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Assessment of therapists’ attitudes towards BDSM

Katherine Kelsey\textsuperscript{a*}, Beverly L. Stiles\textsuperscript{b}, Laura Spiller\textsuperscript{a} and George M. Diekhoff\textsuperscript{a}

\textsuperscript{a}Department of Psychology, Midwestern State University, Wichita Falls, TX, USA; \textsuperscript{b}Department of Sociology, Midwestern State University, Wichita Falls, TX, USA

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Participants in alternative or ‘kinky’ sexual behaviours are a sizable enough minority that psychotherapists are likely to see them in their practices. However, those who engage in bondage and discipline (BD), dominance and submission (DS) and sadism and masochism (SM) (BDSM) are concerned that mental health-care providers will view BDSM as evidence of psychopathology. This research employed an Internet-based survey of 766 therapists in the United States to assess therapists’ attitudes towards the BDSM community. Seventy-six per cent of the sample reported having treated at least one client who engaged in BDSM, although only 48% perceived themselves to be competent in this area. Attitudes towards BDSM were related to socio-demographic variables and self-perceived competence.

Keywords: psychotherapy; BDSM; sexual minorities; attitudes

Introduction

Practitioners of bondage and discipline (BD), dominance and submission (DS) and sadism and masochism (SM) engage in a wide range of consensual erotic behaviours, often but not always involving sexual behaviour, that play out an exchange of power, restraint or pain (e.g. Weinberg, 1995). BDSM is a collective term incorporating BD, DS, SM, slave and master relationships (Connolly, 2006) as well as fetishism and ‘kink’ activities (Nichols, 2006). Individually or as a whole, these activities are often perceived negatively by the general public (Wright, 2006) and mental health professionals (Kleinplatz & Moser, 2004). With varying prevalence estimates as low as 1.8% in an Australian study (Richters, de Visser, Rissel, Grulich, & Smith, 2008) to 10% in the US population according to Masters, Johnson, and Kolondy (1995) and reports as high as 11% of women and 14% of men having engaged in some form of consensual sado-masochistic sexual behaviour (Janus & Janus, 1993), therapists are likely to encounter BDSM participants in their practice. Clinicians may find their perceptions of BDSM pose a challenge for providing effective and supportive services to these clients.

Mental health professionals are likely to have limited information about those who engage in BDSM; hold inaccurate beliefs and negative attitudes about clients involved in the BDSM lifestyle; and inappropriately pathologise BDSM activities (Lawrence & Love-Crowell, 2008; Nichols, 2006). According to Ford and Hendrick (2003), therapists

*Corresponding author. Email: katherinekelsey@my.unt.edu

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expressed more discomfort working with BDSM-identified clients than with those in same-sex relationships and/or group sexual behaviours. Therapists’ perceptions of BDSM reflect the general population’s condemnation of unconventional sexual behaviour on the basis of religious and moral grounds (Yost, 2010). Additionally, therapists are more likely to be influenced by the psychological literature which explains the aetiology of BDSM practices as stemming from past sexual abuse or the replication of violent, oppressive patriarchal relationships (Kolmes, Stock, & Moser, 2006).

Another reason that therapists are likely to stigmatise BDSM is the inclusion of sexual sadism and sexual masochism as paraphilic disorders in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2000). The diagnosis of these disorders is only appropriate when the sexual behaviour has been non-consensual or causes significant distress. There is little evidence that community-based SM practitioners exhibit the characteristics of a mental disorder (Krueger, 2010a, 2010b; Moser & Kleinplatz, 2005). Based on findings from a national survey on sexuality, Richters et al. (2008) concluded that BDSM practice is a variety of sexual interest that is not a symptom of sexual abuse or sexual pathology. This is consistent with BDSM practitioners’ contention that although their sexual practices are not normative in society, they are typically safe, sane and consensual, enrich their lives and do not condone violence or harm (Nichols, 2006; Stiles & Clark, 2011). While many recognise and acknowledge the risk involved in their activities, the safe, sane and consensual guidelines can be a source of controversy within the BDSM community. Still, the intent is to avoid harmful acts of violence (Nichols, 2006; Stiles, Clark, & Hensley, 2008).

