ABSTRACT

Title of Thesis: ARE WE READY TO SERVE? COUPLE AND FAMILY THERAPISTS' ATTITUDES TOWARD BDSM AND THEIR PERCEIVED COMPETENCE HELPING BDSM PRACTITIONERS

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Cultural competence is a core component of delivering effective psychotherapy to clients with diverse sexual lifestyles, including BDSM practitioners, who constitute a substantial minority of the population. Couple and Family Therapists (CFTs) are uniquely prepared to explore relationships and power dynamics, but no research has explored CFTs' psychotherapeutic relationship with BDSM practitioners. This study measures CFTs' BDSM attitudes, perceived competence, and the relationship between these and related professional factors. Results indicated that CFTs (n = 132) have positive attitudes and moderate perceived competence; attitudes and perceived competence were negatively correlated. Controlling for various professional factors such as AASECT certification, we found that participants with at least three or more hours of BDSM-specific training had significantly more positive attitudes and significantly higher perceived competence. Including these hours in graduate training or continuing education credits could help CFTs to feel more "kink aware" and competent to deliver ethical care for this population.

ARE WE READY TO SERVE? COUPLE AND FAMILY THERAPISTS' ATTITUDES TOWARD BDSM AND THEIR PERCEIVED COMPETENCE HELPING BDSM PRACTITIONERS

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Statement of the Problem

The continuing development of cultural competence in practicing psychotherapists is widely understood to be a core component of delivering efficacious therapeutic services for diverse populations (Dyche & Zayas, 2001; Goh, 2005; Moleiro, Freire, Pinto, & Roberto, 2018; Soto, Smith, Griner, Domenech Rodríguez, & Bernal, 2018) and is therefore an ethical mandate across various disciplines of psychotherapy (American Association of Marriage and Family Therapists [AAMFT], 2015; American Psychological Association [APA], 2016; Sommers-Flanagan & Sommers-Flanagan, 2015). Understanding cultural competence in therapy with people of different sexual orientations (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015; Henke, Carlson, & McGeorge, 2009; McGeorge, Carlson, and Toomey, 2015) and sexual lifestyles (Kolmes & Witherspoon, 2012) is a growing area of research interest, especially given findings that bias against diverse sexualities in mental healthcare is associated with poorer health outcomes among clients (Hoff & Sprott, 2009; Kolmes, Stock, & Moser, 2006; Shelton & Delgado-Romero, 2011).

However, diverse sexualities are still appreciably underrepresented in psychotherapy and psychotherapy research, and BDSM practitioners (i.e., those who practice BDSM) and the BDSM community, in particular, are among the most underserved alternative sexualities in psychotherapy and psychotherapy research. This is particularly unfortunate for the discipline of couple and family therapy (CFT), wherein extensive research and training in systemic thinking, interpersonal power dynamics, and relationally-focused therapy (Gehart, 2016) make fertile ground for exploring BDSM relationships, which are often centered on the novel, playful

expression of prescribed and sexualized power dynamics within relationships (Turley & Butt; 2015). Couple and family therapists (CFTs) specialize in interventions that occur at the interpersonal level of couples and families. In their work they not only conceptualize and address the contextualized cultural issues and cultural differences between therapist and client, but also the cultural and identity differences between family members (Ajayi, Marquez, & Nazario, 2013; Ariel, 1999). CFTs could, and perhaps should, be the leading academic figures in understanding BDSM relationships and in providing competent treatment. Even so, there continues to be a lack of standardized training on these identities and practices in existing training programs. The purpose of the current research is to assess the attitudes of CFTs toward "BDSM" (defined below) and their perceived competence in working with clients who identify, discuss, fantasize, and/or participate in this form of kink sexual play. It also aims to assess the degree to which attitudes towards and perceived professional competence in working with BDSM practitioners are associated with one another, and the possible influence of other professional factors (e.g., education level, BDSM-specific training experiences) on these beliefs.

Definitions and Identities

"Kink" refers to any non-conventional sexual practice or fantasy, such as foot fetishism, crossdressing, or furry play (Shahbaz & and Chirinos, 2016). The term "BDSM" is a variable acronym that encompasses various subgenres of alternative, fetish, or kink sexuality (Turley & Butt; 2015), and is defined by Langdridge and Barker as both a practice and an identity (2007, p. 4). In short, all BDSM practice is kinky, but not all kinks are considered BDSM.

