Investigating Bias in Psychotherapy with BDSM Clients

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SUMMARY. There is a concern among consensual BDSM participants that they will receive biased care from mental health professionals. Results are presented of an anonymous Internet-based survey administered to both BDSM-identified individuals who have received psychological care and to mental health professionals. The survey included socio-demographic data and invited participants to write narrative accounts of biased or culturally sensitive care, from which common themes were

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identified. Mental health providers (N = 17) responded in fewer numbers than those who identified as BDSM-identified participants (N = 175). Descriptive characteristics of the sample will be discussed. Themes from the qualitative data may be useful in informing the future development of guidelines for practitioners to work more responsibly with clients who identify as members of this sexual minority group.

KEYWORDS. Psychotherapy bias, paraphilia, cultural sensitivity, BDSM, sadomasochism, sexual minorities

Consensual sadomasochism (BDSM or SM) has both community-based and scientific definitions. By various definitions, sadomasochistic sexual behavior is not uncommon. Up to 14% of American males and 11% of American females have engaged in some form of sadomasochistic (BDSM or SM) sexual behavior defined as pleasure-in-pain practice, in which one inflicts harm and/or pain on another for sexual and/or psychological satisfaction or one achieves sexual gratification by anticipating or experiencing pain before or during sex (Janus & Janus, 1993). Other estimates indicate that up to 50% of the general population has experienced sexual arousal in response to being bitten (Kinsey, Pomeroy, Martin, & Gebhard, 1953), while 5% of the population has experienced sexual pleasure in inflicting or receiving pain (Hunt, 1974). It is likely that many more Americans experience sexual fantasies along the sadomasochistic spectrum, whether or not these fantasies are ever acted upon.

The community-based definition of BDSM is most commonly understood as the, "knowing use of psychological dominance and submission, and/or physical bondage, and/or pain, and/or related practices in a safe, legal, consensual manner in order for the participants to experience erotic arousal and/or personal growth" (Wiseman, 1996 p. 10). However, it is worth noting that Sexual Sadism has been described in the psychiatric literature as a pathological pattern of behavior that may be enacted with non-consenting victims (American Psychiatric Association [APA], 2000). This view of Sexual Sadism and Sexual Masoch-

ism does not allow for the healthy expression of BDSM, especially as a lifestyle as opposed to an isolated behavior. Similarly, it does not acknowledge that the experience and sensation of pain is subjective (Melzack, 1961). These discrepancies between the community-based and scientific definitions likely account for a wide range of experiences for the BDSM client in therapy.

It has been documented that the therapeutic process is influenced by the values and biases of the practitioner, in spite of aspirations of therapeutic neutrality (Lopez, 1989; Murray & Abramson, 1983). Mental health professionals have a long history of holding negative assumptions and stereotypes about the BDSM community, or of being otherwise ill-informed about the practices of this community. This has been demonstrated by the continued inclusion of Sexual Sadism and Sexual Masochism as Paraphilias in the *DSM-IV-TR* (APA, 2000). These diagnoses are listed under the category of sexual disorders or sexual dysfunctions. In our culture in which mental illness is stigmatized, the identification of any practice as pathological can result in related non-pathological behaviors being subjected to the same stigma by those who are unable to distinguish between them (Goffman, 1963). In fact, members of the leather (BDSM or SM) community may often be confused with individuals who are being physically or sexually abused, or may be perceived as acting out low self-esteem, interpersonal difficulties, or compulsive behaviors. Conceptually, the DSM may have led to the misinterpretation that those involved with BDSM were also suffering from various other personality disorders (APA, 1980). This is most likely due to historical writings in the psychological literature in which both sadism and masochism were described initially as personality disorders that might be manifested sexually (Freud, 1905/1957; Krafft-Ebing, 1886/1965). The shifts and changes in the diagnoses for Sexual Sadism and Sexual Masochism, beginning with their being listed as sexually deviant behaviors in the *DSM-II* (APA, 1968), along with the history of the provisional categories for Masochistic (Self-Defeating) Personality Disorder and Sadistic Personality Disorder (APA, 1987, Franklin, 1987) may have contributed to the confusion and pathologizing of these categories. While the diagnostic criteria for Sexual Sadism and Sexual Masochism continue to change in each new revision of the *DSM*, it may be assumed that these behaviors are pathological although there is no data to support this assumption.

The biases and misinformation borne from this history can result in unintentional harm being done to clients who identify sexually as "sadists" or "masochists." At its most extreme, such bias may lead mental

health professionals to pathologize their SM identified clients when there is no associated disorder present. Therapists who are misinformed about the consensual SM community may assume physical or mental abuse in a client's history or current life, or judge a client as an unfit parent without other evidence, based solely on the client's BDSM practices. Other mental health professionals may conceptualize a personality disorder around the client's sexual role, assuming that a desire to explore pain or power dynamics sexually translates by default into a tendency to manifest these experiences consciously or unconsciously in non-BDSM relationships. At the lesser extremes, the consequences of such biases may lead to empathic failures and simple misunderstandings between clients and practitioners.

