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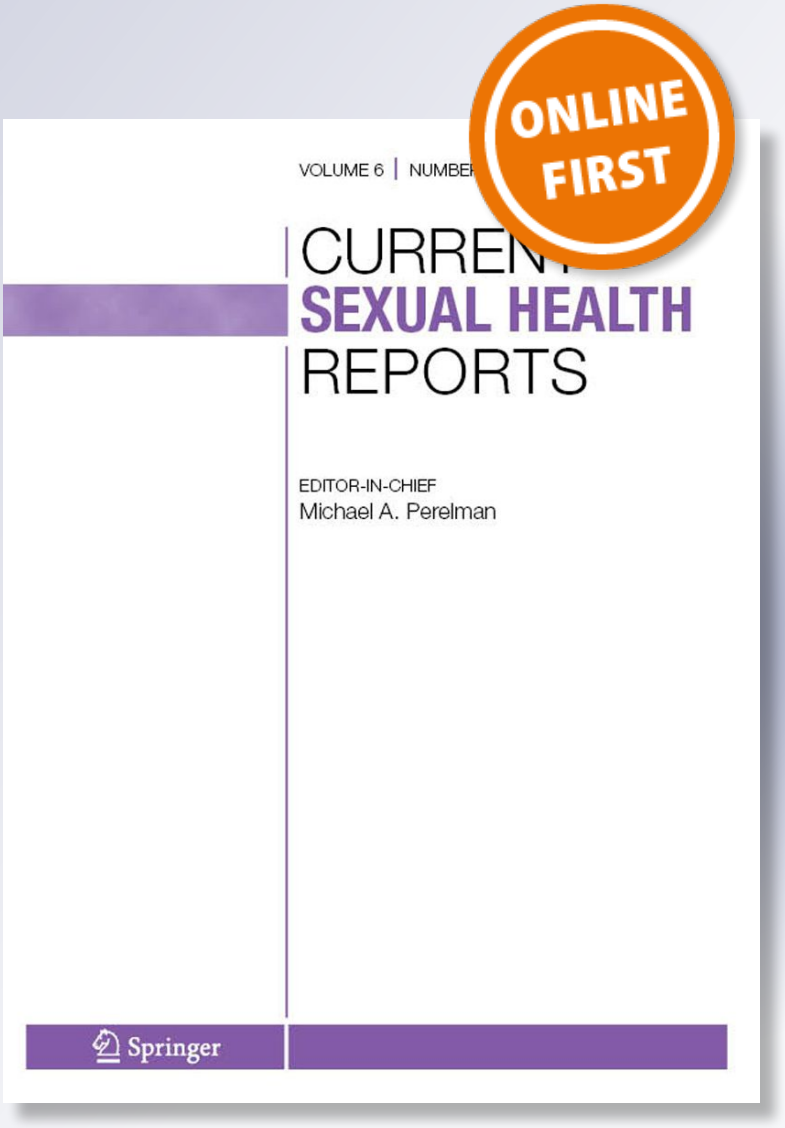

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Health Disparities Among Kinky Sex Practitioners

Richard Sprott[1] · **Anna Randall**[2]

Abstract
Purpose of review This review is to characterize the theoretical and empirical literature about alternative sexual behaviors, predominantly known under the umbrella of bondage and discipline, dominance and submission, and sadism and masochism (BDSM, also known as "kink"). The overview is to aid the clinician in understanding how particular studies might fit into the larger context of the scholarly and empirical literature in order to judge the generalizability of conclusions. The specific concern of whether there are health disparities for this stigmatized sexuality is considered and explored.
Recent findings The literature contains a wide range of positions and perspectives, ranging from always pathologizing BDSM behavior to proposing therapeutic functions of BDSM behavior. There are significant differences across professions in treatment of BDSM, and the medical literature is noted for being disorganized and piecemeal and starting to change over the past 5 years in ways that addresses the earlier problematic approaches that may have hindered clinical practice.
Summary Empirical evidence suggests significant stigma impacting the health of BDSM-identified patients and impacting the healthcare service provided to kinky sex practitioners. The empirical and scholarly literature about BDSM or kink demonstrates a trend that addresses the stigma of alternative sexualities, but more work is needed.