BDSM practitioners are concerned about where to get quality mental and physical health care that does not pathologise their lifestyle (Weinberg, 2006). Kolmes et al. (2006) surveyed 175 BDSM-identified participants regarding their therapeutic experiences. These participants identified approximately equal instances of positive and negative mental health care. Among the several shortcomings in mental health services reported were therapists indicating a BDSM lifestyle was unhealthy, even requiring that clients give up their BDSM activity in order to continue the treatment. Furthermore, psychotherapists often assumed the client to have a history of childhood sexual or physical abuse. The authors concluded that many psychotherapists lacked the training and knowledge necessary to counsel BDSM clientele, and even misrepresented themselves by saying they were competent in this area.

Lawrence and Love-Crowell (2008) conducted a qualitative study of 14 psychotherapists who had extensive experience working with BDSM-identified clients to identify treatment characteristics needed to provide effective services to this clientele. Respondents emphasised cultural competence, including non-judgemental acceptance, adequate knowledge of BDSM as well as avoiding pathologising BDSM activities as the top priority for effectively working with BDSM clients. Their findings also indicated that therapists understood the importance of consultation and supervision with more experienced colleagues.

The APA Code of Ethics requires psychologists to obtain the necessary training, experience, consultation or supervision to develop competency in any area associated with gender identity, ethnicity, culture and sexual orientation (APA, 2010). Although BDSM does not explicitly fit into any of these categories, in 2011, APA further elaborated that ‘Sexual orientation also refers to a person’s sense of identity based on those attractions, related behaviors, and membership in a community of others who share those attractions’ (APA, 2011b). BDSM is best described by this clearer definition of sexual orientation and can therefore be considered a sexual minority group. The practice guidelines for working with lesbian, gay, bisexual and transgendered (LGBT) clients (APA, 2011a) describe specific standards of practice that can be helpful for working with not only LGBT clients.
but also clients who are a part of other sexual minority groups, such as BDSM. These guidelines acknowledge that psychologists may have implicit or explicit negative attitudes towards sexual minority clients, and these attitudes can affect the treatment of the individual. To understand the life issues and special challenges of sexual minorities, therapists need training to increase their knowledge of sexual subcultures; develop awareness of their own values and beliefs regarding these sexual subcultures; and ensure that their work is not biased by prejudices or stereotypes.

Unfortunately, the majority of psychology programmes do not provide much education on LGBT, polyamorous and BDSM subcultures in their curriculum, internship trainings or even textbooks (Miller & Byers, 2009; Weitzman, 2006). Taking into consideration that most psychology programmes do not specialise in sex therapy or sexual minorities, this is not a surprise. It is possible that therapists are seeking postgraduate training or self-study to develop the skills and knowledge for providing competent services to sexual minorities; however, currently there are no available data on how many therapists seek other types of training or additional preparation for working with this population after graduation.

This research sought to provide an initial quantitative description of therapists’ experience with and perception of BDSM. Beyond qualitative data gathered from small samples of clinicians specialising in the treatment of sexual minorities, no data exist on the BDSM attitudes of mental health professionals. We hypothesised that, consistent with the therapeutic experiences of those in the BDSM community and the general public’s perception of BDSM as deviant, the majority of mental health professionals surveyed would tend to view BDSM involvement as unhealthy and indicative of psychopathology. We also assessed therapists’ exposure to training and education on BDSM and other sexual subcultures as well as their ratings of their competency for providing services to BDSM practitioners. In addition, based on the theory that more contact with a minority group allows for greater understanding of and identification with that group (Pettigrew, 1981, 1997), we hypothesised that (1) survey participants with more professional experience with practitioners of BDSM would hold less pathologising, more accepting attitudes towards BDSM and (2) more training on sexual minorities in general would also predict more accepting attitudes towards BDSM. Exploratory analyses investigated whether socio-demographic variables were associated with attitudes.

Method

Participants

Participants were psychotherapists who responded to an email soliciting their participation in an anonymous study. Participants meeting the following criteria were sent an email explaining the goals of the study and providing a link to an online survey:

1. Email address publicly available on the APA’s Practice Directorate website (apapractice.org), which is no longer available. A similar search can be conducted (by members of APA) using the following website, http://memforms.apa.org/apa/cli/mbdirsearch/index.cfm.
2. Residence in the United States.
3. One or more of the following doctoral-level credentials: PhD, PsyD or EdD.
4. Listing under one or more of the following areas of specialty in the apapractice.org database: clinical, counselling or sexuality.
Although the recruitment email was only sent to members of APA who were licensed psychologists, survey respondents included clinicians of varying educational backgrounds. Therefore, no limitations were placed on graduate degree for the final sample. The only criterion for retention in the sample was that the participant be licensed to provide psychotherapy.