The goal of this research was to assess the cultural competence of mental health professionals when working with the consensual SM community. The intent of this study was to address this problem by surveying mental health professionals about their knowledge of treatment issues with SM identified clients. In addition, SM identified individuals received a similar survey asking them about their experiences (or knowledge of other BDSM participants' experiences) in mental health treatment. It is hoped that the results of this study might also be used to develop ethical guidelines for working competently with members of the consensual SM community.

DISTINCTIONS MADE BY THE BDSM SUBCULTURE

Some in the BDSM subculture make the distinction between B/D (bondage and discipline, which frequently involves physical restraint and/or the acting out of power dynamics without any pain-play) and SM (which sometimes includes more sensory experimentation involving pain or the threat of pain than traditional B/D). Others use the term D/S to signify that the interaction is primarily about dominance and submission (which, again, may or may not include B/D or SM types of activities). For the purposes of this study, however, SM and BDSM will be used interchangeably as an umbrella term meant to be inclusive of all types of play involving the conscious, safe, sane, and consensual use of power dynamics.

One position held by those who engage in BDSM is that SM is simply an alternative sexual identity. Others who practice BDSM argue that the term "sexual orientation" does not seem an appropriate descriptor of their BDSM interests. Clearly, referring to BDSM desires and activities

as a "sexual orientation" remains controversial for those who practice SM and also for those who do not. However, in the interest of inclusivity, BDSM will be discussed in this paper as a practice, a lifestyle, an identity, and an orientation.

ETHICAL CONSIDERATIONS

The American Psychological Association's Ethics Code for Psychologists addresses the boundaries of professional competence in Ethical Standard 2. According to 2.01 (a), "Psychologists provide services . . . only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (APA, 2002, p. 4). This standard holds that psychologists working outside of their area(s) of competence do pose a significant risk of harm to their clients. Therefore, no psychologist should be working on BDSM issues with BDSM identified clients without first obtaining the necessary skills or expertise to work with this population. It is also worth noting that having an "interest" in BDSM or even practicing BDSM does not necessarily qualify one to work in this area. The type of skills that would qualify one to work with BDSM issues with BDSM clients might include coursework and specialized training on working with BDSM clients, none of which are routinely available. In addition, those seeking supervision to work with BDSM clients should be supervised by one who is already competent in working with BDSM individuals. Often, students within training programs may be supervised by practitioners who are no more knowledgeable about SM practices than the students themselves. This can be particularly problematic, in that the supervisor may be unwittingly practicing outside of his/her area of competence, rather than modeling for the therapist-in-training how one seeks out appropriate training and supervision.

Standard 2.01(b) states:

> Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals. (APA, 2002, p. 5)

In addition, 2.01(c) states:

> Psychologists planning to provide services . . . involving populations [and] areas . . . new to them . . . undertake relevant education, training, supervised experience, consultation, or study (APA, 2002, p. 5)

Until BDSM practices and lifestyles are included routinely as part of the human sexuality component of training for all practitioners, and until the mental health profession begins to recognize BDSM individuals as a subculture requiring special knowledge, skills, and sensitivity, there remains the risk that therapists may be providing services to BDSM individuals without ever having received appropriate study, training, or supervision. It is worth noting that the Ethical Standards are mandatory and may be accompanied by enforcement mechanisms. Therefore, not only is there a risk of harm to clients by psychologists who are not aware of BDSM practices and the other complex treatment issues that can arise with these individuals, but mental health professionals are also putting themselves at risk. They may be opening themselves up to professional and legal sanctions by remaining ignorant of SM practices.

Many mental health professionals may not recognize the need to seek out training, or to make appropriate referrals for their SM clients. Other mental health professionals may be working from a clinical orientation that defines BDSM as pathological, *a priori.* For these practitioners, it can be argued that implementing routine training about BDSM behaviors would provide them with alternative models with which to view these practices. On this matter, an important component of training might be a strong advisory to therapists to provide BDSM clients with informed consent if their practices are viewed as pathological.

Without formal criteria for therapists who wish to work responsibly with those who practice BDSM, clients in this lifestyle who are seeking those with specialized knowledge of BDSM are left to rely on those professionals who self-identify as "kink aware" (Bannon, 2003). These are professionals who consider themselves to be informed about the diversity of consensual, adult sexuality. While many "kink aware" professionals may have expertise in BDSM practices, many of them may *not* possess the specialized knowledge required to work competently with complex issues in the treatment of BDSM individuals. Meanwhile, other mental health professionals with no training or knowledge of BDSM practices may assume they are knowledgeable enough to work

with BDSM clients while working from the assumption that BDSM practices are pathological. Until training and education about BDSM lifestyles and practices are offered routinely, clients are left without reliable means to assess the expertise of "kink aware" professionals. It is apparent that there is a critical need to develop guidelines for psychotherapy with BDSM clients. This study is intended to begin the process, similar to that which was followed in the development of the guidelines for working with the lesbian, gay, and bisexual (GLB) communities (APA, 2000).