Generally, it is rare for an individual to be interested in every possible practice that BDSM encompasses (Nordling, Sandnabba, Santtila, & Alison, 2006). Instead, the umbrella term embraces a wide variety of activities, practices, positions, and relationship styles that share

common threads (Carlström, 2017). The three overarching variations that fall within the practice of BDSM are: (1) B/D (bondage and discipline), which involves the use of physical or psychological restrains; (2) D/S (dominance and submission), which focuses on power exchanges between partners; (3) and S/M (sadism and masochism, hereafter referred to as SM), in which BDSM practitioners find sexual satisfaction in the act of either giving or receiving pain and humiliation (Weiss, 2011). BDSM practitioners view their kinks as significantly different and more enjoyable that the "vanilla" sex of the mainstream, and also perceive sexual BDSM as an emotional and mental experience that evokes deeper interpersonal connections than those available in physical, genital-focused stimulation (Simula, 2019a). That said, the expression of these practices varies widely between BDSM practitioners – for some individuals BDSM is a part of their sexual identity, whereas others experience it as a lifestyle, an activity, or as a fantasy or desire that is never acted upon (Kolmes, Stock, & Moser, 2006). Most succinctly, BDSM can be described as a "polymodal combination of identity, orientation, lifestyle, hobby and practice, based around a community" (Weiss, 2006b, p. 234).

A recent summary of findings on BDSM identity suggests broad support for BDSM as both a serious leisure activity and/or a sexual orientation, dependent upon the individual (Sprott & Williams, 2019). Regarding orientation, some studies have noted both a correspondence between lesbian, gay, bisexual, and queer (LGBQ) identities and BDSM sexualities (Pitagora, 2016, Waldura, Arora, Randall, Farala, & Sprott, 2016) as well as a significant historical connection between the development of the kink community and gay and lesbian leather and SM social organizations (Sisson, 2007). However, other research focusing on identity construction among BDSM practitioners has found unique kink-focused identities that differ from peers in other sexual communities (Chaline, 2010; Mosher, Levitt, & Manley, 2006). For instance, in a

qualitative study on disclosure and stigma management of BDSM practice, interviews revealed a series of possible milestones in BDSM identity development (Bezreh, Weinberg, & Edgar, 2012) that resemble the milestones of the classic stage models of gay, lesbian, and bisexual (LGB) identity development (Bilodeau & Renn, 2005), including confusion and possible shame upon the realization of BDSM interest in the teenage years and the need for disclosure in adult relationships that can often lead to fear and uncertainty. Although the "coming out" process for LGB people is certainly different, the similarities led Bezreh, Weinberg, and Edgar (2012) to question whether there should be more materials to help BDSM practitioners disclose their identities. Sprott and Hadcock (2018) have argued that clinical approaches for bisexual, queer, and pansexual clients could potentially be shared with BDSM practitioners. In their qualitative study, participants highlighted the category of "queer" as a meaningful intersection between bisexuality, pansexuality, and kink, as all three allow space for "the exploration of sexual orientation and gender identity in some unique ways" (Sprott & Hadcock, 2018, p. 226). Other research has suggested linking clinical practices for BDSM practitioners with other closely linked alternative sexualities, especially consensual non-monogamy and polyamory (Pitagora, 2016; Sprott, Randall, Davison, Cannon, & Witherspoon, 2017).

Despite these options, further research has revealed many distinct types of identities specific to BDSM subculture that have their own idiosyncrasies – dominant, master, top, submissive, slave, bottom, switch, pup, handler, daddy, mommy, baby girl/boy, fetishists, and many more – and each of these identities adds further complexity to a given individual and their process of disclosure and lifestyle (Hébert & Weaver, 2015; Nichols, 2006; Rogak and Connor, 2018). Though split on whether their BDSM identities are innate or learned, BDSM practitioners in one study indicated that their kinks were central to their sexuality (Langdridge & Butt, 2005).