In the final sample, participants consisted of 766 licensed psychotherapists, including 437 (57%) females and 329 (43%) males. The racial composition of the sample was 717 (93.6%) European American, 16 (2.1%) Asian/Asian American, 14 (1.9%) African/African American, 11 (1.4%) Latino American or Hispanic, 5 (0.7%) Native American and 3 (0.4%) bi/multiracial. The degrees held by participants included PhD (n = 521, 68%), PsyD (n = 170, 22%), MA/MS (n = 50, 6.5%), EdD (n = 18, 2.3%) and other (n = 9, 1.0%). Overall, their ages averaged 49.93 (SD = 11.12) with a range from 23 to 76 years. Licensure year averaged 1992 (SD = 11.12) with a range of 1966–2009. The number of clients seen per week ranged from 0 to 60; the average was 20.54 (SD = 13.46).

**Procedures**

This research was reviewed and approved by the university’s Committee for the Protection of Human Subjects (CPHS). Following CPHS approval, potential participants were contacted via email. An initial email introduced the study, provided investigator contact information and alerted the participant to the upcoming survey. A follow-up email provided complete information on study purposes, risks, benefits and contained a link to the online survey website. Those who completed the entire survey were given the option to click on another link that took them to a different survey webpage, where they could enter their contact information which placed them into a drawing for a gift card. The information for entry in the drawing was not connected in anyway to the participants’ responses to the survey.

**Sample attrition**

The participant recruitment email was sent to 10,197 email addresses. The number of participants who attempted to complete the survey was 1136. After eliminating respondents who provided incomplete data, 766 participants were included in the sample used for data analysis. To determine if sample attrition introduced biases into the final sample, the demographic characteristics of the participants who completed the survey were compared with the demographics of the sample who attempted the survey. Those who completed the survey did not differ significantly from those who attempted the survey on any of the background or demographic variables.

**Materials**

The survey included the following sections: socio-demographics, professional information, self-perceived competence to treat clients reporting BDSM activity, attitudes towards BDSM and training/education on sexual minorities. A definition of BDSM was given to the survey participants after the demographics questions, before any questions related to BDSM were presented.

Statements assessing therapists’ attitudes towards BDSM were adapted from Kolmes et al. (2006). The questionnaire included items assessing perceptions of the origin of BDSM; psychological health and/or psychopathology of BDSM participants and practices; problems presumed to be associated with BDSM; and diagnostic and treatment planning.
implications associated with BDSM. Responses were made on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree) with a neutral point of 3 (unsure). The 19 items are listed in Table 1. Eight questions (numbers 1, 3, 5, 7, 11, 13, 15 and 16) were reverse-scored so that high scores reflect negative attitudes about BDSM. The remaining 19 questions were summed to create an aggregate attitude score. Cronbach’s alpha for the 19-item scale was 0.89, indicating adequate internal consistency.

An item analysis of the attitudes questions revealed several items that correlated highly with the total score suggesting that the content of these items can provide a guide for interpreting the meaning of the total scores. The item with the highest item–total correlation \( r = 0.76 \) was ‘A psychologically healthy person does not engage in BDSM.’ The item with the next highest item–total correlation \( r = 0.74 \) was ‘BDSM should be eliminated through psychotherapy.’

**Results**

Of the sample, 76% reported having treated at least one client who engaged in BDSM. Survey participants indicated treating an average of 6.7 (SD = 15.4) clients reporting BDSM involvement. However, this mean was skewed by a small subsample of respondents who have seen high rates of this clientele (12 respondents had seen over 100 BDSM clients). Only 23% of the sample reported no clinical experience with BDSM-involved clients, while over 50% of the respondents had seen 10 or more clients reporting BDSM activity.

