Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education

Volume 4 | Issue 1 Article 6

2022

Counselor Self-Reported Competence for Working with Kink Clients: Clinical Experience Matters

Emily Y. Meyer Stewart
Clarion University of Pennsylvania

James M. Hepburn
Waynesburg University

Recommended Citation

Meyer Stewart, E. Y., & Hepburn, J. M. (2022). Counselor Self-Reported Competence for Working with Kink Clients: Clinical Experience Matters. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education, 4* (1), 42-53. https://doi.org/10.34296/04011062

Counselor Self-Reported Competence for Working with Kink Clients: Clinical Experience Matters

Emily Y. Meyer Stewart
Clarion University of Pennsylvania

James M. Hepburn
Waynesburg University

The experience of counselor stereotyping, bias, and misunderstanding is often very real for those who participate in adult, consensual, non-diagnosable paraphilic sexuality, commonly referred to as kink. A created Counselor Self-Reported Competency Scale, drawn from American Counseling Association competencies, and the Attitudes about Sadomasochism Scale were used to assess counselor knowledge and attitude for working with kink clients. This research suggests competence with kink clients increases as clinical experience working with kink clients increases. The ability to maintain a nonjudgmental attitude and open therapeutic environment seems linked to increased clinical experience with this sexual subculture.

Keywords: counseling, kink clients, bias, competence

Introduction

Depending upon the the historical, socio-political, cultural, or religious contexts, human sexuality can be viewed as either perverse or diverse. There is no consensus on a standard of what is normal versus abnormal sexual expression, or what should or should not be included in sexuality education (Ponzetti Jr., 2015). This lack of consensus adds to the confusion, stigmatization, misunderstanding, and discrimination of sexual subcultures (Moser & Kleinplatz, 2006; Wright, 2006).

Counselor confusion and lack of awareness about what is diagnosable or pathological sexuality is particularly true for the sexual subculture commonly referred to as kink (Hoff & Sprott, 2009; Kolmes, 2003; Pillai-Friedman, Pollitt, & Castaldo, 2014). The terms "kink" and "BDSM" are often used synonymously, and Pollock (2019) states, "kink is shorthand for BDSM" (p. 28). The term "BDSM" reflects three distinct, though sometimes interrelated terms: Bondage and discipline; Dominance and submission (D/s); and Sadism and masochism (SM) (Freeburg & McNaughton, 2017). Other practices included in the kink communities include Master and slave (M/s) (Langdridge, Richards, & Barker, 2007). Put simply, all BDSM is "kink" but not all kink is BDSM. While this distinction is important, for the purpose of this research, kink and kinky are used to define a broad category that includes BDSM but is not limited to BDSM.

Counselors may have conflicting feelings regarding working with clients who self-identify as kinky, due to the very real pathology and victimization that frequently is associated with certain paraphilic sexuality. It is true that some paraphilic sexual behavior is unquestionably pathological, criminal, and diagnosable. This would certainly be true of any sexual behavior that involves victimization of a non-consenting other such as pedophilia, voyeurism, frotteurism, exhibitionism, and in some cases, sadism and masochism.

Some paraphilic sexual behaviors, however, can be viewed as non-pathological, non-criminal, un-diagnosable, adult consensual sexual preferences that are practiced and recognized worldwide (Gross, 2006; Kinsey, Pomeroy, Martin, & Gebhard, 1948; Laska, 2013; Richters, Visser, Rissel, Grulich, & Smith, 2008). The likelihood of a counselor encountering a client who participates in BDSM is as likely as encountering an individual of the LGBTQ+ community (Lawrence & Love-Crowell, 2007; Pillai-Friedman et al., 2014). This paper explores how counselor education and clinical interventions can be enhanced through increased knowledge and understanding of kink culture and practice.

Review of the Literature

Religious, cultural, psychiatric, and educational contexts influence assumptions about kink sexuality (Bhugra, Popelyuk, & McMullen, 2010; Langdridge et al., 2007; Sisson, 2007). Such influences and a lack of graduate school training on the continuum of human sexuality provide a context for

Corresponding Author

Emily Y. Meyer Stewart
Clarion University of Pennsylvania
840 Wood St.
Clarion PA, 16214
E: emeyerstewart@clarion.edu
P: (724)977-4174

misunderstanding as well as continued stigmatization and clinical judgment errors of sexual subcultures such as the kink community (Diambra, Pollard, Gamble, & Banks, 2016; First, 2014; P. Kleinplatz & Moser, 2004; Kelsey, Stiles, Spiller, & Diekhoff, 2013; Laska, 2013; Miller & Byers, 2010; Nichols, 2006; Walters & Spengler, 2016).

Consensual, adult paraphilic sexuality has been referenced in ancient texts and sacred writings of Hinduism and Islam (Bhugra et al., 2010), just as other world religions have vilified such practices. While some cultures and religions have embraced paraphilic sexuality, most have established guidelines and sanctions prohibiting unconventional sexual activities (Bhugra et al., 2010; P. Kleinplatz & Moser, 2004; Ponzetti Jr., 2015). The negative and socially punitive effects of religion and social constraints on human sexuality are still largely in place throughout the world.

Esther Perel (2006), observes that "egalitarianism, directness, and pragmatism are entrenched in American culture and inevitably influence the way we think about and experience love and sex" (p. 55). Such influences can paint kink as wild, pleasure-driven, irresponsible, and exploitive sex that gives little regard to the practical needs of a monogamous, child-bearing, marital relationship (Perel, 2006). This attitude is perhaps a vestige of puritanism's roots in the United States.

Viewing sexuality from the lens of pathology and perversity is a common theme. Throughout the 20th century, most non-normative sexual practices were classified as pathological by medical and mental health practitioners, resulting in a variety of theories about the origins and causes of sexual perversions (Freud, 1905; Péloquin, Bigras, Brassard, & Godbout, 2014; Schachner & Shaver, 2004; Keane, 2004; O'Keefe et al., 2009).

Who is the Kink Client?

