health care, clinical setting	1	Humanistic, behaviourism
Katie[b]	B.S.W.	Registered	28	Female	Western Canada	Church	2	Pansexual, queer, polyamorous
Lynn[a]	M.S.W.	Registered, certified, licenced	46	Female	Western Canada	Public/mandated	18	Eclectic
May[a]	M.S.W.	Registered	30	Female	Alberta	Health care	7	Feminist, narrative, strengths
Nick[a]	Masters of Psychotherapy and spirituality, doctoral student in secondary education	Certified	29	Male	Western Canada	Municipal government	2	Narrative, existential, Jungian
Olivia	B.S.W., M.S.W.	Registered	28	Female	Saskatchewan	Public	4	Strengths-based, narrative, post-modern, feminist

[a] Participant did not respond to one or more qualitative (excluding demographic questions) survey questions

[b] Katie responded with what appears to be a sexual orientation, rather than a theoretical orientation. However, this information may inform her theoretical orientation and provides context for the reader

Containing and Maintaining an Individual

The overarching interpretation of the organizing themes presented was that counsellors wanted clients to be contained and maintained within the boundaries drawn around safety. Individuals were ideally contained within their bodies (bodily integrity), their sense of self

Table 4.2

American Participants' Pseudonyms and Demographics

Participant	Degree	Credential	Age	Gender	Location	Practice setting	Years of practice	Theoretical orientation
Carol	Masters in Mental Health Counselling	Licensed	51	Female	Oregon & Washington	Private	5	CBT, Gestalt, eclectic
Daren	M.S.W.	N/A	38	Male	New England (USA)	Mental Health Center	2	DBT, CBT
Erik	Ed. D.	Licensed	33	Male	Southern United States	Private	5	Transpersonal, Primal integration therapy, transactional analysis
Frank[a]	M.S.W., Doctoral student of social work	Licensed, certification in sex offenders	28	Male	Southeastern US	Private	4	-
Gail	M.S.W.	Yes	32	Female	West Texas	Psychiatric Prison	3	-
Hailey	MSW	Licensed	39	Female	Nebraska, USA	Non-profit	10	Solution Focused
Jay	M.A.	Licensed	74	Male	Southern California	Private	45+	Gestalt, existential

Note. Unknown data are denoted by a dash

[a] Participant did not respond to one or more qualitative (excluding demographic questions) survey questions

(selfhood), within acceptable social boundaries between them and other people (presence of consent and social connectedness), within social norms (presence of consent and social connectedness), and within limits of mental health (mental health and healing). These containers individuated them and perpetuated their corporeal (bodily integrity), mental (selfhood and mental health and healing), and social (presence of consent and social connectedness) existence. Safety was something that perpetuated containment and maintenance, whereas harm was something that interfered with these. At times, what was considered safe or harmful for containing and maintaining an individual was ambiguous and amounted to no deeper a meaning than safety being something desirable for the client and harm being something aversive (threat and safety are vague). This may have reflected a shorthand reference to a sense of common knowledge around

Table 4.3
How counsellors understood harm: Overview of themes

Global Theme	Organizing Themes	Basic Themes
Containing and Maintaining an Individual	Bodily Integrity	Desirable to avoid or repair tissue interference
		Necessary to keep body alive
	Selfhood	Clients should be self-determining
		The self must negotiate its own limits
		Needs are met when people express an authentic self
		Diversity is to be understood, celebrated, and tolerated
	Presence of Consent	Consent is paramount
		Consent is constrained
		Consent should be given freely outside of coercion
		People should be informed of and anticipate risks
	Social Connectedness	Close relationships should be mutually emotionally warm and responsive.
		Social stigma and judgement are barriers to community access
		People benefit from community
		Society sets rules that protect and restrict
	Mental Health and Healing	BDSM a coping tool enhancing or detracting from wellbeing.
		BDSM can be influenced by negative past experiences
		Self-harm can be related to BDSM
		BDSM can be pathological when out of control
	Threat and Safety are Vague	Safety is an ambiguous state
		Harm is an ambiguous state

what safety and harm were constituted by, or, perhaps at times, a sense of the multiplicity of these things as interpreted by self-determining clients. Regardless of where the boundary between harm and safety was set, participants emphasized boundary drawing in their own accounts as well as encouraged it for their clients.

Containing clients within a shroud of safety by staving off harm and keeping it out involved a lot of boundary drawing, which was a negotiation between the counsellors' and the hypothetical clients' understandings. Counsellors generally recognized the authority of clients to self-determine, even to something that contained some amount of risk, however, under certain circumstances (such as potential self-harm, abuse, or serious risk of death) these choices crossed a boundary where self-determination could be voided due to the hard line of serious harm. It then became the purview of the counsellors to act to protect a client, to maintain them. For example, counsellors generally recognized that clients were able to consent to some amount of non-serious bodily interference, but if it crossed over into the territory of potential death, such as that by bleeding out or asphyxiation, it became a serious harm which overrode clients' decision-making capacity. Counsellors wanted clients not only to be contained within these aspects of safety, but to be regulated and maintained in such a condition as well: corporeally whole, self-determining, socially caring and agentic, more abiding, and life-loving.

Bodily Integrity. The organizing theme of *bodily integrity* related to the counsellors' desire for wholeness of physical bodies. Physical bodies were seen as something to preserve, and any disruption that could possibly alter them, at all or permanently, was viewed with some level of concern. Thirteen of the 15 participants articulated some variation of this theme in their accounts. The 2 basic themes supporting this organizing theme include *desirable to avoid or repair tissue interference* and *necessary to keep body alive*.

Desirable to avoid or repair tissue interference. The basic theme of it being *desirable to avoid or repair tissue interference* was expressed by 9 participants. Within this basic theme, there were variations on keeping the integrity of body tissues. While some participants expressed that it was desirable to avoid any interference with the body, others expressed that reparation of any bodily interferences could also be acceptable. Despite the different tolerances for tissue interference, at the core, these two sentiments are united by an underlying wish for people to exist corporeally intact.

This first sentiment was that body tissue interference was inherently aversive and harmful. Lynn reported, "Behaviours that I perceive may break skin or cause other damage stand out to me," indicating that breaking skin equated to damage. Similarly, Nick wrote, "So long as there is mutual enjoyment, love, and respect, and that each client is being safe (not putting their partner at risk for disease) I think I could work with most of these behaviours." While Lynn and Nick give the specific examples of *breaking skin* and infection with a *disease*, Carol's phrasing of *bodily harm* is much more vague. Carol wrote, "My client CAN take activities too far when they break consent or do bodily harm." Here Carol suggests that bodily harm is *too far*. Taken together, these accounts indicate that bodily interference is best prevented. Harm occurs when a bodily boundary is crossed, whether that is a dermal boundary, immunological boundary, or some other vaguely biological one that is damaged, that is going *too far*. This is a concept of wholeness, and safety, that has to do with a *prevention* of any tissue disruption. It also seems to express a valuation of the unadulterated course of the cellular life, as there is a dearth of discussion of any possible benefits one might legitimately gain from altering tissues.

The second sentiment did not contain concern over just any body interference per se, but over one that may not be easily, if ever, repaired. Wholeness was seen as a state which may be safely deviated from, so long as the injury was temporary. Daren wrote "The only sense of going too far would be permanent damage that might be regretted later." Frank similarly commented on the issue of permanence:

> Some of these stand out as being extreme, such as branding due to their permanent nature. Then again, we have people getting tattoos of all sorts of things while drunk, and don't judge them nearly as harshly. It is all relative.

Blair also remarked on the ethics around permanent bodily interference:

> If a client revealed concrete plans to kill or permanently damage himself or others, I would act as the law and my professional ethical guidelines mandate. Whether or not a client expected to be physically aroused while performing such actions has and should have no bearing on this whatsoever.

From these accounts, it appears that the more enduring the change of body tissue, the more concerning it is. If the body remained in a changed state long enough or forever, it could risk causing serious problems, such as *regret*, or it could even end up *killing* a person. Although, Frank cast some doubt on the condemnation of permanent tissue alteration by comparing the

(generally) more socially accepted practice of tattooing to the less socially accepted practice of branding. Blair, however, considers permanent body alteration a serious enough harm to consider reporting, alongside death. Additionally, in Blair's statement is the primacy of the body's integrity over *arousal*; physical wholeness precedes legitimate pleasure. In this basic theme, harm was seen to occur when the boundary of bodily change was lastingly, rather than transiently, crossed.

In keeping with this notion of returning to a state of wholeness, the care of wounds was stressed as an appropriate response to any tissue alteration that may occur. As Frank wrote, "I would recommend that she consult a medical doctor about the behaviours that she engages in, and work with him on the treatment of sex related wounds and how to care for those in a safe way." Thus, safety was aligned with medical *treatment of sex related wounds*. The implication here seems to be that treating enhances the body's chances of healing, thus putting the body on a course towards a pre-injury state of wholeness. Overall, the state of bodily integrity was seen as the logical and safe way for clients to strive to exist.

Necessary to keep body alive. The basic theme of it being *necessary to keep body alive* was expressed by 8 participants. At the core of this basic theme is an urgency to maintain life, even at the cost of revoking clients' rights to confidentiality and self-determination. Ivey wrote:

> As someone who has dealt with acutely suicidal clients, I am sensitive to the fact that someone can die if they are cut deeply. Breaking confidentiality is something that would be considered if there was someone in danger who was not able to help themselves.

Carol also commented on the urgency to prevent death:

> Confidentiality can only be broken if the client is threatening deadly harm to themselves or someone else. If a client is threatening someone else, or is putting themselves in harm's way, it must be a possible and surely death, such as auto-erotic asphyxiation.

The underlying assumption in this theme is that death or activities which risk immediate death are not valid options to choose and, so, a client's behaviour must be stopped if it is likely to result in death. If the client cannot *help themselves*, then it becomes the purview of the counsellor to do so. The interferences with the body that concerned the counsellors due to their potential for such were *deep cutting* and *auto-erotic asphyxiation*. The intent behind or gain from these behaviours is abruptly suspended as the breath and blood of the body takes precedence.

However, granted that the threat to life was not immediate, some allowance for potentially life-risking behaviour was made. For example, May commented on the relatively lower and less immediate risk of engaging in consensual choking:

> However, if there is risk to the life of a person we would need to break confidentiality as we are ethically bound to do so. But if both partners are consenting to risky behaviour (for instance strangling/choking during sex) that is not problematic for me.

This implies that activities which could possibly result in death, but not certain or immediate death may be participated in legitimately. Thus, although the goal is for clients to remain wholly alive, it is not necessary to revoke confidentiality and self-determination if the risk to life is indeterminate. Similarly, Erik commented on the relatively low risk to life conferred by the activities listed in question 7 of this survey. Erik wrote, "The thing that stands out to me is the long list of BDSM related techniques/activities that aren't on the list. My reaction is that these things are fairly tame, especially compared to edge play." Commenting on the same list of activities, Olivia reported:

> Without further context, none of the words above alone suggest risk of death to me; however, if a client informed me that they planned to leave the session and immediately use a rope to choke themselves without a release mechanism and would not agree to a safer method, I could see that as a serious and imminent risk to life that I would potentially need to break confidentiality for the safety of my client.

From these accounts too, it seems that activities which carry some possible risk to life are left to the discretion and self-determination of clients. For example, cutting (listed in question 7 of this survey) which is positioned as safer than *edge play* by Erik or using *safer methods* of auto-erotic asphyxiation which include release mechanisms, as mentioned by Olivia. It is not the activity (nor the pain) itself which appears as problematic, but rather where it lies on the continuum of potential for fatality.

While life was seen as an essential aspect of bodily wholeness, as a superseding extension of tissue integrity, there was also some allowance for people to engage in activities if they conferred only a vague, non-imminent risk to life. Nonetheless, maintaining the life of a person through avoiding or mitigating physical assaults to the body (e.g., restricting breath, cutting too deeply) was of the utmost import.

Selfhood. The organizing theme of *selfhood* concerned respect for the individual as a separate, unique, and self-directing agent. In this theme, the individual was seen as, ideally, deciding their own goals and capable to act relatively autonomously in accordance with such. The boundary of safety here was around individual agency such that people may be informed and influenced by those around them, but ultimately, the individual must be an agentic and autonomous being. Society was viewed as, ideally, supportive of individuals in their quest for self-actualization. All 15 participants articulated some variation of this theme in their accounts. The 4 basic themes supporting the organizing theme of *selfhood* include *clients should be self-determining*, *the self must negotiate its own limits*, *needs are met when people express an authentic self*, and *diversity is to be understood, celebrated, and tolerated*.

Clients should be self-determining. The basic theme of *clients should be self-determining* was expressed by 14 participants. At the core of this basic theme was that clients should be the interpreters of their own experiences as well as set their own goals for therapy and life. In this basic theme the counsellors spoke about supporting the client's process of self-actualization. Olivia wrote:

> I would need to spend some time with Mary getting to know her better before
> forming any conclusive thoughts on how best to support her and would want to form
> those thoughts in conjunction with Mary, as she is the expert on her own life.

Olivia's statement illustrates the significance placed on clients' right to choose the direction of therapy and life goals for themselves. Whatever it is that the clients came to therapy for is what the counsellors wanted to support them in achieving. This held true even when counsellors noted some potential harms or concerns with clients' behaviours.

When harms were seen as distinct possibilities, the counsellors still strove to let the client make their own meanings and, from them, determine what they felt was right for themselves at that given moment. Gail wrote:

> I think my approach with her [Mary] would be to generate mindfulness, and
> awareness around how her actions effectively deal with her symptoms. And are they
> effective? She is still seeking counselling for depressive symptoms, so they aren't entirely
> effective in helping her deal. Are there safer and less risky, more effective alternatives
> she could use? Or is addressing this behaviour right now completely off the table? If so,

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we would have to start with where she thinks the gaps in her ability to deal with her mood are.

This response illustrates that counsellors saw themselves as facilitators of the client's own will to action. Gail's statement involved her being in the role of helping Mary to clarify her desired direction for change by eliciting her participation and reflection on her own behaviours, even though she described Mary's behaviours as *risky*. This predicament of marrying concern for a client's wellbeing and allowing them self-determination to make meaning of their own pain experiences was noted explicitly by Ivey who wrote, "We talk about beneficence and non-maleficence in Psychology, so it creates a new set of ethical questions, certainly, when the concept of pain can be seen potentially as beneficial or maleficent." The question of self-determination was an ethical one, which the counsellors placed great value on when faced with non-reportable harm situations.

When non-reportable harm was thought to have occurred, the counsellor could let the client know of their concerns about it, but again, the choices remained with the client. May stated, "If I thought my client was taking the activities too far, we would have a conversation about safety, and harm reduction but ultimately it is their choice." Similarly, Lynn wrote, "[Desired] outcomes the same...despite my increased discomfort, that she [Mary] be happy and confident with her intentional choices. Would really like to see a reduction in her depressive moods." As evidenced by May and Lynn's comments, their own comfort did not really matter as long as the client was self-determining in a way that was chosen by and/or creating positive moods for them.

Aside from letting the client know about their concern for them, when counsellors interfered with the clients' freedom of choice more authoritatively, they were seen to have done harm. May noted, "Dr. Smith is wrong, and clearly has a problem with BDSM and pain. It's unreasonable to have our clients sign contracts for behaviours we think are wrong." As May illustrates, it is Dr. Smith who, rather than the client, is the one who *has a problem with BDSM and* pain. Imposing the counsellor's will in this manner was also criticized by Olivia as being "too presumptive, directive, and not client-centered." In sum, when the will of the counsellor (at least when there was no immediate danger to their life) was substituted for the will of the client, it was seen as an intrusion and harm to the client.

The self must negotiate its own limits. The basic theme of *the self must negotiate its own limits* was expressed by 12 participants. This basic theme was in keeping with the desire for clients to be self-determining, as at the core of this basic theme was that individuals must determine and express what their own limits were around what was working for them and what was not. This basic theme is similar to the previous one but is distinguished in terms of its specific emphasis on defining the limits for oneself in terms of safety and harm, rather than general life direction and self-actualization.