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Introduction

Approximately 2.5–26% of the population has engaged in sexual practices that involve consensual and negotiated power differences, intense sensations, restraint and control, or sensory experiences that are erotically associated to an object of desire [1, 2••, 3]. In many academic fields, these aspects of sexuality are designated with the compound acronym of BDSM: bondage/discipline; dominance/submission; and sadism/masochism [4]. In the language of the communities and social networks that organize around these sexual practices, they are called "kinky" or "leathersex" or "freaky" [5••]. BDSM or kinky sexual practices are often stigmatized by society generally and that stigma can extend to healthcare experiences, in the context of both medical and mental health services [5••, 6•]. The stigma affects medical care across a wide range of presenting problems and is not limited to care around BDSM related injuries or complications.

In this review, we are guided by three questions: What is the nature of the healthcare literature on kink/BDSM? How much does stigma impact the healthcare of kinky sex practitioners? Are there special risks or health disparities for people who practice BDSM?

Broad Characteristics of the Literature

In this review, we will focus on the possible health implications and the health disparities that might be experienced among the population of kinky sex practitioners. This is an area that is greatly under researched, given the prevalence of kinky practices in the general population.

The literature on alternative sexualities like kink or BDSM can be found in three major types of literature: the classic sexological and psychoanalytic literature (1886–1924), the psychiatric and modern mental health literature, and the social science literature [7]. Generally, the classic sexological literature and the psychiatric literature have presented kink/BDSM interests and behaviors through the lens of pathology. The social science literature (1969–present) has tended to view kink/BDSM behavior through the lens of social deviance or stigmatized subculture, without addressing or incorporating pathology as a conceptual framework.

Medical research is not well represented in the extant literature, although over the last 5 years, there is more work published on this topic. Most of the existing BDSM-related peer-reviewed studies published in the medical literature are in journals related specifically to sexual medicine [5••, 8••]. This limited research coverage is in contrast to potential research about the wide range of behaviors that kinky sex practitioners can incorporate, behaviors such as erotic enema play, impact play such as flogging or paddling, temporary piercing of the skin with needles, bondage, breath control, or choking—all activities that can lead to a wide variety of medical issues, concerns, or conditions beyond typical concerns of sexual health [8••, 9•]. Confusingly, in the medical literature, many articles do not identify or label behaviors as BDSM-related; for example, objects inserted into the rectum are not connected to any behavioral or contextual features that would indicate kink-related sexuality. Much of the relevant medical literature has a focus on sexually transmitted infections including HIV or health risks related to specific behaviors without ascribing them to BDSM, such as anal or vaginal fisting (insertion of hand for erotic purposes) [10]. Very few articles in the medical literature specifically cover medical issues in terms of BDSM or kink sexuality, per se [11]. It is important to note that the connection between interest, behavior, and identity is very complex, and so some BDSM type behavior is enacted by people who do not identify their behavior as kinky or feel connected to an organized BDSM community; however, the status of their identities around kinky sexuality can have important consequences in terms of risks. The tendency to report behaviors and medical sequelae without including the sexual identity or community factors results in a scattered and disorganized literature base, which may impede an effective clinical response.

In our review of the recent literature, we note that there is still a wide range of approaches to analyzing and framing kink/BDSM behaviors and interests. Some researchers approach kink/BDSM as pathology, or discuss sexual sadism as a paraphilic behavior, or analyze sadism as part of a "dark triad" or "dark tetrad" of personality disordered traits [12]; some approaches are focused on the risks of kink/BDSM and often frame the issues from a paternalistic stance by discussing how medical professionals should discourage all kink/BDSM activities because of the risks [13]; and some areas of the literature approach kink/BDSM from a normalizing stance [14] or that highlights strengths and resiliencies of this population and proposes insights that can be applied from the kink communities to the wider population when it comes to sexual health [15]. This presents researchers and clinicians with a body of literature than runs the gamut from discussing kink as always a sign of pathology to discussing kink as a positive factor for well-being [16].

One of the ongoing challenges to a literature search on BDSM health disparities is the lack of a common language or understanding of this subgroup. What do we mean by the term BDSM? Is the term referencing behavior, fantasy, urge, desire, sexual politics, or biology? Each discipline and even individual researcher who explores this topic may use different terms and concepts. The result seems to be an increased risk of inherent bias, misdiagnosis, moralism, paternalism, and over-simplification.

