

## **Psychotherapists' Experience with Clients Who Engage in Consensual Sadomasochism: A Qualitative Study**

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*Consensual sadomasochism (Bondage and Discipline, Dominance and Submission, Sadism and Masochism; BDSM) is relatively common, but the experience of psychotherapists who work with clients who engage in BDSM has received little study. We conducted semi-structured interviews with 14 therapists experienced in working with BDSM clients. Interviews were recorded, transcribed, and analyzed for thematic content. Therapists emphasized the importance of cultural competence, including a nonjudgmental attitude and knowledge of BDSM practices and cultural values. BDSM was rarely a central issue in therapy; relationship issues were clients' most common presenting concerns. Therapists who practiced BDSM themselves often encountered boundary issues with clients.*

A significant minority of U.S. adults regularly engages in consensual sexual behaviors involving the infliction of pain or intense sensation, use of restraint, or power exchange. These behaviors are commonly known by the acronym BDSM (Bondage and Discipline, Dominance and Submission, Sadism and Masochism; Kleinplatz & Moser, 2004; Kolmes, 2003). BDSM encompasses a wide variety of activities. Elements that are frequently a part of BDSM activity include a relationship involving dominance and submission, infliction of pain (e.g., by spanking or flogging), deliberate humiliation (e.g., verbally or with humiliating clothing), physical restriction (e.g., using handcuffs or straitjackets), and the use of fantasy or role-playing (Alison, Santtila, Sandnabba, & Nordling, 2001; Sandnabba, Santtila, Alison, & Nordling, 2002). Sexual partners may engage in BDSM as an occasional or regular part of their

sexual activity; BDSM activity sometimes extends to nonsexual aspects of a relationship as well (Moser, 1988).

Population-based prevalence estimates for participation in BDSM are not available for the United States, but in a representative sample of Australian adults, 2.0% of men and 1.4% of women reported having engaged in BDSM activity with a sexual partner in the previous 12 months (Richters, Grulich, de Visser, Smith, & Rissel, 2003). Studies of U.S. college students have found higher figures, with 3–4% of men and women reporting having engaged in BDSM activities in the previous 3 months and 15–20% reporting having done so at some time in their lives (Hsu et al., 1994; Person, Terestman, Myers, Goldberg, & Borenstein, 1992; Person, Terestman, Myers, Goldberg, & Salvadori, 1989). By comparison, in a representative sample of U.S. adults, 2.7% of men and 1.3% of women reported having had a same-sex sexual partner in the previous 12 months and 7.1% and 3.8%, respectively, reported having had a same-sex partner since puberty (Laumann, Gagnon, Michael, & Michaels, 1994). These figures suggest that BDSM activity in adults may be almost as prevalent as same-sex sexual activity. Just as most psychotherapists who work with adults can expect to encounter lesbian, gay, and bisexual (LGB) clients in their practices, they can also expect to encounter clients who engage in BDSM.

The comparison between BDSM and same-sex sexual activity is instructive. Until recently, homosexuality was considered to be a mental disorder, just as sexual masochism and sexual sadism, the clinical entities that encompass BDSM behaviors, are considered to be mental disorders in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 2000). Despite the nominal depathologization of homosexuality by psychiatrists (American Psychiatric Association, 1974) and psychologists (Conger, 1975) in the 1970s, some psychotherapists continue to hold inaccurate beliefs and negative attitudes about clients who engage in same-sex sexual behavior and continue to employ unhelpful or unethical practices with their LGB clients (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). In response to this problem, the American Psychological Association (APA) has published guidelines for conducting psychotherapy with clients who engage in same-sex sexual behavior (APA, 2000).