METHOD

A broad range of clients who self-identified as BDSM participants and who had sought psychotherapy were recruited through an announcement sent to various BDSM interest groups on the Internet as well as retail establishments and BDSM support groups. This announcement directed participants to a Web address which contained a consent form, along with details for eligibility of the study. This form outlined the procedures of the study, the potential benefits and risks of participating, and explained that participants should refrain from entering their names in any data field. Participants were also informed of how to contact the researchers if they should experience undue distress as a result of participation in the study, but were warned that contacting the researchers would compromise their anonymity. Those who were eligible were able to enter a code which took them directly to the questionnaire. Specific groups contacted included The Leathermen's Discussion Group, The Society of Janus, All Women of Leather, SAMOIS, The Lesbian Sex Mafia, and The Eulenspeigel Society. Internet lists that were contacted included ba-sappho, kinky-grrls, psych-bdsm, SM-ACT, ftmbdsm, leatherdykes, The Society of Janus, The Exiles, AWOL, The Lesbian Sex Mafia, and The Eulenspiegel Society. The announcement was sent to the following establishments: Mr. S. Leather, Ms. S. Leather, Stormy Leather, and Good Vibrations in San Francisco, California; Eve's Garden and Passion Flower in New York City; and Toys in Babeland in Seattle, Washington. All recipients were encouraged to post and/or forward the announcement to interested parties.

BDSM clients were considered eligible for this study provided they were (i) BDSM-identified individuals; (ii) 18 years of age or over; (iii) had actually participated in real life BDSM (as opposed to virtual BDSM on the Internet) for at least two years; (iv) maintained in-

dependent BDSM interests in their personal lives, for those who had also engaged in BDSM for money; and (v) previous or current consumers of mental health services. Participation was anonymous.

In addition, mental health professionals were also recruited for this study. However, there was not a high enough response from therapist participants to provide a meaningful analysis of the submitted data. Therefore, the therapist sample will not be discussed in this publication.

Materials and Procedure

The questionnaire began with 21 questions seeking to elicit demographic information and various distinctions among the terms people used to describe their BDSM behaviors. There were also questions asking participants to list the ages at which they first identified as interested in BDSM as well as the ages at which they became aware of their sexual and gender orientations. In addition, participants were asked to disclose their level of "outness" in various parts of their lives regarding these identities.

The questionnaire asked whether the participant had ever engaged in BDSM play for hire, and if so, whether the participant had maintained a personal interest in BDSM outside of his or her professional BDSM play. Items included the number of therapists seen, respective lengths of treatment, issues that brought the client into therapy, whether the BDSM interests were disclosed to the therapist(s) (and if so, when in the course of treatment the disclosure occurred), and whether the participant sought out the services of a "kink aware" professional. These questions were followed by essay questions using Garnets, Hancock, Cochran, Goodchilds, and Peplau's (1991) survey as a model. Participants were asked for any known incidents of "biased inadequate, or inappropriate care to a BDSM client in psychotherapy"; any known incidents of, "care demonstrating special sensitivity to a BDSM client in psychotherapy"; "what professional practices are especially harmful in psychotherapy with BDSM clients"; and "what professional practices are especially beneficial in psychotherapy with BDSM clients." A copy of the questionnaire is available from the first author upon request.

Sample Population

One hundred ninety-seven client participants responded to the BDSM client questionnaire and seventeen mental health professionals

responded to the psychologist questionnaire. The current report focuses on the client data.

Of the 197 submitted client surveys, 22 did not meet the inclusion criteria for the study, as they had never received mental health services. The remaining 175 client responses were analyzed, and of these respondents, one chose not to provide an age. The mean age of participants was 38.63, with the youngest participant being 18 years old and the oldest being 62. Participants from 40 states in North America took the survey with the majority of participants (36) located in California. In order of response, the four next most frequent rates of response by states were from Washington (12), New York (13), North Carolina (11), and Massachusetts (11).

Of the 175 participants, when asked to indicate their biological sex, 136 (77.7%) were female, 33 (18.9%) were male, 4 (2.3%) identified as "other," and 2 (1.1%) were intersex. Again, a higher number of female respondents could be due to the fact that the announcement was sent to several lists for (bisexual and lesbian) women.

When asked to indicate their gender identity (how participants see themselves regardless of biological sex), 130 respondents (74.3%) listed female, 31 (17.7%) listed male, 7 (4%) listed bigendered, 6 (3.4%) reported other, and 1 individual (0.6%) listed intersex. As a subcomponent of gender identity, all participants were asked to identify themselves as butch, femme, androgynous, none, or other. On this item, 64 participants (36.6%) listed none, 47 (26.9%) were femme, 27 (15.4%) were other, 20 (11.4%) listed butch, 8 people (4.6%) did not respond to this item, and 9 people (5.1%) chose androgynous.

When specifically asked about sexual orientation, 42.3% considered themselves bisexual, 35.4% called themselves heterosexual, 18.9% called themselves lesbian, and 5.1% called themselves gay. For other ways of self-identifying, 4.6% identified as transgendered, 2.9% of participants considered themselves to be bigendered, 2.3% were FTM transitioning transsexuals, 1.1% were transsexual, and 0.6% were MTF transitioning transsexuals. Another 14.9% chose "other" for their sexual/gender orientation. These percentages contradict the numbers given in response to the gender identity question.