For the purpose of the research, kink clients are defined as adults who participate in consensual, non-diagnosable, sexual activity which may include any number of sexual fetish behaviors, cross-dressing, bondage, dominance, submission, sadism and masochism. As with all types of sexual behaviors, kink falls on a continuum from cross-dressing, sexual humiliation, mild biting and spanking, to flogging and a wide variety of sadomasochistic eroticism with a consenting adult or group (Pillai-Friedman et al., 2014).

It is estimated that over 14 million individuals in the U.S. currently participate in some type of kink sexuality (approximately 5-10% of the U.S. population), from mild bedroom game participants to membership and full participation in kink community activities (Sisson, 2007). The kink community contrasts with those who occasionally experiment with what Newmahr (2010) calls "kinky bedroom games" (p. 316), made popular by the E.L. James (2012) book *50 Shades of Grey*. The kink community is a subculture with its own norms, beliefs, attitudes, practices, and artifacts. Zambelli (2016) notes that "a member of this subculture feels a certain degree of attachment and commitment to the community, as shown by the time spent in community activities, like greeting new members during events (i.e. munches [*sic*]), moderating online forums and groups" (p. 472).

In a review of five empirical studies of Finnish citizens who self-identified as SM oriented (n = 184), Sandnabba et al. (2002) found that the kinksters in the studies (response rate of 35%) were well-educated, mid-to high income Caucasians. Newmahr's (2010) ethnographic research echoes the middle-to-upper class distinction found by Sheff and Hammers (2011) and Sandnabba et al. (2002), and she defines the kink community as a "social network of people organized around SM [sadomasochism], who practice and observe [others] in particular public spaces and attend informational and educational meetings" (Newmahr, 2010, p. 316).

Kink behavior often meets non-sexual intimacy needs by providing a way for consenting adults to bond with and nurture one another through acts of service (hair brushing, shoe polishing, house cleaning, etc.) and through clear communication and dialog about needs (Connan, 2010; Sandnabba et al., 2002). Perel (2006) suggests that some who participate in kink are inextricably drawn to the power differential—dominant or submissive—to "correct an imbalance... and replenish something vital" (p. 56) in relationships.

Kinksters—those who identify with kink sexuality— are intentionally focused on ensuring consent, safety and risk awareness. A contemporary expression of these attitudes and approaches is found in the 4C's approach, which emphasizes Caring, Communication, Consent, and Caution as a framework for BDSM negotiation (Williams, Thomas, Prior, & Christensen, 2014). This emphasis on clear, spoken agreements between participants of what is allowed and what is out of bounds, is what makes BDSM activity clearly distinquishable from pathological, non-consensual, criminal sexual acts (Balon, 2013; Connan, 2010; Newmahr, 2010; Peoples & Meyer Stewart, 2017).

Counseling Kink Clients

Clients who want to discuss their kink behavior and attitudes are often working with counselors who lack the knowledge and skills required to address sexual issues in general—not to mention kink sexuality. This compromises the therapeutic alliance and creates an uncomfortable situation for both client and counselor (Harris & Hays, 2008; Walters & Spengler, 2016). In spite of this, no training standards exist to address counselor discomfort with sexuality issues, nor counseling competencies for working with the continuum of human sexuality. It would appear that the reluctance to explore and understand sexual behavior is embedded in

counselor training programs, resulting in counselors who are unprepared and resistant to addressing sexual issues in treatment. This is particularly evident in non-normative sexual behavior such as kink. Several studies have reported that kink clients experience bias and pathologizing—even having their sexual practices reported to legal authorities despite the fact that no criminal sexual activity had been disclosed (Harris & Hays, 2008; Kelsey et al., 2013; Yost, 2010).

Kelsey et al., (2013) surveyed 766 psychotherapists in the United States to assess attitude toward and self-reported competence for working with BDSM clients. While 76% of the participants stated they worked with clients who engaged in kink sexuality, only 48% rated themselves as competent to do so. This study also found that therapists who reported competence in working with BDSM sexuality also reported more positive attitudes for working with kink community members, with 67% (n = 513) agreeing with the statement, "BDSM can be part of a healthy, long-term relationship" (Kelsey et al., 2013, p. 259). These findings seem to contradict other qualitative studies that detail client experiences of bias and pathologizing when working with counselors (Hoff & Sprott, 2009; Kolmes, 2003), yet it is unknown if counselor attitude about BDSM influences their level of self-reported competence.

Sexuality in Counselor Education

The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) standards for counselor education provide little recognition of the importance of human sexuality education for working with clients. Research indicates counselors support the inclusion of sexuality education across counselor education tracks. One descriptive study of 243 counselor educators indicated more than half the participants would require a course on human sexuality in all counseling tracks (Gray, House, & Eicken, 1996). Several updates to the CACREP Standards have occurred since the time of their study without an inclusion of a course on human sexuality outside of the marriage, couples, and family track (CACREP, 2016). While counselors-in-training may consider the appropriateness of taking a human sexuality course as an elective based on their state licensing board requirements, not all CACREP programs provide this course as an elective.

A review of the Association for Counselor Education and Supervision (ACES) syllabus clearinghouse revealed "57 of 395 syllabi, or 9.4%, included the word 'sex' in their content, but only four courses—about 1%—focused specifically on sexuality" (Diambra et al., 2016, p. 77). There are established competencies for working with certain sexual subgroups, such as the LGBTQ+ community (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013), and some researchers suggest that similar competencies should be developed for BDSM and used to increase awareness, knowledge, and skills for working with kink community members (Kolmes, 2003; P. Kleinplatz & Moser, 2004; Lawrence & Love-Crowell, 2007).

Some counselors who reported having training on sexuality issues in graduate school expressed neutrality with regard to competence (Ford & Hendrick, 2003), indicating that addressing the topic of sexuality as a way of meeting a specific CACREP standard does not lead to competence. However, when a specific course on human sexuality is required—as it is for marriage and family therapists—researchers have found a positive, linear relationship between sexuality education and supervision on therapist comfort level in working with sexuality issues (Harris & Hays, 2008). These researchers state, "Measuring therapists' sex knowledge as they perceive it proved to be an influential factor of comfort with sexual content and initiating sexuality discussions. These findings may signify the importance of therapists feeling competent, regardless of their actual competency level" (p. 248). The Harris and Hays (2008) study seems to indicate that counselor self-perception of competence is at least as important as actual, measurable competency. It may be that when counselors reported perceived competence, they also reported a comfort level in discussing sexuality issues with clients.