Similarly, many psychotherapists appear to have limited or inaccurate information concerning persons who engage in BDSM, to be uncomfortable working with such persons, to employ unhelpful or unethical practices with their BDSM clients, and to inappropriately pathologize BDSM activities. Kolmes (2003) noted that BDSM participants who completed an Internet-based survey concerning their psychotherapy experiences frequently reported that their therapists held misconceptions about BDSM and that they had needed to educate their therapists about BDSM practices. Ford and Hendrick (2003) found that practicing psychotherapists reported

being significantly more uncomfortable working with clients who engaged in BDSM than working with clients who engaged in same-sex sexual behavior or group sexual activity. In the survey by Kolmes (2003), both BDSM participants and psychotherapists described many instances of biased or unethical practices by therapists working with clients who engaged in BDSM, similar to those reported by Garnets et al. (1991) among therapists working with lesbians and gay men. A pervasive theme in these BDSM-participant and therapist accounts was the tendency by some therapists to regard consensual BDSM activities as unhealthy or pathological per se, despite language in the DSM (American Psychiatric Association, 2000) stating that sexual sadism and sexual masochism constitute mental disorders only when they cause significant distress or disability and evidence that sexual masochism in particular is "a fairly innocuous activity that is entirely compatible with an otherwise healthy, normal, successful approach to life" (Baumeister & Butler, 1997, p. 227).

Kleinplatz and Moser (2004) proposed the creation of guidelines for therapists who work with BDSM clients, similar to existing guidelines for therapists who work with LGB clients (APA, 2000). Their provisional recommendations were based on their own experiences and "the suggestions of those therapists who are experienced in working with BDSM clients" (Kleinplatz & Moser, p. 1). At present, however, there are few published data to inform the creation of experience-based clinical guidelines. The survey by Kolmes (2003) suggested some of the issues that need to be addressed; it also summarized the opinions of BDSM participants and therapists about helpful and problematic practices with BDSM clients. Bettinger (2002) addressed the boundary issues faced by therapists who work with BDSM clients and who themselves engage in BDSM (not an uncommon situation), based on his experiences and those of four other experienced therapists. With these exceptions, the perspectives of therapists who work with BDSM clients remain largely unexplored.

To address this issue, we undertook a qualitative study of the experiences of psychotherapists who had worked extensively with clients who engaged in BDSM. We hoped to explore a number of issues: What is it like to work with BDSM clients? What issues do these clients typically bring to therapy? What attitudes and practices contribute to successful therapeutic work with BDSM clients? Are there particular challenges related to diagnosis, ethical issues, or countertransference, in working with these clients? Are there particular rewards or opportunities for growth as a therapist?

## METHOD

### Participants

Participants were 14 licensed psychotherapists who had significant clinical experience working with clients who engaged in BDSM. Seven of the

therapists practiced in the Seattle metropolitan area and were recruited from a referral list maintained by the Seattle Sex-Positive Community Center, an organization with a large BDSM membership. Seven other therapists were recruited from the Internet-based Kink-Aware Professionals list ([www.bannon.com/kap](http://www.bannon.com/kap)); 4 of these 7 were contacted because they were known to the investigators from their publications or conference presentations concerning sexual minority issues, 1 was contacted based on the suggestion of another participant, and 2 were contacted at random from therapists practicing in the Chicago area, whom we targeted to increase the geographic diversity of our participants. Three therapists from outside the Seattle area practiced in the San Francisco Bay area, 2 practiced in the Chicago area, and 1 each practiced in the New York City and Atlanta areas. The therapists' mean age was 49 years ( $SD = 9$  years; range, 38–63) and they had practiced psychotherapy for a mean of 17 years ( $SD = 9$  years; range, 2–33). All therapists were of European-American ethnicity; 8 were women and 6 were men. Of the 8 female therapists, 4 identified as lesbian or gay, 1 identified as bisexual, 2 identified as straight or heterosexual, and 1 did not disclose her sexual orientation; 5 of the female therapists had themselves participated in BDSM, including all 3 who did not declare a lesbian, gay, or bisexual identity. Of the 6 male therapists, 4 identified as gay, 1 identified as bisexual, and 1 identified as straight or heterosexual; 4 of the male therapists had participated in BDSM, including the therapist who identified as heterosexual. All male therapists and 6 female therapists held doctoral degrees; 2 female therapists held master's degrees. The median number of BDSM clients the therapists estimated they had seen was 24 (range, 5–700).

## Procedures

We interviewed the therapist participants using a semi-structured interview. We developed preliminary interview questions based primarily on issues identified by Kolmes (2003). Using these items, we conducted a pilot interview with a therapist experienced in working with BDSM clients. This resulted in several questions being reworded, reordered, or eliminated. The final semi-structured interview, which is summarized in the Appendix, focused on (a) the therapists' demographic characteristics and development of expertise; (b) the nature and extent of their work with BDSM clients; (c) their observations concerning BDSM clients' characteristics, presenting problems, and therapeutic issues; (d) their thoughts concerning BDSM as a possible mental disorder, as defined by the DSM; and (e) the challenges and benefits, if any, of working with BDSM clients.