Boundary setting was seen as extremely important for clients. Adrian commented, "The skills of negotiating boundaries are essential in the BDSM and Kink communities and this is a helpful conversation for me to assess the client's capacity regarding boundary setting and negotiation skills." Especially in the context of kink, a client's ability to set and enforce boundaries was seen as an essential element of safety. This boundary setting was remarked upon in terms of that for intrapersonal and interpersonal understandings of harm and health.

Counsellors wondered about how clients might draw boundaries intrapersonally around behaviours that could be potentially self-destructive or helpful. Gail wondered:

> Does she [Mary] know where the line is? How can she tell whether what she is doing is coping? Or damaging? I think it's interesting that there does seem to be a line for her. It might be worth exploring how she came to that line, where it is, and how she knows whether she's crossed it.

Ivey also probed for Mary's ideas of self-harm and sexual use of pain:

> I would discuss her [Mary's] own ideas of the difference between self-harm and sexual pain inflicting, and ways that she might be able in the moment to determine which she's engaging in. I might also discuss ways to boundary the sexual pain inducement from that of other times where it was intended to self-harm.

This distinction or line between helpful and harmful was left up to the clients' evaluation of the impact that behaviours had on their lives. Clients were asked to make delineations about what would be beneficial to include in their lives and what should be excluded as well as under what circumstances that was the case; how does one determine the *boundary* for, say, cutting in sexual masochism versus cutting in self-harm, and how do they know when they've *crossed the line* between the two? While this evaluation was ultimately asked of the client, the implied message

here was that cutting for self-harm was, as the term suggests, viewed as harmful from the counsellors' perspectives and that clients should come to place a protective boundary around it.

Another boundary that counsellors asked their clients to draw was around the level of permeability to others. Gail commented:

I would probably also encourage her [Sara] to consider what she needs to feel safe in a sexual relationship including but not limited to issues of consent, STD testing, disclosure about oneself and the level of vulnerability that one is willing to engage in.

Responses such as this inquired about clients' understandings of wanted interactions with others. Gail asked what it was that Sara *needs to feel safe*, eliciting her limit setting for safety in sexual relationships. She also asked what level of *vulnerability* Sara is willing to engage in, which speaks more pointedly to the boundaries Sara would want between herself and others. Developing some kind of borders between the self and another was encouraged.

Conversely, when the boundaries of the self became dissolved by another, it was seen as unsafe. Adrian remarked:

In his [Alex's] work life he is required to act and behave in a certain way and there are serious consequences and his client's well-beings are at stake. In his sexual relationship with his girlfriend, it would seem that he has permission to surrender everything to her without lasting consequences. Their sexual actions together represent a safe container for Alex to surrender, whereas his relationship with his boss requires him to submit. With Alex's surrender he is able to maintain an aspect of his self; with the submission to his boss he must sacrifice his self for the will of his boss. Although this may seem like a moot distinction, I would be curious about how large of a contrast these two relationships are between each other.

Here Adrian discusses *submission* by force as a *sacrifice* of the self while *surrender* by choice allowed maintenance of *an aspect of his self*; evidently Alex's boundaries are maintained by his choice. Surrender by choice was not seen as having *serious consequences* to wellbeing, while submission by force dissolved Alex's self into another. Olivia also emphasized the assertive negotiation aspect of self-maintenance wanting "to know more about how [Alex] communicates his needs at work with his boss so that he might have more ways to assertively address his work issues." Maintaining the limits of the self in relation to others was seen as beneficial and

counsellors generally wanted clients to set their own boundaries around what felt welcome and unwelcome to them in their sexual (and other) experiences.

However, counsellors still had to navigate their own understandings of harm in relation to that of the clients. Counsellors could display a somewhat more directive tone when situations appeared to them to be potentially self-harming or abusive. Thus, clients were not always ultimately in charge of their own limits, but it was instead a negotiation that was sought between the clients' current boundaries and the boundaries that counsellors idealized for the clients. Erik wrote:

> My immediate reaction is frustration with Dr. Smith for not being more aware of BDSM. My interventions with the client [Mary] would focus on psychoeducation for self-harm versus masochism as well as how to identify when masochism loses its consensuality and becomes abuse.

Erik offered information to Mary about the line that he had come to understand between self-harm and masochism as well as abuse and masochism; *psychoeducation*. From this statement, it is unclear what amount of leeway that Erik may have given to Mary in terms of defining that line between self-harm and kink and abuse and kink for herself. However, it is certain that Dr. Smith was viewed as being overly restrictive of Mary's rights to define her own boundaries to include participation in BDSM, indicating that Erik likely wanted to help Mary set limits which are more comfortable to her, but perhaps to himself as well.

Although therapists want their clients to self-determine their own limits in terms of risks and rewards in sex and relationships, they simultaneously expressed valuation for some boundaries that they desired for the client to adopt. Namely, when the kink activities functioned in a way that appeared to be abusive, self-harming, or disruptive to life outside of kink, counsellors became concerned, which impacted how non-directive (or directive) they were in supporting clients to set their own limits.

Needs are met when people express an authentic self. The basic theme of *needs are met when people express an authentic self* was expressed by 14 participants. At the core of this basic theme was that individuals possessed needs and characteristics that were beneficial to actualize. Barriers to getting needs met and expressing oneself included shame, stigma, and secrecy. Clients' sexuality was seen as part of their selfhood. Nick wrote:

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I'm always really interested in hearing about my clients' sexual lives, and I've always felt

that their sexual identity can assist us in making sense of their overall sense of being.

Almost as if their sexual behaviours are an extension of who they are as people.

Sexuality was an *extension* of a person, a part of their core identity. When the client's inner

needs and identity were expressed, counsellors glowingly endorsed this self-expression of

sexuality. May wrote:

Good for Sara! She is exploring her sexuality with a partner who appears to be

encouraging and consenting. It makes sense that she would like to engage in things she

never got a chance to in a marriage that she was unhappy with. I would commend her for

listening to herself and her body and reclaiming her own sexuality.

Katie also remarked on the sexual expression of self:

I have [worked with a client previously], in that the individual described it as part of their

identity and part of their relationship dynamic. I responded in a supportive way and

affirmed their identity. We continued on in our conversation as we were talking about

their identity and how it pertained to their long-term goals.

According to these reports, clients *have* kinky sexualities to *reclaim* ownership of as well as

corresponding kinky *identities*. Their sexualities and identities are something that were seen as

belonging to the clients and residing inside of them; *I would commend her for listening to herself

and her body*. This sense of self was a deeply rooted urge within a person that could be

uncovered through experience and exploration. Uncovering and expressing the self was

encouraged, as Daren commented, "[Sara] is expressing herself sexually, which is a beautiful

thing". Moreover, the characteristics of the self should ideally inform as well as support a

client's *long-term goals*. Overall, selfness encompassed sexual aspects of a person and it was

ideal to be able to express this part of the self.

If one's sense of self was inhibited from authentic expression by some kind of

oppression, it was to be further explored with the goal of removing the need to deny or hide the

true self's needs. Nick noted:

I'm curious about what parts of her self [Sara's self] were being denied through her

sexual relationship with Joe. I don't see her desire for rougher sex as a part of her sexual

identity, necessarily, but instead wonder what outlet, desire, or need she is meeting in her

sexual actions with Gary. … I would want to find more out about her sexual history and

how this sense of sexual self came to be, then interested in what aspects of her life might

she feel that this part of her being is being oppressed or denied.

Whether the sexual self constituted an identity or was purely need fulfillment is called into question by Nick when he says that he doesn't see her *desire for rougher sex as a part of her sexual identity, necessarily*, but yet he still alludes to Sara having a *sense of sexual self* that should be freed from *oppression*. It is a d*esire* of the self, rather than an identity which is propelling Sara to act in Nick's sentiment. Regardless of whatever the self was said to be (an essential identity or an agent acting to get biopsychosocial needs met), it yearned to be free. Katie wrote:

I would ask if there were reasons for her [Sara] to feel shame about something that is

clearly an affirming experience for her (perhaps relating to her divorce?) and perhaps

explore that.

Katie's statement emphasized the utility of exploring what it is that is holding the client back from seeking *clearly* self *affirming* experiences. Katie speculates that the blockade is possibly related to Sara's experiences with others holding her back (*the divorce*). Olivia also explored the importance of freely self-expressing:

The overarching theme of the therapy work with Sara though would likely be to

normalize her viewing her needs as important and having a right to express her needs and

practicing how to do so in an assertive manner, such as with her children.

Olivia's statement exemplifies the motion towards claiming the *rights* to one's own needs; and ownership of something about the self that others are not able to declare for a person. Exploration of the inner sense of self was significant in this basic theme in that knowing oneself outside of the smothering conditions of suppression could lead to developing tools for expressing that authentic self; an act which was seen as being fulfilling for clients. Under the concealment of *oppression*, *denial*, and *shame* lay a gem of (in these accounts, primarily sexual) self to be uncovered.

Diversity is to be understood, celebrated, and tolerated. The basic theme of *diversity is to be understood, celebrated, and tolerated* was expressed by 14 participants. This basic theme was characterized by a sense of curiosity, respect, and admiration for clients' experiences, regardless of whether these experiences resonated personally with the counsellors. In keeping with the sense of curiosity and respect, counsellors engaged in reflection, drew from their own

previous experiences, and participated in professional learning activities to better understand and serve clients. The idiom *whatever floats your boat* describes the ethos of this basic theme quite succinctly.

Counsellors generally expressed a sentiment of admiration for kinky clients' unique positive qualities. Daren commented, "Sounds like a creative and healthy way [For Alex] to deal with fears," and Adrian wrote, "I feel quite honored to be present with these clients." These clients were seen as c*reative* and bestowed *honor* upon the counsellor by their presence. This held true for counsellors even when they had some difficulty imagining themselves participating in certain activities.

In situations where the counsellor did not personally resonate with clients' activities, they expressed a sense of curiosity and wonderment, even jealousy, at kinky clients' sexuality. Nick wrote, "Activities that stand out to me: riding crops (because I have no idea what that is), applying stinging nettles (never would I think to be so creative), testicle kicking (that hurts my testicles just thinking about it)." Similarly, Gail commented:

> My response personally would be one of curiosity and even one of Envy, given my own sexual experiences and my trust issues are having being sexually vulnerable and intimate, so that if someone that I'm treating is able to achieve a level of trust and vulnerability with someone for whom that these activities are safe and healthy, then that would be something I would want to acknowledge to myself and to address in supervision if I needed to.

These comments illustrate a sense of awe at clients' ingenuity: they are *so creative* and *enviable* in their achievement of such a level of trust. May also adds the notion of trusting clients despite ones' own reactions:

> The only one that stands out is testicle kicking, I don't know why but the visual makes me cringe, but if you're into it...good for you! I make sense of these activities by normalizing them. There's nothing wrong with them, and pleasure is pleasure! No judgement.

Taken together, these comments indicate an evaluation of the clients as sovereign beings who are capable of making sound decisions about their own different (from the counsellors') tastes: even though it *hurts my testicles just thinking about it* and *the visual makes me cringe*, these activities might be s*afe and healthy* for someone else to do and *if you're into it… good for you!* This difference was tolerated, respected, and even celebrated on the basis of respect for individual

self-determination. Even when counsellors had difficulty imagining themselves participating in some of the activities that clients enjoyed, they emphasized that this difference was simply a matter of personal taste and should be respected.

Counsellors mentioned many sources that they had gained a better understanding of BDSM from. Adrian wrote, "I have learned about BDSM and Kink through workshops, presentations, research journals, independent reading, retreats, personal involvement in BDSM, and discussion with other BDSM involved healthcare practitioners. They have all been useful to me personally and professionally." Adrian's comment illustrates that counsellors learned from firsthand experience in addition to a variety of print and online materials as well as from colleagues. This suggests that BDSM was a lifeworld worth knowing and understanding, both *personally and professionally.*

If counsellors had not had much prior learning on the topic, they remarked on where they would likely seek out information to better serve clients. Ivey noted, "To find more information, I might consult another professional who works with the general adult population, consult a few sexual health centers, or research in academic journals." The intent to learn more for clients, if and when they may be encountered, indicates that clients' diversity would be worth making efforts to understand to *support* clients.

Presence of consent. The organizing theme of *presence of consent* related to the endorsement of consent as a necessary element of safety. The constituents of valid consent were discussed in terms of free, informed, decision making by capable persons. There was also emphasis on communication of mutual consent. However, there were also limits to what one may consent to. According to this organizing theme, consent was integral to safe BDSM interactions and absence of any of the elements of consent indicated some level of harm worth remediating, either in conversation with the client or through harm reporting. Fourteen of the 15 participants articulated this theme in their accounts. The 4 basic themes supporting this organizing theme include *consent is paramount*, *consent is constrained*, *consent should be given freely outside of coercion*, and *people should be informed of and anticipate risks*.

Consent is paramount. The basic theme of *consent is paramount was* articulated by 14 participants. The counsellors stressed that consent was an absolutely essential component of BDSM interactions. Adrian wrote, "I would ask clarifying questions to ensure that all activities are undertaken with consent." Counsellors wanted to *ensure* that consent was present. In fact, it

was such an important part of client's safety, that some counsellors saw a lack of consent as a situation that required them to break confidentiality. Daren commented, "I don't see any reason to break confidentiality unless lack of consent was planned toward another person." Lynn similarly wrote, "If a client is identifying non-consenting, life threatening behaviour, I would break confidentiality." Thus, a lack of consent was sometimes seen as harmful enough to spur active prevention efforts from the counsellors. Daren's statement suggests that any lack of consent that could be prevented in the future should be reported, however Lynn's statement is less clear. Her statement suggests that *non-consenting* and/or *life threatening* behaviours warrant reporting. However, it reads as though Lynn indicated that a lack of consent itself is worth breaking confidentiality for. Regardless of this ambiguity, correcting a lack of consent through some means of intervention, possibly including harm reporting, was seen as paramount to clients' wellbeing.

Persons involved in BDSM acts together had the responsibility to communicate their needs with one another in order to achieve a mutually agreeable result. Communication was important in terms of continuously negotiating boundaries. Frank wrote, "I stress communication a lot because as work and life roles change, so might sexual attitudes, and they should continuously be reassessing for a shared vision." Adrian also commented, "The skills of negotiating boundaries are essential in the BDSM and Kink communities and this is a helpful conversation for me to assess the client's capacity regarding boundary setting and negotiation skills." It was seen as necessary to be able to continuously negotiate boundaries as *attitudes changed*. *The skills of negotiating boundaries* were indispensable for participating in kink and counsellors were concerned about whether or not the messages around boundaries were effectively relayed between partners; Lynn asked, "Does partner understand what is going on with her?" And, as Katie wrote, "if...communication is good, this sounds like it could be really healthy." Clear communication of consent was not only vital as a prerequisite for safety, but additionally conferred a health potential to kink activities.

Consent is constrained. The basic theme of *consent is constrained* was expressed by 10 participants. At the core of this basic theme was that consent had limits based on one's capacity to give consent and the activity to which one was consenting.

Only people who met some kind of criterion for the ability to choose were seen as able to give consent. This criterion was often interpreted as adulthood or at least a legal age of consent. Gail wrote:

> I tried to go with encouraging consensual activity between adults who have the capacity to consent … If it's an adult and a consensual relationship that I'm treating who's engaging in consensual activity is, then I would rely on them to know where the line is for harm versus health.

Adulthood was seen as a necessary condition of capacity. Adults should generally be able to be trusted to make decisions for themselves, as Gail would *rely on them to know* what activities were beneficial for them to participate in. Many other participants also referred explicitly to consensual sexual activity as the purview of adulthood in statements such as: "healthy limits of adult exploration" (Frank), "adult sexual behaviour" (Blair), and "consenting adults" (Ivey). It was important to counsellors that people consenting to kink were mature enough to make valid decisions.

