PSYCHOLOGY & SEXUALITY
https://doi.org/10.1080/19419899.2026.2621753

Routledge
Taylor & Francis Group

RESEARCH ARTICLE

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Subcultural webs of (health)care in kinked communities of gay fist-fuckers

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ABSTRACT

Existing research on kink-identified people's healthcare experiences has focused largely on encounters with mainstream systems, where disclosing kink practices can invite stigma, misunderstanding, or denial of care. Far less attention has been given to the alternative forms of (health)care cultivated within kink subcultures themselves. This article reports findings from a qualitative study of such practices among fist-fuckers. An international sample of 20 kink-identified gay men participated in four online focus groups. Reflexive thematic analysis generated five themes: (1) skill and resource exchange; (2) emotional and psychological support; (3) placemaking care; (4) embodied and experiential knowledge; and (5) communal care and resilience. Framed through queer worldmaking, the findings show how everyday care practices among fist-fuckers form subcultural webs of health promotion and (health)care grounded in reciprocity, intimacy, and collective responsibility rather than hierarchical biomedical models. These practices are affective, emergent, and distributed through embodied knowledge and a communal ethics of care. The article argues that fist-fuckers enact queer worldmaking through the construction of health-and kink-sustaining subcultural webs that allow them to flourish in their kink. In doing so, they offer a critical rethinking of what counts as care, who provides it, where it takes place, and the ethics which organise it.

ARTICLE HISTORY
Received 9 October 2025
Accepted 17 January 2026

KEYWORDS
Care webs; fisting; health; kink; queer worldmaking

Introduction

Kink-identified individuals often encounter misunderstanding, stigma, and discrimination when seeking healthcare for kink-related needs (Jansen et al., 2024; Waldura et al., 2016; Wright, 2008). Limited affirmative training and the historical pathologisation of kink within medicine and psychology has meant that healthcare systems are not always 'fully trained or prepared to provide effective care' for members of the kink community (Jobson, 2021; Sprott & Randall, 2017, p. 107; Sprott et al., 2023). Consequently, kinksters frequently delay or avoid disclosing their identities or injuries to healthcare providers (Sprott et al., 2021).

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Supplemental data for this article can be accessed online at https://doi.org/10.1080/19419899.2026.2621753

Most research on kink-identified individuals' experiences of healthcare has concentrated on the trust deficits and service gaps within mainstream, institutional healthcare. Far less attention has been paid to what happens beyond these encounters, particularly how subcultures of kink cultivate and sustain healthcare. In this article I address that gap by examining how gay men who fist-fuck employ practices of health promotion and (health)care that form alternative, subcultural webs of (health)care.

Fist-fucking, or anal fisting, is an erotic practice involving the insertion of one or both hands into the anus and rectum, sometimes extending into the lower colon. Within fisting communities, fist-play is governed by 'defined techniques and a strict code of ethics' (Shook et al., 1985, p. 320) that emphasise preparation, skill, trust, and consent. Nonetheless, fist-play carries elevated risks (Silverstein & Picano, 2004), including mucosal tears, rectal bleeding, increased susceptibility to infection, and bowel injury, particularly when undertaken while intoxicated or without adequate preparation (Cohen et al., 2004; Shockey, 2009).

Research shows that fisters have developed extensive harm-reduction strategies to manage the risks of their kink. While the foundations of these practices were evident in some of the earliest studies of organised fisting communities in U.S. urban centres during the 1970s (Navin, 1981; Rubin, 1991), they have evolved through the 'unique subcultural elaboration and institutionalization' of fisting communities (Rubin & Butler, 1994, p. 96) and, in particular, in the wake of the HIV/AIDS pandemic (Barcelos, 2024). Contemporary practices include deep rectal douching, anal training, manicured nails, the use of gloves and specialised lubricants, hygiene protocols, and attentive aftercare (Martin, 2025a; Richters et al., 2003). Together, these subcultural protocols of health and care reflect an expertly honed knowledge of safe play and a subcultural ethos that recognises how fisting renders the receptive body open and vulnerable (Califia, 2000; Martin, 2024).

What remains unexplored is how these practices extend beyond discrete acts of risk management to form interconnected systems that sustain wellbeing and build subcultural webs of care, as an alternative to mainstream healthcare. This study therefore asks: What practices shape the webs of (health)care that emerge within contemporary communities and networks of fist-fuckers?

Queer worldmaking: theorising subcultural webs of (health)care

Building on Leah Lakshmi Piepzna-Samarasinha's (2018) concept of care webs, this paper understands the care practices of fisting communities as both emerging from and contributing to subcultural systems of (health)care that are, at least in part, borne out of the neglect, misunderstanding, and marginalisation fisters experience or anticipate within mainstream healthcare. Decades of feminist scholarship have shown how care has been routinely devalued, feminised, and treated as unproductive (Himmelweit & Plomien, 2014; Warin et al., 2024), despite the vital role it plays in safeguarding individual health, communal wellbeing, and planetary sustainability (Puig de la Bellacasa, 2017). Within this body of work, Fisher and Tronto's (1990, p. 40, emphasis added) seminal account conceptualises care as:

> everything that we *do* to maintain, continue, and repair our world so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.