We contacted prospective participants by telephone or e-mail. Therapists who reported having worked with a minimum of three BDSM clients

and who agreed to participate signed an informed-consent document and received the list of interview questions by e-mail. Six of the 7 Seattle-area therapists were interviewed face-to-face; all the other therapists were interviewed by telephone. Therapists were encouraged to speak at whatever length they desired and to raise any issues they considered important. The duration of the interviews ranged from about 20 minutes to about 65 minutes. All interviews were recorded and transcribed verbatim for analysis. These procedures were approved by the Human Participants Review Committee of Argosy University, Seattle, Washington.

### Data Analysis

We began data analysis by individually reading the interview transcripts. We then jointly conducted a line-by-line microanalysis of the transcripts, using an open coding technique. This involved examining transcript text to identify and categorize significant thematic material and then comparing our impressions. Any disagreements were resolved by consensus. Thematic categories emerged quickly from the data, with most categories appearing in the first two or three transcripts analyzed. For each thematic category identified, we extracted relevant transcript excerpts. Word processing software was sufficient for this task and using it contributed to our familiarity with the data. During data analysis, we compared new thematic material to previously coded excerpts in order to assign categories, using the constant comparative method (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Whenever a new category emerged, we re-examined previously coded transcripts for possible instances of the new category. As we read, analyzed, and coded the interview transcripts, we created memos concerning emerging themes and patterns. Interrelations between subsets of thematic categories quickly became evident and a coherent set of themes emerged from the interview data.

## RESULTS

We describe the therapists' experience with BDSM clients by considering their observations concerning three interrelated elements of that experience: (a) therapists' attitudes and knowledge, (b) BDSM clients' issues and characteristics, and (c) considerations in conducting therapy with BDSM clients. These elements of the therapists' experience and the specific observations relevant to each are summarized in Table 1. To directly convey the flavor of the therapists' responses, we include verbatim interview excerpts that address these elements and observations.

**TABLE 1.** Therapists' Observations about Psychotherapy with BDSM Clients

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Observations about therapists' attitudes and knowledge:
Cultural competence is essential to working effectively with BDSM clients.
An accepting, nonjudgmental attitude is an element of cultural competence.
Knowledge about BDSM practices and values is an element of cultural competence.
Refusal to pathologize BDSM is an element of cultural competence.
Seeking supervision or consultation as appropriate is an element of cultural competence.
Therapists' experience of sexual minority status contributes to cultural competence.
Therapists' knowledge about BDSM comes from many sources.
Observations about BDSM clients' issues and characteristics:
BDSM is typically a background issue but is occasionally a central issue in therapy.
Shame and guilt are frequently issues for BDSM clients.
Relationship concerns are the most common presenting issue of BDSM clients.
"Lifestyle" BDSM can be a challenging relationship issue.
Coexisting mental health problems can create difficulties for BDSM clients.
BDSM clients often bring significant strengths to therapy.
Observations about the conduct of psychotherapy with BDSM clients:
Therapists who practice BDSM themselves often confront boundary issues.
Distinguishing between BDSM and physical or sexual abuse is usually not difficult.
Concerns about unsafe BDSM practices are infrequent.
Transference issues involving sexuality and power are not uncommon.
Countertransference issues include revulsion, sexual arousal, and advocacy.
Stigma associated with BDSM can affect therapists who work with BDSM clients.
Working with BDSM clients contributes to professional growth.

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## Therapists' Attitudes and Knowledge

### CULTURAL COMPETENCE IS ESSENTIAL TO WORKING EFFECTIVELY WITH BDSM CLIENTS

Cultural competence was the most important theme discussed by the therapist participants, who considered such competence essential to the conduct of effective therapy with BDSM clients. Therapists believed that cultural competence primarily involved two elements: (a) an open, accepting, nonjudgmental attitude toward BDSM clients and their activities and (b) knowledge about BDSM practices and cultural values.