Younger individuals and vulnerable adults participating in BDSM were generally not looked upon permissively. These populations were seen to require more protection from harm. Katie wrote, "I would break confidentiality in the same way in a non-kink setting-following the guidelines set by the ACSW. If underage BDSM is occurring, I would question it (under the age of consent)." *Questioning underage* participation in BDSM suggests a concern for young people's capacity to make decisions, as they are not yet mature enough. Katie *questioned* their participation, presumably in an effort to determine whether or not harm is in fact occurring. From this statement it is not clear what answers Katie would seek. However, Erik specified that "confidentiality would have to be breached if there was nonconsensual involvement with vulnerable adults or minor children." In this statement *vulnerable adults* as a population were considered alongside *minor children*. Both populations were viewed as less capable than non-vulnerable adults in terms of making their own decisions to seek help for abuse. Counsellors saw people who were younger than an age cutoff (i.e., *underage* or *minor children*; it should be noted that the age cutoffs are not specified and, therefore, interpretation remains ambiguous) as well as adults who were *vulnerable* as less capable of giving consent – either in terms of consenting to BDSM activities or to help seeking for abuse. Counsellors wanted to protect these populations by either investigating a situation with a client or by harm reporting.

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Consent was also constrained if the activities were not allowed to be consented to; any c*onsent* that might be given to such an activity was null and void. There was a sense of protection emanating from the counsellors' statements. This notion of void consent was closely linked to the *bodily integrity* theme, as it was often discussed in the context of potential death. Ivey wrote:

> If there was an escalation in the sexual activity and a partner was planning to escalate to an activity that had a good potential to result in death, it might be within my responsibility to divulge this information for the protection of the client…If there is an absence of permanent, long lasting, life impacting harm, I believe people should be able to interact with one another sexually however they please if they are both consenting adults.

Implicit in Ivey's statement, and the ethical guidelines she dutifully follows, is the notion that consent is circumscribed. Clients *should be able to interact however they please* except in the event of *life impacting harm*. There are caveats to consent such that what a person chooses to do is valid, unless it impacts their life in a way that endangers it, at which point it becomes the responsibility of a third party to intervene for the *protection of the client*.

Consent should be given freely outside of coercion. The basic theme of *consent should be given freely outside of coercion* was discussed by 7 participants. At the core of this basic theme was the conviction that a partner must have the power to deny participating in activities in order for their consent to be valid. If a power differential prevented a client from freely consenting, it was seen as harmful.

Exploitation was a key concept in terms of the power to consent. Frank wrote, "As long as the husband/partner is not exploiting their partner, this can be healthy." Gail similarly commented, "Glad that his [Alex's] gf seems to be consent-oriented in their activities and not exploitative." Frank and Gail both discuss safety and health in terms of a lack of exploitation. One partner was not using the other, nor did they have undue influence to do so, and thus, the counsellors were not alarmed, rather they were *glad* at the *healthy* activity that the clients were participating in.

If the converse was thought to be the case, and a partner may be exploiting another, it was concerning. Blair wrote:

The vignette twice presents Mary as solely responsible for acts performed upon her by others…Whether this represents bias in the survey design and vignette composition, or whether this indicates Mary's refusal to acknowledge her sexual partners as equal -- and equally responsible -- participants is unclear.

Whether Mary is abusing Jeff by using him as an instrument of self-harm, or whether he is abusing her by requiring some undefined state of being "at his mercy" as the price of fulfilling his requests, is entirely unexplored in this vignette and cannot be determined from the information given.

Basic education in the signs of abusive relationships is useful for all people in intimate relationships; "heavy masochists" are not exempt. Mary's conviction that she must be absolutely trusting and at her partner's mercy simply because she is a physical masochist is concerning and merits exploration.

Blair was concerned that Mary and/or Jeff (her partner) were potential victims of abusive acts. Both partners were potentially not *equal and equally responsible*, which was alarming. Jeff was seen as conceivably being abused by Mary as an agent of her own *self-harm*. The harm that may befall Jeff was unstated, as a speculation, perhaps he was thought to be duped into unknowing participation in her self-harm. The harm that might befall Mary was explored more fully in Blair's comment. Mary's trust for Jeff was seen as possibly signifying an abusive revocation of her liberty; it did not matter that she was a *physical masochist*, she should be free to make her own decisions rather than be *at his mercy*. Overall, having the freedom to consent and freedom from coercion was highly valued.

In keeping with this valuation, helping a client gain better control of their own participation in kink was an aim of counsellors' interventions. Carol wrote, "Desired outcome of intervention: … tools to allow her [Mary] to retain control of consensual BDSM scenes." Carol commented on Mary's lack of control of *consensual BDSM scenes* as remediable. Her statement was ambiguously interpretable as a lack of control within either the relationship with her depression or with her partner. Regardless, it is viewed as desirable for Mary to be free to make her own choices without undue influence from a force external to herself.

People should be informed of and anticipate risks. The basic theme of *people should be informed of an anticipate risks* was discussed by 14 participants. The essence of this basic theme was the that participants of BDSM should be knowledgeable about what it is they are consenting

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to and plan accordingly; they should have access to information and weigh the costs and benefits accordingly. Different knowledge types were mentioned, including self-knowledge and technical knowledge of skills. It was seen as harmful if clients did not know the risks of what they were consenting to and, consequently, an imparting of knowledge was hoped to ameliorate this.

The first type of knowledge that counsellors thought was beneficial was that of the self. Insight was discussed as a positive attribute in terms of resilience. Lynn wrote, "Sex [behaviour] for coping isn't great, but her [Mary's] insight seems astounding." Hailey also commented on Mary's insight, "Dr Smith is a dick. If the relationship with Jeff is consensual and isn't causing lasting harm or creating a safety hazard, I think it could be a positive outlet for her. She seems to have good insight." Mary's self-insight was talked about in a way that suggested it was a protective factor. Although using sex to cope *isn't great*, at least Mary had *astounding insight* on her side. Additionally, kink could be a *positive outlet* for Mary seemingly because of her *good insight*. Nick too commented on Alex's level of insight:

> Immediately I would react by feeling proud of Alex for having the insight he has to make sense of his current situation. His understanding of how these behaviours make him feel and his ability to speak them out, without large amounts of shame or guilt (it would seem) would impress me.

In Alex's case, his insight helped him to cope with his *current situation* and protected him from *shame or guilt*. Self-awareness was seen as a factor which protected clients from ill-fitting decisions, as Lynn commented, its "all around the intentional… behaviour focus". As long as the clients knew what they *intend* to do was congruent with their knowledge of themselves, potential harms were mitigated. Although a certain coping skill may not always be safe, it is so in the context of someone with great insight, and although someone may feel shame and guilt from society, they are resilient due to their self-reflection. Engaging cognitively with what one does and why was seen to be protective in terms of consent-related decisions.

A second type of information that was seen as beneficial was technical knowledge. Counsellors wanted clients to have access to information on how to implement BDSM techniques in a way that reduced risk. Adrian wanted to "ensure he [Alex] has sufficient information and support to maintain physical and emotional safety." As did Olivia, who wrote:

> Some of the activities that I perceive could have health risks if there is not education on safer methods stand out to me, as I would want to ensure that my clients have access to

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information about how to engage in BDSM activities that have less risk due to safer

techniques.

Counsellors wanted clients to have *sufficient information* to support their wellbeing and to *engage in safer BDSM techniques*. *Education* was integral to knowledge, which allowed clients to choose to implement safety techniques.

If clients did not have access to this information, counsellors expressed concern. Ivey wrote:

I would also talk about safety, as far as this vignette described "cutting", however it doesn't include any information about Jeff's knowledge of how to safely engage in this activity - I'd also want to make sure my client [Mary] wasn't in any danger of being unintentionally harmed... I might overshadow the importance of safety, as it's my own understanding that with activities like cutting or choking, it's possible to do harm to your partner if you aren't educated.

An absence of education and knowledge was seen to harbor the potential for harm; if you *aren't educated* or don't possess *knowledge of how to safely engage* you may *do unintentional harm*. Also drawing attention to client's education levels, Hailey commented that, "Electrical play is v dangerous and should by monitored and performed by professionals." Therefore, if you don't have *professional* knowledge of a skill that is advanced, there is similar potential for danger, due to that lack of knowledge. Without an awareness of the risks involved, and corollary preventative action, harm could occur. Ivey wrote:

Truly any of the above listed activities could cause harm if done repeatedly and without caution about the potential for harm. I think if someone was engaging in these without a real sense of the potential for harm it would be worrisome.

An absence of *caution* and action without *a real sense of the potential for harm*, suggests that counsellors found it troubling when a full understanding of risks and prophylactic measures was not present. While knowledge was seen to lead to making safer, caution-wary decisions, a lack of knowledge and (an assumedly) corresponding lack of due caution created a potential for harm.

Social connectedness. The organizing theme of *social connectedness* encapsulated the importance of inclusion within communities. It was seen as positive when clients were able to access warm, caring, supportive relationships within the wider community. Stigma and discrimination were a primary barrier to inclusion. Access to partners, peers, and health

professionals who were nonjudgmental was a factor in clients' wellbeing. Not only were established communities important in terms of clients' social ties, but they were also important in that they served as a bench mark for counsellors to reference when negotiating and interpreting clients' behaviour. Established communities served as a normalizing force which could envelop harmful activities and transform them into acceptable ones. Society was also seen to protect the individual through laws and regulation. Regulation could, however, become too restrictive and act in conflict to inclusion whereby it ironically created stigma and barriers to accessing community services. All participants articulated this theme in their accounts. The 4 basic themes supporting this organizing theme included *close relationships should be mutually emotionally warm and responsive*, *social stigma and judgement are barriers to community access*, *people benefit from community*, and *society sets rules that protect and restrict*.

Close relationships should be mutually emotionally warm and responsive. The basic theme of *close relationships should be mutually emotionally warm and responsive* was discussed by 14 participants. At the core of this basic theme was the desire for clients to have intimate and caring relationships with their partners, as well as warm and empathetic relationships with their therapists.

Counsellors emphasized that of aftercare and intimacy was a factor that characterized healthy BDSM. May wrote:

> It makes sense that this client [Alex] would want to role play a situation that makes him feel vulnerable and afraid in his outside world. I wonder if it may give him a sense of control/lack of control and powerlessness that is similar to how he feels in work but dissimilar in that he participates in these with a loving partner who then takes care of him.

Frank similarly commented, "It appears as though they [Alex and his partner] are doing this in a healthy way. They speak and communicate about their thoughts and feelings afterwards, express emotions and intimacy, and attend to any physical secondary issues as well." It is unwanted for Alex to be in *a situation that makes him feel vulnerable* when he is at work, but in the context of his relationship with *a loving partner who takes care of him* and who shares *emotions and intimacy* with him, his vulnerability is transformed into something *healthy*. The sense of duty to another's wellbeing was seen to be beneficial for clients and transformed potentially harmful activities into something that was healthy in the context of the relationship.

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Correspondingly, having a scarce relationship with one's partners was seen as potentially troublesome. Lynn wrote:

Engaging in sexual behaviours with potential strangers is worthy of further exploration, but that's all around the intentional and safe behaviour focus… I go to a reality therapy place and focus on consent, intention, communication with known reliable adult partner(s). And I try not to get distracted by it if that isn't really the issue…

Clients possibly doing sexual things with people that they do not know well was *worthy of further exploration* to ensure safety. It was also recommended that clients have sexual relationships with *known reliable partners*. Without some kind of prior relationship with a partner, a client could not judge whether they could be counted on to have the client's well-being in mind.

Within the therapist-client relationship, warmth was also seen as an important factor. Adrian wrote:

My desired outcome for my interventions are for the client [Alex] to feel heard supported and not charged. To know that he is welcome to speak of his experience in the therapeutic container and he will be respected in his choices.

This kind of relationship was a *therapeutic container* where clients would be *welcome* and *supported*. Jay similarly commented:

I feel sad for him. I understand his conflict: a new hire, little experience, low on the power hierarchy. Thinking "I've got to 'suck it up', get out of here as fast as I can, live to fight another day. Viscerally; I cringe. Shoulders hunch up. I want to hold him. (I don't hold him. But somebody needs to hold him).

Counsellors would show warm feelings and they want *somebody to hold* the client. There is a sense that it was desirable for both sexual partners and therapists to be responsive and attentive to clients' by contributing to caring and intimate interactions that created a safe area for the client to be embraced and contained within.

Social stigma and judgement are barriers to community access. The basic theme of *social stigma and judgement are barriers to community access* was discussed by all participants. The foundation of this basic theme was that acceptance and non-judgement from others were key to clients' accessing of relevant community resources, such as loved ones and health care workers. Access was seen to improve health and safety through allowing the person to

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participate fully in society as themselves, while judgement by others contributed to barriers and were thus, harmfully cloistering.

Judgement from general society was noted by counsellors as a harm to BDSMers through hindering their access to loved ones. Adrian commented:

> I can totally understand her [Sara's] concerns about her children's opinion of her if they were to find out about her kink involvement. I would speak about the ways in which stigma and discrimination is profound in our culture around people involved in BDSM and kink.

Ivey similarly wrote:

> I might investigate the possibility of projection - that the way she [Sara] feels her kids might react the way either she feels society views her, her ex-husband views her, or perhaps the way a small part of her views herself.

These comments suggested that, because *stigma and discrimination are profound* for BDSM practitioners, there was the potential for people to internalize the way *society views* them and develop an accompanying sense of *shame*. Daren also stated that there was an "Overwhelming sense of shame or idea we need to hide our sexuality. BDSM is much more common than people realize." Hiding kept BDSMers safe from judgement, but also in fear and cloistered from fully expressing themselves to those close to them.

Stigma in the community also negatively affected access to healthcare. Adrian remarked on the barriers to obtaining healthcare:

> Often their presenting psychological needs have nothing to do with their BDSM or kink activities, but they are looking for someone who will not pathologize or judge them. Clients have said this to me directly on many locations - that they have left previous therapists or health care providers because they either did not feel safe enough to disclose their kink involvement, or when they did disclose they were met with stigmatizing, judgmental responses from their healthcare providers… I would explore what his [Alex's] relationship with his primary healthcare provider is like and ask if he feels comfortable to share his BDSM involvement with his doctor, and what kind of response he might receive there.

Due to *stigmatizing, judgmental responses* kinky clients faced challenges accessing counsellors or doctors. These types of responses from care providers made them feel *unsafe* to disclose.

Disapproval was expressed for professionals who held misinformation and contributed to this stigma. Erik wrote, "My immediate reaction is frustration with Dr. Smith for not being more aware of BDSM." Gail also commented on Dr. Smith's interventions:

> I understand where Dr. Smith is coming from. Limiting liability is a pretty big deal especially in private practice. But I think we know that contracts for safety don't work. They don't limit the behaviour, and they don't inspire trust and confidence in the therapeutic relationship…

Dr. Smith's unawareness induced *frustration* for Erik, and even though Gail conceded with Dr. Smith's intentions, she too indicated that Dr. Smith's interventions were contrary to what *we know*. Thus, they were ineffective due to a lack of information. Generally, Dr. Smith's interventions were deemed to be misguided by misunderstanding, even when they were granted concessions for limiting liability. Clearly, access to correct information about clients was seen as dispelling stigmatic responses.

Even the current author came under scrutiny as a potential spreader of misinformation and stigma. A commenter on the online forum recruitment advertisement wrote:

> As someone who does therapy work with people in the BDSM lifestyle, I don't find myself motivated to spend time on this anonymous survey, especially due to the way that this advertisement comes across. It assumes that therapists have no information about BDSM and seems like the researchers don't really understand the topic/hold biases given the use of the word "play" in the title – not everyone thinks of it that way.

Here, they suggested that I lacked information on or was biased towards BDSM from the use of the non-universal word *play*. Carol also commented on my intentions:

> I wish other therapists would stop judging them and start listening and trying to understand them. Once we have judged something, we stop trying to look deeper into the meaning of it. I'm wondering what sort of judgments this survey team has about BDSM...

Carol used more cautiously worded sentiments questioning my motives, *wondering* about the possibility of judgements from the research team. But, overall, there was a strong sense of suspicion towards and denunciation for professionals who were perceived to be passing judgment as well as a sense of protectiveness over the BDSM community.