For ethnicity, 153 participants (87.4%) were Euro-American, 8 people (4.6%) listed themselves as bi/multi-racial, 6 people (3.4%) listed other, 3 people (1.7%) were Asian-American, 2 people (1.1%) failed to respond, 1 person (0.6%) identified as Native-American, 1 person (0.6%) as Latino, and 1 person (0.6%) African-American.

Participants were asked to disclose their current annual income. The three categories indicated most often were $30,000-39,000 (21.7%), followed by $40,000-49,000 (16%) and $20,000-29,000 (14.9%). At the upper and lower ranges, 8% selected "under $10,000" and 2.9% listed "over $150,000" as their annual income.

For geographical area, 46.9% live in the suburbs, 41.7% live in a city, 9.7% live in a rural area, 1.1% live on a farm, and 0.6% did not respond. In terms of the size of community, 41.7% said they lived in an area with a population over 500,000, 29.1% lived in a place with a population between 100,000 and 500,000, 27.4% lived in an area with a population under 100,000, while 1.7% did not respond to the question.

Respondents were given a list of BDSM terms and asked how they self-identified. Answers were not limited to one choice. "BDSM" was selected by 87.4% of respondents, "Kinky/bent/perverted," was chosen by 60% of participants, 37.1% selected "SM," as their identity, 35.4% chose "D/S," 22.3% of people selected "B/D," and 5.1% of participants called themselves "vanilla." Another 11.4% of participants said they used some "other" term to self-identify. The researchers assume that those who selected "vanilla" did so because they see this as part of their identity, along with other BDSM self-descriptor(s).

Participants were asked to report the ages at which they first became aware of their various identities and orientations. The responses are shown in Table 1.

Participants were also asked to check the settings in which their various identities and orientations were known to others. The responses are shown in Table 2.

RESULTS

Involvement in Professional BDSM Services

Participants were asked if they had ever engaged in BDSM play for hire, and, if they said yes, they were asked to describe these experiences. Ninety-four (53.7%) of the participants reported never engaging in BDSM for hire. Forty-four (25.1%) participants did not respond to this question. Another 22 (12.6%) participants said they had engaged in BDSM for pay, 3 (1.7%) said they had been paid once, another 3 participants (1.7%) said they had assisted others in their work (but had not received payment), 1 (0.6%) said they had done it two or three times, and another person (0.6%) had assisted someone several times without be-

TABLE 1. Age at Which Participants First Self-identified

Identity	Youngest Age	Oldest Age	*M* Age	*N*
BDSM[a]	0	58	26.45	506
Vanilla	0	32	15.39	18
Heterosexual	0	41	12.94	79
Lesbian	12	43	20.63	46
Gay	4	36	18.23	13
Bisexual	8	56	22.77	91
Bigendered	7	33	18.17	6
Transgendered	7	48	27.20	10
Transsexual	14	50	32.00	2
Transitioning	30	50	40.00	2

[a]Mean age for BDSM identity is a weighted mean for various responses including "kinky," "BDSM," "B/D," "D/S," and "SM." Number of responses for BDSM is the total of those who selected "kinky," "BDSM," "B/D," "D/S," and "SM," as their identity.

ing paid. There were two people (1.2%) who indicated that they had been paid for educational demonstrations on BDSM, while 1 person (0.6%) indicated that she seriously intends to begin providing professional BDSM services in the near future. Another four respondents (2.3%) stated that they had been paying customers in BDSM interactions. Those who responded yes to this question were asked if they had maintained a personal interest in BDSM play outside of their professional services. The 37 individuals who indicated that they had engaged in BDSM for hire all said that they had also maintained a personal interest in BDSM. One individual selected no for this item, but it was presumed to be an error because this individual wrote extensively about his personal interest in BDSM, and he also stated that he had not engaged in BDSM for hire.

Number of Therapists Seen

Participants were asked how many therapists they had seen over the years. Most of the sample had seen between one and five therapists. The

TABLE 2. Settings in Which "Kinky," "BDSM-Identified," "B/D," D/S," or "Vanilla-Identified" Identity Is Known to Others

Settings	*N*	*P*
Most friends	114	65.1
Primary partner	100	57.1
In home	96	54.9
All partners	94	53.7
In the community	72	41.1
Some friends	55	31.4
Most of nuclear family	45	25.7
At work	29	16.6
Some partner(s)	22	12.6
Extended family	11	6.3
Only to self[a]	5	2.9
To no one[b]	1	0.6

[a]All participants who indicated that they were only "out" to themselves listed other arenas in which they were "out." [b]The individual who indicated that she was "out" to no one listed other arenas in which she was "out." It is assumed that these responses are inaccurate.

most frequent response reported (21.7%) was one therapist. Another 20% of participants had seen two therapists, 19.4% had seen three therapists, 13.7% had seen four therapists, and 10.3% had seen five therapists. One individual (0.6%) reported seeing fourteen mental health professionals and another individual (0.6%) reported seeing as many as thirty. When totaled, the number of therapists seen by all clients was 633. The 17 therapists surveyed reported seeing at least 186 BDSM clients, or an average of 11 BDSM clients each.