In a related study of 128 male and 144 female BDSM practitioners, researchers also found that BDSM practitioners explanations for the development of their BDSM sexual preferences evenly split between essentialist (i.e., they were born with BDSM desires) and constructionist (i.e., they developed BDSM desires via social learning) (Yost & Hunter, 2012). Interestingly, I could not find any research that explores whether the physical practice of BDSM is central to BDSM identity – for instance, if someone cannot participate in BDSM activities due to a disability (Tellier, 2017) or fantasizes about BDSM but never acts on it, how does this alter their relationship to BDSM as an identity and therefore alter research into BDSM identity? In short, although there is much empirical work to be done in this area, it is clear that there are many issues of identity that are unique to the distinct experiences of the BDSM population, and it would be important for a clinician working with BDSM practitioners to have expertise in navigating these issues.

Prevalence

Unfortunately, there is limited data on the prevalence of BDSM in the general population, which in turn makes it difficult to cultivate or expend funds for research on the topic. Rates and estimations of prevalence vary widely, as do the definitions of kink and BDSM within the few studies that exist. As a result, Kelsey, Spiller, Diekhoff, and Stiles (2013) concluded that it is likely that clinicians will encounter clients who are involved with or have had experience with BDSM/kink. Reviewing older statistical data, Lawrence & Love-Crowell (2008) went so far as to suggest that therapists may encounter BDSM or kink clients as often as they encounter LGB clients.

Regarding BDSM in particular, there are only two recent prevalence studies I could find that specifically address BDSM practice. First, an oft-cited Australian phone survey found that

roughly 1.8% (n = 19,307) of sexually active people were involved with BDSM within the previous year (Richters, de Visser, Rissel, Grulich & Smith, 2008). However, this study is problematic for two primary reasons. First, the researchers failed to define BDSM for the participants, leaving the question open to interpretation. Second, the item requested that participants report activities performed only within the past year, whereas lifetime estimates would likely reflect greater prevalence of the behavior. A more recent and smaller study (n = 1,027) of Belgian participants was better-constructed, with a questionnaire that included both definitions of BDSM practice and a list of 54 distinct BDSM activities for which participants could rate their interest and involvement (Holvoet et al., 2017). Of the total sample, 46.8% reported performing at least one BDSM activity in their lives and 12.5% of the total sample indicating that they perform at least one BDSM activity on a regular basis.

Other research has surveyed the self-reported prevalence of behaviors and fantasies consistent with BDSM practice without asking participants to self-identify as BDSM practitioners. A study surveying 1,516 men and women about their sexual fantasies found that 53.3% of men and 64.6% of women had fantasies about being sexually dominated, and 59.6% of men and 46.7% of women had fantasies about dominating someone sexually (Joyal, Cossette, & Lapierre, 2015). In a later study, 1,040 adults were surveyed about the occurrence of paraphilic sexual interests in their experience and 23.8% of the sample reported having experienced masochistic desire (Joyal & Carpentier, 2017). Most recently, Apostolou and Khalil (2019) utilized evidence from a qualitative study to identify 13 aggressive and humiliating sexual acts that are commonly preferred and then asked respondents in a quantitative online study to rate the desirability of these acts. Of the men and women in the 1,026 person sample, 70% reported

finding at least one aggressive or humiliating sexual act desirable, and roughly half reported desire for at least three acts.

Relatedly, 65% of college students reported fantasizing about being tied up and 62% reported fantasizing about tying up someone else (Renaud & Byers, 1999). In a later study, 60% of college-age males reported fantasizing about bondage and sadism (Williams, Howell, Paulhus, Cooper, & Yuille, 2009), although the increase in adolescent access to internet pornography may play a role in the increase in prevalence of these fantasies (Peter & Valkenburg, 2006). Regardless, these findings indicate that a substantial proportion of the population may fantasize or engage in BDSM, but, perhaps due to stigma, fear of bias, or lack of access to educational materials, they do not self-report these fantasies or practices when the BDSM label is applied. Notably, as Moser and Kleinplatz (2006b) point out, BDSM-lite activities such as spanking, biting, and hair-pulling are not uncommon and may blur the line between atypical and conventional sexual proclivities in these fantasy studies. This blurred line would be an important area for CFTs to feel competent in addressing when working with couples or individuals.