Education is seen as a bridge towards increased ethical practices and social justice for marginalized communities of all kinds (Arredondo et al., 1996; P. J. Kleinplatz & Ménard, 2007). Counselor awareness, knowledge, skills, and action are woven throughout the 2016 Multicultural and Social Justice (MCSJ) and 2013 Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) counseling competencies and provide the foundation upon which ethical counselor education programs are developed. Diambra et al., (2016) in their content analysis of 24 master's level counselor-in-training responses to an anonymous survey on sexuality themes, including BDSM, found students lacked factual information and were eager to learn. Diambra et al. (2016) contend that a "parallel process of sorts" may be at work "in that if our students bring with them sexual questions, secrets, and fantasies, their future clients are just as likely to bring them into counseling sessions" (p. 87). To maintain fidelity to the ACA ethics code (2014), increased counselor preparedness on sexuality issues is needed.

Counseling Competencies and Sexuality Issues

Embracing sexuality as a multicultural counseling issue is worth considering in light of the multiplicity of sexual diversity and the differences between sexual expression among various cultures. Distinguishing multiculturalism from diversity is important. Multiculturalism's focus is only on ethnicity, race, and culture, while diversity is all other issues that define the differences between people (Arredondo et al., 1996). However, thoughts, beliefs, and practices related to

sexuality are part of one's cultural landscape, and therefore sexual practices are a part of the multicultural-self.

Consideration of sexuality as a cultural diversity issue is recognized in other helping professions, such as nursing, which works to provide care for the whole of a person, including the person's sexuality and sexual issues (Witte & Zurek, 1995). As Witte and Zurek (1995) observe, "Sexuality is not limited to genitalia or behavior; it is an all-encompassing sense of self-identity, part of a bio-psycho-social-spiritual person...As ethnocentrism in our culturally diverse world is a common problem, so is what we would call 'sexualcentrism'" (p. 10-11). Broadening multicultural courses to include an overview of the continuum of human sexuality seems an appropriate way to increase counselor self-awareness of sexualcentrism, and for building knowledge, skills, and action sets with client sexual identities.

With regard to teaching a multicultural counseling course, Mitcham et al. (2013) believe, "An important aspect of multicultural competence lies in the counselor educators' awareness, knowledge, and skills regarding special populations" (p. 5). As described, the kink community seems to qualify as a special population with a unique culture based on the norms, behaviors, narratives, and artifacts that are unique to this community (Zambelli, 2016). Competency issues, especially when working with the kink community, are a "lingering concern" (Kelsey et al., 2013, p. 264).

Procedure

A stratified, random sample was drawn from a combination of various online counseling Listservs, ACA Division contacts, Licensed Professional Counselor listings on the Psychology Today website, online professional members who self-identified as willing to help with research, and dozens of personal, professional contacts. Emailed invitations to participate and online invitation posts had the potential to reach more than 5,000 counselors, who were invited to take an anonymous, online survey with three parts:demographics, a created Counselor Self-Reported Competence Scale (see Figure 1), and the Attitudes about Sadomasochism Scale (ASMS; Yost, 2010).

From April 2018 through mid-June 2018, a total of 167 surveys were either fully or partially completed, with 97 usable, completed surveys, for a completion rate of 58.08%. All data were entered into the Statistical Package for the Social Science (SPSS) program for use in a predictive model research design. Compliance with the National Institutes of Health, Office of Extramural Research, ethical research guidelines, and the University's Internal Review Board (IRB) was maintained throughout the research.

Predictor variables were used to determine if a correlation existed between each variable and scores on the counselor self-reported competence for working with kink community members and for predicting scores on the ASMS. Predictor variable data gathered in the demographic section is included in Table 1. Information gathered in the demographic section was used to enhance data interpretation for this study. Using the standard ratio of 10-15 participants per variable (8), the minimum number of total participants (80) was met, with 97 useable surveys.

The Counselor Self-Reported Competence Scale

The 10-statement scale was created from wording drawn from the Multicultural and Social Justice Counseling Competencies (American Counseling Association, 2015), and the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) Competencies for Counseling (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013). Participants used a 7-point Likert-scale to respond to the survey statements, with a range from one (disagree strongly) to seven (agree strongly) following the same format and wording as the ASMS scale, thus maintaining consistency between the instruments.

The Attitudes about Sadomasochism Scale

Yost (2010) developed and validated a 23-item scale, designed to measure negative attitudes towards sadomasochists reporting that her scale "demonstrates excellent internal consistency and concurrent validity" (p. 89) and suggesting use of this instrument as a research tool for assessing discriminatory attitudes of therapists working with sexual minorities. She determined discrimination between participant groups by using three variables (Group 1, prior knowledge of SM; Group 2, contact with SM participants; and Group 3, personal SM practices). The ASMS derived four sets of attitudes about SM, including: Socially Wrong (SM is immoral and socially undesirable); Violence (SM activity involves violence against an unwilling partner); Lack of Tolerance (SM is sexually unacceptable); and Real Life (SM practitioners carry their SM interests into the rest of their daily lives).

While Yost (2010) found excellent discrimination between groups, a multiple regression analysis determined that the four sets of attitudes did not account for all variance between groups, with 58% of the variance unexplained by the four sets of attitudes. Yost (2010) determined, "The ASMS captures a set of attitudes specific to SM that do not overlap with already-developed attitudinal scales" (p. 88). Therefore, the ASMS was a useful instrument for this study, as it captures counselors' negative attitudes specific to working with members of the kink community. Example items on the ASMS (Yost, 2010, p. 91) include:

- Sadomasochism is a threat to many of our basic social institutions.
- If I was alone in a room with someone I knew to be a Dominant, I would feel uncomfortable.

Survey of Self-Reported Counseling Competence

This survey is designed to capture your self-assessment of competence for working with a marginalized sexuality. Your honest self-appraisal will help determine initial steps to addressing counselor awareness, knowledge, and skills for working with this population (*must read before ability to continue with survey*).