Following this, care is conceptualised in this article as both a practice and an ethical orientation to the systems in which one is embedded (Tronto, 1993). This therefore includes but also goes beyond the narrow dyadic models of caregiver and receiver to encompass 'the messier, interwoven spatialities and socialities present in caring as a practice' (Traill et al., 2024, p. 192).

From a disability justice perspective, Piepzna-Samarasinha (2018) observes that marginalised communities often build 'complex webs of exchanges of care' (p. 42). These communal webs subvert the conventional hierarchies of healthcare that position them as passive recipients of care, foregrounding instead their agency, expertise, and capacity for mutual aid and solidarity. As they note, such webs of care are 'controlled by the needs and desires of the people running them' (p. 41).

In this article, I contend that the alternative webs of (health)care developed among fist-fuckers can be understood as a form of queer worldmaking (Berlant & Warner, 1998; Muñoz, 2019; Yep, 2003). This framing highlights the generative potential of (health)care practices within kink communities. Queer worldmaking emphasises that such communities do not simply resist dominant systems but actively re-create the social, affective, and material arrangements that sustain alternative modes of kink living and thriving. For fist-fuckers, health promotion and care are not adjuncts to risk reduction but performative projects that contest biomedical authority and reimagine their health through interdependence, reciprocity, and communal ethics. These subcultural webs of (health)care do not merely compensate for the (anticipated) failures of mainstream healthcare; they reconfigure what counts as healthcare, who provides it, where it takes place, what ethics underpin it, and who is entitled to receive it.

Method

Study design

This study used an interpretive, reflexive qualitative design to explore how gay men who fist-fuck develop alternative forms and systems of (health)care within their kink communities. Grounded in a constructivist ontology and interpretivist epistemology, it assumes that meanings of care are socially constructed and shaped by subcultural discourses and lived experience (Levers, 2013). Adopting a reflexive stance meant recognising myself as the primary research instrument (Luttrell, 2019) and understanding participants' accounts as co-produced through the focus groups and my interpretive engagement during analysis (Braun et al., 2022).

Participants

Between March and April 2025, participants were recruited using purposive and snowball sampling. Gatekeepers from organised fisting clubs in the United States, Germany, and Australia, as well as informal networks in South Africa and Japan, were asked to circulate an e-poster outlining the aims, eligibility criteria, and my contact details for the study.

Table 1. Participant characteristics.

Participant	Focus group	Age	Country of residence	Self-reported number of years fisting	Self-reported number of years in a fisting community
P1	FG1	34	USA	12	10
P2	FG1	46	Germany	20	18
P3	FG1	37	Australia	15	13
P4	FG1	31	Japan	8	6
P5	FG1	43	South Africa	10	8
P6	FG2	52	USA	25	22
P7	FG2	39	Germany	14	12
P8	FG2	44	Australia	18	16
P9	FG2	35	Japan	9	7
P10	FG2	41	South Africa	13	11
P11	FG3	29	USA	6	5
P12	FG3	50	Germany	22	20
P13	FG3	38	Australia	10	9
P14	FG3	40	Japan	12	10
P15	FG3	33	South Africa	7	5
P16	FG4	61	USA	30	28
P17	FG4	45	Germany	19	17
P18	FG4	36	Australia	11	10
P19	FG4	39	Japan	13	11
P20	FG4	48	South Africa	20	18

Contact with the identified gatekeepers had already been established through a series of research projects with fisting communities (Martin, 2020, 2022, 2023a, 2023b, 2024, 2025a, 2025b, 2025c).

Eligible participants were 18 years or older, proficient in English, identified as fist-fuckers, and belonged to a formal or informal fisting community. They were also required to have some experience of giving, receiving, or facilitating care within their community. To avoid prescribing a definition for care, the specific nature, form, or scope of their care practices and experiences were left open for prospective participants to interpret.

Owing to the logistical challenges of coordinating online focus groups across different time zones, recruitment was concluded at 20, with one participant from each country being allocated to one of four focus groups. The final sample comprised 20 gay men aged 29–61 years, with 6–30 years of fisting experience and 5–28 years of community involvement (see Table 1).

Procedure

Focus groups were selected because they allow participants to discuss sensitive topics in a setting where shared identities and experiences can foster openness and comfort (Liamputtong, 2011). This approach created space for participants to reflect on, compare, and contrast their experiences of (health)care, revealing both personal and collective practices within contemporary fisting communities from different regional and socio-cultural contexts.

I facilitated each focus group via a secure video-conferencing platform. Lasting between 90–120 minutes, a semi-structured guide prompted discussion across five areas: care within kink communities, resource sharing, informal care economies, emotional support, and healing spaces. Participants described their involvement in kink, their experiences of giving or receiving care, and how they navigated formal healthcare

systems. The sessions concluded with an open-ended reflection on what participants viewed as the most valuable contributions of their communities to their health and wellbeing.