Contrary to expectations and BDSM practitioners’ therapy experiences, the majority of respondents did not agree with statements equating BDSM with pathology. Sixty-seven per cent agreed or strongly agreed with the statement: ‘BDSM can be part of a healthy, long-term relationship.’ Similarly, 70% disagreed or strongly disagreed that interest in BDSM should be eliminated by therapy. The attitude items are presented in Table 1 along with percentages of the sample providing each response. Means, SDs and correlations between variables are presented in Table 2.

As hypothesised, therapists with more experience treating BDSM-identified clients reported more accepting attitudes, \( r = -0.16, p < 0.05 \). However, the \( r^2 \) was small at 0.023, making it much weaker than expected. Forty-eight per cent of participants considered themselves currently competent to see BDSM clients while 52% did not. Participants who felt competent to treat BDSM clients had more positive attitudes towards BDSM (\( M = 39.04, SD = 10.13 \)) than those who did not rate themselves as competent (\( M = 47.73, SD = 10.13 \)); \( t(745) = -11.19, p < 0.05 \). The Cohen’s \( d \) for the effect size of self-perceived competence association with attitudes was 0.82.

Graduate training on the general topic of sexual minorities was dichotomised as no training versus some training. Seventy-four per cent of the participants reported at least some training on sexual minorities. Graduate and postgraduate training specific to BDSM was similarly dichotomised. Sixty-four per cent of the participants reported no training that included BDSM throughout their graduate education. Fifty-two per cent of the participants reported seeking additional training on their own after graduation.

As hypothesised, training variables predicted attitudes towards BDSM. Survey participants with no graduate training on BDSM (\( M = 44.66, SD = 10.79 \)) had less accepting attitudes towards BDSM than those with some training (\( M = 41.16, SD = 12.4, t(700) = 3.68, p < 0.05 \)). This effect size was small as indicated by a Cohen’s \( d \) of 0.29. Similarly, survey participants with no additional BDSM postgraduate training (\( M = 47.61, SD = 10.1 \)) held less accepting attitudes than those with some additional training on BDSM.
Table 1. Perceptions survey items and percentages endorsing each response option.

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly disagree (%)</th>
<th>Disagree (%)</th>
<th>Unsure (%)</th>
<th>Agree (%)</th>
<th>Strongly agree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beliefs about the origin of BDSM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDSM is a sexual orientation like heterosexualitya</td>
<td>12</td>
<td>42</td>
<td>28</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Most BDSM practitioners have a history of childhood abuse</td>
<td>7</td>
<td>33</td>
<td>51</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>A person’s interest in BDSM is innate, more than just a matter of choicea</td>
<td>6</td>
<td>37</td>
<td>45</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>BDSM is caused by maltreatment during childhood</td>
<td>11</td>
<td>40</td>
<td>41</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td><strong>Health/pathology of BDSM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDSM can be part of a healthy, long-term relationshipb</td>
<td>2</td>
<td>8</td>
<td>22</td>
<td>50</td>
<td>17</td>
</tr>
<tr>
<td>People can engage in BDSM without being physically harmedc</td>
<td>1</td>
<td>4</td>
<td>12</td>
<td>55</td>
<td>28</td>
</tr>
<tr>
<td>Most practitioners of BDSM are psychologically healthy individualsd</td>
<td>2</td>
<td>16</td>
<td>50</td>
<td>29</td>
<td>4</td>
</tr>
<tr>
<td>A psychologically healthy individual does not engage in BDSM activities</td>
<td>15</td>
<td>49</td>
<td>22</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Sexual masochism can be practised in healthy waysd</td>
<td>2</td>
<td>12</td>
<td>22</td>
<td>52</td>
<td>13</td>
</tr>
<tr>
<td>People can engage in BDSM without experiencing emotional problemsd</td>
<td>2</td>
<td>9</td>
<td>21</td>
<td>54</td>
<td>14</td>
</tr>
<tr>
<td>Sexual sadism is unhealthy</td>
<td>8</td>
<td>30</td>
<td>33</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td><strong>Problems presumed to be associated with BDSM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who engage in BDSM are more likely to become involved in domestic violence</td>
<td>17</td>
<td>46</td>
<td>32</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Individuals who engage in sexually sadistic behaviours are likely to be abusive in other areas of their lives</td>
<td>13</td>
<td>42</td>
<td>32</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Parents who engage in BDSM are more likely to abuse their children</td>
<td>29</td>
<td>48</td>
<td>21</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>People who engage in submissive behaviours suffer from poor self-esteem in other areas of their lives</td>
<td>11</td>
<td>42</td>
<td>33</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>People who engage in sexually dominant behaviours are aggressive in other areas of their lives</td>
<td>11</td>
<td>50</td>
<td>32</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td><strong>Beliefs about treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDSM interests can be eliminated through psychotherapy</td>
<td>14</td>
<td>44</td>
<td>34</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>It could be helpful to refer individuals troubled by their BDSM desires to a BDSM support groupa</td>
<td>1</td>
<td>6</td>
<td>28</td>
<td>56</td>
<td>10</td>
</tr>
<tr>
<td>BDSM should be eliminated through psychotherapy</td>
<td>22</td>
<td>48</td>
<td>25</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Notes: BDSM, bondage and discipline (BD), dominance and submission (DS) and sadism and masochism (SM).
aReverse keyed.
Table 2. Means, SDs and correlations between study variables.