In responding to the following statements, please use the following definition of competence, taken directly from the article, *"What does it mean to be a culturally-competent counselor?"* by Ahmed, Wilson, Henriksen, Jr., and Jones (2010, p. 18), *(must read before ability to continue with survey).*

> The definition of multicultural competence means, in part, to approach the counseling process from the context of the personal culture of the client (Sue, Arrendondo & McDavis, 1992; Sue & Sue, 2013), *(must read before ability to continue with survey).*

Using the following scale, please respond to the statements below:

1	2	3	4	5	6	7
disagree strongly	disagree moderately	disagree mildly	neither agree nor disagree	agree mildly	agree moderately	agree strongly

1: I have professional competence with regard to appropriate use of language for sexual minorities and how certain labels, such as Poly, Kink, and SM, require contextualization to be utilized in a positive and affirming manner.

2: I acknowledge that cross-cultural communication is key to connecting with privileged and marginalized clients in sexual subcultures, including the kink community, and have professional competence in the area of cross-cultural communication.

3: As either a privileged or marginalized counselor, I have awareness, knowledge, and skills (AKS) for understanding kink clients' worldview, and use the American Counseling Association's competencies to increase my AKS in this area.

4: I am aware of misconceptions and/or myths regarding affectional orientations and the sexual expression of kinksters, and I have professional competence in this regard.

5: I acknowledge that affectional orientations are unique to individuals and they can vary greatly among and across different populations of kink community members, across the lifespan, and I have professional competence in this regard.

6: I recognize and acknowledge my professional competence in understanding that historically, counselors and other helping professionals have compounded the discrimination of kink individuals by being insensitive, inattentive, uninformed, and inadequately trained and supervised to provide culturally proficient services to kink individuals and their loved ones.

7: I utilize an ethical decision-making model that takes into consideration the needs and concerns of the kink community member when facing an ethical dilemma with clients who identify as kink and/or BDSM/SM. I have professional competence in this area.

8: I attend professional development trainings to learn how stereotypes, discrimination, power, privilege, and oppression influence privileged and marginalized clients, ***including*** those who identify as members of a kink community.

9: I assess the degree to which historical events, current issues, and power, privilege and oppression contribute to the presenting problems expressed by privileged and marginalized kink community clients. I have competence with this type of self-assessment.

10: I continue to acquire culturally responsive critical thinking skills to gain insight into how stereotypes, discrimination, power, privilege, and oppression influence privileged and marginalized kink clients. I have competence with such critical thinking skills.

Figure 1. This figure shows the Counselor Self-Reported Competence Scale created for this study

Table 1
Participant Demographics

Characteristic	n	%
Age		
20-29 years old	27	27.8
30-39 years old	35	36.1
40-49 years old	19	19.6
50-59 years old	10	10.3
60-69 years old	4	4.1
70+ years old	2	2.1
Gender		
Female	76	78.4
Male	15	15.5
Transgender	4	4.1
Other*	1	1
Prefer not to disclose	1	1
Sexual Orientation/Identity**		
Exclusively heterosexual	47	48.5
PTOH	17	17.5
PTMH	10	10.3
ETH	6	6.2
PHMT	2	2.1
PHOT	10	10.3
Exclusively homosexual/lesbian	5	5.2
Other**	0	0
Education		
Master's (CACREP Program)	30	30.9
PhD (CACREP Master's)	67	69.1
Experience with Kink Clients		
No experience	56	57.7
Experience with 1-2 kink clients	22	22.7
Experience with 3+ kink clients	19	19.6
Master's Coursework in Sexuality		
Yes	43	44.3
No	54	55.7
Master's Multicultural Course***		
Yes	62	63.9
No	35	36.1
Continuing Ed on Sexual Diversity		
Yes	62	63.9
No	76	78.4

Note: ETH = Equally heterosexual and homosexual/lesbian; PHMT = Predominantly homosexual/lesbian, more than incidentally heterosexual; PHOT = Predominantly homosexual/lesbian, only incidentally heterosexual; PTMH = Predominantly heterosexual, more than incidentally homosexual/lesbian; PTOH = Predominantly heterosexual, only incidentally homosexual/lesbian; *The choice of "other" as an option was included so that those who identify as cisgender male, cisgender female, male transgender or female transgender had a way to acknowledge their personal choice of gender language as different from the other choices; **The Kinsey Scale offers a visual continuum of non-binary sexuality. The use of this scale is justified as a starting point for this research only and the authors acknowledge that it does not represent all sexual behaviors or preferences. The use of "other" was provided for inclusivity not identified on the Kinsey Scale;***Including sexual diversity

- Many sadomasochists are very moral and ethical people

Main Findings

Data analysis using multiple regression predictive design answered the following questions:

- What is the relationship between level of counselor self-reported competence for working with kink clients and counselor attitude towards SM?
- Can scores on the Attitudes about Sadomasochism Scale (ASMS) be predicted by factors such as age, gender, sexual orientation, master's coursework, continuing education, or American Counseling Association Division affiliation?
- Can scores on the Counselor Self-Reported Competence Scale be predicted by age, gender, sexual orientation, master's coursework, continuing education, ACA Division affiliation, and scores on the ASMS?

Research Question 1 and Hypothesis

Question 1 asked *"What is the relationship between level of counselor self-reported competence for working with kink clients and counselor attitude towards SM?"* A Pearson Correlation found a weak, negative relationship between these variables, and although the correlation between the full self-reported competency scores and the full ASMS scores was weak (r = -.260) the result was statistically significant (p = .010). Something other than chance was creating the correlation. Due to the findings, the null hypothesis (H_0 = no relationship between the level of self-reported competence and attitude) was rejected.

Further exploration of the relationship between counselor self-reported competence and the ASMS determined that counselor self-reported competence significantly correlated with three of the ASMS subscales: Socially Wrong (r = -.246; p = .015), Violence (r = -.224; p = .028), and Real Life (r = -.227; p = .025) in a pattern consistent with the overall ASMS. The correlation results indicate that if a counselor is reporting high self-confidence for working with kink clients, the counselor also appears to have a more open attitude towards SM as morally and socially acceptable alternative sexual expression.