Elsewhere, cultural analyses of SM based on older available research from the 20th century show estimates that up to 10% of the US population may currently engage in BDSM (Moser & Kleinplatz, 2006a; Sisson, 2007), whereas survey data released in the early 1990s show a range of estimates from 5% to 25% (Simula, 2019b). Some of this variance is likely the result of differing definitions of BDSM culture and practice between surveys. Regardless, many researchers suggest that the number of BDSM practitioners may be higher than their estimates given the ever-increasing exposure of BDSM motifs and iconography (e.g., black leather, whips, chains, etc.) in mainstream films, books, and other media. Examples include references to BDSM by well-known television shows such as *Law and Order*, *Will and Grace*, *CSI*, and *Family Guy*,

as well as in music videos by Rihanna, Madonna, Nine Inch Nails, Lady Gaga, and others (Simula, 2019b). Recently, Netflix released a television comedy series entitled *Bonding* that dramatizes the complicated life of a professional BDSM practitioner and her kinky clientele (Behm, 2018).

BDSM and Stigma

Even so, BDSM is still largely misunderstood and even maligned by society at large, and many practitioners experience cultural and systemic stigmatization for their lifestyle (Bezreh, Weinberg, & Edgar, 2012; Kolmes, Stock, & Moser, 2006). This is not uncommon for atypical sexualities that divert from traditional expectations. For instance, consensual non-monogamy – in which partners agree to an arrangement that allows extradydic sexual or romantic relationships – has been shown to face consistent stigma across several studies (Conley, Moors, Matsick, & Ziegler, 2013). According to Rubin (2011, p. 149), people interested in atypical sexual practices fall near the bottom of the social-sexual hierarchy, which is topped by married heterosexuals practicing reproductive sex, and then, in descending order: unmarried monogamous couples, solitary sexual practice (e.g., masturbation), and long-term same-sex couples. Beneath these more respected levels of the erotic pyramid are promiscuous heterosexuals, gay men, and lesbian women. Further down still are "…transsexuals, transvestites, fetishists, sadomasochists, sex workers such as prostitutes and porn models, and the lowliest of all, those whose eroticism transgresses generational boundaries" (Rubin, 2011; p. 149). Rubin's picture helps us begin to understand BDSM's role as a maligned minority cultural and sexual identity.

Though book series such as *Fifty Shades of Grey* and movies such as *Secretary* have brought BDSM sexual practices to mass market attention, BDSM communities have long decried these properties and other mainstream references for misrepresenting their culture (Barker, 2013;

Wilkinson, 2009). As Weiss (2006a) describes, the increased consumption of BDSM by popular culture also increases the regulation of BDSM by the titillating pop culture machine, the purpose of which is to offer audiences a window into transgression and risky behavior. Weiss writes, "Viewers do not want BDSM to be something acceptable (and normal) or something understandable (and pathological); they want BDSM to be somehow outside these systems of power and privilege, discipline and control" (2006a, p. 122). Her survey data revealed that viewers become bored when BDSM hues too closely to typical sexual practices. The public appears to want and expect the representation of BDSM to be excessive, extreme, and salacious, and as such, it is possible that BDSM can never truly be mainstream because of its definition as a dirty desire "just out of reach" (Weiss, 2006, p. 128). These public expectations of BDSM imply that there may be no room for a proper representation of BDSM culture in the dominant discourse, resulting in the perpetuation of negative stereotypes about BDSM practitioners.

It is therefore unsurprising that concealment and secrecy have become central components of the BDSM lifestyle (Stiles & Clark, 2011), providing both self-protection and the protection of others at the cost of allowing stigma and misrepresentation to grow. As Wright (2006) discusses, this cycle of stigma finds its genesis in a long history of discrimination against BDSM-identified individuals, particularly in the realms of child-custody (Ridinger, 2006), job discrimination, and opposition to SM events. Surprisingly, there is also a history of feminist opposition to BDSM and an historical cold-shouldering of BDSM practitioners by LGBQ activists who were often trying to distance themselves from the edgy "whips and chains" aesthetic because it did not align with the "safe" image that the LGBQ movement was pursuing after the Stonewall riots (Wright, 2006).