<table>
<thead>
<tr>
<th></th>
<th>Mean (SD)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total attitudes score</td>
<td>43.0 (10.11)</td>
<td>–</td>
<td>0.24*</td>
<td>−0.12*</td>
<td>−0.27*</td>
<td>−0.13*</td>
<td>0.37*</td>
<td>−0.10*</td>
<td>−0.25*</td>
</tr>
<tr>
<td>2. Age</td>
<td>49.9 (10.69)</td>
<td>–</td>
<td>0.00</td>
<td>0.03</td>
<td>0.13*</td>
<td>−0.03</td>
<td>−0.05</td>
<td>0.09*</td>
<td>0.07*</td>
</tr>
<tr>
<td>3. Community diversity</td>
<td>2.4 (1.21)</td>
<td>–</td>
<td>−0.09*</td>
<td>0.10*</td>
<td>−0.12*</td>
<td>0.02</td>
<td>0.07</td>
<td>0.04</td>
<td>0.06</td>
</tr>
<tr>
<td>4. Sociopolitical philosophy</td>
<td>2.8 (0.92)</td>
<td>–</td>
<td>−0.08*</td>
<td>−0.11*</td>
<td>−0.08*</td>
<td>0.07</td>
<td>0.06</td>
<td>0.04</td>
<td>0.03</td>
</tr>
<tr>
<td>5. BDSM-identified clients</td>
<td>6.6 (12.41)</td>
<td>–</td>
<td>−0.30*</td>
<td>0.23*</td>
<td>0.25*</td>
<td>0.28*</td>
<td>0.44*</td>
<td>–</td>
<td>0.34*</td>
</tr>
<tr>
<td>6. Self-perceived competence</td>
<td>n/a</td>
<td>–</td>
<td>−0.28*</td>
<td>−0.44*</td>
<td>–</td>
<td>0.34*</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>7. Number of types of graduate BDSM trainings</td>
<td>0.51 (0.95)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.34*</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>8. Number of types of additional BDSM trainings</td>
<td>1.06 (1.22)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.34*</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

Notes: Higher scores on the attitudes measure indicate more negative attitudes. Higher scores on community diversity show more diverse communities. Higher scores on sociopolitical philosophy indicate a more liberal philosophy. Self-perceived competence was a dichotomous yes/no rating coded 0/1. BDSM, bondage and discipline (BD), dominance and submission (DS) and sadism and masochism (SM).

*p < 0.05.
Exploratory analyses examined whether socio-demographic variables predicted attitudes towards BDSM. Older participants reported more negative attitudes, $r = 0.25$, $p < 0.05$. Males ($M = 43, SD = 11.37$) and females ($M = 44, SD = 11.52$, $t(745) = -1.18$, $p = 0.238$) did not differ in their attitudes towards BDSM. Ethnicity was not examined due to lack of ethnic diversity among the participants (i.e. the sample was 93% Caucasian). Survey participants living in more diverse communities reported more accepting attitudes towards BDSM, $r = 0.09$, $p < 0.05$. Although the correlation is statistically significant, community diversity does not contribute meaningful variance to the prediction of attitudes, $r^2 = 0.0081$. Survey participants describing their sociopolitical philosophy as more conservative reported more negative attitudes towards BDSM, $r = -0.27$, $p < 0.05$. This effect size was medium ($r^2 = 0.073$); thus, only 7% of the variance of attitudes was predicted by sociopolitical philosophy.