The ASMS subscales showed a strong positive correlation between the Violence subscale and the Socially Wrong subscale (r =.782)—that is, those who tended to score high on the Violence subscale (belief that BDSM is associated with violent sexual acts against an unwilling person) also tended to score high on the Socially Wrong subscale (belief that BDSM is morally and socially wrong). This correlation was significant (p = .000). The Socially Wrong subscale had a significant (p = .015) negative correlation (r = -.246) with the

overall self-reported competence scale indicating that those who believe SM is morally and socially wrong tend to rate themselves as less competent for working with clients who participate in some type of kink/SM sexuality. These findings have implications for counselor educators who train students on human sexuality and diversity issues.

The Real Life subscale (the belief that SM practitioners carry their SM interests into the rest of their daily lives) had a significant (p = .025), strong, negative correlation (r = -.227) with counselor self-reported competence indicating that counselors who rate themselves as being less competent for working with kink clients tended to disagree that SM interests are carried into other parts of the client's life. The Lack of Tolerance subscale (a reverse-scored measure of one's belief that SM behavior can be an acceptable form of sexuality among willing partners) had no significant relationship (p = .173) with the overall score for counselor self-reported competence for working with kink clients.

Research Question 2 and Hypothesis

Question 2 asked *"Can scores on the Attitudes about Sadomasochism Scale (ASMS) (Yost, 2010) be predicted by factors such as age, gender, sexual orientation, master's coursework, continuing education, or American Counseling Association Division affiliation?"* Yes. A stepwise multiple regression analysis found several factors able to predict scores on the ASMS and therefore the null hypothesis (H_0 = scores cannot be predicted) was rejected. Data were inspected for analysis assumptions of linearity, homoscedasticity, and normality. All assumptions were met.

The multiple regression analysis produced three prediction models: Model 1, which included the variables of sexual orientation/identity score and age score; Model 2, which added course score and continuing education score to those of Model 1; and Model 3, which added the further variables of experience with kink clients. ACA Division status was reported as a descriptive factor for the sample only.

Regression results indicated that the third model significantly predicted ASMS scores, R^2 = .161, R^2adj = .115, F = 3.502, p = .006. This model accounts for 16.1% of the variance in ASMS (see Table 2). After removing gender and ACA Division, the data were rerun and standardized coefficients revealed several significant findings in the three models that emerged. Per an ANOVA, significance of individual predictors was increased when combined with other predictor variables (significance at ≤ .05), and Model 3 showed significance (p = .005) in predicting 16% of the change in variance of scores on the ASMS (R^2 = .161), due to the addition of experience with kink clients (the 5th predictor variable) to the other four predictor variables. Conversely, Model 1 predicted just 6% of the change in variance of scores on the ASMS (R^2 = .067) and Model 2 just 8% of the change in variance (R^2 = .084).

Table 2
ASMS Prediction Model Coefficients

Predictors	B	T	p
Age	0.252	2.521	.013*
Sexual Orientation/Identity	-0.079	-0.757	0.451
Course Score	-0.153	-1.569	0.12
Continuing Ed Score	0.036	0.351	0.726
Experience w/ Kink Clients	-0.319	-2.891	.005**

Note: *p<.05, **p<.01

Overall, analysis of the data determined that if a counselor has experience working with kink clients, their overall score on the Attitude about Sadomasochism Scale (Yost, 2010) can be predicted at twice the rate than if the counselor's age, sexual identity, courses, and continuing education is known, or that 16% of the change in variance of scores on the ASMS can be predicted based on Model 3. See Table 3.

Table 3
Model Summaries

Model	R^2	SEE
1. Sexual identity & age	.067	.81
2. Sexual identity, age, course score, & continuing ed score	.084	.81
3. Sexual identity, age, course score, continuing ed score, & experience w/ kink clients	.161	.78

Note: SEE = Standard error of the estimate

Research Question 3 and Hypothesis

Question 3 asked *"Can scores on the Counselor Self-Reported Competence Scale be predicted by age, gender, sexual orientation, master's coursework, continuing education, ACA Division affiliation, and scores on the ASMS?"* Yes. A stepwise multiple regression analysis found that 23% of the variance in self-reported competence score can be predicted by combining all of the predictor variables except age and gender. Therefore, the null hypothesis (H_0 = scores cannot be predicted) was rejected. Data was inspected for analysis assumptions of linearity, homoscedasticity, and normality. All assumptions were met.

Regression results indicated that the third model significantly predicted ASMS scores, R^2 = .327, R^2adj = .298, F = 11.191, p = .000. This model accounts for 32.70% of the variance in ASMS. Age and gender were excluded variables due to lack of significance (age: p = .436; gender: p = .792) The residuals for each predictor within this model are presented in Table 4.

Continuing education, surprisingly, did not predict scores

on self-reported competence, nor did continuing education on diversity issues, also an unexpected finding. As with Question 2 outcomes, experience with kink clients had strong significance, at the < .001 level, and experience was able to predict almost 40% of the change in variance in scores on self-reported competence. Participants who worked with even one kink client reported increased competence with this subculture. Results of the ANOVA support Model 3 as significant for predicting outcomes on self-reported competence. The same three models were used to group data for analysis and Model 3 was able to predict 33% of the change in score on self-reported competence (R^2 = .327). Simply by adding experience to the model, there was a 13% increase in predictability of competence scores.

Table 4
Counselor Self-Reported Competency Scale Prediction Model 3 Coefficients

Predictors	B	T	p
Sexual Orientation/Identity	0.23	2.466	.016*
Course Score	-0.17	-1.978	0.051
Continuing Ed Score	0.064	0.712	0.478
Experience w/ Kink Clients	0.394	4.09	.000**

Note: *p<.05, **p<.01

Discussion

The relationship between counselor self-reported competence for working with kink clients and counselor attitude about SM was weak yet correlations became stronger when the four ASMS subscales were applied to the scores. Counselors who viewed SM as socially and morally wrong, per the ASMS subscales, also had less self-reported competence for working with kink clients and were older. This is an important finding of the study as it reflects prior research findings on bias against kink sexuality and has implications for counselors and counselor educators.