The most significant stigma for BDSM practitioners is in the misrepresentations of their cultural notions of consent (Barker, 2013; Wilkinson, 2009). Despite the aggressive, violent, and apparently non-consensual sexual acts audiences may see or read about, communication and perceptions of empathy regarding partner experiences are central tenets of BDSM culture (Barker, 2013; Hébert & Weaver, 2015; Simula, 2019b) that may in fact be treated with a lower degree of respect or go unaddressed in culturally typical romantic relationships (Carlström, 2018). As described by Sophia in "Who is in Charge of an SM Scene?" (2007), despite the outward appearance of the dominant inflicting their will on the submissive during BDSM play, it is in fact the submissive who has established the ground rules and limits of the exercise before handing the reigns over to a partner that they trust to remain within those consensual boundaries. The dominant is trusted to have heard what the submissive was communicating to them, and empathy and responsibility for both partners' needs is shared.

Members of the BDSM community remain firm in their conviction that BDSM practice is built on consent and communication between partners about the boundaries of their romantic relationship and the limits of their power exchange (Baker, 2013). Consent is one of the strongest themes in BDSM culture – "Safe, Sane, Consensual" (SSC) and its updated counterpart "Risk-Aware Consensual Kink" (RACK) are the two primary models of consent that underlie activities in BDSM spaces and are used as scaffolding in BDSM play and relationships (Simula, 2019b). Based on these tenets and related cultural creeds, Nichols (2006) argues that increased communication, trust, and intimacy are all benefits of a BDSM relationships. Whereas imbalanced roles may exist without discussion in "typical" romantic relationships, communication regarding power exchange is central to the sexual play, and by extension, a given BDSM couple's relationship boundaries (Carlström, 2017; Hébert & Weaver, 2015). It is through

these constructs that the clinical utility of the systemic/relational perspectives employed by CFTs becomes clear – CFTs' existing training in interpersonal communication, family structure, power, and consent (Gehart, 2016) could provide a great starting point for generating new research and empirically-informed guidelines for working with BDSM practitioners and couples.

That said, it is important to note that stigma extends into the clinical world for BDSM practitioners. Assumptions that BDSM activity and diverse sexuality in general indicate pathology persist in the healthcare field despite a preponderance of evidence suggesting such diagnoses are not warranted (Sprott, et al., 2017). In fact, BDSM practitioners have not been found to have higher rates of mental illness than non-practitioners (Connolly, 2006; Cross and Matheson, 2008) and a literature review by Weinberg (2006) spanning 3 decades of empirical research found that BDSM practitioners seem to be well-adjusted psychologically and socially. Despite this, BDSM practice alone still causes practitioners to be labeled as people suffering from mental illness (Simula, 2019b). The DSM-5 (American Psychiatric Association; 2013) classifies BDSM (alongside pedophilia and others) as "paraphilic" sexual fantasy, and although the text acknowledges that atypical sexual practices may not be associated with mental disorders, its placement in opposition to "normophilic" sexual interests increases the possibility for stigmatization in the mental health field (Joyal, 2015). Indeed, misunderstandings and misattributions of BDSM activity by clinicians can lead to an unnecessary diagnosis of pathology in the participating client (Nichols, 2006). All of this is highly problematic, especially given that bias in mental healthcare against alternative sexualities corresponds with poorer health outcomes (Hoff & Sprott, 2009; Kolmes, Stock, & Moser, 2006; Kolmes & Witherspoon, 2012; Shelton & Delgado-Romero, 2011).

There has been a push in the last 10 years toward greater research into how to support BDSM and kink clients in general (Sprott, et al, 2017). Research on therapy for BDSM and kink clients will produce consistent themes and useful interventions of which therapists should be aware, much in the way that research on LGB clients led to the development of informed clinical practices for that population (APA, 2011; Kelsey et al., 2013). Research groups such as The Alternative Sexualities Health Alliance (TASHRA, https://www.tashra.org/), the Community-Academic Consortium for Research on Alternative Sexualities (CARAS, https://www.carasresearch.org/), and the Kink Clinical Practice Guidelines Project (https://www.kinkguidelines.com/) are all committed to pooling resources to collect data and work toward providing clinicians with the information they need to support BDSM practitioners and clients who participate in other kinks. Again, CFTs could be leading the way in this area of research, but so far, there is no existing data on CFTs' work with BDSM clientele.