Discussion

The primary purpose of this research was to assess whether psychotherapists endorse commonly held negative beliefs about BDSM and to identify factors associated with perceptions of BDSM. Seventy-six per cent of the sample had seen at least one client who identified as participating in BDSM. This finding is consistent with the findings of Janus and Janus (1993) who found that people participating in alternative sexual behaviours are a sizable minority in our communities and that therapists are likely to encounter clients who identify as BDSM practitioners.

Contrary to the censure and pathologising anticipated by members of the BDSM community (Kolmes et al., 2006; Stiles & Clark, 2011), the majority of clinicians did not universally equate these unconventional activities with individual psychopathology or dysfunctional relationships. Even with a significant percentage of uncertain respondents (21%), most clinicians (68%) endorsed that people can engage in BDSM without experiencing emotional problems. Consistent with expert treatment recommendations (Kleinplatz & Moser, 2004; Lawrence & Love-Crowell, 2008; Nichols, 2006) a significantly large amount of clinicians (70%) disagreed with targeting BDSM behaviours for reduction without the client specifically saying that was the goal for treatment, while 25% were unsure. Thus, overall, therapists’ beliefs appear consistent with a few established recommendations that BDSM should not be considered as a central therapeutic issue if it is only peripherally related to the client’s presenting concerns (Kleinplatz & Moser, 2004; Lawrence & Love-Crowell, 2008; Nichols, 2006).

Although respondents tended to avoid characterising BDSM practitioners as deviant, they did not consistently endorse a clear acceptance of BDSM as a benign variation in sexual behaviour. On a number of items, a substantial percentage of respondents indicated that they were unsure how to answer, neither agreeing nor disagreeing. For example, 50% of respondents indicated uncertainty as to whether most of those practising BDSM are psychologically healthy. This likely reflects an acknowledgement of the diversity of people and BDSM practices as well as difficulty providing an overall characterisation applicable to the entire group. However, another contributor to this uncertainty is a lack of empirical research describing BDSM participants and activities and a subsequent lack of consensus among researchers or experts. Currently, studies on BDSM are often small and qualitative; however, a few scholarly articles offer clinicians some clinical, objective data about this sexual subculture. For instance, Connolly (2006) assessed levels of
psychopathology in BDSM practitioners and discovered prevalence rates approximate to those established in the general population. Conversely, narcissistic characteristics and dissociative symptoms were slightly higher than in the general population, but these were the most notable differences indicating BDSM practitioners should not be characterised as pathological (Connolly, 2006). Additional quantitative research is needed to provide further objective data about sexual minorities.

Determining whether a psychotherapist is competent to provide services to diverse clients is difficult given the dynamic nature of competency (Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010). One rough measure of whether a therapist has the requisite knowledge and skills to work with sexual minority clients is the extent of training received. We found that the majority of psychotherapists had not had any formal training that addressed issues of sexual diversity, such as BDSM. We found relatively little variance in the graduate training as most participants had little to no exposure to information about the BDSM subculture, practices and participants, while reports of postgraduate training included a much wider range of information seeking and exposure. Furthermore, training on BDSM practitioners while in graduate school was not associated with attitudes at the same level as training sought after graduation. Although the knowledge and skills gained through training itself may directly influence attitudes, it is also likely that interest in working with BDSM-identified clients is associated with both less prejudicial views about BDSM and a greater likelihood of therapists seeking training opportunities. Overall, survey respondents reported professional behaviours consistent with ethical recommendations for providing services to minority groups; over half of the participants reported seeking additional training after licensure and those participants who did not perceive themselves as competent to counsel clients engaging in BDSM were less likely to see those clients.

We hypothesised that therapists who had more BDSM-identified clients would express less negative attitudes towards BDSM, but the number of BDSM-identified clients seen by the therapist related very little to attitudes. However, self-perceived competence did significantly relate to attitudes. Consistent with recent treatment recommendations promoting acceptance of client sexuality (Kleinplatz & Moser, 2004; Lawrence & Love-Crowell, 2008; Nichols, 2006), respondents reporting more accepting attitudes were more likely to rate themselves as competent to treat BDSM-identified clients.