Non-judgment was correspondingly seen as a positive approach to doing therapy work with these individuals. May wrote, "Yes, I have worked with BDSM clients. Normalize, consent, safety, and non-judgement!". Ivey similarly wrote, "With an emphasis on non-judgment, I would find it important to assess the function of this interaction and what might be helpful for him [Alex] within it.". Counsellors put *an emphasis on non-judgement* as an aspect of effective work. As Jay stated, a goal of therapeutic work was to "build a strong, accepting relationship." Nonjudgmental acceptance was a safe counterpart to the harms of stigmatizing responses.

If and when counsellors found judgmental or emotion-based responses roused in themselves, they indicated that it was important to recognize and process what was happening for them. Hailey commented, "... I tried to be mindful of my own experience potentially impacting my approach to treatment." Gail similarly remarked, "I think it's important to evaluate someone's level of distress associated with these activities. And to recognize any issues of countertransference that come up because we may be uncomfortable with what they're doing doesn't necessarily mean that they are." Being *mindful* of one's personal experiences was important in that it was desirable to reduce the impact the counsellor may have on the *approach to treatment*. The counsellors' *countertransference* was not what was important, but rather the client's comfort with themselves. Reflexivity was seen as one way that counsellors could prevent stigmatizing and doing harm to clients.

Aside from reflexivity, counsellors expressed that psychological professionals could reduce stigma through knowledge and resource sharing. May wrote, "We need more education and more research on this area. Thanks for doing this project!!" Likewise, Adrian wrote, "I'm glad you're doing this research. I think there is a great deal of pain created by healthcare practitioners for their clients from stigmatizing, discriminatory, judgmental, or fear-based responses." Researching and spreading information that could reduce judgement was seen as one role that professionals could enact to clients' benefit. Some therapists expressed that the current research project was important precisely because of the need for *more education and more research* due to the *fear-based*, rather than information-based, responses existing among some health professionals. Additionally, Katie identified that "it's really important for folks who are sex positive to identify themselves as such so they can be easily found for clients". Thus, another role that counsellors could play in reducing stigma was by helping clients to navigate which

resources were safe. Actions that contributed to kinky clients having access to non-judgmental therapy was deemed to increase safety from stigma for clients.

       People benefit from community. The basic theme of *people benefit from community* was discussed by 13 participants. The core of this basic theme was that support from an established community enhanced the wellbeing of clients through relationships and protection.

       Having access to supportive others was something that counsellors saw to increase wellbeing. Frank wrote, "I think this is a normal reaction to this situation, to go out and explore different ways of being. Due to her [Sara's] years of feeling unhappy and unheard, she has found someone who responds to her sexually." Similarly, Adrian commented:

> I would assess the circle of support he [Alex] has for his chosen activities, and what learning he has done around BDSM, kink, safety, spiritual or emotional growth… I would speak with her [Sara] about her choices around selective disclosure, about finding community with other like-minded people, and encourage her to participate in a support or introductory group with others who have been dealing with some of the same questions she has. Especially for someone who is entering into BDSM a bit later in life, and the challenges of being a parent relative to this involvement.

The client having someone who *responds* counteracts *years of feeling unhappy and unheard*. Not only was this important in terms of finding a sexual partner, but also a wider peer group, a *circle of support* of people who were *like-minded* and *dealing with some of the same questions*. This was said to help in managing the social *challenges* of being involved in kink. Having access to support from members of the community, either a partner or group of peers, was seen to *support* a clients' happiness and pursuit of authentic expression as well as assist them in managing their wellbeing in the face of stigma-related challenges.

       A larger community could also serve as a measuring stick for what behaviours were acceptable; if a behaviour fell into a recognizable pattern within a group, it could be considered appropriate. Frank wrote, "I feel that while some of her [Mary's] behaviours are high risk, they follow a pattern or norm within a certain community (BDSM). Many people engage in this and live a healthy life." Even if activities might be considered *high risk*, if they *follow a pattern or norm* that generally leads to people leading *healthy lives* then the risk is dissolved to some extent. Gail also wrote about the normalizing force communities had:

In college I was a feminist studies minor, and after college I participated in the queer

young adult scene, which really expanded my ideas of what's normal and appropriate and

in the range of human experience as far as sex, sexual identity, and sexual behaviour.

What is *normal and appropriate* sexuality and behaviour can depend on the community to which one was exposed. There was a sense that when many people were doing something similar, there was some amount of safety; as if the behaviours were tried and true, and so it should be unproblematic for clients to do the same.

Likewise, the therapy context could also be a place of community support. Many counsellors talked about normalization as a beneficial response to kinky clients. Daren remarked, "I respond like any other revelation. Sexuality is just another normal part of life. I normalize it and say it is OK within a healthy relationship." Likewise, Erik wrote:

I work with a large number of individuals that identify as ABDL/DDLG [Adult Baby

Diaper Lover/Daddy Dom Little Girl]/some variation on age play, and there is an overlap

with BDSM. I can't say that my reactions have been negative; I simply see this as

another aspect of a person's sexuality with no reason for disgust. Interventions with these

individuals have focused primarily on self-acceptance and dealing with issues related to

shame.

When encountering a client who had divulged a kinky sexuality, it was seen as helpful to *normalize it and say it is OK* and to view it *simply* as *another aspect of a person's sexuality*. The primary interventions would be to work on *self-acceptance and dealing with issues related to shame*. In these responses, kink was incorporated into two wider discourses that were generally considered to be normal: relationships (it occurs *within a healthy relationship*) and self-actualizing (it is *simply another aspect of a person*). In sum, therapists could and should become non-stigmatizing agents that incorporated clients into a larger, normalized community.

Society sets rules that protect and restrict. The basic theme of *society sets rules that protect and restrict* was discussed by 5 participants. The essence of this basic theme was that laws were put in place to maintain things worth maintaining, but by the same token, they could become too protective.

Laws and professional regulations were seen to be authoritative in preventing harm. Blair wrote:

'How might you determine whether a client's activities are acceptable?' If asked this by a client, I would tactfully explain that it is not within my power or purview to deem adult sexual behaviour "acceptable." Only the law and one's own sexual partners are empowered to do that. The laws against assault, rape, and abuse, along with the typical therapist disapproval of manipulation, co-dependence, and coercion, apply universally if they can be said to apply at all. No ethical person in any profession makes a special exception for special sex subcultures. BDSM practitioners are not above or outside of any normal standards of decency and health and neither require nor profit from special standards of treatment.

Blair saw that ethics and laws prevented harm, but also indicated that it was only under the purview of *only the law* to determine what was acceptable. And in addition, these laws were absolute and *applied universally* without *exception for special sex subcultures* in order to prevent abuses. While a client and *one's own sexual partners* were also *empowered* to deem what sexual behaviour was acceptable, it seems, from this passage, as though the absoluteness of the law would, in certain circumstances, disempower that same client if they did not fall within the universal set of ethics; BDSMers were *not above any normal standards of decency and health*, which the laws protected. Clearly, laws and ethical standards were compelling protective measures designed to safeguard clients' wellbeing.

However authoritative the law could be, it could also be authoritarian. Adrian was the only participant to note this:

I think these attitudes [stigmatizing, discriminatory, judgmental, or fear-based] are furthered by regulatory bodies that are inherently highly conservative in nature, and the risk this puts kink-aware professionals in if / when they have open dialogue with their clients about the client's kink involvement.

Here Adrian chides regulatory bodies for being too *inherently highly conservative* which could, in itself, cause some type of harm in terms of perpetuating stigma and hindering healthcare access. Although society set laws to protect individuals, they could also become a source of harm.

Mental health and Healing. The organizing theme of *mental health and healing* related to the role of BDSM in creating and/or maintaining a state of mental wellbeing. BDSM was constructed as a coping skill that, like any coping skill, had helpful and less helpful uses. As

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such, sometimes kink behaviour was not problematic and other topics were pursued for therapeutic ameliorating. However, sometimes, the use of kink as a coping method was seen as potentially problematic and was a focus of therapeutic intervention. Counsellors negotiated the relationships between BDSM and stress, self-harm, and trauma that, such that they did not implicate BDSM inherently in pathology per se, but rather as a coping mechanism that arose *in response* to and *for dealing with* the stressor. Unhealthiness in the context of using kink as coping existed more so in the way the BDSM coping tool functioned for an individual, rather than its sometimes-traumatic etiology. All participants articulated this theme in their accounts. The 4 basic themes supporting this organizing theme include *BDSM a coping tool enhancing or detracting from wellbeing*, *BDSM can be influenced by negative past experiences*, *self-harm can be related to BDSM*, and *BDSM can be pathological when out of control*.

BDSM a coping tool enhancing or detracting from wellbeing. The basic theme of *BDSM a coping tool* enhancing or detracting from wellbeing was discussed by 14 participants. This basic theme was about BDSM as a method of coping which could mitigate harms and act as a method of healing. If it was used in a beneficial way, the focus of therapy was thusly on other issues and/or simply bolstering a general set of coping skills. By contrast, BDSM as a coping skill could also be used in the wrong situation or become overused, thereby becoming problematic.

Kink was seen as a potentially very helpful tool for coping with and healing from mental distress. Frank wrote:

> I find a lot of women who have jobs that require lots of responsibility and power tend to engage in this to some degree, that when they come home they let their husband/partner take the more dominant role so they can "turn their brains off" for a while… I see this as a type of coping and searching for balance.

Similarly, Olivia commented:

> My immediate reaction [to the Alex vignette] was one of relief. When I read the first half of the vignette, I felt very worried for this young man, and I was relieved to hear that he found a (although unconventional) way to cope with all of this pressure.

Using BDSM was helpful for clients in that it helped them to find *balance* and to *cope with all of this pressure*. According to Adrian, it was also possible for BDSM to play "a healing role for people's psychological or spiritual distress." It was *a relief* that clients had this positive outlet

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and coping skill. Overall, BDSM could play a role in restoring a state of mental wellbeing by helping clients to process distressing emotions and events that had thrown them off balance.

However, coping using kink behaviours could be problematic or unhelpful when it was not life-affirming or when aspects of it were overly relied on. Olivia wrote:

> When Mary states, "I like it when I'm celebrating my life, but also when I'm mourning it" as well as, "she sometimes wants to engage in BDSM when she feels down", I worry that she may be using BDSM as an unhealthy coping mechanism for depression.

BDSM could, thus, be also be used as an *unhealthy coping mechanism*. Presumably, the distinction between healthy and unhealthy use of pain here was in that it was not affirming Mary's life, but rather the pain was enjoyed in a context of lamentation towards her life. Ivey also commented on the appropriateness of using BDSM to cope:

> I might work towards establishing goals for him [Alex] to add to his skill set of how he's going to deal with the pressure. Since this method of coping (regardless of its sexual involvement) includes actions of another person, it might be helpful for him to integrate additional coping strategies that he can engage in independently.

Additionally, over reliance on another person to help with coping through BDSM could potentially cause problems due to a lack of *independence.* Frank also posits that becoming "overly reliant" on the BDSM activity itself could indicate an unhealthiness. Overall, BDSM that was not affirming of a client's life or implicated the client in a level of dependency (upon another or upon the tool of kink itself) was seen as unhelpful.

Other ways of coping were sought for clients, both when the BDSM behaviour was working well as a coping skill and when it was seen as harmful. When it was going well, counsellors simply wanted to strengthen a client's overall repertoire of coping skills. Olivia stated:

> Like with any client, I would want to work with him to expand his [Alex's] tool belt of coping mechanisms beyond just role-play scenarios with his girlfriend, but I would not discourage him from continuing to use the role-play in addition to other coping alternatives.

In this report, BDSM was helping the client, but learning more ways to *help deal beyond just role-play* provided the client with even more beneficial alternatives that they could draw upon.

However, when BDSM behaviours were seen to be unhelpful, counsellors were inclined to focus intervention on harm reductive strategies to reduce or change the coping behaviour. Gail asked, "Are there safer and less risky, more effective alternatives she [Mary] could use?" Frank similarly commented, "I might also have her [Mary] engage in mindfulness training and look at alternative ways of coping or dealing with stress such as DBT, to continue to increase]/maintain her current level of safety." Katie, too, remarked that she would "...find out what her [Mary's] interests were outside of self-harm and BDSM and to affirm that and to provide a harm reduction plan for that." Counsellors wanted to explore *less risky* and *alternative ways* that Mary could use to cope besides kink. It was desirable to look at and promote interests *outside of self-harm and BDSM*. It is implied that, in contrast to BDSM (and what Katie labelled as *self-harm*), these other ways would be beneficial for Mary's *safety*. These reports indicate that other alternatives to using BDSM, in Mary's case, would be *preferable* alternatives rather than just alternative ways of coping to bolster a client's general tool kit. Instead of helping, kink can be doing harm as a way of coping.

When BDSM was a way of coping for a particular issue or life event, counsellors were focused on pursuing this issue rather than the coping mechanism itself. Gail wrote:

> Probably something that needs to be addressed is that if, she [Sara] is going through a divorce, and not already divorced, whether she is completely finished with her marriage relationship. It might be difficult for her to separate any kind of resolution she would get from a divorce while she could be distracted by her current activities and their exhilaration. I would encourage her to a line her stated goals as far as emotional resolution and her marriage and help her determine whether her activities in the bedroom are helping her recover from her marriage or are distracting her from her ability to get what she wants out of the ending process.

Gail focused on the possibly sorting out the *ending process* around Sara leaving her previous marriage. Although there was still a concern about BDSM potentially getting in the way of resolving feelings around the marriage, due to its *distracting* allure, enticing Sara away from dealing with a possibly more pressing issue. Katie wrote about similar themes in Alex's work situation:

> I would want to know what he [Alex] would want to change in his workplace, and how he could see himself gaining agency. I think that he could be empowered by being

submissive at home, but I think further conversations need to happen first. Ultimately, he

may be happier in a new workplace.

His work situation, one which *he may be happier* to change, was a far more critical issue to attend to than his use of kink which helped him cope by allowing him to be *empowered by being submissive at home*. Overall, in these comments, BDSM was not the main focus of treatment or amelioration, but instead, other topics that clients were dealing with were of more import to the therapeutic work.

Counsellors also saw the potential need for attention to other mental health issues, which were not inherently linked to kink activities. Hailey reported, "I don't see the need for an intervention. She's [Sara's] exploring her sexuality and getting out of a relationship that's been somewhat unfulfilling. I'd probably screen for [symptoms] of mania just as a rule out." Here, it was thought to be prudent to screen Sara for mania *just as a rule out*, as she was likely simply excited at exploring newfound fulfilling activities. Likewise, Daren, "would need to learn more. Possibly get a release signed to find out if Dr Smith is kink aware. I would want more history on client for an accurate diagnosis (cluster b or not)." Daren expressed a desire to obtain a more detailed history of Mary, in order to better assess for the possibility of a *cluster b* personality disorder. In these reports, kink as coping was unrelated or tangential to any possible cooccurring mental health diagnoses.

BDSM can be influenced by negative past experiences. The basic theme of *BDSM can be influenced by negative past experiences* was discussed by 5 participants. The essence of this basic theme was that BDSM can be a reaction – either helpful or unhelpful – to a traumatic or negative event. This suggests an understanding of BDSM as a way of coping, like in the last basic theme, however, this basic theme is distinguished in that it concerns coping specifically for trauma. BDSM was said to have possibly developed from as well as contribute to the amelioration of traumatic experiences. Gail wrote:

So much sexual trauma occurs in so many of our lives, that we often don't know how to

express it. It gets played out in the bedroom, it gets played out in our intimate

relationships and our friendships alike. I think there are certainly safe ways to practice

BDSM and I think that the range of appropriate and healthy sexual behaviour is probably

a lot wider than most people are comfortable with considering.

Here, *sexual trauma* may get *played out in the bedroom* in the form of BDSM. Although related to trauma, this reaction can play out in *safe ways* and might be *appropriate and healthy sexual behaviour.* Adrian similarly commented:

> I would be assessing if the behaviours appeared to be a simple reenactment of previous traumas, without a clear healing component. I would be assessing the impetus or motivation for the client's involvement in these activities, and the meaning to them.

From Adrian's comment, BDSM in response to trauma might, in fact, have a *healing component*, if it exceeds being merely a replication of the traumatic event. Overall, BDSM can both stem from a traumatic event as well as help heal it.