Relationship of Mental Health Issues to Clients' BDSM Interests

Participants were asked to indicate those issues that had brought them into therapy and whether they were in any way related to their BDSM interests. Most participants (74.9%) said that the issues that brought them into therapy were not related to their BDSM interests in

any way. A smaller percentage (12%) of the sample said that their BDSM interests were related to the issues that brought them into therapy. Another 11% said that their BDSM interests were tangentially related to the concerns that led them to seek psychological care. Two participants (1.1%) were not sure whether their BDSM interests were in any way related to the concerns that brought them into therapy.

Disclosure of BDSM Interests to Therapists

Participants were asked whether they had disclosed their BDSM interests to their therapist(s). Most participants (65.1%) had shared their BDSM interests with their therapist, while 28.6% had not told their therapists about their BDSM interests. There were seven participants (4%) who had specifically not told their therapists about their BDSM interests, indicating that this was because they were not yet aware of their BDSM orientation at the time that they were in therapy. Another three people (1.7%) did not respond to this question and one participant (0.6%) provided an uninterpretable response.

Most who disclosed their BDSM interests tended to do so early on in their treatment ("immediately," "right away," and "first or second visit," came up frequently in responses), explaining that it was their way of assessing whether they would feel comfortable in treatment. Others waited until the end of treatment. Those (32.6%) who did not disclose their BDSM interests indicated that this was because they were not yet aware of their BDSM interests (4%) or because their BDSM was not related to their treatment. Eight participants from both groups of those who had and had not disclosed their kink-orientation to their therapists reported being fearful at some point that it was too risky to "come out" to their therapists because the therapists would not understand or might think they were "crazy." A few individuals said that they had "come out" about other alternative sexual issues (multiple partners or same sex relationships) but not specifically about BDSM. Some stated that they had chosen to "come out" about these issues as a way of testing the waters about their therapist's attitudes towards BDSM, while others claimed that they had done so because these issues were more relevant to their treatment concerns than their BDSM identity.

Seeking Out Kink Aware Professionals

Participants were asked whether or not they had at any point sought out the services of a "kink aware" professional. The majority of the par-

ticipants (59.4%) had not done so. Those who gave more information on why they did not seek one out listed reasons such as BDSM not being the primary treatment issue, not being aware that "kink aware" professionals exist, not yet being aware of their own BDSM interests, not having any "kink aware" professionals in their community, or having to accept therapists based upon health insurance rather than personal choice.

However, 33.7% of participants had sought out the services of kink aware professionals or had included questions about the therapist's BDSM knowledge when choosing a mental health professional. Many of those who sought out "kink aware" professionals said they would always do so. A number of people located "kink aware" professionals but found them to be inappropriate for a variety of reasons: three people found therapists who were too expensive; one person said the "kink aware" therapist was "unprofessional," but did not provide additional details; one located a male "kink aware" professional; however, finding a female therapist was of higher priority for her than seeing one who was "kink aware," and another participant said the therapist was "too far away." Of the two others who were dissatisfied in their search for a "kink aware" therapist, one offered that she had looked at a list and "did not find any who seemed to suit me," while another said that the therapist she found "seemed more interested in sharing stories about fun S/M stuff we'd both done than in acting as my therapist."

Of the remaining participants, 3.4% did not respond to the question, and 3.4% responded in a way that did not answer the question clearly.

Themes of Biased and Culturally Sensitive Care to BDSM Clients in Therapy as Reported by Sample

The researchers identified and coded the major themes that emerged in response to the answers given by participants. Regarding reports of "biased, inadequate, or inappropriate care to a BDSM client in psychotherapy," participants listed several major categories: (1) considering BDSM to be unhealthy, (2) requiring a client to give up BDSM activity in order to continue in treatment, (3) confusing BDSM with abuse, (4) having to educate the therapist about BDSM, (5) assuming that BDSM interests are indicative of past family/spousal abuse, and (6) therapists misrepresenting their expertise by stating that they are BDSM-positive when they are not actually knowledgeable about BDSM practices.

One participant responded: "A friend told me that her therapist told her that BDSM can never be done safely, is always abuse, and that the

therapist could no longer see my friend if she would not stop." Another participant described the time she wasted in therapy: ". . . BDSM only came into play when I had to educate her therapist that it was not abuse, that it was not harmful to me, that I was not self-sabotaging with it, nor acting out past family/spousal abuse. It actually took quite a few sessions to get the therapist over their hang-ups and misconceptions about BDSM. Time that could (have) been better spent on the actual issues I was there for." Another respondent shared the following: "I disclosed my interest in SM to (my) therapist after seeing her for about 2 months. She told me that she believed BDSM to be aberrant and harmful to the people who practice it." This individual eventually decided that SM was not pertinent to the issues that brought her into therapy so they would have to "agree to disagree." But she mentioned that "the inability to freely discuss my sexuality has marred my therapy experience somewhat . . ."

In terms of the total number of incidents of "biased" or "inadequate" care reported by the sample, there were 118 reported incidents of therapists providing poor care to BDSM clients. Most participants listed the incidents clearly and each incident by an individual therapist was counted. If an individual reported several things that her or his therapist did that demonstrated bias, these were linked to one therapist and counted as one incident. However, when clients reported hearing of "some" cases, but did not indicate the number of incidents, these were coded as three incidents. This choice provided the most conservative estimate, assuming that "some" would refer to some unknown quantity that was more than two incidents.