While it appears that therapists are recognising that more training and greater knowledge are needed to provide effective services, it is alarming that 76% have seen a client reporting BDSM involvement while only 48% rated themselves as competent in this area. This clearly suggests some therapists are seeing these clients despite an awareness of their lack of preparation. Perhaps there are no clear referral options because very few clinicians specialise in sexual minorities. Those therapists who do have expertise in this area should be encouraged to provide training for other professionals and inform their colleagues of their availability for consultation and referral. The increase in distance communication technology (e.g. video conferencing, web-based communication) should make it easier for clinicians to take advantage of consultation with experts regardless of their location. For example, The National Coalition for Sexual Freedom (2011) has compiled a database of ‘Kink Aware Professionals’ (KAP) who have identified themselves as ‘informed about the diversity of consensual, adult sexuality’ (https://ncsfreedom.org/resources/kink-aware-professionals-directory/kap-directory-homepage.html).

Socio-demographic variables were predictive of attitudes towards BDSM. For instance, older therapists were more likely to report negative perceptions of BDSM and those identifying with a more liberal sociopolitical philosophy reported more accepting views. This information is important because people in the BDSM community may be able to use these
data when seeking treatment providers. BDSM participants seeking treatment can look for younger, liberal counsellors, if possible; however, personal characteristics of therapists are often not publicised and simply seeking young, liberal counsellors is obviously not an adequate plan for potential clients. BDSM clients should seek therapists identified as BDSM friendly or specialising in therapy with sexual minorities when possible. Those living in areas where there are few if any therapists with expertise treating sexual minorities may be able to access therapists practising in other locations via distance communication technology.

To locate a BDSM-friendly treatment provider, potential consumers have access to a few resources, specifically through the Internet, that would assist them in this endeavour. For example, APA provides a website (http://locator.apa.org/) that is publicly available to allow for potential clients to search for treatment providers that best suit their needs. There is an option in the search criteria to choose specialty areas pertaining to sexual issues. However, it is presented in a manner that implies the potential client is seeking help for sexual issues and not just interested in locating a clinician who is culturally sensitive and trained to work with sexual minorities. BDSM practitioners should not let this deter them from using the APA website and this particular search option to locate a therapist competent in sexual minority issues. Additional resources available include KAP, which is a resource for the general public as well as clinicians. Furthermore, many local and national BDSM organisations have referral sources available for members of their community that they know to be safe and competent professionals.

This research is not without limitations. The high non-response rate and the large number of respondents who chose to or were unable to finish the entire survey (due to errors in survey programme) resulted in only about 9% participation rate. This was less than the expected response rate based on the survey methodology literature (Van Horn, Green, & Martinussen, 2009). Although the sample of survey completers was representative of the larger sample of attempters, it is clear that this is only a small sample of therapists, and it is probable that therapists with greater interest in or experience with sexual subcultures were more likely to participate. Regardless, future research should survey a more representative sample of mental health professionals to achieve greater generalisability.

The Perception and Attitudes Survey was adapted from Kolmes et al. (2006) to assess therapists’ perceptions of the BDSM community, lifestyle and participants. We believe that the presence of the predicted relations between the BDSM perceptions scores and other professional experience and competence variables provides preliminary support for the validity of the perceptions measure, although further validation of this questionnaire is needed.

Competency issues are a lingering concern and more research on practitioners of BDSM would assist clinicians to attain greater understanding of their experiences and motivations and therefore increasing their level of competence to treat this sexual minority. Without further empirical knowledge of the community itself, therapists may feel at a loss when faced with the challenge of treating a population with which they are likely unfamiliar.

Nichols (2000) highlighted a parallel between the 1970s gay community and the BDSM community from the early twenty-first century. Specifically, she compared how many individuals in both minority groups struggled with the same internalised shame regarding their sexual interests (Nichols, 2000, 2006). These similarities indicate that the literature regarding psychological practice with LGBT clients can provide a model for the types of research that may inform ethical and competent services with BDSM practitioners seeking psychotherapy. For instance, do BDSM practitioners typically present with universal
problems (e.g. relationship distress, self-esteem, depression) as has been found with LGBT clients (Murphy, Rawlings, & Howe, 2002)? In what ways might participation in a BDSM community interact with universal problems as well as present problems unique to this group (Lyons et al., 2010)? An example of the latter would be divorce and child custody issues (Klein & Moser, 2006). These are common problems which cause distress to most healthy individuals, but on combining sexual activities stigmatised by the general public, a therapist may face legal and mental health issues very unique to BDSM. While some issues may be similar to LGBT clients, such as concern over stigma and disclosure (i.e. ‘coming out’), other issues may be distinct to BDSM clients, such as disclosing BDSM desires to a vanilla (or non-BDSM-participating) partner or negotiating limits or role boundaries in a BDSM relationship (Nichols, 2006).