In this section, we present some points from the literature to highlight some of these approaches, framings, and stances, to illustrate the range of perspectives. In doing so, we recognize that there is a need for a systematic content analysis of the professional literature on this subject, which we hope will be coming in the near future.

On One End: Pathology or the Dark Tetrad

Because BDSM includes a variant of behaviors and identities, research often focuses on one or more of the acronyms contained within. In the exploration of one of these behaviors, under the umbrella of *paraphilia* or *paraphilic disorder,* sadism has long been studied in the literature. Psychiatry and personality psychology often discuss sadism as a disordered aspect of functioning or developmental process, defining sadism as pleasure derived from the distress and suffering of others and not being limited to erotic or sexual motivations. The dark triad personality traits include psychopathy, Machiavellianism, and narcissism, with some arguing that sadism is closely intertwined with these three anti-social personality traits, making a dark tetrad [17, 18]. This dark tetrad set of traits includes overlapping characteristics of callousness, antagonism, and egocentrism. The line between sadism or masochism, as a trait, and sexual sadism or sexual masochism, is not always clearly defined in this part of the literature. We note that sexual sadism and sexual masochism are still diagnoses in the DSM-5, and there are proposals to remove several paraphilic disorder categories from the ICD-11, but to replace them with "Other paraphilic disorder involving solitary behavior or consenting individuals" if there is significant distress or direct risk of injury or death.

While this part of the literature is large, it is not especially clear that this conceptualization of sexual sadism or sexual masochism is comparable to the phenomenon found in

BDSM practices or kink communities. It is not clear that the terms are denoting the same qualities or referents. Very few references in the psychiatric literature make a distinction between pathological and non-pathological conditions where interest in BDSM activities is concerned, although the DSM-5 has recently made it clear that clinicians should diagnose a paraphilic disorder only if criteria around distress or nonconsensual behavior are met [19, 20]. The presence of a paraphilia, or unusual sexual interest or behavior, is not itself pathognomonic for a mental disorder.

On the Other End: Normalizing or De-stigmatizing

The assumptions that kink/BDSM interests or behaviors reliably indicate pathology appear increasingly unwarranted given the preponderance of research that finds little or no difference in psychological functioning and attachment styles when compared with controls [21–23]. These studies often frame kink or BDSM interests and activities as a non-pathological variation in human sexuality [24]. These studies often use snowball sampling or purposive sampling of populations in order to locate participants who identify as kink-oriented and avoid using clinical samples. The Australian study of health and relationships (ASHR) is one study to examine psychological distress and sexual functioning in a national representative sample. This study found 2.2% of sexually active men and 1.3% of sexually active women had engaged in BDSM activities within the past year and found no difference in past sexual abuse history, levels of psychological distress, or sexual functioning difficulties between the BDSM subgroup and the non-BDSM population [22]. A study in the Netherlands, comparing 902 kink-identified participants with 488 participants in a control group, found no differences in attachment style and found the BDSM group to score higher on personality traits of extraversion, openness to new experiences, and conscientiousness, and lower on neuroticism and agreeableness. The BDSM sample had higher scores of subjective well-being as well [23].

Stigma and Discrimination within Healthcare Settings

There are very few studies of kink-related stigma within healthcare settings. The National Coalition for Sexual Freedom conducted a survey of kink-identified individuals, collecting data from April 2007 to June 2008. This resulted in a sample size of 3058 respondents. 11.3% of that sample reported discrimination by a professional or service provider, with 48.8% of the subgroup indicating that it was a medical doctor that discriminated (n = 169 people). Comments included "One medical doctor refused to continue treatment after I showed him bruising" and "I hurt my shoulder throwing a flogger. When asked, I told the truth. He refused to treat me and asked me to leave (of course, he still charged me my co-pay and billed my insurance)" [25]. Waldura et al. [5••] conducted a qualitative study of kink-identified people's experience in healthcare settings, interviewing 115 participants between January 2013 and October 2014. Forty-four percent of the sample had visited a medical care provider about a concern that was related to their kink activities or behaviors. But while the incidence of experiencing discrimination was low, the fear of encountering stigma in the health care setting was a clear and prominent theme in the interviews. The issue of anticipated stigma was also expressed in terms of disclosure to medical providers; only 38% of the sample had disclosed their kink interests and behaviors to their current primary care clinician. There are limited resources addressing the decision to disclose to medical providers, with the most comprehensive resource still Moser [26] *Health Care Without Shame*, published in 1999.