The overall findings of the research determined that a single variable, experience working with kink clients, had statistically significant predictive capability for scores on both the ASMS and the counselor self-reported competency scale. In addition, counselors who identified as not exclusively heterosexual, appeared to be more accepting of SM sexuality and report increased levels of self-competence for working with kink clients. Interestingly, having a master's level course on human sexuality or a multicultural counseling course that included sexual diversity topics, had little predictive value for high levels of counselor self-reported competence for working with kink clients or on counselor attitude about SM sexuality. Counselors who self-identified as not exclusively heterosexual and had experience with one or more kink clients seem to have the most self-reported competence and the least restrictive view of SM sexuality.

Kink sexuality may be particularly offensive or off-putting to those counselors who continue to assign stigma and shame to consensual sexual choices with which they are unfamiliar or that are held in contempt for personal reasons. This study seems to indicate lack of experience and exposure to kink culture or working directly with counseling issues rooted in kink behavior as contributors to the lack of self-reported competence among counselors.

Implications for Counselors

This research study gives additional support for counselor increased awareness, knowledge, and skills (competency) for working with SM clients since the overall mean score on counselor self-report of competence was 4.30 reflecting an inability to agree or disagree with the statement. Increasing self-reported competence is correlated with counselors' reported experience working with one or more kink clients. For counselors, then, it is reasonable to say that gaining competence with kink clients requires an ability to maintain a nonjudgmental and open therapeutic environment for the client so that a trusting, therapeutic relationship can be established. Gaining insight into what brings the client into the counseling room and allowing for unconditional positive regard for clients who report kink sexuality practices is a way to refrain from misdiagnosing SM practices as pathologic or ignoring pathology that may be present.

To reduce stigma and bias against kink clients, it appears that personal knowledge of someone who identifies with kink sexuality practices may help in this process. Given the increased negativism and violence in the United States towards anyone who is viewed as other-than, it is important to note that personal contact with someone outside of a socially acceptable group of peers may reduce or eliminate prejudicial attitudes, at least in the short-term. McBride (2015), in a study supported by the Scottish government, recognized "interventions which facilitate positive intergroup contact, or are based on principles of perspective-taking or empathy-induction are considered to be effective," in reducing prejudicial attitudes (p. 5).

Implications for Counselor Educators

The current study seems to indicate that coursework and continuing education on human sexuality and diversity issues has little effect on counselor attitude or perceived self-competence for working with kink clients. This is a surprising find in that multiple studies indicate experiential education helps to increase awareness of hidden bias and address known bias in these areas (Adams, Bell, & Griffin, 2007; McBride, 2015; Ponzetti Jr., 2015). It is noted that experiential education allows for a different level of processing than lectures and power points on sexuality topics. An experiential approach would include taking learning from

the typical classroom environment into the community, thus bridging learning to a real-world environment. In this way, experiential learning "integrates new learning into old constructs" (Eyler, 2009).

Since experiential learning was not clearly defined in the current study, it may have been better to obtain participant data on the actual type of coursework and training received. In addition to type, a question about the perception of the education received as helpful in their overall attitude towards sexually marginalized clients, such as those in the kink community, may have strengthened the results.

Ford and Hendrick (2003)suggest increased opportunities for practicums and internships that expose students to the continuum of human sexuality in ways that will complement their future work and allow for supervision around these topics. They also suggest multiple training modules that create an opportunity for graduate students to fully engage in a discussion of sexuality topics (Ford & Hendrick, 2003). Harris and Hays (2008) view the graduate student supervisor as the initiator of discussions on sexuality in clinical situations and vital to increasing student comfort level with their own awareness of self. They note that increasing comfort in addressing sexuality with their future clients works to facilitate student self-perception of competence (Harris & Hays, 2008). Supervisors might use Yost's (2010) Attitude about Sadomasochism Scale or the survey created for this research as a way to begin a small-group discussion. Recommendations for film studies, both documentary and movie titles, are another way to begin important discussions on sexuality topics that may then allow students to increase their understanding of a variety of issues related to human sexuality.

Limitations

Survey bias creates the halo effect and sexuality surveys are particularly prone to this type of research bias (Dodd-McCue & Tartaglia, 2010; Dunne, 1998), perhaps wanting to view themselves as competent, open-minded counselors. Surveys that use a 7-point Likert scale may also encourage bias since participants might choose the neutral response or simply pick the number that best supports a positive perception of self, as suggested by Cummin and Gullone (2000).

Had the number of useable, completed surveys been higher, age, gender, and ACA Division affiliation may have proved useful as predictors of scores on self-reported competence and attitudes about sadomasochism. The positive linear correlation found between increased tolerance and experience with SM clients may be affected by the counselor's own bias towards a positive SM attitude due to their own participation in kink. Additionally, the Counselor Self-Reported Competence Scale asked about familiarity with using certain labels to affirm non-traditional sexual practices such as "Poly," "Kink," and "SM" but did not provide definitions for these terms, which may have skewed the responses.

Yost's (2010) ASMS is SM specific and does not consider the variety of other sexual behaviors that one might consider kink. Although Yost's (2010) development of the Attitude about Sadomasochism Scale (ASMS) demonstrated validity, her participants were not counselors. Rather, they were a convenience sample of undergraduate students enrolled in an introductory psychology course (n = 471). The subscales she created measured four different levels of sexual conservatism, but the subscales did not explain the variance on the ASMS. Yost (2010, p. 79) noted that "...the ASMS measures a unique attitudinal construct," about SM, unexplained by the variance in score on the ASMS. Since the attitudinal construct is unknown, a guess might be that the ASMS measures a level of discomfort with kink sexuality that cannot be associated with sexual conservatism. Since inflicting pain is one part of the SM dynamic, perhaps the construct is an aversion to pain, which may help explain why so many responses on the ASMS in the current study fell close to the mean of 4 (neither agree nor disagree).

Implications for Further Research

Further research that captures additional participant insight is needed to help determine best practices for increasing counselor competence when working with kink clients, and to increase counselor self-awareness of attitude towards BDSM. This suggests a mixed methods research approach.

The current research was conducted in a time of shifting attitudes toward consensual, adult, non-diagnosable, paraphilic sexuality as a legitimate form of adult sexual expression. Further research is needed on this population that considers if a change in counselor attitude towards kink clients equates to a change in counseling behaviors. Approaching future research with a mixed methods approach is suggested so that deeper meaning can be drawn from participant statements on a questionnaire or survey.