Ethics

The study received approval from the University of Pretoria Humanities Research Ethics Committee (reference: HUM011/0125). Informed consent material outlined the study's aims, procedures, voluntary participation, and potential risks, including exposure to what may be other participants' difficult experiences of (health)care. At the start of each focus group, participants were reminded of the study purpose and ground rules regarding confidentiality, mutual respect, and non-judgement. They were encouraged to use pseudonyms and could choose to disable video, although all participated on video using first names. At closure, all participants were offered contact details for free, independent counselling services available in their countries.

Analysis

Transcripts from each focus group were imported into NVivo 14 for inductive analysis following Braun et al. (2022) six phases of reflexive thematic analysis: familiarisation, coding, theme development, review, naming, and writing. Guided by Braun et al. (2022, p. 27) view that themes capture 'patterns of shared meaning … and tell stories about what such patterns mean and why they matter', my coding and theme development focused on how fist-fuckers developed alternative webs of (health)care and the subcultural logics and ethics that make these practices meaningful and sustainable.

The analysis involved iterative reading, annotation, and coding of moments where care practices were described, enacted, or problematised. Inductive codes were consolidated into categories reflecting both practical activities (for example, glove preparation or injury support) and abstract concepts (such as trust, expertise, and attunement). These were refined into sub-themes representing shared communal practices of health-oriented care. Recursive engagement with the data and my own reflexive notes guided the development of five final themes that describe how fisters build alternative webs of (health)care. A summary of consolidated codes, subthemes, and main themes is provided in the online Supplemental Material (see Table S1).

Researcher's reflections, positionality, and poetry

As both a researcher and community member who identifies with and has participated in kink subcultures, my interest in the alternative webs of (health)care among fist-fuckers is not merely academic. It is informed by my own experience, community involvement, and a commitment to understanding how those at the margins of normative health systems have negotiated health, wellbeing, and care.

Over the years, I have participated in spaces of queer kink that operate outside formal health systems and within networks of subcultural expertise and communal care. I have witnessed scenes where care was not clinical but felt; not institutional but intimate. These experiences have taught me that health and healing do not only

reside in hospitals or clinics but are also found in bathhouses, private playrooms, Telegram groups, workshops at kink events, social gatherings, and quiet decompression spaces after a scene.

This positionality offered both advantages and challenges. It facilitated access to participants who might otherwise hesitate to disclose stigmatised practices and enabled a shared language that built trust. It also required acknowledging that blind spots from my own investment in these communities may have shaped data gathering and interpretation. My position as a participant, friend, playmate, and partner influenced how I asked questions, what I noticed, and how I interpreted the data, aligning with Braun and Clarke's (2021, pp. 334–335) view that 'meaning and knowledge are understood as situated and contextual [in reflexive thematic analysis], and researcher subjectivity is conceptualised as a resource for knowledge production, which inevitably sculpts the knowledge produced . . . '.

I am not an impartial observer of the tensions that emerge when (health)care fails. Elsewhere I have written about a former partner who felt abandoned after I failed to check in on their wellbeing (Martin, 2025b). At the time I rationalised my neglect as unintentional, citing the pressures of academic work and deadlines. I told myself that being a young scholar required an emotional unavailability in intimate relationships to prioritise productivity and career development.

That experience forced me to confront the gap between studying care and practising it. It also shaped my interest in what care means, where it happens, and how it is lived within kink communities. During data analysis, I used poetry as a reflexive method to think, pause, and feel through my anxieties about doing care and justice to participants' stories. I have written poetry since I was a student to help me navigate difficult moments, and there is now growing recognition that reflexive poeming helps researchers develop insights into themselves, participant data, and the research journey (van Rooyen & d'Abdon, 2025). A poem written during this project formed part of this process (see Supplemental Materials), allowing me to hold the emotional weight of the work while remaining accountable to its central concern: care.

The present study is therefore part of an ongoing personal-professional (re)search to make sense of my own failures at care and to avoid reproducing the same patterns of neglect that many kinksters have reported in their interactions with mainstream healthcare.

Findings

Caring is sharing: practices of skill transmission and resource exchange

This first theme describes how knowledge and resources circulate within fisting communities to support safety and preparedness for play. Participants depicted peer-to-peer sharing, mentoring, storytelling, and play as key ways of transmitting subcultural knowledge and skills. These exchanges occurred through clubs, events, digital groups, and everyday social interactions.

Many participants spoke of concrete, material forms of sharing that helped others prepare for play, reduce harm, and feel supported. These included online repositories, starter kits, and organised panels and workshops at community events:

> We've got a Google Drive of J-lube [mixing] instructions, injury prevention stuff, ... It gets passed around like a family cookbook. (P13, FG3, 38, Australia)

> . . . at FistFest they've really leaned into expert panels. Last weekend [25–27 April 2025] they had about two or three [panels], over what is basically two days. All with real pros who talk about safe play. It's become such a great event where you get everything. You play, you learn, you can connect . . . . (P6, FG2, 52, U.S.A.)

> I got gifted a starter kit from a friend who really helped me get into the community. It had gloves, wipes, puppy pads, even some of those electrolyte sachets. (P11, FG3, 29, U.S.A.)