The Current Study

In order to create the best possible research in this area, it is first important to investigate the current state of psychotherapy for BDSM practitioners by establishing a baseline for CFTs attitudes toward BDSM and their perceived competence in working with BDSM clientele. As with any other intersectional minority sexual population, BDSM practitioners who seek therapy for any issue, even when not related to their sexuality, come with a unique set of experiences that requires at least a general knowledge of BDSM on the part of a "kink friendly" therapist, and at most, a "kink aware" therapist with specific knowledge of kink concepts and alternative therapeutic interventions. The latter has yet to be clearly defined due to the dearth of research in this area (Shahbaz & Chirinos, 2016). This lack of research, guidelines, handbooks, and trainings for working with the BDSM community is problematic, as it significantly hinders therapists'

attempts to meet the basic ethical standards of empirically and culturally informed treatment set by professional licensing organizations such as APA (2017) or AAMFT (2015). Existing research on BDSM practitioners' utilization of psychotherapy reveals experiences of clinical bias resulting in termination of therapy and an anticipation of future stigma and negative reactions that causes clients to not disclose their sexuality (Hoff & Sprott, 2009; Kolmes, Stock, & Moser, 2006).

Previously, Henke, Carlson, and McGeorge (2009) measured 741 licensed CFTs' attitudes toward "homosexuality" [sic] and their perceived competence in working with lesbian and gay clientele; their findings showed (1) low levels of homophobia across the sample, and (2) predictive associations between variables, in which higher levels of homophobia were associated with lower self-reported clinical competency, and vice-versa. Given the relationships between LGBQ identities and BDSM identities established above, the research of Henke, Carlson, and McGeorge (2009) constitutes a strong methodological example for the current study.

With this framework in mind, the current research study seeks to answer two distinct, but interrelated research questions:

1. What are CFTs' self-reported attitudes toward BDSM and perceived competency in working with BDSM practitioners? Furthermore, what is the association between BDSM attitudes and perceived competency?
2. What is the relationship between CFT's specific professional experience (e.g., education level, years of clinical experience, BDSM-specific training experience, AASECT certification, number of BDSM-identifying clientele, and an advertised specialty in BDSM, CNM, LGBTQ, or other alternative sexuality populations) and

their self-reported attitudes and perceived competency in working with BDSM practitioners?

This, and other studies like it, will hopefully help to establish how CFTs are currently approaching treatment with BDSM practitioners. This knowledge can then be used to develop the research and clinical acumen of CFTs in this area.

Literature Review

History and Conceptualization

The first concern of this work is the attitude of therapists toward BDSM sexuality. The idea that any type of sexual expression should be considered abnormal and pathological by clinicians can be traced from early Victorian-era sexologists straight through to the current DSM-5 (Turley & Butt, 2015). Richard von Krafft-Ebing's foundational sexology text *Psychopathia Sexualis* (Krafft-Ebing, Klaf, LoPiccolo, & Blain, 1886/2011) established the classifications of heterosexual, homosexual, and bisexual alongside other categories of sexual desire such as sadism, masochism, and fetishism, and indicated that anything outside of the "natural sex" of heterosexuals required clinical treatment. Sigmund Freud would expand on these ideas in his *Three Essays on the Theory of Sexuality* (Freud & Strachey, 1905/1962), in which he significantly widened the field of thought by arguing that sexuality should be considered separately from reproduction, but reinforced the labeling of homosexuality and sadomasochism as perverted and requiring treatment. These early perspectives are understandable given that the authors lived most of their lives in the sexually conservative Victorian era and only encountered sadomasochism in the narrow confines of clinical practice, in which their clients were actively seeking help for many often unrelated problems (Weinberg, 2006). The prominent role of these and other pioneering works in opening the discussion around sexuality in academia and medicine is undeniable. Unfortunately, their longest-lasting influence on our contemporary classification systems, such as the DSM-5 (APA, 2013) and *International Classification of Diseases 11* (WHO, 2018), may be the perpetuation of intolerance toward diverse sexualities, or the "sexual perversions" (Turley & Butt, 2015).