BDSM was also seen to possibly stem from negative patterns of interactions from family. Jay wrote:

> Hmm; where's the 'disconnect' here? Ah!! He [Alex] feels 'unworthy'! This must be a characterological issue for him. What's the history, the development of his unworthiness? Family dynamics. Encourage him to free-associate about his role in his family of origin.

Here, long term familial relational patterns contributed to *characterological* problems, feeling *unworthy*, and a consequent use of BDSM. Carol also commented on Alex's development:

> The actions of daily work VERY RARELY are that directly tied to a person's current sexual activity. A more likely situation is that this person [Alex] had an overbearing parent when they were a teen, with very little direct involvement from the daily job.

Alex having had an *overbearing parent*, was posited to be a far more likely origin of his kinky desires than his experience at work. In these accounts, BDSM was understood as potentially having roots in trauma from entrenched family patterns. The value of the role of BDSM to cope was more uncertain here, but still appears to be inherently neutral, while the traumatic etiology of BDSM was appraised negatively and separated from the (at least neutral) coping mechanism.

Self-harm can be related to BDSM. The basic theme of *self-harm can be related to BDSM* was discussed by 7 participants. The essence of this basic theme was that self-harm *could* be connected to BDSM but was at once a distinct construct. A line could separate the two constructs, even if that line could become blurred.

Erik discussed masochism in a way that suggested that it could constitute a form of self-harm:

From a perspective of SFBT, it appears that the client [Alex] is able to utilize what superficially appears to be a form of masochism, as a strategy for creating resilience. I might point this out and draw parallels to a documentary film in which an individual used masochism as a coping strategy in order to become (at that time, in the 1990s) the oldest living person with cystic fibrosis.

The phrasing, *what superficially appears to be a form of masochism,* appears to distinguish something that merely imitates the *form* of masochism from a veritable masochism. This superficial masochism was a *strategy for creating resilience* for Alex, and indeed, one that might even contribute to longevity in the face of grave illness. There seems to be an implication here that somehow, a more authentic masochism may lean towards a self-destruction, rather than the regenerative qualities of a pseudo masochistic coping strategy.

A self-harming versus self-healing distinction was made for the use of pain by many other participants as well. Adrian wrote:

I would recommend she [Mary] watch the movie, The Secretary, immature young woman who has a history of self-harm comes to terms with her own kink inclinations and the differential between pain for pleasure and pain of self-harm.

And Gail commented:

It might be important for her [Mary] to understand though, that there is a risk of harm to her while she engages in these practices, especially because she has a history of self-harm…. I think eventually she probably needs to examine the fact that at some point in her life, someone communicated to her that it is okay to use physical violence to deal with her emotions, even if that behaviour is self-directed aggressive behaviour.

There was clearly a *differential between pain for pleasure*, or *sexual pain* and *pain of self-harm*. The distinction here was one of pleasure; if it was used to feel good, then the pain was sexual pain. By contrast, if the pain was used to feel bad, perhaps as a *physical violence* to the self, then it was self-harming pain. Lynn postulated that Mary's behaviour "could be self-harming behaviour with deeper levels of complexity." Thus, due to the multiplicity of pain, it was possible for Mary's use of kink to be a *self-harming behaviour with deeper levels of complexity*, and perhaps because of this possibility, there was *a risk of* (self?) *harm to her while she engages* in kink. Thus, sometimes self-harm could masquerade as kink when it was an extremely

complicated self-harming behaviour. Nevertheless, these responses demonstrated that kink and self-harm could possibly be intertwined, while remaining distinguishable.

When the lines were blurry between BDSM and self-harm, it seemed as though kink with another person could mitigate some of the harms involved in self-harm. Frank saw "the fact that she [Mary] has stopped personal self-harm and has limited this to intimate sexual play as being a positive." For Frank it seems that the actions of self-harm could be appropriated into an activity that reaffirms engaging with others relationally, *intimately*, and for presumably pleasurable *sexual play*. Again, the pleasure versus pain dichotomy was invoked to set kink and harm apart.

BDSM can be pathological when out of control. The basic theme of *BDSM can be pathological when out of control* was discussed by 5 participants. The foundation of this basic theme was that kink could be evaluated in terms of how it functioned for a client, with control over the use of BDSM in one's life was seen as a critical factor in the healthiness of the functioning.

How BDSM functioned for a client was of prime significance in interpreting the behaviour. Gail wrote:

> My therapeutic approach that includes harms reduction and motivational interviewing as far as meeting clients where they are and determining their levels of distress and desire for change certainly informs how I look at behaviour like this in the broader context of what it's doing for a person rather than in a context of being right, wrong, disgusting, or pleasurable.

It mattered *what it's doing for a person*. In addition to functioning, the *levels of distress and desire for change* were significant. Is what the BDSM doing working for the client? This is the question that mattered more than a sense of whether it is *right, wrong, disgusting, or pleasurable*, which is consistent with a client-centered model. The functionality of the behaviour was evaluated in terms of whether an individual was content with the results of their kink activities, but also in whether they were in charge of them.

When a person lost control over the impact BDSM had on their lives, it was seen as harmful. Erik wrote:

> The line between acceptable and 'going too far' starts to become visible when (a) there is a lack of consent/kink is being forced unknowingly onto others, (b) the BDSM activities

become so frequent that it appears obsessive and/or compulsive, or (c) frequent

preoccupation with BDSM activities or lifestyle is a distraction from everyday life/work.

Olivia also commented, "I would determine if things were going "too far" by talking with my

client about how these activities are impacting other areas of their lives, and if they are feeling as

though these potential impacts may be harmful." These comments highlight that when BDSM

becomes *obsessive and/or compulsive*, takes up too much space from *everyday life/work*, or is

impacting other areas of their lives in an undesirable way, it crosses over into some level of

unhealthiness. Jay compared this loss of control to addiction when he reported, "Hey; I have my

own fantasies about women who like rough sex. I am well aware of the power of 'the dark side,

Luke'. And I...   ...   ...BUT I also find sex 'exciting'. And 'exciting' can be addicting."

Presumably, *rough sex* can be *the dark side* which, seduces a person into a cycle beyond their

control. Overall, healthy kink manifested in a way that produced no ill effects for clients in the

realm of *everyday* life, whereas pathological manifestations of kink seeped into other areas of

life and took over, leaving the client with less power over their unchecked kink.

     Threat and safety are vague. The organizing theme of *threat and safety are vague*

pertained to an ambiguity expressed in participants' responses addressing safety, health, danger,

and sickness. At times, these concepts were left at face value, almost as if they were self-

explanatory or common knowledge, or alternatively, perhaps the ambiguity reflects an

acknowledgement of multiple versions of safety and harm that a client may author. Fourteen of

the 15 participants articulated this theme in their accounts. The 2 basic themes included in this

organizing theme included *safety is an ambiguous state* and *harm is an ambiguous state*.

     Safety is an ambiguous state. The basic theme of *safety is an ambiguous state* was

discussed by 13 participants. The essence of this basic theme was a haziness around the meaning

of health and safety. Health and safety were sometimes discussed at face value, with little or no

indication of their semantic content. Carol touched on this when she reported resources which

had been useful, namely, "Any workshops on informed consent. Social media like Fetlife.com,

and meetup groups. Real live humans that participate in kink in a healthy way." There are

perhaps hints at what a *healthy way* is or what constitutes *safety*, but those hints largely need to

be inferred through context, if they even can be. What exactly *real live humans* contribute to the

healthiness of kink is uncertain, other than perhaps setting a good example of using *informed*

consent. Lynn also highlighted the ambiguity of safety when she wrote about her desired

outcomes, where the client was "intentional, safe and happy with choices, whatever they are" The statement, from Lynn, indicated that there may be some room to negotiate safety, as it was the goal for clients to be safe with *whatever* their choices were. This suggests that safety may be reliant on clients' personal meanings, but this interpretation is not clearly the appropriate one. In sum, safety was, at times, vaguely constructed.

   Harm is an ambiguous state. The basic theme of *harm is an ambiguous state* was discussed by 12 participants. This basic theme concerned the haziness around what constituted harm. It was the counterpart to the above basic theme safety is an ambiguous state. Concepts of harm, risk, and danger were also depicted in counsellors' responses without much indication of the meanings behind these concepts. Jay pondered, "What would you do if you thought your client was taking their activities too far? Danger to self or others? I'd be taking a good look at that." When Jay spoke of *danger to self or others*, it was clear that danger was something to be wary of, but a deeply meaningful interpretation of d*anger*, other than it being something vaguely aversive, is impossible. Lynn similarly wrote about harm in a vague way:

> Humiliation/pain based role play is complicated. His [Alex's] explanation of it being confidence boosting (fear busting) is interesting and where my exploration may lead. If this was a first visit and I had no other info, I would want to explore safety issues around pain seeking behaviour and other risk areas.

Pain seeking behaviour was lumped in with *other risk areas* to be assessing for. The meaning of *risk* in Lynn's statement was also quite ambiguous and would take a large interpretative leap to reach any notions richer in meaning. Overall, harm and safety were, at times, discussed in a vague and ambiguous manner with no clear deeper meaning readily interpretable.

<h2 style="text-align:center">Summary</h2>

   This chapter explored the themes produced through analysis of the 15 participants' survey responses. In keeping with a thematic method of data analysis, commonalities between participants responses were highlighted while over patterning the results was avoided by discussing relevant discrepancies and idiosyncrasies within the themes (Braun & Clark, 2006). In total, 6 organizing themes related to the research question were generated: *bodily integrity*, *selfhood*, *presence of consent*, *social connectedness*, *mental health and healing*, and *threat and safety are vague*. In *bodily integrity* counsellors expressed safety in terms of keeping the body whole and alive, and harm in terms of altering it permanently, potentially causing death. In

<p style="text-align:center">100</p>

selfhood counsellors denoted safety in terms of client self-determination and expression of their authentic sexual selves, whereas harm was signified by coercion or imposition of another's will onto the client. In *presence of consent*, free, informed, and mutually communicated consent between capable persons was seen as safe, so long as the activities consented to fell within some limits of acceptability; breeches of any element of this description of consent, such as a coercive power differential or consent to imminently fatal activities, was seen as harmful. In *social connectedness* participants expressed notions of safety in terms of having a sense of belonging, caring, and support from others in a community as well as fitting into some kind of community norm of conduct or having *normalizing* experiences. Barriers to social inclusion, such as judgement and stigma, were seen as harmful. In *mental health and healing* safety was expressed in terms of BDSM being used as a life-affirming, pleasure inducing coping skill that contributed to mental wellbeing. Here harm was seen to occur when BDSM as a coping skill became self-punishing or harming or seeped out of an individual's control. In *threat and safety are vague*, concepts of safety, health, danger, and harm were expressed at face value with little indication of a deeper meaning. These six themes coalesced into one overarching global theme.

The global theme overarching these was *containing and maintaining an individual*. In this theme, safety was interpretable as anything that helped an individual to draw boundaries around themselves, such that they contained their physical and mental self while they were in relation to others. Safety was also seen as anything maintaining the individual, keeping them alive and well in their physical, mental, and social containers. Harm was interpretable as the opposite, where boundaries between people and others were ill-formed and individuals lacked a life affirming view which could destroy them. In sum, individuals were ideally contained within skin, ego, social boundaries and norms, and mental health and maintained in such a state.

CHAPTER FIVE: DISCUSSION

The purpose of this research study was to increase knowledge about how counsellors understand the concepts of harm and serious reportable harm in the context of clients' BDSM pain play. There has been a long lineage of pathologizing and treating individuals with sadomasochistic interests (e.g., Freud, 1938) and some recent studies suggest that, while the psychological field is progressing away from a pathologizing view, clients' sadomasochism may still cause uneasiness for some therapists (Garrott, 2008; Kelsey et al., 2013; Kolmes, et al., 2006) and consequent repercussions for clients (e.g., Bezreh, Weinberg, & Edgar, 2012; Kolmes, et al., 2006). Thus, a better grasp of how counsellors make sense of BDSM play, specifically pain play, in terms of potential harms to clients was sought. This chapter will discuss the results presented in chapter four in relation to the current literature. The strengths and limitations of this study, implications for counselling practice, and suggestions for further research will also be discussed.

Few previous studies have looked at counsellors' views of BDSM (e.g., Garrott, 2008; Kelsey et al., 2013; Lawrence & Love-Crowell, 2008) and none have focused on their evaluations of specific play activities that might be considered painful. There has, however, been indication that the use of pain in BDSM may be alarming (Garrott, 2008) or bring about uncertainty (Kelsey, et al., 2013) for some counsellors. The current study aimed to impart a fuller understanding of counsellors' perceptions of clients' BDSM pain play. It was hoped that by introducing vignettes, counsellors would provide their understandings of specific activities (Garrott, 2008). Secondarily, this research was designed to pay attention to how these understandings might impact counsellors' treatment decisions.

While reading the counsellors' accounts, it became apparent that the harms they talked about encompassed far more than pain. In fact, concern about pain was nearly absent in the participants' accounts. Rather, harm was determined by the function of the painful activity on boundaries of bodies, minds, and relationships.

Harms and corresponding treatments discussed by the participants were consistent with a liberal ethic of self-fulfillment (Rubin, 2010) as well as a liberal interest-based ethic (Gourevitch, 2009). If harm was not present or not serious, interventions were focused mainly on self-determination (e.g., asking the client to define and reflect on their experiences, goals, and boundaries or psychoeducating the client so that they could make informed choices). But once

harm became serious, interventions (e.g., reporting potential harm to prevent it) could be described by the paradox involved in the modern ethic of self-fulfillment. Although, in this ethical paradigm, an individual is seen as a self-determining agent, they are simultaneously required to stay alive in order to uphold the morality of enjoying life (Rubin, 2010).

Gourevitch (2009) described this paradox of modern liberalism as an interest-based ethic. In an interest-based paradigm (Gourevitch, 2009), the best interests of a client are safeguarded, and their rights enforced for them by a vague other (in this case, the counsellor and authorities may act as such a third party). As Gourevitch (2009) described, liberalism originally conceived of the rights bearer as a moral and political agent, but in an interest-based paradigm:

> … the theory reconceives of the rights-bearing subject not as a self-willing moral agent but as a needy individual whose vital interests need protection. Second, this reconceptualization of rights opens the door for a paternalistic political practice, in which an external, third party "exercises" the rights rather than the rights-bearing subject himself (p. 302).

In this line of reasoning, people become victims whose needs must be protected, rather than bearers of rights who are in control of choosing to enforce those rights (Gourevitch, 2009). This is generally consistent with current CPA (2017) and CCPA (2007) ethical guidelines which emphasize self-determination, but also prescribe protective action on clients' behalf under certain circumstances, such as when there is a threat to life, vulnerable persons involved, or there are other vague, grave consequences.

The global theme connecting the harms discussed in this study, *containing and maintaining an individual*, had, at its root, a desire to both encourage clients' self-determination, yet circumscribe and endorse life-affirming uses of BDSM and preserve life. Six organizing themes feeding this global theme were generated: *bodily integrity*, *selfhood*, *presence of consent*, *social connectedness*, *mental health and healing*, and *threat and safety are vague.* These themes are discussed in turn in the following sections.

Containing and Maintaining an Individual

The global theme *containing and maintaining an individual* suggests that these results are not about the controversy of pain play, but rather, whether or not a client's actions and motives crafted and confirmed a continued physical, mental, and relational self. A discussion of pain seemed to be almost absent, suggesting that pain itself, if life affirming for the client in act and

purpose, was seen as a non-issue and a valid self-determined pursuit by the counsellors who participated in this study. This contrasts with the sizeable minority of Garrott's (2008) counsellor participants who viewed pain as aversive, the sizeable minority of Kelsey and colleagues' (2013) counsellor participants who were uncertain about whether sadomasochism could be healthy, as well as the pain-averse discourse recounted by Newmahr (2010a). However, the findings of this study are consistent with Garrott's (2008) in that the majority of Garrott's participants did not view pain as inherently aversive. The present findings are also consistent with various authors' views that a growing number of psychotherapists appear to be increasing their levels of comfort with BDSM and moving away from explicit discrimination (Kelsey, et al., 2013; Kolmes et al., 2006; Nichols, 2006). Pain as a non-issue is also similar to the counsellors in Kelsey and colleagues (2013) who mainly (though not wholly) endorsed statements that allowed for sadomasochism to be considered healthy. Taken together with previous literature, these findings suggest that a growing number of counsellors are less concerned with BDSM itself, and more concerned with the function of it in terms of supporting clients' various dimensions of life.