People who practice BDSM seek a therapist who has some level of knowledge and is open to their lifestyle . . . so that it can be a nonissue, or so that they can talk about it with the ease that they might talk about any other aspect of their sex life. (Therapist A)

### AN ACCEPTING, NONJUDGMENTAL ATTITUDE IS AN ELEMENT OF CULTURAL COMPETENCE

Therapists believed that an accepting, nonjudgmental attitude toward BDSM was the most crucial element of cultural competence. Every therapist we interviewed discussed this issue. Some described situations in which clients had been alienated or traumatized by the unaccepting or judgmental attitudes of previous therapists:

A lot of people come in and . . . their concern is that I'm not going to think that . . . they are crazy or sick. In many cases they have had previous therapy experiences and the therapist couldn't handle it. (Therapist B)

KNOWLEDGE ABOUT BDSM PRACTICES AND VALUES IS AN ELEMENT OF CULTURAL COMPETENCE

Ten of the 14 therapists also mentioned the importance of having adequate knowledge of BDSM practices, cultural values, and associated phenomena, such as polyamory (partnered relationships involving more than two persons):

[Therapists] really need to learn about this world of BDSM. . . . Everything that we've learned about multi-cultural stuff applies here. It's very useful to look at [BDSM] as a separate culture with separate norms, different sets of expectancies. (Therapist C)

REFUSAL TO PATHOLOGIZE BDSM IS AN ELEMENT OF CULTURAL COMPETENCE

Most therapists believed that, to work effectively with BDSM clients, it was important not to pathologize BDSM activities and not to regard BDSM as a mental disorder per se:

[The therapist must] not make them feel like what they are doing is wrong or inherently bad or harmful. (Therapist D)

Most therapists had never encountered instances in which BDSM had been associated with sufficient distress or dysfunction to meet DSM diagnostic criteria for sexual masochism or sexual sadism. A few therapists, however, reported that they had occasionally encountered situations in which BDSM activities might meet these DSM criteria:

I think it's infrequent but not nonexistent. I have certainly had clients come in and have a lot of turmoil over the issue. It's certainly there, but infrequent. (Therapist E)

SEEKING SUPERVISION OR CONSULTATION AS APPROPRIATE IS AN ELEMENT OF CULTURAL COMPETENCE

Several therapists emphasized the importance of obtaining supervision or consultation when appropriate as an important aspect of practicing competently with BDSM clients.

If you're getting to an area that's going to start pressing a lot of your buttons—and talk of sexuality and BDSM especially is going to press a lot of buttons—get good consultation around that. (Therapist F)

#### THERAPISTS' EXPERIENCE OF SEXUAL MINORITY STATUS CONTRIBUTES TO CULTURAL COMPETENCE

Every therapist reported personal experience as a member of a sexual minority, either identifying as gay, lesbian, or bisexual, having engaged in BDSM activities, or both. Many therapists believed that this personal experience had contributed significantly to their empathy for BDSM clients and to their commitment to working with them:

My experiences, I think, as a gay man have very much shaped my commitment to approaching BDSM folks in the same way and being interested in working with them. . . . I know a little bit about what it's like to feel as though you may or may not be understood, you may be pathologized without being considered first as an individual. (Therapist G)

Many therapists reported that their personal experience with BDSM, either in the form of direct participation or observation of BDSM activities engaged in by others, contributed significantly to their clinical work:

Having some experience gives me a sense of . . . the kinds of questions to ask that someone who doesn't have the personal experience simply may not know to ask. So, it's just another base of knowledge and empathy, sympathy, receptivity, understanding. (Therapist A)

#### THERAPISTS' KNOWLEDGE ABOUT BDSM COMES FROM MANY SOURCES

Therapists mentioned learning about BDSM from a variety of sources, including engaging in BDSM themselves, attending BDSM community events, reading books and information on the Internet, attending continuing education courses, and listening to their clients.