Evolving Norms

Definitive recognition of what is normal versus abnormal sexuality continues to shift and evolve with changes in social and cultural mores. The historical shift in defining sexual pathology highlights the strong influence of psychiatry, religion, and education in shaping heteronormative, monogamous sexuality as the ideal in the United States. If professional counselors want to promote systemic attitudinal change, the ACA competencies serve as a path towards this change (Toporek, Lewis, & Crethar, 2009).

The call for counselor awareness, knowledge, and skills is not a stagnant opportunity one receives in a CACREP program, but one that requires ongoing self-awareness and recognition that conventional sexual and social mores can have negative implications when working with kink clients. Increasing counselor competence in working with kink

clients may increase contact with this sexual subgroup, thereby decreasing stigma and bias. This study supports the idea that counselors who have experience working with at least one kink client seem more willing to view kink sexuality as a creative form of relationship building and self-expression for some consenting adults. It is hoped that this research encourages counselors to set aside any pre-conceived bias against this sexual subculture so that the work of counseling can take place.

References

Adams, M., Bell, L. A., & Griffin, P. (Eds.). (2007). *Teaching for diversity and social justice* (2nd ed.). Routledge.

ALGBTIC LGBQQIA Competencies Taskforce, Harper, A., Finnerty, P., Martinez, M., Brace, A., Crethar, H. C., ... Hammer, T. R. (2013). Association for lesbian, gay, bisexual, and transgender issues in counseling competencies for counseling with lesbian, gay, bisexual, queer, questioning, intersex, and ally individuals. *Journal of LGBT Issues in Counseling*, *7*(1), 2–43. doi:10.1080/15538605.2013.755444

American Counseling Association. (2014). *Code of ethics*. Author. Retrieved from https://www.counseling.org/Resources/aca-code-of-ethics.pdf

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, *24*(1), 42–78. doi:10.1002/j.2161-1912.1996.tb00288.x

Balon, R. (2013). Controversies in the diagnosis and treatment of paraphilias. *Journal of Sex & Marital Therapy*, *39*(1), 7–20. doi:10.1080/0092623x.2012.709219

Bhugra, D., Popelyuk, D., & McMullen, I. (2010). Paraphilias across cultures: Contexts and controversies. *Journal of Sex Research*, *47*(2-3), 242–256. doi:10.1080/00224491003699833

Connan, S. (2010). A kink in the process. *Therapy Today*, *21*(6), 10–15. Retrieved from http://www.pinktherapy.com/Portals/0/GB_Kink.pdf

Council for Accreditation of Counseling and Related Educational Programs. (2016). *2016 standards*. Author. Retrieved from http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

Cummin, R., & Gullone, E. (2000). Why we should not use 5-point likert scales: The case for subjective quality of life measurement. In *Second International Conference on Quality of Life in Cities.* Singapore.

Diambra, J. F., Pollard, B. L., Gamble, R. M., & Banks, B. P. (2016). Teaching a human sexuality course: What are counseling students thinking? *American Journal of Sexuality Education*, *11*(1), 76–91. doi:10.1080/15546128.2016.1141737

Dodd-McCue, D., & Tartaglia, A. (2010). Self-report response bias: Learning how to live with its diagnosis in chaplaincy research. *Chaplaincy Today*, *26*(1), 2–8. doi:10.1080/10999183.2010.10767394

Dunne, M. (1998). Sex surveys: what does it mean when thirty to forty percent don't participate? *Venereology*, *11*(2), 33-37.

Eyler, J. (2009). The power of experiential education. *Liberal Education*, *95*(4), 24–31.

First, M. B. (2014). DSM-5 and paraphilic disorders. *Journal of the American Academy of Psychiatry and the Law Online*, *42*(2), 191–201. Retrieved from https://end-the-stigma.com/resources/DSM-5_and_Paraphilic_Disorders.pdf

Ford, M. P., & Hendrick, S. S. (2003). Therapists' sexual values for self and clients: Implications for practice and training. *Professional Psychology: Research and Practice*, *34*(1), 80–87. doi:10.1037/0735-7028.34.1.80

Freeburg, M. N., & McNaughton, M. J. (2017). Fifty shades of grey: Implications for counseling BDSM clients. *VISTAS 2017*. Retrieved from http://www.counseling.org/knowledge-center/vistas

Freud, S. (1905). Three essays on the theory of sexuality (1905). In J. Strachey (Trans.), *The standard edition of the complete psychological works of sigmund freud, volume vii (1901-1905): A case of hysteria, three essays on sexuality and other works* (pp. 123–246). Hogarth.

Gray, L. A., House, R. M., & Eicken, S. (1996). Human sexuality instruction: Implications for couple and family counselor educators. *The Family Journal*, *4*(3), 208–216. doi:10.1177/1066480796043004

Gross, B. (2006). Please of pain. *Forensic Examiner*, *15*(1), 56-61.

Harris, S. M., & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. *Journal of Marital and Family Therapy*, *34*(2), 239–250. doi:10.1111/j.1752-0606.2008.00066.x

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

James, E. L. (2012). *Fifty shades of grey: Book one of the fifty shades trilogy (Fifty shades of grey series, 1)*. Bloom Books.

Keane, H. (2004). Disorders of desire: Addiction and problems of intimacy. *Journal of Medical Humanities*, *25*(3), 189–204. doi:10.1023/b:jomh.0000036637.03254.38

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

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1948). *Sexual behavior in the human male*. W. B. Saunders.

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

Kleinplatz, P. J., & Ménard, A. D. (2007). Building blocks toward optimal sexuality: Constructing a conceptual model. *The Family Journal*, *15*(1), 72–78. doi:10.1177/1066480706294126

Kolmes, K. L. (2003). *BDSM consumers of mental health services: The need for culturally- sensitive care* (Unpublished doctoral dissertation). California School of Professional Psychology.

Langdridge, D., Richards, C., & Barker, M. J. (Eds.). (2007). *Safe, sane and consensual: Contemporary perspectives on sadomasochism*. Palgrave Macmillan.