The counsellors' understandings around maintenance and containment of life are consistent with a self-fulfillment morality (Rubin, 2010) and interest-based morality (Gourevitch, 2009). Both allowing self-determination for clients and a notion of protecting people's best interests, sometimes despite themselves, is apparent in discourse around kink. Contextualized within these lines of ethical reasoning, the findings of the current study suggest that life-sustaining, recognizably well-being enhancing benefit of pain was viewed as an acceptable self-defined goal, whereas self-destructive activities which carried serious risk to life and liberty was the domain of a protective, interest-based ethic meant to serve a clients' inherent needs to continue self-fulfilling (Rubin, 2010; Gourevitch, 2009).

This interpretation is consistent with Garrott's (2008) conclusion that counsellors worked to balance value-neutrality in order to make space for clients' self-determined values, with the prevention of harm. The current study, however, adds further detailed discussion on what comprises counsellors' notions of harm and how those might impact counselling interventions. The following sections on organizing themes delve into what constituted specific types of harm.

Bodily Integrity

The organizing theme of *bodily integrity* illustrated the importance of the wholeness of physical bodies; whether they remained whole or regained wholeness, it was important to

counsellors that they exist relatively uninterrupted in order to maintain life. The desire the counsellors expressed for physical wholeness was similar to sentiments expressed by some of Garrott's (2008) counsellors, who talked about physical tissue damage and pain as being contentious. The construction of impermanent bodily interference as a potentially acceptable kind of bodily interference is also consistent with the current Canadian Criminal Code which suggests that one may only consent to bodily harms which are transient and trifling (Criminal Code, 1985).

While bodily integrity was important for both Garrott's (2008) participants and the current ones, there was more discussion amongst Garrott's participants about the aversiveness of authentic bodily - rather than feigned - pain, whereas none of the counsellors in the current study constructed pain as being inherently harmful. Instead, the counsellors in the current study placed emphasis on tissue damage, rather than pain per se, as the aspect of pain play that may be aversive and/or harmful. This view from the counsellors in the current study was divergent from a measurable minority of Garrott's participants, but consistent with some of the relatively more kink- comfortable counsellors who also allowed for pain and bodily damage to exist in "a more complex, multidimensional map of the range of "healthy behaviour" (Garrott, 2008, p. 94). This difference in talk about pain might reflect participant sampling (i.e., who chose to respond to an internet survey versus Garrott's in-person interviews), or, alternatively, it may also reflect an advancing general societal acceptance of BDSM since Garrott's research was conducted. It may be that more painful activities are now more widely constructed as acceptable. However, the latter supposition should be interpreted cautiously, as participants from both Garrott's (2008) and the current study expressed concerns about judgment from insensitive mental health professionals. Thus, those professionals may have simply not been represented in the current study. Overall, the current findings suggest that counsellors saw bodily integrity as a more important factor in safety than pain, per se.

The valuation of life and limb above all else is consistent with counselling ethics (CPA, 2017; CCPA, 2007) which explicitly outline loss of life and bodily injury as serious harms necessitating preventative action from counsellors. Undoubtedly, the counsellors' understandings were impacted by the ethical standards which guide their profession. The counsellors' understandings, and the ethical standards from which they were informed, are

consistent with a modern ethic of self-fulfillment (Rubin, 2010) in that pain was seen as something that may be enjoyed by self-determining beings.

This ethic of self-fulfillment, however, also contains a paradox which *requires* individuals to choose to continue living and enjoying life (Rubin, 2010). Self-determination was endorsed when dealing with non-harmful, non-serious, or indeterminant harm, where activities were perceived to have only a vague - and not immediately certain - possibility of bodily tissue interference. In these activities - for example, choking, cutting, and activities that risked transmitting disease - the decision to participate was generally left up to the client. However, the limits of self-determination were also predicated on maintaining a whole body, presumably for further enjoyment (i.e., healing sufficiently and living in order to enjoy oneself later; Rubin, 2010). Some counsellors saw some permanent bodily interference as potentially acceptable, such as a brand being akin to a tattoo, and others saw permanent interference with the body (ranging from branding to autoerotic asphyxiation) as a serious harm which required preventative action. Regardless of a client's choice to pursue self-fulfillment in an activity, it was necessary that they live through it (sometimes unmarked) or else the counsellors were compelled to act on their behalf to protect them. Thus, the counsellors' understandings were also consistent with an interest-based ethic (Gourevitch, 2009) and generally with counselling ethics (CPA, 2017; CCPA, 2007), but there was some disagreement over what constituted serious bodily harm when it came to non-fatal activities.

This disagreement brings up more questions about how counsellors might make sense of ethical standards in this context. Would reporting certain types of permanent bodily changes due to kink be unethical and take away people's rights to self-determination? Under what circumstances are permanent changes okay? Does this apply to scars, piercings, or just other more intensive modifications such as amputations? Does the reasoning change if they are incidental or pre-planned changes? And how does the sense-making for kink-induced body modifications compare to other reasons, such as cosmetic surgery, that people undergo potentially risky, voluntary bodily changes? This study provides some insight into how counsellors might answer these questions, but it is a preliminary step analyzing only themes, and further investigations are needed.

The notion of an interest-based ethic is entirely consistent with mandated reporting of serious harm. In these cases, individuals are not allowed to exercise their own rights, but rather,

they are exercised for them. The rights to bodily integrity and life are not always choices. There is not always a right to change one's body and there is no right to die in a sexualized circumstance. It is by this interest-based ethic that consent to an activity which produces bodily interference may be voided in order to arrest an individual from pursuing their own choices (Downing, 2004). This notion is consistent with some of the critiques of BDSM normalization which act in a similar way, only allowing recognizable pleasure, rather than pain or potential threat to life, to be pursued (e.g., Dymock, 2012).

Selfhood

The organizing theme of *selfhood* highlighted the importance and respect counsellors gave to clients expressing an authentic, unique, self-determined identity with autonomy and agency. Anything that impinged on this process of being oneself, such as oppression and shame from society and other counsellors, was seen to be harmful. This theme is consistent with an ethic of self-fulfillment (Rubin, 2010). It is also consistent with Taylor and Ussher's (2001) finding that many BDSMers understand their practices as an essential part of themselves that was always present, or that had been discovered by the coaxing influence of external influences, which they termed "socialised essentialism" (p. 251). Taylor and Ussher suggest that this essentializing narrative is more likely to be celebrated than a constructionist one, and that it may hold more political clout in terms of avoiding moral judgements from society. Thus, the negotiation of selfhood might have been a moral and political one which, while focused on a unique individual, remained in both tension and commune with societal mores.

Counsellors endeavored to preserve space for individuals to determine and discover themselves. Similar to Garrott's (2008) results, which highlighted therapists' struggles to remain value neutral while also acting to prevent harm, the counsellors in the present study valued clients' self-determination and expression of a sexual self while also noting some perplexity at how to ensure a client was safe. If the situation was not reportable, the current participants' solution was often to let clients determine whether an activity was harmful and/or worth doing for them, whether something was within their self-determined boundary or not. However, counsellors simultaneously desired to provide information which they thought might help clients determine where the line between safety and harm was, such as by providing psychoeducation about what limits distinguished safe and harmful BDSM. This quandary of allowing self-

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boundary making, while also preventing harm as the counsellors saw it, was perplexing for the participants, as well as for myself.

When another's will (such as an imposing counsellor, partner, or societal oppression) replaced that of the client, it was seen as harmful, suggesting that participants placed significance on an inviolable, authentic self. As Downing (2004) noted in a discussion of the ethics of lust murder, the "precondition of violability" (p. 14) is no longer seeing the humanity in the victim which allows the killer "permission to 'break up, smash, or break into' the other" (p. 14). This observation is consistent with the current participants' desire to have clients boundary themselves in negotiating limits in BDSM play and in relationships generally. Thus, their humanity should be preserved by their boundaries. However, Downing also notes that, in the case of a "victim" (p. 14, 2004) who "instrumentalizes the killer" (p. 14, 2004), the victim's consent, voice, and subjectivity are actually in the forefront. Dymock (2012) too notes that agency is required to ask for kink activities which are actively discouraged by wider society. An active and consensual breaking of a self-boundary represents an interesting dilemma where to value an uninterrupted self is also a dismissal of that very person's self-determination. This begs the question: what is violence? Relating this discussion back to the issue of essentialist and constructionist selves, the question expands: what is essentialized versus constructed violence? The notion of violability of the self is closely tied in with the following section, which discusses the matter of consent.

Presence of Consent

The organizing theme of *presence of consent* emphasized the importance of free, informed, consent to acceptable activities by capable persons. Interest-based ethical reasoning is congruent with the counsellors' preference to protect a client's personal liberty (Gourevitch, 2009). The counsellors in this study understood an unequal power dynamic to be a sort of harm, sometimes serious harm, depending on the context of the imbalance. There was a notable amount of concern around ensuring a person's freedom to consent. For example, there was concern around whether Mary was truly free to consent to Jeff or whether she was a victim of abuse. While the counsellors generally did not want to be overly restrictive and offered Mary choice in exploring her own experience of the relationship, there was also indication that anything that fit into their understanding of abuse or non-consent would sit uncomfortably with them. This could become an especially complicated area in a BDSM setting, where activities may play on the

borders of conventionally conceived valid consent and personal boundaries by practitioners who actively pursue, plan, and accept the risks and benefits of such practices (e.g., Beres & MacDonald, 2015; Miller & Devon, 1995). Indeed, in Beres and MacDonald's (2004) study looking at women's experiences with consent in kink there was indication of a similar dilemma. While the women noted positive experiences where they enjoyed a lack of choice with one woman, for example, "making an informed choice to leave the selection of included activities to her dominant partner" (Beres & MacDonald, p. 425, 2004), the authors suggested that experiences such as this may be influenced by the oppressive heteropatriarchy. Thus, Beres and MacDonald's critique of this kind of experience renders the women helpless to protect themselves from the heteropatriarchy even though the women constructed themselves as agents actively seeking these types of experiences. In this interest-based ethical paradigm, clients are bound to be free.

Another example of an interest-based third party rights enforcing reported in the previous literature is that of police apprehending and charging purported assailants, in order to "free gay slaves" (Attias, 2004, p. 57). These slaves, however, had in fact, entered into a consensual BDSM power exchange with the purported assailants. Although the slaves which Attias (2004) spoke about had enacted, or played, such a part volitionally, police interception was guided by the morality to protect their liberty, albeit against their will. This kind of discussion is about "who decides" (Gourevitch, 2010, p. 316). Gourevtich (2010) reasons that "it is a tension between those for whom human rights is a morality and those for whom it is a politics of individual liberty" (p. 317). This tension seems to describe that for counsellors in the current study who wanted clients to have liberty and be self-determining, while also upholding the moral imperative to prevent abuses. I am not arguing that no one is ever in need of protection or help enforcing their rights, nor that it is necessarily paternalistic that the counsellors displayed concern for Mary. However, it is apparent that enforcing people's rights on them and against them may occur in some circumstances, particularly, in a BDSM setting. This theme prompts reflection on how this might occur in counselling.

Social Connectedness

The organizing theme of *social connectedness* illustrated the importance counsellors placed on access to inclusion from partners, peers, and professionals within the community. Warmth, caring, and non-judgmental relationships with others were seen as an aspect of health

and inclusion, whereas stigma and discrimination were seen as an aspect of harm and exclusion. This is congruent with much discourse around discrimination.

Many authors note the harms of secrecy for BDSMers. From having to conceal oneself from judgement from loved ones, workplaces (Stiles & Clark, 2011), and counsellors (Hoff & Sprott, 2009) to dealing with internalized shame (Kolmes, et al., 2006; Nichols, 2006), there are many potentially undesirable consequences of secrecy for clients. This sense of secrecy was noted to have a distancing effect by the participants in this study, however, distance is not undesirable in all cases. While many people conceal their kink involvement due to fear of social stigma, others make sense of concealing in such a way as to create a sense of identity (Stiles & Clark, 2011). Constructing secrecy as unanimously undesirable is consistent with an interest-based ethic in that clients may be positioned as helpless rather than able to act in defense of themselves (Gourevitch, 2009).

Another harm stemming from exclusion in a social group could effectively be described as deviance. Not only was belonging in an established community important in terms of social support, but community connection was also used as a measuring stick of health. A cultural group of kink community norms could usher in an otherwise harmful activity into the health category. This is congruent with Dymock's (2012) supposition that, whatever norms are created and recreated and recognized, they are not allowed to be transgressed. Indeed, only one participant in the current study, Adrian, mentioned that some norms could become too restrictive. This suggests that counsellors are, unsurprisingly, impacted by modern social norms.

Mental Health and Healing

The organizing theme of *mental health and healing* related to the role of BDSM as a coping skill in creating and/or maintaining a state of mental wellbeing. BDSM was sometimes seen to originate as a response to some traumatic or unpleasant experience, however, the response was not seen as inherently pathological. Rather, the function of using BDSM to cope could alleviate distress, only morphing into pathology when it was done in a self-harming or out-of-control way.

The counsellors saw BDSM largely as a generally healthy coping mechanism for dealing with stressors. This is congruent with the phenomenology of many BDSMers who find their activities to be an emotional release, confidence boost, and type of psychological healing (Hébert, & Weaver, 2014; Hébert, & Weaver, 2015; Lindemann, 2011; Newmahr, 2010b;

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Nichols, 2006). The use of BDSM as a coping skill only became problematic for the counsellors under circumstances, such as overreliance on others to help oneself cope with kink activities. The understanding of BDSM as a coping tool not only related to everyday stressors, but also had a relationship to coping with trauma.

The trauma etiology narrative is an old one (e.g., Nichols, 2006) that has caused problems for clients when counsellors automatically assume trauma and pathology (e.g., Kolmes, Stock, & Moser, 2006). However, the counsellors in this study acknowledged the possibility of BDSM stemming from, while also coping with, trauma or a disrupted family pattern. Some also acknowledged the possibility of harm to come of such a coping skill, which is congruent with the kink-aware counsellors in one study who sometimes had concerns about clients retraumatizing themselves in BDSM (Lawrence & Love-Crowell, 2008) as well as other literature expressing this same concern in the context of working as a professional dominatrix (William & Storm, 2012). Engaging in BDSM as a response to trauma was not inherently seen by the counsellors as pathological, and in fact, could be healing. This is consistent with the argument of Williams and Storm (2012) that the work of professional dominatrices is parallel to other helping professions. In sum, actions that fit into a therapeutic or coping narrative were seen by the counsellors as healthful.

Those actions which countered the therapeutic narrative where seen as harmful. When BDSM activities were understood be a form of self-injury, they existed in opposition to the best interests of the client. The distinction between self-harm and BDSM was noted to be, at times, blurry by the participants. Although the line could be blurry, it was conjured into solid existence in the space between pain for feeling good, which fell onto the healthy side, and pain for feeling bad, which fell into the unhealthy side. Indeed, there is a newly budding area of research into these distinctions, which is currently in the preliminary analysis stage (Aaron, 2016). Aaron's study looked at the experiences of people who engaged in non-suicidal self-injury, BDSM, or both. The preliminary interpretation suggests that emotional phenomenology is what distinguishes self-harm from BDSM. Aaron (2016) noted that the experience of non-suicidal self-injury tended to flow through a pattern of negative emotions, release and distraction, and then shame and regret, while the pattern for BDSM tended to be anticipation and pleasure, followed by connection to one's partner. This research seems to fit with the current counsellors' delineation of pain to feel good versus pain to feel bad. Although the action may be outwardly

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similar, the inner effect is dissimilar. Aaron (2016) suggests that BDSM may, for a minority of BDSMers who also engage in non-suicidal self-injury, be a harm reduction approach to self-harming behaviours. Participants in the current study also made reference to BDSM with a partner potentially being a harm reduction strategy for self-harm. Overall, there was an effort made by counsellors to distinguish BDSM from self-harm, which fits with the current normalizing narrative which would necessitate placing BDSM on the life-affirming, recognizable pleasure side of the pleasure-pain dichotomy (e.g., Dymock, 2012), thus, putting in in opposition to concepts of self-harm.