Not surprisingly, there is a notable lack of training about kink/BDSM sexuality among healthcare providers, given the very limited time given to education and training about sexuality matters in general [3, 27]. In the mental health field, there has been a more prominent and sustained call for better training regarding kink/BDSM [1, 4, 14, 28].

Possible Health Disparities for Kink-Oriented Populations: Are Kinky Sex Practitioners a Sexual Minority?

Kink/BDSM-oriented people are currently unidentified as a sexual minority as defined by the Centers for Disease Control. The CDC limits the term "sexual minority" to LGBT and gender non-conforming persons. However, some of the recent literature includes BDSM practitioners under of the umbrella of sexual minority or may even identify BDMS practitioners as a distinct sexual minority [5••, 8••], but this conceptualization of kink-oriented people as a sexual minority is not widely shared or addressed [24, 29••].

Recent research suggests that there might be an empirical basis for identifying BDSM or kinky sex practitioners as a sexual minority. Preliminary results of our 2016 National Kink Health Survey may begin to give some detail about possible health disparities [30•]. Data was collected between April 2016 and October 2016. Inclusion criteria were 18 years or older, living in the USA, have had fantasies, desires or longings around kink/fetish activities, and currently practice a kink or fetish behavior. A sample size of 987 participants completed the survey, which measured health status, healthcare experiences, aspects of identity, and health implications of kink behavior. Fourteen percent of the sample reported a kink-related injury or medical complication at some point in their lives. Thirty-one percent of the sample reported having a discussion about a kink-related health concern or question with a medical professional. Fifteen percent of the sample (n = 162) reported feeling disrespected or discriminated against by a health provider. Several measures of mental health

demonstrated heightened levels of distress, with possibly higher rates of depression, alcohol/drug use, and suicidality. Higher risk of suicidality, connected to higher levels of shame, has also been found in a sample of 321 adults who were involved in BDSM: a point prevalence of 37.5% had a non-zero level of suicidal ideation [31••]. The pattern of mental health issues resembles the same patterns experienced by LGBT populations, a pattern well established in the literature [32]. These differences in behavioral health are analyzed as reactive to stigma and minority stress for the LGBT population [33]. Given the stigma surrounding kinky sex interests and behaviors, it is possible that the same dynamics between stigma and mental health consequences are at work for the kink/BDSM population, lending support to the concept of kinky sex practitioners being a sexual minority.

On the surface, it would seem that the studies of psychological functioning that find no difference in trauma, abuse, or distress contradict the possible findings of health disparities due to minority stress and stigma. The same surface contradiction can be found in the LGBT health literature, and therefore, it is important to recognize the development of strengths and resiliencies in the face of minority stress [33, 34]. Development of a positive sexual identity and finding social support have been found to significantly counter the internalization of homophobia, and internalized homophobia strongly predicts depression [35]. The dynamics between stigma, minority stress, social support, and positive identity may work the same for kink-oriented people. If so, then it seems that medical providers can improve the health of kink-oriented patients by providing nonjudgmental care that acknowledges the importance of positive identity development as a sexual minority.

Conclusion

It is safe to assume that engaging in some kinky sex behaviors can result in higher risks for medical complications, such as sexually-transmitted infections, blood-borne pathogens, or injury [5••, 9•, 11]. However, it is difficult to find data on rates of infection or injury, because case reports and epidemiological studies do not provide information on the sexual identities or relational contexts of behaviors that could be kink-related. But given that people who engage in kinky sex are more likely to engage in higher-risk activities (though their actual risk may be mitigated by cultural norms of negotiation and disclosure), they are more likely to experience stigma with resultant levels of stress and shame and are more likely to come into contact with a healthcare system that is not fully trained or prepared to provide effective care. It is not a surprise that there might be significant health disparities. We are only at the beginning of empirically mapping out these possible disparities and addressing the gaps in education and training that would address any health disparities among kinky sex practitioners.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

Human and Animal Rights and Informed Consent All reported studies/experiments with human or animal subjects performed by the authors have been previously published and complied with all applicable ethical standards (including the Helsinki declaration and its amendments, institutional/national research committee standards, and international/national/institutional guidelines).

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