

Investigating Bias in Psychotherapy with BDSM Clients

Keely Kolmes, PsyD

Stanford University

Wendy Stock, PhD

Alliant International University

Charles Moser, PhD, MD

Institute for Advanced Study of Human Sexuality

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

Keely Kolmes is Staff Psychologist, Counseling and Psychological Services, Vaden Health Center, Stanford University. Wendy Stock is affiliated with Alliant International University. Charles Moser is Professor and Chair of the Department of Sexual Medicine, Institute for Advanced Study of Human Sexuality. Correspondence may be addressed: Keely Kolmes, Vaden Health Center, Stanford University, 866 Campus Drive, Stanford, CA 94305-8580.

[Haworth co-indexing entry note]: "Investigating Bias in Psychotherapy with BDSM Clients." Kolmes, Keely, Wendy Stock, and Charles Moser. Co-published simultaneously in *Journal of Homosexuality* (Harrington Park Press, an imprint of The Haworth Press, Inc.) Vol. 50, No. 2/3, 2006, pp. 301-324; and: *Sadomasochism: Powerful Pleasures* (ed: Peggy J. Kleinplatz, and Charles Moser) Harrington Park Press, an imprint of The Haworth Press, Inc., 2006, pp. 301-324. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST). E-mail address: docdelivery@haworthpress.com].

Available online at <http://www.haworthpress.com/web/JH>

© 2006 by The Haworth Press, Inc. All rights reserved.

doi:10.1300/J082v50n02_15

301

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.]

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

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

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

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

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

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

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

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

DISTINCTIONS MADE BY THE BDSM SUBCULTURE

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

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

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

ETHICAL CONSIDERATIONS

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

Standard 2.01(b) states:

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

In addition, 2.01(c) states:

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

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

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

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