Another circumstance in which BDSM was seen to denigrate from its healthful coping purpose was when it resembled addictive or compulsive behaviour. A narrative around BDSM as addiction is also old and generally discounted (Nichols, 2006), but persists even in some current literature (Kurt & Ronel, 2016). In Kurt and Ronel's (2016) qualitative inquiry into sadomasochist's experiences, they drew themes which corresponded to an addictive cycle and cast a negative light on losing control as a masochist. A sense of losing control over one's use of BDSM was seen as unhealthy by the counsellors in the current study as well. Thus, for the BDSM activities to best serve the individual, they must remain under the clients' will.

Threat and Safety are Vague

The organizing theme of *threat and safety are vague* highlights the ambiguity that accompanied responses about harm and health. Interpretation of these vague accounts is, in itself, ambiguous; maybe the ambiguity reflects a notion of common knowledge, perhaps an honoring of many diverse, client-directed senses of harm and health. Regardless, this theme does line up with the notion of a harm and health dichotomy, whereby a line must boundary the two concepts (Dymock, 2012). Safety and health were clearly approachable things while danger and harm were clearly aversive, but whatever items were allotted into these two categories was left open to interpretation.

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Strengths of the Study

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There are several strengths of this study. The first of which is that, although some research has been conducted on counsellors' understandings of clients who participate in BDSM (Garrott, 2008; Kelsey et al., 2013; Kolmes et al., 2006; Lawrence & Love-Crowell, 2008), this study is one of the first few studies in this growing area. Secondly, this study is the only one to specifically investigate the understandings of harm in this specific context. Building primarily on

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Garrrot's (2008) findings of tension between self-determination and harm prevention, this study added a deeper understanding of what the harm in harm prevention actually might look like in a BDSM pain play context. This was done through the use of the vignettes and questions which prompted participants to respond to specific circumstances.

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Limitations of the Study

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This group of counsellors could be described as sex-positive, kink-positive, and generally kink-aware. Many participants described experience in working with sexually diverse clients, and even disclosed being a part of kink communities themselves. It appears that therapists who had a vested interest, or at least any interest, in the kink community or sexuality more broadly were more likely than other therapists to respond. Indeed, during network sampling in the data collection phase of the study, one of my personal contacts informed me that their eligible contacts who had received an invite were not *comfortable* participating in a survey of this nature. Thus, despite the use of an anonymous survey in an attempt to alleviate discomfort and enhance participation of counsellors who were not already kink-aware, some counsellors may still have been too uncomfortable to participate. This information combined with (a) personal experience of kink-negative reactions from fellow professionals, (b) counsellors' testimonies of clients encountering kink-negative therapists (e.g., Kolmes, Stock, & Moser, 2006), (c) similar testimonies from participants in this study, and (d) the 20% to 50% of professionals expressing uncertainty about BDSM (Kelsey, et al., 2013), it seems reasonable to conclude that this study did not include the views of counsellors who were less comfortable with kink. Rather, these results likely reflect fairly sex-positive, liberal counsellors' views on BDSM that uses pain.

Another limitation of this study was that we did not employ a member-checking procedure, and so, it is possible that participants may disagree with the author's interpretations. The author wants to acknowledge this possibility. However, member checks were not employed due to the pragmatic constraints of maintaining participant anonymity, which prevented obtaining participants' contact information in order to carry out member checks. This methodology also did not allow me to ask clarification questions, and so I did make some interpretative leaps, however when these occurred, they were identified in the analysis the as my suppositions. Moreover, regardless of the survey platform and lack of member-checking, given the paradigm outlined in this study, all results would have been viewed as co-constructions with my role being that of an actively interpreting agent.

Another limitation was the construction of the vignettes. Some participants commented that they seemed unrealistic. Despite this flaw, the current study still achieved the aim of providing deeper understanding of counsellors' reasoning. However, in future, there should be a more thorough review of vignettes prior to commencing research.

Implications for Counselling Practice

One implication that this study has for practice is that it may serve as a resource for counsellors dealing with ethical dilemmas. Counsellors may or may not be able to access peers and supervisors with knowledge and willingness to discuss clients who participate in BDSM (Garrott, 2008). This research can help aid counsellors grappling with ethical dilemmas of their own in that they may look to the understandings of the counsellors in this study to help them determine what might be of notable concern to their peers. The most key point that counsellors in this study used to determine harm was whether or not the function of the practice contributed to a fulfilling and continued life for the client.

Although the results of this study suggested that relatively sex- and BDSM-positive views were held by the counsellors, the paradox around the morality of interest-based ethics remains. While I am not necessarily arguing that an interest-based ethic is undesirable, I feel that, in an age of legalized medically assisted dying (Rubin, 2010) and a growing trend in psychological professions to tout empowerment of clients - where counsellors are not the experts and attempts are made to equalize power between client and therapist- there are some fundamental questions to grapple with. The most basic of which being, *why are our ethics codes the way they are*? If the morality of the counselling professions is oriented towards individual empowerment and self-determination, so long as no others are harmed by an individuals' pursuit of self-fulfillment (Rubin, 2010), then why does this morality circumscribe certain acts that an individual may choose? How can one decide when another's rights are infringed upon? Or can they decide when their own rights are infringed upon? Even if these - and endless more – are not immediately pragmatic questions which could radically change the course of counselling treatments as we know them today, they are at least philosophical ones worthy of reflection. Should reevaluations occur after further reflection, this could have tangible impacts on not only the role and understandings of counsellors, but also on laws pertinent to sexual and medical consent.

Future Research

Future research should use enhanced vignettes. There are a few enhancements that could provide additional insight into counsellors' ethical reasoning around harm. Firstly, participants in the current study suggested that more transgressive activities than were depicted in the current study would be warranted. Namely, one participant suggested that this study could have benefitted from vignettes with harder edge play. Judging from the participants' responses, this might be things such as asphyxiation and autoerotic asphyxiation, but anything else that seriously and permanently changes the body would also be of interest. Future research may also look at counsellors' reasoning around psychological edge play, such as consensual nonconsent, where clients consent to something unknown (e.g., Beres & MacDonald). These kinds of inquiries would deepen the knowledge generated about harm from the current study. Secondly, the populations that the vignettes present for analysis may be expanded. These may include people who fall into intersections of gender, sexual orientation, race and socioeconomic status and are underrepresented in research, as well as BDSM play that uses these categories to represent power roles (Bauer, 2008). The vignettes in this study were also erotocentric and vignettes which depict use of BDSM pain play in an asexual context (Sloan, 2015) may elucidate counsellors' strategies to normalize and understand clients which may be different (or similar to) those that are used to normalize BDSM in a sexualized context. Another context which might prove interesting in terms of the question of self-harm versus BDSM would be to depict clients engaging in autoerotic (or auto non-erotic) BDSM activities. Future research may also look more heavily at the interpretation of people who inflict pain. While the vignette of Sara was incorporated into this study, this is generally an overlooked area left solely to criminology (Newmahr, 2010a). These different populations may produce more information about counsellors' understandings of diverse harm in diverse populations.

In terms of methodology, future research might benefit from different recruitment strategies which more actively recruit kink-negative or kink-neutral counsellors. The use of an anonymous online survey in the current study still, like Garrott's (2008) study, resulted in participation from counsellors who had some previous level of kink-awareness and or familiarity with the researcher. Accessing different viewpoints could provide a better understanding of how less kink-friendly counsellors understand harm and navigate the ethics around working with kinky clients. One reason that this study may be is because participation in the study was not

enticing enough for counsellors who did not have any personal stakes in BDSM, general sex positivity, or helping the researcher. One suggestion to ameliorate this in the future may be to use a survey, or interviews, with some kind of compensation for their time, as feedback from respondents and forum commenters suggested that participation took too much time for a professional on their off time, especially one who was not already invested in kink or sex positivity. Another suggestion is to specifically recruit counsellors who feel uncertain or negatively towards kink.

Another methodological change that may be considered in future research is to employ a member checking-procedure. While this was foregone in the current study in order to retain anonymity, the goal of obtaining participants with varying comfort levels with BDSM seems to have been largely unachieved. Thus, doing in-person interviews with a member-checking procedure may provide more insight in further explorations.

Future research may also consider adding to the one quantitative study on this topic (Kelsey et al., 2013). This suggestion comes from a couple of participants, who mentioned that a quantitative survey, perhaps with a Likert scale, that took less time would have been easier to complete. While a quantitative methodology would yield different information than a qualitative one, it could prove useful in determining the prevalence of certain beliefs counsellors hold around the harms and benefits of pain play. As a qualitative study with a generally sex-positive base of respondents, this study could not, and did not attempt to, quantify the statistical prevalence of kinkphobic or kink-positive beliefs amongst mental healthcare providers, whereas this may be possible in a quantitative survey that takes less time to participate in. In Kelsey and colleagues' (2013) study, an anonymous survey method was employed to examine counsellors' beliefs about BDSM, and this large-scale study did reveal significant numbers of counsellors who were uncertain about the healthiness of BDSM. It may be useful to conduct a similar kind of study on the more specific topic of understanding specific actions and motives of BDSMers that signify harm and serious harm to counsellors.

Finally, thematic analysis has so far been the only qualitative method of analysis used to understand counsellors' perceptions of BDSM. Future research should consider using deeper analytic methods, such as interpretative phenomenological analysis (Larkin & Thompson, 2012). In order to engage in deeper analytic strategies, however, in person interviews would likely be necessary and could incorporate vignettes. Possibly this could be combined with quantitative

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methods to craft a more comprehensive and in-depth picture of counsellors' reasoning about BDSM as well as the state of mental health care for kinky clients.

Conclusion

This study was one of the first to investigate counsellors' understandings of clients who participate in BDSM, and the first to look specifically at themes in counsellors' reasoning about harm and serious harm in pain play. To the author's knowledge, it was the first qualitative study in this area of inquiry since Garrott's inquiry in 2008, and thus, the present research contributed an updated and further nuanced understanding of how counsellors interpret clients' BDSM activities. Namely, this research cautiously suggests that counsellors, at least some, do appear to be growing in acceptance for BDSM. It also suggested that they negotiate harm for people participating in sadomasochism in a multitude of complex ways. The dichotomy of health and harm was upheld in the counsellors' constructions, but pain play alone was not allotted into one or the other category. Rather, the health or harm of a pain play activity was based on various dimensions of the self that were important to contain and continue. If any of these dimensions were at risk of breech, this connoted some form of harm. The counsellors' negotiations were generally consistent with ethical theories de jour, namely, self-fulfillment ethics (Rubin, 2010) and interest-based liberal ethics (Gourevitch, 2009), which also correspond to current counselling ethics (CCPA, 2007; CPA, 2017).

At the beginning of this research, I expected to encounter at least some explicit, or perhaps thinly veiled, judgement and aversion to BDSM pain play. I was surprised to encounter a strong sense of acceptance and protection over people who participated in such activities. My understanding of counsellors as potential agents of discrimination morphed into counsellors as negotiators navigating a complex set of social constructs in order to try to ethically serve their clients. However, I still believe that counsellors who discriminate against BDSMers are working in the field currently, as did some of the participants in this study. Throughout the course of this research, my gaze shifted to encompass something much larger than the psychological profession and the professionals enacting it. The heart of this inquiry ended up being about how morality is constructed, rather than the ethics of doing psychological work specifically. Quite fittingly, it became a journey about social power reaching beyond the denigration of sadomasochists and into the utterly arbitrary construction of all power in society (Byrne, 2013). It appears that the negotiation of health, harm, and what to do about it will always be founded upon complex, yet

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essentially arbitrary lines. Given this supposition, my hope for this research is not to help future researchers uncover some absolutely true moral resolution, but rather that it serves to spur on ethical discussion and contributes to a negotiation of health and harm which best serves counsellors, kinksters, and their societies alike.

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APPENDIX A: AUDIT TRAIL FORMAT

Decisions regarding data generation format, data collection instrument, and data analysis method

Design Considered	Reasons used/ thoughts on use	Reasons Not used/ thoughts on non-use

Decisions regarding data analysis

Code/THEME Considered	Support For inclusion	Reasons against inclusion	Decision to keep/remove/merge

APPENDIX B: REFLEXIVITY JOURNAL FORMAT

Date	Topic of Interest	Thoughts	Decision/Outcome

Counsellors/psychotherapists Needed for Online Survey on Clients' BDSM Play

We are looking for participants to complete an on-line survey to explore mental health professionals' understandings of harm for clients who participate in bondage/discipline, Dominance/submission, sadism/masochism (BDSM) activities involving pain. We realize that this can be a controversial topic and so we invite you to share your thoughts anonymously, so that you can have your voice heard freely and without judgement. The results of this study will further inform the budding discussion on ethical practice with clients belonging to this sexual minority group.

We are aware that mental health professionals are very busy doing important work! However, we sincerely hope that you are able to contribute to this study. We thank you for your time and consideration!

Who is eligible?

Registered, certified, or licensed, mental health professionals who provide counselling/psychotherapy services to clients and who are over 18 years of age. You do not need to have seen a client who has disclosed engaging in BDSM.

How long will it take?

About 30-60 minutes.

What does participation entail?

Anonymously answering open-ended, online survey questions.

Please copy the link into your browser for the informed consent information and the electronic survey. https://www.surveymonkey.com/r/9MRK58D

This study was approved by the Behavioural Research Ethics Board on 07/18/2017 (REB#17-262). If you have any questions or comments, please contact Meaghan at mjb369@mail.usask.ca or Dr. Martin at stephanie.martin@usask.ca.

If you have colleagues who may be interested in participating, it would be greatly appreciated if you could pass this message along to them!

APPENDIX D: ONLINE RECRUITMENT ADVERTISEMENT FOR THE CANADIAN PSYCHOLOGICAL ASSOCIATION AND THE SASKATCHEWAN ASSOCIATION OF SOCIAL WORKERS WEBSITES

Title: Understandings of Harm in the Context of BDSM Pain Play: Mental Health Professionals' Perspectives

Description of Study: The purpose of this study is to better understand how mental health professionals interpret the notion of harm when they are dealing with clients who participate in bondage/discipline, Dominance/submission, and sadism/masochism (BDSM). When clients disclose participating in BDSM, it can be difficult for mental health professionals to know how to interpret these behaviours. This study aims to further clarify how mental health professionals make sense of BDSM activities that involve pain by asking participants to share their understandings in an anonymous online survey.

Study Population: Anyone who is a registered, certified, or licenced mental health professional who provides counselling or psychotherapy to clients may participate. Participants must also be over 18 years of age. There is no geographical restriction.

Participant Obligation

Participation includes reviewing a consent form and filling out an online questionnaire which asks for demographics, responses to vignettes of hypothetical clients, and other open-ended questions. The expected time is 30-60 minutes.

Location of Study: Online-Saskatoon, Saskatchewan

Researcher: Meaghan Baker, student in the Master's of School and Counselling Psychology program at the University of Saskatchewan. She is supervised by Dr. Stephanie Martin.

Ethics: This study was approved by the Behavioural Research Ethics Board on 08/18/2017 (REB#17-262). If you have any questions or comments, please contact Meaghan at mjb369@mail.usask.ca or Dr. Martin at stephanie.martin@usask.ca.

Link to Study Website: https://www.surveymonkey.com/r/9MRK58D

APPENDIX E: ONLINE RECRUITMENT ADVERTISEMENT FOR ALBERTA COLLEGE OF SOCIAL WORKERS MAIL OUT NEWSLETTER

Call for Counsellor Research Participants

Registered social workers who do counseling/psychotherapy are invited to take an anonymous, online survey. The purpose of this thesis project is to better understand how counsellors interpret what is or is not harmful to clients who engage in BDSM activities involving pain. Previous experience with clients who engage in BDSM is not required. Survey takes about 30-60 minutes to complete. This study was approved by the Behavioural Research Ethics Board on 07/18/2017 (REB#17-262). If you have any questions or comments, please contact Meaghan at mjb369@mail.usask.ca or Dr. Martin at Stephanie.martin@usask.ca.