Participants were asked to describe "any incidents where a therapist provided care demonstrating special sensitivity to a BDSM client in psychotherapy." Themes in the responses to this question included (1) therapist(s) being open to reading/learning more about BDSM, (2) therapist(s) showing comfort in talking about BDSM issues, (3) therapists who understand and promote "safe, sane, consensual" BDSM. A participant was pleased that her therapist "was both sensitive and interested in being educated when she (had) not (been previously) exposed to matters relating to my BDSM activities."

Similarly, therapists who responded to this question spoke about incidents in which they had let BDSM clients know that they were comfortable speaking about BDSM. They did this by being sensitive to when a client might be testing the waters about these issues, letting the client know that it was acceptable to talk about such things, having intake forms that reflected their awareness of alternative sexuality issues,

and treating BDSM issues as part of the normal spectrum of human sexuality. One therapist also felt that making referrals when a therapist believed s/he was biased about BDSM showed sensitivity to BDSM clients.

The total number of incidents reported in which a therapist provided sensitive or culturally-aware care to a BDSM client was 113. Again, in cases in where the participant reported that "some" friends had shared positive experiences with them, these were coded as three incidents so as to provide the most conservative estimate of "some," with the assumption that the individual was referring to more than two incidents. In response to this question, nine individuals indicated that the therapist whom they were describing as demonstrating special sensitivity to them as a BDSM client was the same therapist whom they had previously described as providing biased care. Some of these individuals explained that after a therapist had made a particular blunder, he or she then showed a willingness to learn more about BDSM or came to better understand the role of BDSM in the client's life.

As for participants' ideas of those professional psychotherapy practices that can be especially harmful to BDSM clients, some of the themes that BDSM clients listed included: (1) not understanding that BDSM involves consensual interactions, (2) "kink aware" professionals who lack appropriate boundaries (e.g., "I find it frightening to see the lack of professional boundaries among those therapists who are specifically trolling for BDSM clients," says one participant, (3) assuming that "bottoms" are self-destructive, (4) therapists abandoning clients who engage in BDSM behavior, (5) trying to "fix" the BDSM client solely on the basis of the BDSM interests, (6) making reports/breaking confidentiality because the therapist assumes others are at risk solely due to the BDSM activities, (7) assuming past trauma is the cause of the BDSM interests, (8) expecting the client to teach the therapist about BDSM, and (9) having a prurient interest in the client's BDSM sexual lifestyle. One person was emphatic that "It is patently unfair of therapists to expect their clients to educate them on the subject of sexual variations."

Therapists also described practices that they considered harmful to BDSM clients: therapists who shame their BDSM clients or become judgmental, and therapists who adhere to theoretical perspectives that may give them pathological explanations for a client's BDSM interests. Therapists also acknowledged the dangers of assuming that all BDSM clients are healthy, emphasizing the need for therapists who can recog-

nize the complexity and presence of both abuse and BDSM in some BDSM relationships.

BDSM clients were also asked what professional psychotherapy practices they would consider especially beneficial to a BDSM client. These themes included (1) asking questions about BDSM, (2) helping the client to overcome shame and stigma as related to the BDSM identity, (3) open-mindedness and acceptance, (4) not expecting the client to do all of the educating about BDSM, (5) understanding the distinction between BDSM and abuse, (6) being someone who practices BDSM and identifies with the BDSM lifestyle, and (7) the ability to appreciate the complexity of BDSM play and to realize that some clients need help to determine if they are using BDSM in a positive way in their lives. One participant wrote that she would appreciate a therapist who understood that "BDSM is not inherently a mental illness," but who also understood that "certain perceptions, behaviors, or practices (that can occur within a BDSM context) may be inappropriate, self-compromising, and/or self-destructive." Another offered: "I think that there are definitely aspects of BDSM that can be harmful when someone isn't mindful of their own limits, needs, and such . . . finding a therapist who would be open to helping me along that path in the healthiest way possible would be invaluable!"

Therapists agreed that beneficial therapy practices for BDSM clients include: the therapist being willing to raise questions about BDSM, normalizing BDSM interests for clients new to BDSM, open-minded acceptance, being well-informed about BDSM and the subculture (or even identifying as one who engages in BDSM practices), and not focusing on kinky behavior when it is not the client's focus of treatment. Therapists were also aware of the importance of appreciating the complexity of BDSM play and realizing that not all clients are engaging in it in a way that is healthy for them. Therapists discussed the need to sometimes acknowledge their own values and the willingness to refer when necessary. They talked about helping clients discuss safety issues in BDSM and helping them to set boundaries in their play (if the client struggles with setting such boundaries). Therapists also acknowledged that some BDSM-identified individuals might have issues of compulsivity in their sexual interactions that might need to be addressed and that knowing and being able to refer to other kink-friendly professionals is part of being able to provide culturally-sensitive care to BDSM clients.