Due to these developments, Western clinicians have often defined normative sex as an activity between two heterosexual, monogamous, young, and able-bodied partners for the purpose of procreation (Kleinplatz & Moser, 2007). Debates over this Victorian definition of sex as an enterprise for procreation versus an activity of pleasure and/or procreation have continued throughout recent academic and sociological history. However, the push-pull between these forces has historically been resolved by the pathologization and/or criminalization of non-reproductive sexual enjoyment (Spinelli, 2006). Oral sex, for instance, was a criminal offence in several states until as recently as 30 years ago (Turley & Butt, 2015). The fact that Western society has accepted some non-reproductive sexual acts as normative is evidence that the society overall agrees on the perspective that sex can be for pleasure, which should in turn justify the depathologization of other non-reproductive sexual acts including BDSM practices (Spinelli, 2006).

Considering this, Turley and Butt (2015) argue for an alternative conceptualization of BDSM as an activity fitting into the "serious leisure" model of adult recreation (Stebbins, 2007). In this model, time, effort, money, and a learned skillset are all needed to make an unusual, but not "deviant," hobby or practice come to life, much in the way some people commit themselves to extreme sports. According to a survey of just under 1,000 BDSM practitioners, BDSM does meet Stebbin's serious leisure criteria (Williams et al., 2016), a finding echoed by an extensive ethnographic study of the SM community (Newmahr, 2010) and recently reiterated again by Sprott and Williams (2019).

Pathology and BDSM Practitioner Mental Health

Intolerance toward the "perversions" (e.g., BDSM) still dominates the discourse and lay-people are thus incentivized to concur with a psychopathological-medical perspective that

identifies BDSM sexual practices as deviant, partially explaining why labeling BDSM practitioners as mentally ill is a common pop culture trope (Simula, 2019b). Moreover, a theory of the "imperative of health" now pervades our contemporary culture, stating that the reduction of health risks supersedes all other goals, and even if people fail to stay healthy, health as a most basic goal cannot be rejected (Willig, 2008). This idea now permeates the discipline of psychology: Active participation in any risky behavior, including possibly risky sexual behaviors such as BDSM, presents a conceptual problem that psychologists often try to solve by ascribing cognitive bias to the behavior or by pathologizing it, rather than seeking broader, rational explanations for the potential value those acts bring to the individual (Willig, 2008).

This diagnosis of pathology remains a significant issue for BDSM practitioners. Early versions of the *DSM* (I-II) referred to most non-normative sexual practices as "sexual deviations" (APA, 1952). "Paraphilias" were introduced in *DSM-III* (APA, 1986), and *DSM-III-R* (APA, 1987) through *DSM-IV TR* (APA, 2000) used this term to define most non-normative practices such a sexual sadism, sexual masochism, pedophilia, transvestitism, exhibitionism, fetishism, and more. In some cases, certain activity could be deemed playful or harmless if acted out with mutually consenting partners. Currently, the *DSM-5* (APA, 2013) separates paraphilia into its own chapter separate from sex and gender identity disorders. The DSM-5 also separates "paraphilic disorders" from "paraphilia" in order to help recognize the distinction between non-normative and disordered behavior (APA, 2013).

Regarding diagnosis, the *DSM-5* uses criterion A to define the paraphilia, and criterion B to denote the presence of a "clinically significant distress" that would elevate the paraphilia to the level of disorder (APA, 2013). This separation supports the text's claim that not every person practicing a paraphilia has a mental disorder. For instance, "sexual sadism" as a diagnosis has

been renamed "sexual sadism disorder" so as to delineate between consensual, non-distressed sadism and disordered sadism (APA, 2013). Even so, researchers note continuing problems with *DSM-5* classifications. Moser (2019) details several frustrations, including arbitrary timespans for criterion A, no coherent definitions for "clinically significant distress" or other concepts central to criterion B, and an overall narrow view of normative sexual activities that leads to several seemingly obvious misattributions. These include the "premise that a preference for solitary masturbation over coitus is problematic" and the idea that people who prefer partners with shaved genital have a diagnosable paraphilia because of a preference for partners who are "not phenotypically normal" (Moser, 2019, p. 684). Some, including the British Psychological Society, have argued for the complete removal of non-criminal paraphilias from the DSM, citing concerns about the application of stigmatized labels to normal experience (2011).