Click here for more information or take the survey https://www.surveymonkey.com/r/9MRK58D

APPENDIX F: RECRUITMENT LETTER FOR SNOWBALL SAMPLING WITH PERSONAL CONTACTS, THE PSYCHOLOGICAL ASSOCIATION OF SASAKTCHEWAN, AND THE PSYCHOLOGICAL ASSOCTIATION OF PRINCE EDWARD ISLAND EMAIL DIRECTORIES

Re: Study Opportunity: Professionals' Perspectives on Clients Who Participate in BDSM

Dear NAME, /Greetings!

(**Cold Emails only**: I have found your contact information through [website] and thought you might be interested in the research I am conducting. Specifically,)

I am writing to let you know about an opportunity to participate in an online research study. This study is about mental health professionals' understandings of clients who participate in bondage/discipline, dominance/submission, and sadism/masochism (BDSM). The results of this study will further inform the budding discussion on ethical practice with clients belonging to this sexual minority group.

__Please know that you are in no way obligated to contribute to this study!__ However, if you are interested in participating or are willing to share this invitation with colleagues who may be interested in participating, here are the details!

Who is eligible?

Registered, certified, or licensed mental health professionals who provide counselling or psychotherapy services to clients and who are over 18 years of age. You do not need to have seen a client who has disclosed engaging in BDSM to participate.

How long will it take?

About 30-60 minutes.

What does participation entail?

Anonymously answering open-ended, online survey questions.

Please follow the link for the informed consent information and the electronic survey

https://www.surveymonkey.com/r/9MRK58D

This study was approved by the Behavioural Research Ethics Board on 08/18/2017 (REB#17-262). If you have any questions or comments, please contact Meaghan at mjb369@mail.usask.ca or Dr. Martin at stephanie.martin@usask.ca.

We realize that mental health professionals are very busy doing important work! Thank you for your time and consideration!

 (**Email directory only**: This message has been delivered to you through (Name of Association). The researcher does not have access to your email.)

Thanks again for your consideration,

Meaghan Baker

M. Ed Student, School and Counselling Psychology

University of Saskatchewan

APPENDIX G: REMINDER LETTER FOR PERSONAL CONTACTS

RE: Reminder of Study Opportunity: Professionals' Perspectives on Clients Who Participate in BDSM

Dear Name,

You have previously received an invitation to participate in my thesis project about mental health professionals' understandings of clients who participate in bondage/discipline, dominance/submission, and sadism/masochism (BDSM). This message is a friendly reminder about this opportunity. ***If you have already participated or do not wish to participate, please disregard this message. If you are interested in participating or sharing this research with colleagues, the details are recapped below!***

Please follow the link for the informed consent information and the anonymous, 30-60 minute long survey https://www.surveymonkey.com/r/9MRK58D

This study was approved by the Behavioural Research Ethics Board on 07/18/2017 (REB#17-262). If you have any questions or comments, please contact Meaghan at mjb369@mail.usask.ca or Dr. Martin at stephanie.martin@usask.ca.

We realize that mental health professionals are very busy doing important work! Thank you for your time and consideration!

Thanks again,

Meaghan Baker
M. Ed Student, School and Counselling Psychology
University of Saskatchewan

1. Please list the following demographics about yourself:

   a. your degree (e.g M.Ed. in Counselling Psychology, PhD in Clinical Psychology, etc)

   b. your age

   c. your gender

   d. the country where you practice psychotherapy/counselling

   e. the setting in which you practice psychotherapy/counselling in (e.g., private practice, health region, etc)

   f. how long you have been practicing psychotherapy/counselling

   g. your theoretical orientation(s) for counselling

2. This is a qualitative research project and, as such, the research team asks for you to provide AS MUCH DETAILED DESCRIPTION AS POSSIBLE for the following open-ended questions. Please aim for at least 400 words per text box. You may find it helpful to create your responses in a word processor and then copy them to the survey. There will be prompts listed for each question to assist you in your description. However, should you feel uncomfortable, please remember that you are free to leave any item or prompt unanswered, or exit your browser to exit the study entirely to quit the study.

   Response options:

   a. I understand the above request

3. Imagine that, as a mental health professional, you encounter the client in the following fictional vignette:

   A young male client, Alex, has come to you for help in dealing with troubles at work. He has mentioned in a previous session that he often feels inadequate because the atmosphere in the law firm that he works at is one of cutthroat competition. He feels he is under constant threat of humiliation and job loss by his punitive boss if he makes even a small mistake. In his last session with you, he

says that he and his girlfriend role played a boss-employee scenario where she used office-themed implements to cause him pain (e.g., stapling him, hitting him with rulers, stepping on him with high heeled shoes) while she verbally derogated him for his poor performance. He mentions that sometimes likes this to continue until he cries. He says, "it makes me feel more confident in dealing with criticisms from my boss knowing that at least my girlfriend accepts my vulnerabilities. It's also really cathartic and helps me to let go of all that stress that's bottled up".

a. How do you react viscerally to this vignette?
b. How do you react emotionally to this vignette?
c. What is your immediate cognitive response to this vignette?
d. How do you make sense of the client's actions?
e. How do you imagine you might respond if this client was in front of you?
f. What would be your desired outcome of your interventions?

4. Imagine that, as a mental health professional, you encounter the client in the following fictional vignette:

Sara, a middle-aged woman who works as bank teller, has come to your counselling office for support while she is going through a divorce. Sara has been married to her husband, Joe, for 25 years, but has been unhappy with the way that Joe never listens or pays attention to her. She feels bad about splitting up their marriage because she has tried to stay with Joe for the sake of their children, however, they are now adults. She feels guilty for not being able to fix their relationship, even though she also knows that marriage is a two-way street and that she has been wanting more from a partnership for a long time. During the separation process, she has sought a partner on an online dating service for people interested in BDSM. Sara has always enjoyed rougher sex and wanted to be more dominant, but Joe never seemed to take the hint and she didn't feel that he would respond to any direct requests as "Joe is old-fashioned and would have thought me asking for that kind of sex to be crude and unladylike". The lack of

communication and sexual attention was a big motivator for Sara to leave the marriage. She is now using this opportunity to explore her sexuality with her new partner, Gary, who identifies as a submissive. "We've tried more together than Joe and I had tried in two and a half decades!" she exclaims to you, "I've just bought these candles that you use to drip hot wax onto the skin. I'm so excited, I feel like I've found a part of myself I never really had the chance to listen to before! Gary also listens to that part of myself, quite well I might add! He is very obedient.". She pauses for moment, and says, "But I do feel a bit weird about what my children might think if they found out what their mother was doing. I'd hate for them to disown me or think I'm some sort of sick sadist or something…."

a. How do you react viscerally to this vignette?
b. How do you react emotionally to this vignette?
c. What is your immediate cognitive response to this vignette?
d. How do you make sense of the client's actions?
e. How do you imagine you might respond if this client was in front of you?
f. What would be your desired outcome of your interventions?

5. Imagine that, as a mental health professional, you encounter the client in the following fictional vignette:

Mary is a young adult seeking your services for a second opinion. She has recently sought help from Dr. Smith for depressive symptoms. She has struggled with feelings of sadness and guilt as a young teenager, in the past, cut or burned herself to dull the pain inside. As a teenager, she also started trying out sadomasochistic acts with her past boyfriend. She would get him to cut, slap, bite, whip, pierce, or otherwise cause her pain. At times, she asked for this to dull the emotional pain but, at others, to simply enjoy how it felt.

Since her teenage years, Mary has ceased self-harming but still gets her current boyfriend, Jeff, to inflict pain on her. She usually enjoys these acts as a sexual or sensual release, telling you that "it is like it puts you in a meditative state; it

brings me closer to myself because I'm paying acute attention to my body, and to Jeff because I'm at his mercy and I have to- and do- trust him. It can be very relaxing and you just kind of get into the rhythm of it. But, I guess I'm what you'd call a 'heavy masochist', I like a lot of pain and intense pain. I like it when I'm celebrating my life, but also when I'm mourning it." She goes on to say that, while she no longer self-harms, she sometimes wants to engage in BDSM when she feels down, although sometimes engaging in BDSM when she feels depressed helps her to "re-ground" herself too.

Mary says to you that Dr. Smith considers her behaviour self-harm, even if she gets Jeff to do it. She says that he asked her to sign a no-BDSM and no-self-harm contract in order to progress through treatment. He also started to educate Mary on what an abusive relationship looks like. Mary does not want to give up BDSM because she enjoys it for its sexual benefits and enhanced closeness with Jeff, she just wanted Dr. Smith to help her to be happy more of the time. She is now coming to you because she is confused about how best to achieve her goals.

a. How do you react viscerally to this vignette?

b. How do you react emotionally to this vignette?

c. What is your immediate cognitive response to this vignette?

d. How do you make sense of the client's actions?

e. How do you imagine you might respond if this client was in front of you?

f. What would be your desired outcome of your interventions?

g. Please comment on Dr. Smith's interventions.

6. Have you ever encountered any therapy/counselling clients who have disclosed participating in BDSM activities? IF SO, please describe what that was like for you without revealing any identify information. IF NOT, please describe how you imagine that experience might be for you:

a. Have you encountered any clients who participated in BDSM (Yes or no)?

b. How did (or might) you react viscerally?

c. What was (or might be) your emotional response?

d. What was (or might be) your cognitive response?

e. How did (or might) you respond to the client?

f. What was (or might be) your desired outcome of your interventions?

7. Using the prompts below, please respond to this list of techniques that some people who engage in BDSM might use:

Biting, spanking, whipping, caning, paddling, riding crops, abrading the skin, punching, hitting, slapping, applying stinging nettles, testicle kicking, piercing, cutting, scratching, branding, dripping hot wax onto the skin, pinching, clamping, and electrical shocks.

a. Are there any particular activities that stand out to you? Why do they stand out?

b. How do you react to the activities that stand out to you? (viscerally, emotionally, and cognitively)?

c. How do you imagine you might make sense of a client participating in these activities?

d. How might you determine whether a client's activities are acceptable or whether they are 'going to far'?

e. Thinking of the activities listed above, can you imagine an instance where you might consider having to break confidentiality? Please explain.

8. Please consider the different platforms through which you have gained experience or knowledge about BDSM (e.g., media, books or journals, friends, consultation, professional training, etc.). How does your previous learning through these platforms inform your understanding of your clients who participate in BDSM and/or the vignettes shown to you today?

9. Is there anything else important about your experience with BDSM-identified clients in real life and/or about your experience filling out this survey?

10. **Thank you for taking the time to complete this survey! Your answers will be collected once you press the "submit" button. As outlined in the consent screen,**

your answers are collected anonymously and they cannot be connected to you or your IP address. Thus, they cannot be withdrawn from use in this Master's thesis project *after* **you press the submit button.** If any responses you have provided might make it likely for others to identify you or a third party, they will be altered when reported to protect anonymity. Should you, for any reason, decide to not contribute your data, simply exit the web browser without pressing the "submit" button. Before you go, here is some more information about the study.

The purpose of the research project you have participated in is to understand how mental health professionals understand harm in the context of clients' bondage/discipline, Dominance/submission, and sadism/masochism (BDSM) pain play. Traditionally, BDSM activities have been stigmatized, criminalized, and crimin. However, today there are research findings to support that people who participate in BDSM are not more likely than others to be criminally involved or have a mental illness. Generally, current research suggests that BDSM activities exist on a spectrum of healthy sexual expression. Nonetheless, some people who participate in BDSM have reported encountering stigma, discrimination, and ethical violations in contemporary mental healthcare settings.

One area that appears to be particularly challenging for mental health professionals is that of BDSM activities which involve the use of pain. "Pain play" seems to be a point of personal and ethical importance for many counsellors who must balance considerations of value neutrality with preventing harm to clients. Because counsellor interpretations of pain play have ethical implications in terms of clients' self-determination and deciding when to break confidentiality to report harm, it is an important area to explore further.

In this study, you were asked to provide some demographic data so that we could describe who responded to our survey. The following vignettes and questions regarded your perspectives on what harm means in terms of clients' participation in activities that might be viewed as painful. Your participation in this study will help to deepen the current knowledge about counsellors' understandings regarding the use of pain in BDSM. Ultimately the results from this study may help to inform training for navigating ethical

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issues with this sexual minority group.

If for any reason participation in this study has caused you negative feelings please seek counselling services which are local to you. **If you have any further questions or concerns about the study or would like to receive a copy of the final results please contact the researcher at mjb369@mail.usask.ca**.

If you are interested in this research, you may want to look into the following studies:

Kelsey, K., Stiles, B. L., Spiller, L., & Diekhoff, G. M. (2013). Assessment of therapists' attitudes towards BDSM. Psychology & Sexuality, 4(3), 255-267.

Kolmes, K., Stock, W., & Moser, C. (2006). Investigating bias in psychotherapy with BDSM clients. Journal of Homosexuality, 50(2-3), 301-324.

Garrott, R. (2008). The effects of psychotherapists' values on their work with clients who practice consensual sadomasochism. (Unpublished doctoral dissertation). Massachusetts School of Professional Psychology, United States.

Thank you again for your contribution to this research!

Questionnaire Consent Form: Understandings of "Harm" In the Context of BDSM Pain Play: Mental Health Professionals' Perspectives

Researcher: Meaghan Baker, B.A. (Hons), School and Counselling Psychology graduate student; Department of Educational Psychology & Special Education; University of Saskatchewan. Email: mjb369@mail.usask.ca

Supervisor: Dr. Stephanie Martin (RD Psych); Department of Educational Psychology & Special Education. Email: stephanie.martin.usask.ca

Participation Criteria: You are invited to participate in this study if you are **a registered mental health professional who has experience providing psychotherapy/counselling to clients and are 18+**.

Purpose: The purpose of this study is to better understand how mental health professionals interpret the notion of harm when they are dealing with clients who participate in bondage/discipline, Dominance/submission, and sadism/masochism (BDSM). When clients disclose participating in BDSM, it can be difficult for mental health professionals to know how to interpret these behaviours. This study aims to further clarify how mental health professionals make sense of BDSM activities that involve pain.

Procedures: The study will consist of anonymously providing general demographics and answering open ended questions about experiences with BDSM-identified clients, hypothetical vignettes, and discussing your understandings of BDSM behaviours.

Funded By: This research has been supported by a grant from the Canadian Institutes of Health Research (CIHR).

Potential Risks and Benefits: Should you experience discomfort, <u>you may leave any question unanswered</u> or <u>exit the study by exiting your browser</u>. If distress persists, you are encouraged to seek psychological support available in your area (e.g., a local helpline). There are no direct

benefits to you if you participate, however you will have contributed to research that may inform resources for doing psychological work this sexual minority group!

Confidentiality: This online survey has been designed by the researcher not to collect or track your personal information in conjunction with the survey results, so that <u>you may talk freely and anonymously without fear of judgement. The SurveyMonkey platform keeps records of both your IP address and your responses, and stores them in the USA, but they are not connected to each other.</u> SurveyMonkey takes precautions to keep your answers private and secure, however, the limitations of these precautions are outlined in their privacy statement: <u>https://www.surveymonkey.com/mp/policy/privacy-policy/</u> and security statement <u>https://www.surveymonkey.com/mp/policy/security/</u>.

Dissemination: The data will be used for a Master's thesis and may be published in conference presentations or journal publications.

Ethics: This study was approved by the Behavioural Research Ethics Board on INSERT DATE. Any questions regarding your rights as a participant may be addressed to the Behavioural Research Ethics Board through the Ethics Office (306-966-2084). Out of town participants may call collect.

Right to Withdraw: Your participation is voluntary. You may choose to not submit your responses by exiting your web browser at any time before having pressed the "submit" button. After submitting, you will not be able to withdraw.

Consent: By clicking "Next" you are indicating that you have read and agree to the terms above.