DISCUSSION

One hundred seventy-five individuals from 40 U.S. states responded to the BDSM-identified client questionnaire. The response to the call for participants indicated that BDSM individuals exist nationwide, and that they are utilizing mental health treatment for both BDSM-related and non-BDSM-related issues. Although there were a higher number of BDSM participants located in California, the comparatively higher concentration of California participants is likely accounted for by the greater outreach to the San Francisco Bay Area. When totaled, the number of therapists seen by all clients was 633. We wondered how many of these therapists had knowledge or awareness of working with BDSM clients–especially considering the low response rate of therapists in this particular study.

It is of note that 65.1% of BDSM clients had disclosed their BDSM interests to their therapist(s). Considering that 74.9% did not feel that the issues bringing them into therapy were kink-related, one might assume that these clients would not be bringing the issue up in treatment–especially given that 59.4% had not actively sought out the services of a "kink aware" professional. However, it became clear that disclosure of BDSM interests early on in treatment is used as a screening process by some BDSM clients in order to assess whether a therapist is going to make them feel comfortable. Nevertheless, "coming out" in therapy was experienced as too risky by some individuals who feared that there might be dire consequences. This is important because these individuals are obtaining psychological services with therapists whom they do not trust to manage important information regarding their lives and relationships competently. Withholding any information from one's therapist out of fear of consequences certainly can have an impact on the quality of treatment and the therapeutic relationship.

In terms of seeking out a "kink aware" professional, 59.4% had not sought one out. Some of these individuals were unaware that "kink aware" professionals even exist. As consumers of mental health treatment, BDSM clients deserve to have easily accessible resources for finding culturally sensitive treatment. The lack of awareness by some BDSM-identified individuals of mental health treatment geared specifically to their special needs is further evidence of the marginalization of BDSM practices and lifestyles. About one-third of BDSM participants were interested in seeking mental health treatment from a "kink aware" professional.

Important information was gleaned by the responses of those who were disappointed when they sought out "kink aware" clinicians. Poor boundaries were mentioned by one individual when her therapist seemed more interested in exchanging fun personal stories about BDSM than maintaining a professional stance. This comment echoed another participant's response when asked for professional psychotherapy practices that can be harmful to BDSM clients. This individual worried about therapists who "troll" for BDSM clients. Although it was unclear whether the participant was referring to therapists who seek BDSM clients as a guise for finding BDSM play partners, the implication was that this might be the case. Comments of this nature highlight the significance of appropriate boundaries in treating sexual minority clients. Some inappropriate therapists may have voyeuristic interests in working with BDSM clients. Other "kink aware" professionals who are BDSM-identified themselves may also have other boundary issues to be aware of: the potential for running into clients when attending BDSM play parties or other community events, and the possibility of those who are both BDSM- and poly-identified to inadvertently find themselves (or their partners) engaging in BDSM play with a client's partner (or their own clients). These possible scenarios are not that uncommon when one considers the relative size of the BDSM population in some communities and the limited BDSM resources that may be available to these communities. Clearly, confidentiality issues can arise quickly. They must be anticipated and dealt with ethically by practitioners who wish to call themselves competent at working with BDSM clients.

There were many significant similarities between the client and therapist themes in the qualitative data collected. More than one individual mentioned incidents in which a client was required by a therapist to give up BDSM as a condition of treatment. These scenarios are extremely disturbing when compared to the imagined scenario of a client being told by a therapist that she must discontinue kissing her husband or stop having sexual relations with him in order to continue in treatment. Yet, abuses of this nature were among the more common themes described. Other responses made it very clear that therapists are in great need of resources to help them distinguish consensual BDSM from nonconsensual violence in a relationship. Many individuals were annoyed with having to serve as educators for lazy therapists who had not done their homework. The clients' annoyance over having to educate their therapists about BDSM or having therapists misrepresent their expertise about BDSM seems particularly significant when one

considers that five out of the seventeen therapists in this study cited their clients as their primary source of information regarding BDSM.

In both the therapist and BDSM client group, the number of reported incidents of positive and negative care to BDSM clients in therapy was similar. The therapist group reported 12 cases of biased care and 12 cases of culturally-sensitive care. The client group reported 118 cases of biased care and 113 cases of culturally-sensitive care. The researchers note that the sample of BDSM clients recruited for this study already have access to BDSM resources, and are therefore more likely to be aware of both positive and negative experiences in treatment. Those who are most likely to have had more negative experiences are not likely to be represented by this sample. Also, participants were not asked to describe the consequences of biased care that they (or others) received. This question would be an important follow-up question in a future study. For example, some individuals who have sought treatment in the past may now avoid the therapy they need for fear of having another bad experience. Others may have tried to change or suppress their BDSM desires after being treated by therapists who believe BDSM is sick.

Several parallels exist between the experiences and needs of BDSM clients in psychotherapy and the experiences and needs of GLB clients in psychotherapy. These parallels include issues of disclosure, the need for a non-prejudiced, well-informed therapist, and the need for a therapist who is sensitive to the complex issues that can arise in BDSM relationships. In addition, as with GLB clients, BDSM clients need therapists who are able to differentiate diagnostically problems that are related to BDSM practices from those that are non-related. Furthermore, like GLB clients, BDSM clients who are already identified with the BDSM subculture may be more empowered in interacting with the mental health establishment because they may be better able to articulate their needs for a BDSM-sensitive or "kink aware" therapist and actively seek one out. Clients who have been traumatized by therapists who are ignorant about BDSM or who view it as pathological may fearfully steer clear of the treatment they need. Other clients may be new to BDSM, and these individuals may feel lost and in need of information. They may not know to pursue these resources without the help of a therapist who has access to them. Therefore, it is important for therapists to be aware of resources for their BDSM clients who are just "coming out" but who have not found the larger community. This is similar to how therapists working with GLB clients who are just "coming out" may also have to help these clients gain access to the GLB community.

The researchers hope that these findings will add to the creation of ethical guidelines for culturally-sensitive treatment with BDSM individuals similar to those created by the Division 44 Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (APA, 2000). This Task Force was developed after the study by Garnets et al. (1991) which was the first step in identifying positive and negative experiences for GLB clients in psychotherapy. Suggested guidelines for psychotherapy with BDSM clients have been developed by Kleinplatz and Moser (2004) and are based upon the Guidelines for working with GLB clients. They also reflect many of the responses given by both the BDSM client and the therapist sample. Kleinplatz and Moser's guidelines for psychotherapy with BDSM clients address psychologists' attitudes towards BDSM, their knowledge about BDSM relationships and families, their awareness of issues of diversity for BDSM clients, and education for psychologists on BDSM issues and treatment. One recommendation is that Kleinplatz and Moser's guidelines should be expanded to reflect the needs of GLB and transgendered BDSM members. While GLB refers to gay, lesbian, and bisexual individuals, it should be acknowledged that the interests of transgendered individuals overlap considerably with those of the GLB community, and Division 44 currently includes a Transgender Task Force.

It appears that there is a great need for specific training in BDSM for mental health professionals. Such training would familiarize therapists with the BDSM subculture and the community codes and practices. It would help mental health professionals gain access to BDSM groups and literature. This training would also help practitioners understand the differences between the healthy expression of BDSM and abuse, and it would help therapists understand how to assess when something may be going awry in an otherwise healthy BDSM relationship. Mental health professionals need to understand how boundaries are established in BDSM relationships. In addition, there is a pressing need for an APA Division for those who are interested in the psychological study of sexuality. This Division would provide a home for practitioner groups, research, education, and policy. Therapists who want to work competently with BDSM clients also would benefit greatly from e-mail lists and consultation groups in which cases can be discussed and supervised by those who have developed expertise in working with BDSM clients.

A current challenge to both BDSM clients and those seeking supervision from "kink aware" professionals is that cultural competence is dif-

ficult to define given the current lack of formal training on working with the BDSM subculture. Even kink positive therapists will undoubtedly have their own biases and stereotypes and countertransferences to various BDSM behaviors, and they will need ongoing consultation with other "kink aware" professionals to address these issues as they arise. Creating professional literature will help both therapists and clients. Mental health professionals can share techniques and problems that are specific to this population. Unique challenges may exist when working with BDSM clients. Some clients may have multiple partners or roles. For example, a practitioner's standard model of couples therapy would have to be expanded upon when working with a BDSM individual who presents with a Master/slave lifestyle and wants to resolve a relationship conflict while maintaining the power differential in this relationship. Other issues that are specific to this population include "coming out" and countering BDSM negativity that can exist for a client internally as well as in his or her relationships with friends, family, partners, or work environment.

Given the findings of this study, it is apparent that mental health professionals are needed who are prepared to work with BDSM-identified clients on the issues they present in therapy without attempting to refocus the treatment on BDSM issues when this is not the client's desire. As some BDSM-identified clients may also be in abusive relationships concurrent with their BDSM interests, therapists need to be able to help a client distinguish between BDSM and abuse.

CONCLUSIONS

It is clear that BDSM interests span various ages, genders and sexual orientations, and there are BDSM participants nationwide who are utilizing mental health treatment for both BDSM-related and non-BDSM-related issues. BDSM interests are not in and of themselves pathological interests and there is no study that demonstrates that BDSM is pathological. There are times when BDSM fantasies and behavior may become symptoms of pathology whether acted out in a non-consensual fashion or when a participant is unable to make distinctions about his or her own boundaries. Therapists treating BDSM clients must be able to differentiate between BDSM and abuse.

It is hoped that these results will contribute to the contemporary development of ethical guidelines for culturally-sensitive treatment with BDSM individuals similar to those developed by the Division 44 Com-

mittee on Lesbian, Gay, and Bisexual Concerns Joint Task Force on Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (APA, 2000). Suggested guidelines for psychotherapy with BDSM clients would look very similar to those created for working with GLB clients, and they would reflect many of the suggestions made by both the BDSM participants and the therapist participants regarding what would constitute culturally-sensitive care to BDSM clients.

It is incumbent upon the field of psychology to recognize the need for specific training to help mental health providers to better meet the particular needs of BDSM clients in therapy. This would include training based on more accurate information about this population, awareness of the effects of cultural bias and stigma, and sensitivity to the complexities that BDSM-identified individuals present in therapy.

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