Importantly, in their criticism of the paraphilia category in the DSM-5, Shindel and Moser (2011) highlight a lack of empirical evidence linking higher than usual rates of distress or increased risk of harm to BDSM practice. This sentiment has been echoed even more recently by Sprott et al. (2017), who concurred that there is limited evidence to suggest that BDSM practice is significantly correlated with increased distress or mental health concerns. Indeed, many of the arguments for the pathologization of BDSM activity operate on a moral or theoretical level wherein BDSM practice is defined as an ethical abomination or illness itself, rather than addressing the crucial question of whether or not BDSM practitioners are measurably more distressed or symptomatic than the general population. In other words, stigma mediates the connection between BDSM and mental health, and increased cultural competence in BDSM could help reduce bias for BDSM practitioners seeking treatment.

The few studies that directly address this issue continue to produce evidence contrary to the pathological imperative. In one study, seven common measures of psychopathology and a demographics questionnaire were administered to 32 self-identified BDSM practitioners, and the findings showed that by comparison to normative samples, the BDSM practitioners had lower levels of depression, anxiety, post-traumatic stress disorder, psychological sadism, psychological masochism, borderline pathology, and paranoia, and equal levels of obsessive-compulsive disorder (Connolly, 2006). BDSM practitioners only scored higher-than-average levels in non-specific dissociation symptoms and narcissism. A national survey of sexual practices assessed respondent's psychological distress and found that respondents who did practice BDSM did not have greater psychological stress than those who practiced typical sex, and men who practiced BDSM reported significantly lower distress (Richters et al., 2008). More recently, survey data on a variety of fundamental psychological characteristics from 904 BDSM practitioners was compared to 434 non-BDSM control participants, and findings showed that the BDSM practitioners had higher levels of conscientiousness, openness to experience, extraversion, and subjective well-being, as well as lower levels of neuroticism and rejection sensitivity (Wismeijer & van Assen, 2013). In their discussion, the authors argue for a recreational or serious leisure perspective on BDSM rather than psychopathological.

A related study by Cross and Matheson (2008) critiqued the accuracy of several academic models of the development of sadomasochism in individuals, specifically the psychopathological-medical model, psychoanalytic model, escape-from-self model, and the radical feminist argument, in which BDSM is seen as an inherently misogynistic repetition of heterosexual patriarchy. The researchers administered an intensive battery of psychological tests to 93 self-identified sadomasochists. These tests included the Sexual Behaviors Inventory (SBI),

the stress subscale of the Differential Personality Questionnaire (DPQ), the neuroticism subscale of the Eysenck Personality Inventory (EPI), the Symptom Checklist-90 (SCL-90-R) for somatic complaints, interpersonal sensitivity, hostility, and psychoticism, the Rosenberg Self-Esteem Scale (RSES), the Dissociative Experiences Scale, the Social Personality Inventory (SPI) to address antisocial personality disorder, the Feminist Attitudes Scale, the Spanos Attitudes Towards Women Scale, and more. None of the four academic models were supported by the results, thereby calling into question the validity of these models in application to the population (Cross & Matheson, 2008).

That said, suicidality has been shown to be a concern in the BDSM community. Survey data from 321 self-identified BDSM practitioners showed that practitioners may be likely to experience stigma-based shame and guilt, which in turn contribute to suicidal ideation (Roush, Brown, Mitchell, & Cukrowicz, 2017). Furthermore, self-identifying male BDSM practitioners may be at higher risk for suicide due to positive associations between experience with BDSM sexual behavior, acquired capability components of suicide (i.e. fearlessness of death and pain tolerance) (Joiner, 2007), and past suicide attempts (Brown, Roush, Mitchell, & Cukrowicz, 2017). This is a new area of inquiry that could benefit from further research.

BDSM Practitioners and Relationship Satisfaction

Additional research concerning the impact of BDSM activity and partnerships on relationship health and quality has suggested that BDSM practice between consenting adults may increase emotional intimacy and relationship satisfaction. In a qualitative study of BDSM practitioners, researchers found that consent, as a first step, is the "meaning-making" process of sexual bargaining by which sadomasochistic acts are transformed into a "game" deemed normal, comfortable, and safe by the partners (Faccio, Casini, & Cipolletta, 2014, p. 760). As Cutler

(2003) found in his own series of interviews, BDSM practitioners tend to use SM "games" to increase bonding in their relationship. Observations of 58 top and bottom SM practitioners participating in a variety of SM activities revealed that both tops and bottoms reported increased relationship closeness after SM play (Sagarin, Cutler, