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. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2006 by The Haworth Press, Inc. All rights reserved.]*

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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 life-style, 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-