First, hands-on experience. . . . Second, attending many classes and conferences where genuine experts presented their knowledge. Third, extensive reading from the growing shelf of participant literature. (Therapist H)

## BDSM Clients' Issues and Characteristics

BDSM IS TYPICALLY A BACKGROUND ISSUE BUT IS OCCASIONALLY A CENTRAL ISSUE IN THERAPY

Most therapists reported that their BDSM clients typically come to therapy with presenting issues that are only indirectly related to BDSM, although occasionally BDSM is itself the presenting issue:

Most of the people who come to me out of that community are not coming to me with problems about . . . BDSM particularly. They are coming to me with the same kinds of problems [with which] any other human being or couple might come to me. (Therapist H)

Some therapists felt that an important element of culturally competent practice with BDSM clients was the ability to keep BDSM from becoming a central issue in therapy when it is genuinely peripheral to the client's concerns.

A lot of times they are not coming in because there is a problem with BDSM. . . . [One should not] turn the focus into that instead of what they really came for, which may not be anything to do with their BDSM practices. (Therapist D)

SHAME AND GUILT ARE FREQUENT ISSUES FOR BDSM CLIENTS

Some therapists observed that shame and guilt were common therapy issues for many BDSM clients, regardless of their presenting concern:

A common problem is the shame in itself, people feeling that they are all alone and that there is something inherently wrong with them. (Therapist F)

RELATIONSHIP CONCERNS ARE THE MOST COMMON PRESENTING ISSUE OF BDSM CLIENTS

Several therapists observed that relationship concerns are the most common reason that BDSM clients seek psychotherapy:

Usually what they come in for [is] . . . compatibility issues or issues of how to deal with "people in my life who don't know about this side of me." . . . It's often relationship issues. (Therapist B)

Some therapists noted that their BDSM clients often reported difficulty finding partners who shared their interest. Disparate levels of interest in BDSM within established couples was mentioned as another common relationship issue.

Therapists reported that, in heterosexual couples, the male partner typically expresses greater interest in BDSM than the female partner:

[One of the] predominant problem areas [is] where one partner is interested in pursuing some form of dominant-submissive relationship . . . and the other is turned off by the very idea. In those instances, . . . it is usually the man who is interested in the BDSM and the woman who is not, in a heterosexual relationship. (Therapist A)

Disparate levels of interest in BDSM within couples can be especially problematic when the more-interested partner wants the less-interested partner to dominate him or her:

Very often you'll have somebody that doesn't want to be mean to their partner, when their partner is looking for dominance. No matter how hard the "vanilla"<sup>1</sup> partner tries, they can never get the attitude right. (Therapist I)

#### "LIFESTYLE" BDSM CAN BE A CHALLENGING RELATIONSHIP ISSUE

"Lifestyle" BDSM relationships, where dominance and submission are not confined to sexual activity but are extended to involve many or all aspects of the relationship, were sometimes described as especially challenging or problematic:

People in [lifestyle BDSM] relationships: That's a really tough one for therapists. . . . The question of whether it's healthy or unhealthy is huge. And I don't think anyone really, really, understands it completely or has the answers. (Therapist A)

Some therapists felt that healthy, long-term relationships precluded lifestyle BDSM arrangements:

Where I think they run into trouble is when they try to make it real, like, "This is the way our real relationship should be," rather than having it be play within enclosed boundaries. (Therapist J)

One therapist reported, however, that facilitating lifestyle BDSM relationships by helping clients create contracts was a routine aspect of therapeutic work:

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<sup>1</sup>In BDSM parlance, the term *vanilla* denotes conventional sexual interests and, specifically, a lack of interest in BDSM.

With people who are into the scene really seriously, into the BDSM lifestyle, I help them with contracts, safe contracts, relationship contracts. (Therapist I).

#### COEXISTING MENTAL HEALTH PROBLEMS CAN CREATE DIFFICULTIES FOR BDSM CLIENTS

Mental health problems or conditions that therapists mentioned having observed in their BDSM clients included anxiety, depression, bipolar disorders, attention deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder, dissociative identity disorder, and personality disorders, especially borderline personality disorder. Histories of physical or sexual abuse were also commonly mentioned. A few therapists believed that coexisting mental health problems were more prevalent among BDSM clients:

I wish I could give you a politically correct answer but, yes, I think there is a higher frequency of dual diagnoses.<sup>2</sup> (Therapist E)

Other therapists doubted that the prevalence of mental health problems in BDSM clients was higher than in other clinical populations:

I do see people with personality disorders and depression within this community, but I don't think that it would be any greater than the rest of the population. (Therapist I)

A few therapists observed that, in clients with histories of physical or sexual abuse, questions sometimes arose about whether BDSM activities might constitute an inappropriate reenactment of past abuse or might precipitate traumatic reexperiencing of past abuse.