These accounts demonstrate how care is embedded in material exchanges that strengthen connection and mentorship. Objects such as glove kits, douching nozzles, or safety guides were not neutral tools but affective gestures that initiated and sustained communal belonging. Rather than acts of charity, such exchanges operated as queer pedagogies of kink health promotion that encouraged the horizontal flow of knowledge and collective responsibility.

Participants also described the sharing of experiential knowledge through conversation. Talking about play, exchanging advice, and warning others about unsafe practices were integral to communal (health)care:

> At meetups, it's very rare there won't be conversations about our experiences. What toys are good or bad, prep, places to avoid. (P2, FG1, 46, Germany)

In more culturally conservative contexts, these exchanges were especially meaningful:

> P4 (FG1, 31, Japan): It's still very conservative [in Japan] and there can be cultural stigma around [kink]. You cannot always talk about it openly. . . . [T]alking to each other is such a powerful part of our community. Sharing experiences, sharing our stories with each other – {P1 Interjects}

> P1 (FG1, 34, U.S.A.): You're so right [P4]. And the best part is [that] it's free. It costs nothing to pay that forward, to help someone else in the community play safe.

Together, these narratives show that sharing knowledge and resources is not merely about refining technique or managing risk but constitutes a shared sense of (health)care. Through storytelling, advice, and peer education, fist-fuckers reinforce norms that sustain communal wellbeing.

Being there: practices of emotional and psychological support

Participants described how emotional and psychological care are enacted, sustained, and ritualised within fisting communities. Health and wellbeing were understood not only as physical safety but also as emotional presence before, during, and after play. Across focus groups, participants expressed a commitment to being present for one another in moments of vulnerability or recovery. Acts of 'being there' became practices of mental healthcare, central to the subcultural fabric of community life.

Aftercare, a ritualised form of care and emotional holding that monitors playmate wellbeing following the intensities of play, was repeatedly identified as the clearest example of this communal commitment:

> When you've opened your body that much, pushed it to those limits, you can't just zip yourself back up and carry on like nothing happened. [. . .]. It's the whole reason for aftercare. It's a recognition of the physical and emotional care that's needed with something that intense. (P8, FG2, 44, Australia)

> . . . [aftercare] creates a space that holds you emotionally. There're things I think we all expect. Like, the blanket, the water, the soft voice, the holding. It all says, 'I'm still with you'. (P18, FG4, 36, Australia)

> Most of us are taught that aftercare is part of the scene. The wellbeing of your partner comes first. That tells you everything you need to about this community. (P7, FG2, 39, Germany)

While forms of aftercare varied, it consistently involved gestures that signalled attunement and responsibility. The expectation that partners remain emotionally present even after play reflected a broader ethic of ongoing care embedded in fisting subculture.

Beyond aftercare, participants described communal networks that functioned as reliable systems of psychological support. From private LINE groups to regular check-ins, these networks were often viewed as more accessible and trustworthy than formal mental health services:

> Me and some [fist-]friends and set-up a LINE group where we go if we're feeling wobbly or need to unpack. Just having that space makes a difference. (P14, FG3, 40, Japan)

> [Following an injury] . . . I was in a dark place after struggling to bottom for a year. Like, I couldn't pay to see a therapist but my community got me through it. Friends came over and we just talked or watched movies. (P11, FG3, 29, U.S.A.)

> After my last relationship [ended], I kind of lost the headspace to play. But the guys I usually play with didn't disappear. They still checked in. Even now, if one of us is not in the best emotional space, we take a break from playing and do other stuff. (P9, FG2, 35, Japan)

Grounded in an ethics of queer kinship, vulnerability, and trust, these accounts show how friendship, companionship, and consistent emotional presence operate as subcultural practices of psychological (health)care for fist-fuckers.

Creating a safe space: practices of placemaking care

The third theme highlights how the intentional design and regulation of kink spaces function as practices of care. Participants described crafting physical and emotional environments that prioritised consent, sensory regulation, and wellbeing. Several participants detailed the deliberate preparation of play spaces to foster safety, comfort, and readiness. Rituals such as lighting candles, playing music, or socialising before a scene were described as practices of proactive care:

> P3 (FG1, 37, Australia): [Before play], we always light candles. . . . . Sometimes there's music playing low, maybe incense or essential oils . . . . The lighting's soft, the room's warm. It sets the tone. This is a safe space.

> P5 (FG1, 43, South Africa): It's a must. Respecting how someone needs to feel safe before playing has to be the starting point of every scene. I like to hang out a bit first, have a drink or two, chat, laugh, just ease into the space. It helps my headspace.

Participants also described organising spaces to reduce risk and support health needs, from cleaning routines to event-level design features:

> When I walk into a play space and see it's been prepped properly and its clean, that attention to detail tells me my playmate knows what they're doing, and that they care about my body and safety. (P10, FG2, 41, South Africa)

> I help with planning a party [in Berlin]. And the big thing is that everyone has a buddy, someone to look after them, especially if they're new. On one level, its event planning, right, but it's also making that space up deliberately to make sure everyone is cared for. (P17, FG4, 45, Germany)

> Our parties have quiet corners if someone experiences a sensory overload. There's no music, a place to lay down and there's always a volunteer to check and monitor if you're okay. They're pretty great for decompression. We make space for recovery. (P16, FG4, 61, U.S.A.)

Some noted that health posters and rules displayed in clubs served as visual markers of shared responsibility and collective wellbeing:

> Most of [the fisting clubs] I've been in are very health conscious. In Europe, you will find most of the fisting clubs have posters and health information on the walls for us. They're always working to keep the community safe while we play. (P2, FG1, 46, Germany)

Together, these accounts show how fist-fuckers practise an intentional ethics of care through spatial and sensory design, be these private play spaces of larger scale events and parties. Such practices create not only the physical conditions for safe play but also the emotional atmosphere necessary for comfort, trust, and responsive care.

Expertise without authority: practices of embodied and experiential knowledge

Participants emphasised the importance of experiential and embodied knowledge that operates outside formal healthcare systems. Lived experience was regarded as the primary source of care expertise, accumulated through mentoring, self-play, and communal learning rather than credentialed training.

Many described learning to care for themselves and others through these peer exchanges, whether in online groups, casual conversations, or scenes of play:

> No doctor taught me how to take a fist. I learned from other bottoms and I learned it for myself. (P19, FG4, 39, Japan)

> If something goes wrong, we figure it out together. I don't need to wait for a consultation [with healthcare professional]. I can pick up my phone and have five people in the group chat saying, 'Here's what I did, here's what helped'. (P15, FG3, 33, South Africa)

> The way we care for each other doesn't have that hierarchy you'll get if you have to go the clinic. No one's the nurse and no one's the patient. We've all had to learn from experience, from mistakes, from each other. If someone's new, we support them, but not like we're above them. We just know what it's like to need guidance and not be judged for it. (P12, FG3, 50, Germany)

These accounts highlight forms of care that privilege humility and reciprocity over hierarchical models of provider and patient. Communal care displaced formal power relations, allowing for more responsive and affirming interactions.

While participants valued these communal systems, they also acknowledged their limits. Participants' accounts showed that, while community expertise was trusted, decisions about seeking clinical care outside of the community could also be deliberated collectively, with experienced fisters or peers offering guidance about when injuries exceed what can be safely managed in the community. Navigating when to rely on community knowledge and when to seek mainstream professional help required careful judgement:

> P20 (FG4, 48, South Africa): . . . most of the time I can manage things myself. The minor tears, swelling, hygiene stuff. Most of us probably know what to do or we know someone who knows what to do if we don't. But if someone's bleeding heavily or in pain for days, it would be unethical to be like 'I know best'. I'll take them to the emergency room myself. Like, we're not doctors, and I'm not pretending to be one. P18 (FG4, 36, Australia): Yeah, but I think a lot of us avoid going to doctors because we've been humiliated. We've had to create all these other alternatives in our communities. I'm not saying it should replace going to a doctor, but I understand why some guys wait so long.

As the exchange between P20 and P18 suggests, community-based (health)care is both empowering and precarious. While timely, relevant, and affirming, it cannot fully substitute for medical expertise or shield fisters from the judgement they may still face in institutional healthcare. At the same time, P20's account reflects an implicit ethical code that recognises the limits of one's capacity to care as a community member. Knowing when to defer to formal medical expertise becomes a crucial expression of responsibility and care within the community's ethical framework.

Stronger together: practices of communal care and resilience

This final theme captures how mutual aid, solidarity, and collective resilience emerged in response to discrimination, exclusion, and gaps in mainstream healthcare. Participants described (health)care extending beyond play into broader acts of social organising, resource pooling, and activism, particularly where formal healthcare was absent or hostile. By gathering together, creating peer-led initiatives, and participating in solidarity-based interventions, fisters developed collective strategies to safeguard wellbeing.

Drawing on community expertise and labour to fill institutional voids, some participants organised grassroots, fist-positive (health)care through wellness gatherings, hosting, and public health initiatives:

> My partner and I have hosted, I guess you could call it a wellness night. There's no play. We just get together to talk, eat, share info. One guy's a nurse, another's a sex educator, and we just offer what we can. It's our own kind of clinic, in a living room. (P8, FG2, 44, Australia)

> I've opened my house a few times to people coming in from out of town for events, especially if they're new. We cook, hang out, prep together. It's not just about having a bed to sleep in. It's about creating a soft landing, a sense of belonging. (P6, FG2, 52, U.S.A.)

> During the Mpox outbreak [in 2022], our group volunteered to do a vaccine drive at some events and shared some info on our telegram. No government health agency did that for us

> and, if they did, it was focused on anal sex. We had to take that and adapt it for our own use. We had to take care of our own. (P17, FG4, 45, Germany)

Others supported community-led health organisations catering to queer and kink-identified individuals through advocacy and fundraising:

> . . . [A local NGO that] runs a clinic [in Pretoria]. They're queer friendly and kink friendly. I've used it to get free PrEP and the nurses there don't even flinch if you start talking about fisting. . . . . But the challenge now is they're at risk of being shut down because of cuts to funding they receive from [the US]. . . . . I'm talking with some friends at the moment about how we can help fund raise or keep them open because they're part of our community. (P10, FG2, 41, South Africa)

P10's account highlights how queer- and kink-affirming health services form part of a fragile ecosystem of (health)care sustained through community mobilisation. Participants positioned themselves not only as recipients of such services but also as stewards, protecting them as shared assets of care.

Yet these networks of care were not without some tension. A few participants expressed discomfort towards those who engaged in chem-enhanced play, questioning if care should be extended or withheld:

> Honestly, if someone shows up out of their mind on Tina [crystal methamphetamine], ... I won't even feel bad about walking away. We're all adults, and if you don't care for yourself, why should I? (FG2, P6, U.S.A.)

> There's this idea we take care of our own, right? But chems complicate that. It's hard to know when to help and when to step back if they're using in ways that feel unsafe or disrespectful. (FG1, P3, Australia)

While others urged compassion and non-judgement, these tensions revealed how substance use could test the subcultural logics of care, straining trust and shared responsibility. Even within networks built on solidarity, chems sometimes introduced ethical uncertainty about who is seen as deserving of care and when its withdrawal feels justified.

Discussion

This study explored how gay fist-fuckers develop subcultural practices of health promotion and care that affirm their healthcare needs, sustain wellbeing, and enable participation in their kink. Using reflexive thematic analysis, five themes were identified across four focus groups: (1) skill transmission and resource exchange, (2) emotional and psychological support, (3) placemaking care, (4) embodied and experiential knowledge, and (5) communal care and resilience. Each theme reflects a distinct dimension of subcultural care, yet together they form interconnected webs of (health)care that draw on and adapt communal logics and ethics of care, reimagining what healthcare means and how it is practised beyond mainstream institutions.

Although these themes were consistent across the dataset, it is worth noting how participants' diverse geographical contexts also shaped their (health)care webs. In the focus groups, participating fisters often made reference to cultural, infrastructural, and healthcare landscapes that influenced how care was practised and negotiated. Japanese participants, for example, navigated kink within a more culturally conservative

environment, which heightened the value of discreet digital networks and private exchanges. German participants frequently referenced structured club infrastructures and formalised health protocols, while those in South Africa emphasised resource constraints and the importance of queer-affirming community clinics. Participants in Australia and the United States, by contrast, foregrounded community events and workshops as well as decentralised online knowledge-sharing. Taken together, these accounts show that while the core logics and ethics of subcultural (health)care holds resonance with communities of fist-fuckers in different parts of the world, their expression is locally situated, shaped by the socio-cultural and healthcare conditions in which fisters live and play.

Theories of health and healthcare typically begin with the individual, focusing on the personal capacity to identify health needs and on the availability of information, education, and services to meet them (Levesque et al., 2013). Across all focus groups, participants emphasised playing responsibly and acquiring knowledge and skills, yet the (health)care webs they described reconfigured this individual model by collectivising how health knowledge is produced and shared. Within these webs, shame-free information is made easily accessible through physical, social, and digital networks that collectively function as queer pedagogical strategies for communal teaching and learning. These practices create formal and informal pathways through workshops, community events (P6), or casual gatherings among fisters (P4) that conscientize and acculturate them into understanding and addressing their own and others' care needs within knowledgeable, health-conscious networks, shaping their kink health beliefs, practices, and literacy.

In research with migrant gay, bisexual, and other men who have sex with men, Chan et al. (2025) found that peer-based social and sexual networks are 'perceived as uniquely credible or trustworthy' (p. 10) sources of health information that influence sexual health norms and behaviours. Similarly, fisters in this study viewed their communal networks as the most reliable sources of knowledge and support. Their care webs function as systems through which norms, ethics, and practices of health and care are continually produced and reinforced. Within these subcultural systems, where trusted information circulates horizontally among peers, pleasure, wellbeing, and care are understood as interconnected dimensions of a fist-fucker's health, with erotic fulfilment and mutual safety functioning as defining rather than oppositional aspects of their kink (P7, P8).

Within fist-fuckers' care webs, health knowledge and care are both distributed and embodied. As Piepzna-Samarasinha (2018, p. 19) notes, 'we're so used to … care being professionalised, to assuming that medical and therapeutic professionals are the only ones qualified to intersect with our terrifying bodies'. In contrast, fisters cultivate a deprofessionalised expertise grounded not in credentials but in corporeal knowledge. Here, knowing about health and care is queered as it shifts from disembodied cognition to a sensual and intercorporeal understanding (Machin, 2018; Murray, 2007). For fisters, this embodied knowing develops through intimate, corpo-erotic experiences with their own bodies and those of others (P19). Learning to provide and receive care entails physical and emotional labour in which caregiving and care-receiving bodies are intimately implicated (Nayak, 2025). Through such encounters, fisters accumulate 'practices of [care] knowledge held in the body' (Hamington, 2004, p. 4), archiving, enacting, and transmitting this

knowledge through care-full play techniques, trusted mentors and websites, and the sensual awareness of what feels safe and pleasurable.

The embodied expertise and peer-led learning among fisters challenges the authority of medical and mental health professionals as the sole holders of health knowledge and unsettles the hierarchical logics that underpin biomedical systems of science and healthcare (Haraway, 1991). These systems have long reinforced binary relations between provider and patient, subject and object, observer and observed, positioning healthcare users' bodies as passive sites of intervention rather than active and knowing. The expertise shared among fisters is not governed by what Foucault (2012, p. 15) terms the 'medical gaze', which reduces the body to an object of diagnosis and healthcare to a search for pathology. Instead, it rests on a subcultural understanding of the fist-fucker's body as erotically alive and capable of both giving and receiving (nonnormative) pleasure, with that pleasure recognised as essential to their wellbeing. This holistic model of care centres erotic pleasure and treats injuries or illnesses not as defining pathologies but as contingencies to be managed within an ethic of sexual agency and kink identity.

These embodied forms of expertise and care are also expressed and sustained through the placemaking practices by which fisters create scenes of play and spaces of (health) care. Haverkamp and Eckenwiler (2022) describe placemaking as the intentional design or adaptation of space to shape how people inhabit and experience it. In fisting communities, such practices reimagine what healthcare spaces can look and feel like. Care is not confined to clinics or therapy rooms but extends into all dimensions of kink life and play. Bedrooms (P3), online forums (P15), and play parties (P17) become environments for exchanging health knowledge and, when needed, for enacting care.

However, fisters practices of placemaking care are multiple and layered. They are ambient, as in using music and lighting to create an affective atmosphere of comfort before play (P3); material, as in preparing gloves, lubricants, and douching equipment to ensure hygiene (P10); and ritualised, as in providing tailored aftercare post-play (P8). Some are deliberate, such as designating decompression areas after scenes (P16), while others are improvised, as when fisters establish referral pathways for emergency medical needs (P18). Together, these practices are not isolated acts of care but expressions of a queer intentionality and collective effort towards '*making* queer worlds', that is, creating fisting spaces that proactively support physical, psychological, and communal wellbeing (Muñoz, 1996, pp. 12, italics original).

These placemaking practices build 'alternative infrastructures of care' (Traill et al., 2024, p. 191) within fisting networks. Unlike conventional infrastructures that are fixed or state-administered, these are creative, mobile, and adaptive arrangements that reorganise the social, material, and affective dimensions of healthcare among fisters (Power & Mee, 2020). Within these networks, opportunities for responsive consultation (P15), referral pathways and emergency responses (P20), and paraprofessional ethical codes of care (P7, P20) are developed and revised as needed. Collectively, these grassroots systems displace the bureaucratic barriers of mainstream healthcare, where access is often delayed by queues, paperwork, or costs, replacing them with immediate, communal pathways to (health)care. Yet, as P20 noted, these webs of care are not closed systems. They do not replace formal healthcare but can connect with ambulances, clinics, or emergency rooms when a fister's needs exceed community expertise. In this regard, participants described a range of thresholds for recognising when an injury exceeded what could be responsibly

managed within the community. These thresholds were often reached when pain was acute or persistent, when bleeding did not resolve, or when an injury continued to impair daily functioning in the days after play. While the specific scenarios varied, they were indicative of a shared ethical sensibility: that care involves knowing not only how to support one another within the community, but also when to defer to clinical expertise. In these moments, decisions to seek formal healthcare were shaped by both personal judgement and collective consultation, as individuals weighed the risk of stigma against the risk of medical neglect. Such decisions were frequently negotiated collaboratively. Play partners, experienced mentors, or group-chat peers might recommend seeking urgent care or accompany someone to a clinic to help buffer anticipated stigma, highlighting that communal care was grounded in mutual responsibility rather than a rejection of non-communal professional healthcare.

At the same time, access to care within these webs is not always granted equally. In the accounts of P3 and P6, the use of chems, was described as a potential disqualifier for receiving care. Although this view was not shared across all focus groups, their reflections show that care holds different meanings for different fisters and is shaped by communal discourses of sobriety and consideration for one's playmates. The status of chems remains contested within the fisting community (Bigbuttgeek, & Jazzmatazz. Hosts, 2021). Many formal clubs, such as MAFIA (Mid America Fists in Action), prohibit their use at events (Mid America Fists in Action, 2025), reflecting a concern that intoxication poses excessive health risks (Martin, 2023b). Although chemsex was not central to this study, the pejorative attitudes expressed by some participants to substance use points to possible additional barriers and tensions within fisters' care webs, reinforcing that webs of (health)care and decisions to offer/seek care within and outside of these webs are shaped only by broader subcultural values but also by the specific behavioural codes that govern organised communities of fisters which might interlink with these webs.