Future research focused on promoting cultural competence for treatment issues unique to BDSM practitioners would offer therapists resources not yet available in the literature. This study established that the majority of therapists do not explicitly stigmatise BDSM practitioners. In addition, they have the ability to attain competence in order to treat these individuals as demonstrated by the awareness of training and supervision required by APA. However, it is also evident that psychologists are not receiving the necessary training and do not have the educational foundation for working with BDSM clientele. Many studies offer culturally competent treatment strategies for working with sexual minorities such as LGBT individuals (Burckell & Goldfried, 2006; Lyons et al., 2010; Murphy, Rawlings, & Howe, 2002). Only a few studies and articles compose the literature specific to BDSM cultural competence (i.e. Kleinplatz & Moser, 2004; Kolmes et al., 2006; Lawrence, & Love-Crowell, 2008; Nichols, 2006) to provide essential information for practising psychologists. Additional guidelines addressing the issues mentioned in the preceding paragraph are needed, as well as education about the possible issues unique to this population. Future studies should not only clarify and educate psychologists about the potential problems faced when treating BDSM individuals, but also establish and validate effective treatment strategies. The next logical step would be cultural competency courses specific to BDSM and appropriate competency courses should have substantial educational research to inform practices and validate treatment approaches.

Research on the BDSM community poses several challenges given the negative judgement they often perceive. They are typically fearful of stigmatisation and research that would contribute to the stereotypes and biases against them (Nichols, 2006). Few openly display this aspect of their lives even to close family and friends (Stiles & Clark, 2011). These challenges limit the breadth and depth of current research; however, with more studies being published about stigmatisation experienced within this sexual minority group and continued efforts to address these concerns opportunities are becoming more available.

Despite deficits in the current literature and the difficulties researchers face, therapists should anticipate that individuals engaging in BDSM will present for services and should either be prepared to provide competent services or have a plan for making an appropriate referral. Proper clinical care for sexual minority clients requires therapists to develop an awareness of their own sexual values and a knowledge base about diverse sexual practices (Ford & Hendrick, 2003; Kleinplatz & Moser, 2004; Lawrence & Love-Crowell, 2008; Nichols, 2006).

Notes
1. We assume that recipients of the original recruitment email forwarded the survey link to interested peers. Although inclusion of these self-selected participants may bias this sample in favour
of those with experience and interest in sexual subcultures, the initial, exploratory nature of the study benefits from inclusion of the larger sample size.

2. Technical problems with the survey software resulted in a large number of incomplete surveys. The complexity of the questionnaire and high volume of simultaneous responses overloaded the survey site not allowing respondents to complete the survey. Some participants were able to finish the survey at a later time.

Notes on contributors

Katherine Kelsey graduated from Midwestern State University, in 2009, with an MA in Clinical Psychology. Currently she is a Doctoral Candidate studying Clinical Psychology at the University of North Texas. Her research interests include psychopathy and response styles.

Dr. Beverly L. Stiles earned her PhD in Sociology from Texas A&M University in 2000. She is currently a Full Professor and Chair of the Department of Sociology at Midwestern State University. Her research interests are in the areas of sexual minorities, deviant behaviour and social issues related to HIV.

Dr. Laura Spiller graduated from the University of Texas at Austin with a BA in Psychology. She earned her PhD in Clinical Psychology from the University of Houston in 2000. She is currently an Assistant Professor in the Department of Psychology at Midwestern State University. Her research program focuses on identifying, measuring and modifying individual and community-based risk factors for sexual coercion in young adult dating relationships.

Dr. George M. Diekhoff earned his PhD in Experimental Psychology from Texas Christian University in 1977. He is now Regents Professor and Chair of the Department of Psychology at Midwestern State University. His research interests are in applied psychology.

References