A lot of times I'll be seeing clients who have a history of sexual abuse or some kind of physical abuse. . . . There have been times where I've been concerned that someone's involvement in BDSM is a kind of acting out, or it's retraumatizing them. (Therapist K)

None of the therapists suggested, however, that histories of abuse were more common in BDSM clients than in other clinical populations.

Some therapists felt that BDSM activities and relationships were particularly challenging and potentially problematic for clients with coexisting

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<sup>2</sup>Based on the context of these remarks, Therapist E appeared to use the term *dual diagnosis* in a general sense, to denote any mental health diagnosis coexisting with the primary condition or diagnosis (i.e., BDSM), rather than in its more specific sense, to denote a chemical-dependency or substance-abuse problem coexisting with the primary condition or diagnosis.

mental health problems, especially those with personality disorders. One therapist suggested, however, that the negotiation skills required in BDSM play tended to weed out persons with significant psychopathology:

It takes really good boundaries to negotiate anything in sex and in particularly around dealing openly with fantasy and stuff. And mentally ill people really aren't good at that and they don't get very far. (Therapist L)

#### BDSM CLIENTS OFTEN BRING SIGNIFICANT STRENGTHS TO THERAPY

Several therapists reported that BDSM clients often possess characteristics that contribute positively to the therapeutic process:

They seem smarter than the average client, I think. . . They tend to be articulate, imaginative, creative people. (Therapist J)

#### Considerations in Conducting Therapy with BDSM Clients

##### THERAPISTS WHO PRACTICE BDSM THEMSELVES OFTEN CONFRONT BOUNDARY ISSUES

Nine of the 14 therapists had engaged in BDSM themselves and most of them reported having had to contend with boundary issues, including determining appropriate levels of self-disclosure and avoiding or managing potential or actual dual relationships with their BDSM clients:

The biggest [challenge] for me is keeping my private life separate from my life as a professional. . . . This is a community that likes to play out in public. I can't do that, it's unethical. (Therapist C)

##### DISTINGUISHING BETWEEN BDSM AND PHYSICAL OR SEXUAL ABUSE IS USUALLY NOT DIFFICULT

None of the therapists reported significant difficulty in distinguishing between BDSM activities and genuine instances of physical or sexual abuse that might endanger clients or third parties.

It's always been really clear where the line is, what is play and what might be abuse. There are lots of emotional abuses in all relationships and those things are present in BDSM relationships, [too]. . . . But it was generally clear to me what part of that was healthy and what part of that was abusive. (Therapist F)

A few therapists conceded, however, that distinguishing between BDSM and genuine abuse might not always be easy for less experienced therapists:

Some of the fine-line distinctions between [BD]SM and abuse, you kind of have to know what [BD]SM is about to make those distinctions. (Therapist L)

#### CONCERNS ABOUT UNSAFE BDSM PRACTICES ARE INFREQUENT

Only two therapists mentioned concerns about the safety of BDSM practices that clients had described; both instances involved the potential transmission of a blood-borne disease:

[There] is the rare case when I am aware there has been blood play or exposure to blood and I am aware that my client is HIV-positive or carrying a communicable disease. (Therapist E)

#### TRANSFERENCE ISSUES INVOLVING SEXUALITY AND POWER ARE NOT UNCOMMON

None of the therapists reported experiencing unusual transference reactions from BDSM clients. A few therapists discussed having to deal with sexualized transference reactions at times:

Occasionally, people are going to sexualize me or eroticize the therapeutic environment. But that isn't specific to BDSM; that could happen with anyone. (Therapist I)

Other therapists mentioned instances of what appeared to be BDSM-style interactions or enactments occurring within the therapy setting:

There have been times when I have had to exercise some caution about power struggles with "tops" [dominant partners] when doing therapy. (Therapist M)

#### COUNTERTRANSFERENCE ISSUES INCLUDE REVULSION, SEXUAL AROUSAL, AND ADVOCACY

A few therapists experienced occasional difficulties listening to descriptions of certain BDSM practices, although other therapists denied experiencing any such difficulties:

The nature of what thus far has been described to me has never left me feeling, like, repulsed or "I don't want to know" or "I feel too sickened" by something. That hasn't happened yet. Not that it couldn't, but it hasn't thus far. (Therapist G)

Sometimes therapists reported experiencing, or being concerned about displaying, sexual arousal during clients' descriptions of sexual activities:

These are clients whose own sexual interests are closer to my own than some of my other clients. The ethical issue is potentially being more turned-on than I would ordinarily. I think that every therapist is going to get turned-on by clients, so you deal with that the way you deal with any other ethical issue. (Therapist B)

One therapist commented on the need to avoid acting as an advocate for a particular attitude toward BDSM:

[I must be] sure that I don't . . . promote some moral agenda on my part, which might be very sex-positive or BDSM-positive, but allowing people to find their own way and their own answers. (Therapist F)

#### STIGMA ASSOCIATED WITH BDSM CAN AFFECT THERAPISTS WHO WORK WITH BDSM CLIENTS

A few therapists observed that, because BDSM is stigmatized in American society, working with BDSM clients is potentially stigmatizing, too:

There's part of my clientele that is very "vanilla"<sup>1</sup> and they would be shocked about that, so, as a BDSM-friendly therapist, I have to be careful about how I advertise. (Therapist N)

#### WORKING WITH BDSM CLIENTS CONTRIBUTES TO PROFESSIONAL GROWTH

Some therapists reported that working with BDSM clients had helped them to grow professionally, by encouraging them to think more deeply about sexuality and presenting them with unusual relationship issues:

It's a great opportunity to experience dynamics and relationship issues that don't always come up in the mainstream situation. (Therapist K)

### DISCUSSION

The purpose of this study was to learn about the attitudes and experiences of therapists who had worked extensively with BDSM clients, as a step toward formulating experience-based clinical guidelines for this sexual minority population. The central themes expressed by the therapist participants were consistent with the recommendations offered by Kleinplatz and Moser (2004) for work with BDSM clients and with the guidelines created by the APA (2000) for conducting therapy with LGB clients, although none of the therapists referred to these documents. The therapists' central theme of cultural competence, which included nonjudgmental acceptance, knowledge of BDSM cultural practices, refusal to pathologize, and appropriate use of

consultation, closely parallels the content of the first two APA guidelines for work with LGB clients, which emphasize that same-sex sexual behavior is not indicative of mental illness, that therapist attitudes and knowledge concerning LGB issues are relevant to clinical care, and that seeking consultation when indicated is an aspect of ethical practice (APA, 2000). Although we do not claim that the issues of LGB clients and BDSM clients are isomorphic, our results suggest that existing guidelines, experience, and research concerning therapy with LGB clients might inform and sensitize clinicians in formulating guidelines for psychotherapy with BDSM clients.

The therapists' observations concerning issues that BDSM clients bring to therapy were largely consistent with previous research. Most therapists felt that concerns related to BDSM *per se* were uncommon presenting issues, an opinion also expressed by most of the BDSM clients surveyed by Kolmes (2003). The observation that shame and guilt were prominent issues for many clients is also not unexpected, given the widespread pathologization of BDSM; Moser and Levitt (1987), for example, documented a high prevalence of guilt and shame among the male BDSM participants they surveyed. The therapists noted that the relationship issues BDSM clients discussed in therapy often concerned disparate levels of interest in BDSM within couples and observed that finding satisfying partnerships was especially challenging for submissive heterosexual men. Sandnabba et al. (2002), in their study of Finnish BDSM participants, also emphasized the difficulties masochistic heterosexual men faced in finding female partners with compatible interests. The therapists disagreed about the prevalence of coexisting psychological problems in BDSM clients, but a few therapists mentioned that abuse histories were not unusual in their BDSM clients. This is consistent with the report by Nordling, Sandnabba, and Santtila (2000) of an increased prevalence of self-reported childhood sexual abuse among BDSM participants.

The therapists' observations concerning psychotherapy with BDSM clients were mostly unsurprising. The need for sensitivity to boundary and dual-relationship issues by therapists who are members of small communities they serve, a concern many therapists discussed, is a recognized issue in psychotherapy practice (Brown, 1991; Morrow, 1999; Schank & Skovholt, 1997). Because BDSM activities involve sexuality and power, it is not surprising that transference and countertransference reactions involving these themes might emerge during therapy. The experienced practitioners we surveyed reported little difficulty in differentiating between BDSM and genuine abuse, while conceding that this might not always be easy for less experienced persons. Although potential stigmatization of clinicians who conduct therapy with BDSM clients was a genuine concern, some therapists reported that working with BDSM clients contributed to their professional growth.

All the therapist participants gave histories of personal experience as members of a sexual minority group. A majority had engaged in BDSM, consistent with a previous report by Kolmes (2003) and unsurprising, given

that many BDSM participants seek therapists who have personal experience with BDSM (Bettinger, 2002; Kolmes, 2003). Many gay men and lesbians likewise prefer therapists with similar sexual orientations (Liddle, 1997) and this kind of client-therapist matching has been associated with improved client benefit and satisfaction (Jones, Botsko, & Gorman, 2003; Liddle, 1996, 1997). It is less clear why a majority of the therapists were also LGB-identified, although this, too, has been reported previously (Kolmes, 2003). Some gay and lesbian therapists suggested that their experience as members of a sexual minority group made them more knowledgeable and accepting of minority sexuality generally, which we find entirely plausible.

### Limitations and Generalizability

Our use of a convenience sample and the small number of therapists we surveyed are the two most obvious limitations of this study. A larger or more representative sample of therapists might have produced somewhat different results. Consequently, extrapolation of our findings to other therapist populations should be undertaken cautiously. Our decision to limit the survey to therapists who were experienced with BDSM clients may also have influenced our results. Less experienced therapists, for example, might have reported greater difficulty distinguishing between BDSM and genuine abuse or more problematic countertransference. Because many of the therapists had personal experience with BDSM, they may have had a positive bias toward BDSM participants and activities; their opinions and recommendations should be interpreted accordingly. However, given the preference of many BDSM clients for therapists who share their interest, recruitment of a less-biased therapist sample with comparable experience might prove difficult.

We anticipate that experience-based clinical guidelines for psychotherapy with BDSM clients will eventually be created, based on the results of large-scale therapist surveys, such as that conducted by Garnets et al. (1991). Until such guidelines are available, our results suggest that therapists who report substantial experience working with BDSM clients are in general agreement with the recommendations offered by Kleinplatz and Moser (2004) and with the principles outlined in the APA guidelines for psychotherapy with LGB clients (APA, 2000). We propose that these recommendations and principles, along with the specific observations made by our therapist participants, provide a useful starting point for therapists seeking guidance in culturally competent practice with BDSM clients.

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**Appendix** Semi-structured Interview Questions

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1. Please describe your experience in working with clients who participate in BDSM.
  2. How did you come to work with a significant number of BDSM clients?
  3. What problems or issues have BDSM clients typically brought to therapy?
  4. To what extent have clients' BDSM practices been among the issues addressed in therapy?
  5. What have been the biggest challenges for you, if any, in working with BDSM clients?
  6. What ethical issues, if any, have come up in your work with BDSM clients?
  7. What have been the most important sources of information for you in learning about BDSM?
  8. The DSM-IV states that BDSM can constitute a mental disorder if it causes significant distress or disability. How frequently have your BDSM clients experienced enough distress or disability from their practices that you considered them to have a mental disorder?
  9. If an inexperienced colleague came to you for consultation about a BDSM client, what are the most important insights or suggestions you would want to share?
  10. To what extent, if any, has your sexual orientation influenced your work with BDSM clients?
  11. To what extent, if any, has your personal experience with BDSM influenced your work with BDSM clients?
  12. What personal challenges or emotional issues, if any, have you experienced in your work with BDSM clients?
  13. What have been the rewards or benefits to you, if any, from working with BDSM clients?
  14. What additional thoughts do you have about doing therapy with BDSM clients?
  15. Demographic information, if not obtained previously: Age, gender, ethnicity, highest degree earned, number of years in practice, estimated number of BDSM clients seen, sexual orientation, personal participation in BDSM (yes or no).
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