Laska, R. S. (2013). Surrendering safely: Increasing clinicians' understandings of kink. *Master of Social Work Clinical Research Papers*. Retrieved from https://sophia.stkate.edu/msw_papers/222/

Lawrence, A. A., & Love-Crowell, J. (2007). Psychotherapists' experience with clients who engage in consensual sadomasochism: A qualitative study. *Journal of Sex & Marital Therapy*, *34*(1), 67–85. doi:10.1080/00926230701620936

McBride, M. (2015). *What works to reduce prejudice and discrimination? A review of the evidence.* Scottish Government. Retrieved from https://dera.ioe.ac.uk//24516/

Miller, S. A., & Byers, E. S. (2010). Psychologists' sexual education and training in graduate school. *Canadian Journal of Behavioural Science / Revue canadienne des sciences du comportement*, *42*(2), 93–100. doi:10.1037/a0018571

Mitcham, M., Greenidge, W.-l., & Smith, S. D. (2013). Teaching the multicultural counseling course: Facilitating courageous conversations and transformational multicultural pedagogy. *VISTAS Online*. Retrieved from https://www.counseling.org/docs/default-source/vistas/teaching-the-multicultural-counseling-course-facilitating-courageous-conversations-and-transformational-multicultural-pedagogy.pdf

Moser, C., & Kleinplatz, P. J. (2006). DSM-IV-TR and the paraphilias. *Journal of Psychology & Human Sexuality*, *17*(3-4), 91–109. doi:10.1300/j056v17n03_05

Newmahr, S. (2010). Rethinking kink: Sadomasochism as serious leisure. *Qualitative Sociology*, *33*(3), 313–331. doi:10.1007/s11133-010-9158-9

Nichols, M. (2006). Psychotherapeutic issues with "kinky" clients. *Journal of Homosexuality*, *50*(2-3), 281–300. doi:10.1300/j082v50n02_14

O'Keefe, S. L., Beard, K. W., Stroebel, S. S., Berhie, G., Bickham, P. J., & Robinett, S. R. (2009). Correlates of inserted object-assisted sexual behaviors in women: A model for development of paraphilic and non-paraphilic urges. *Sexual Addiction & Compulsivity*, *16*(2), 101–130. doi:10.1080/10720160902724418

Péloquin, K., Bigras, N., Brassard, A., & Godbout, N. (2014). Perceiving that one's partner is supportive moderates the associations among attachment insecurity and psychosexual variables. *The Canadian Journal of Human Sexuality*, *23*(3), 178–188. doi:10.3138/cjhs.2443

Peoples, K., & Meyer Stewart, E. (2017). Systems-focused therapy with paraphilic disorders. In J. Russo, J. Coker, & J. King (Eds.), *DSM-5 and family systems* (p. 501-532). Springer.

Perel, E. (2006). *Mating in captivity: Reconciling the erotic and the domestic*. Harper.

Pillai-Friedman, S., Pollitt, J., & Castaldo, A. (2014). Becoming kink-aware – a necessity for sexuality professionals. *Sexual and Relationship Therapy*, *30*(2), 196–210. doi:10.1080/14681994.2014.975681

Pollock, K. (2019). Kink in the counselling room: Karen Pollock dispels some of the many myths about kink. *Therapy Today*, *30*(6). Retrieved from https://www.bacp.co.uk/bacp-journals/therapy-today/2019/july-2019/articles/kink-in-the-counselling-room

Ponzetti Jr., J. J. (Ed.). (2015). *Evidence-based approaches to sexuality education: A global perspective*. Routledge.

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48. doi:10.1002/jmcd.12035

Richters, J., Visser, R. O. D., Rissel, C. E., Grulich, A. E., & Smith, A. M. (2008). Demographic and psychosocial features of participants in bondage and discipline, "sadomasochism" or dominance and submission (BDSM): Data from a national survey. *The Journal of Sexual Medicine*, *5*(7), 1660–1668. doi:10.1111/j.1743-6109.2008.00795.x

Sandnabba, N. K., Santtila, P., Alison, L., & Nordling, N. (2002). Demographics, sexual behaviour, family background and abuse experiences of practitioners of sadomasochistic sex: A review of recent re-

search. *Sexual and Relationship Therapy*, *17*(1), 39–55. doi:10.1080/14681990220108018

Schachner, D. A., & Shaver, P. R. (2004). Attachment dimensions and sexual motives. *Personal Relationships*, *11*(2), 179–195. doi:10.1111/j.1475-6811.2004.00077.x

Sheff, E., & Hammers, C. (2011). The privilege of perversities: race, class and education among polyamorists and kinksters. *Psychology and Sexuality*, *2*(3), 198–223. doi:10.1080/19419899.2010.537674

Sisson, K. (2007). The cultural formation of s/m: History and analysis. In D. Langdridge & M. Barker (Eds.), *Safe, sane and consensual: Contemporary perspectives on sadomasochism* (p. 10-34). Palgrave MacMillan.

Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling & Development*, *87*(3), 260–268. doi:10.1002/j.1556-6678.2009.tb00105.x

Walters, N. T., & Spengler, P. M. (2016). Clinical errors and therapist discomfort with client disclosure of troublesome pornography use: Implications for clinical practice and error reduction. *Psychotherapy*, *53*(3), 354–359. doi:10.1037/pst0000079

Williams, D., Thomas, J. N., Prior, E. E., & Christensen, M. C. (2014). From "SSC" and "RACK" to the "4Cs": Introducing a new framework for negotiating BDSM participation. *Electronic Journal of Human Sexuality*, *17*(5), 1–10.

Witte, K., & Zurek, E. (1995). Sexuality: A cultural diversity issue. *Creative Nursing*, *1*(5), 10–12.

Wright, S. (2006). Discrimination of SM-identified individuals. *Journal of Homosexuality*, *50*(2-3), 217–231. doi:10.1300/j082v50n02_10

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

Zambelli, L. (2016). Subcultures, narratives and identification: An empirical study of BDSM (bondage, domination and submission, discipline, sadism and masochism) practices in italy. *Sexuality & Culture*, *21*(2), 471–492. doi:10.1007/s12119-016-9400-z