The webs of (health)care described by fisters in this study extend beyond meeting individual needs to building a collective capacity for health and wellbeing within the subculture. Fisters enact a communal ethic of care that challenges discourses of self-responsibilisation by centring interrelation and mutuality in everyday practices of play and (health)care. These practices can be read as forms of the disidentificatory labour that Muñoz (1999) describes as working 'on, with, and against a cultural form' (p. 12) in queer worldmaking. Such acts allow minoritarian subjects to rework and reimagine their worlds rather than assimilating into dominant systems or rejecting them entirely. Similarly, the care webs sustained by fisters disidentify with neoliberal logics of mainstream healthcare. They selectively draw on biomedical and public health knowledge, including vaccination messaging, while reworking these through their own subcultural ethics of reciprocity and interdependence. In doing so, fisters perform new worlds of (health)care that make communal thriving in their kink both possible and sustainable.

Tronto's (2013, p. x) concept of 'caring with' is instructive here. Whereas traditional framings of care emphasise providing care for another, caring with describes a relational ethic grounded in trust and solidarity, performed *with* others rather than *for* them (Power, 2019). Within fisters' (health)care webs, caring with was evident in communal mobilisation during health crises, such as volunteer-led vaccine drives (P17), collective efforts to sustain queer- and kink-affirming clinics (P10), and mutual aid initiatives like hosting or offering accommodation (P6). Participants also described digital and in-person networks that

enabled ongoing check-ins, accompaniment, and the exchange of health advice (P14, P15, P9). Intergenerational mentoring and the sharing of knowledge (P19, P12) were seen as vital for sustaining communal capacity and transmitting care across time and space. The subcultural ethics and practices of caring with ingrain an 'affective connective tissue' of trust, mutual responsibility, and solidarity within fisters care webs that Hobart and Kneese (2020, p. 2) assert 'offers visceral, material, and emotional heft to acts of preservation that span a breadth of localities: selves, communities, and social worlds'.

Limitations

Although I recruited a regionally diverse sample of participants, all were based in contexts where some degree of relatively safe participation in kink was possible. This was the case even where conservative attitudes towards sex and intimacy still contributed to prejudice against kink-identified individuals. All the fisters in this study had access to organised clubs, online networks, and social events, often facilitated through either physical or digitally networked communities. The sample, therefore, reflected variation across the Global North (United States, Germany, Australia, Japan) and Global South (South Africa) but did not capture the experiences of fisters in countries where same-sex practices and, by extension, kinked same-sex practices remain criminalised or heavily stigmatised.

Mujugira et al. (2024) show how legal and cultural surveillance under Uganda's 2023 Anti-Homosexuality Act has restricted healthcare access for sexual and gender minorities. In such environments, the visibility and viability of kink communities may be severely limited, and seeking medical care may involve substantial personal risk. This study therefore cannot fully represent how webs of (health)care are imagined or sustained (if at all) under sexually repressive political or legal regimes. This limitation is important because the very conditions of precarity, criminalisation, and enforced secrecy may reshape the nature, form, and function of care in environments where queer/er identities and practices are rendered not only invisible but also punishable.

Conclusion

This study has shown that for many gay fist-fuckers, healthcare extends beyond the clinic. Beyond the spaces and practitioners of mainstream healthcare, fisters build, sustain, and adapt subcultural systems of health promotion and care through their everyday practices. Across the focus groups of this study, participants described five interconnected sets of practices that respond to individual needs while embedding a subcultural architecture of durable norms, ethics, as well as physical, social, and affective infrastructures of collective wellbeing. In the face of experienced or anticipated misunderstanding and kinkphobic discrimination within conventional healthcare, fist-fuckers practices of skill transmission and resource exchange, emotional support, placemaking, embodied knowledge, and communal resilience mobilise a subcultural 'set of vital but underappreciated strategies for enduring precarious worlds' (Hobart & Kneese, 2020, p. 2).

By drawing on Piepzna-Samarasinha's (2018) concept of care webs, this article offers a more capacious framework for understanding the subcultural forms of healthcare knowledge, labour, and relationships that fist-fuckers establish outside of, adjacent to, and in interconnection with mainstream systems. This does not

suggest that fisters entirely abandon mainstream medical or psychological services, but rather that the intimate, communal, and virtual webs of (health)care within their subculture act as the most trusted frontline for healthcare information, consultation, and support. Within these webs, health and care are understood and enacted through mutuality, reciprocity, and a communal ethic of care, rather than professional hierarchy or clinical institutional authority. In doing so, fisters pursue a project of queer worldmaking and kinship that collectively reimagines what healthcare can and should be for them: a kink-affirming experience that takes their pleasure, play, and wellbeing seriously, and supports them and others to flourish in their kink.

Acknowledgments

I extend my gratitude to all the fisters who volunteered to participate in this study, for generously sharing their stories, and for honouring the focus group space with respect and care. I also want to thank FFJPaws for their assistance with the recruitment of participants in Japan. In addition, I want to thank the anonymous reviewers as well as the guest editor for their constructive comments during the peer review process.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This study was partially supported through funds awarded under the Professional Development Programme for Early Career Academics by the University of Pretoria.

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Data availability statement

To protect study participant privacy the data cannot be shared openly; for this reason, consent was not sought from participants to share the data.

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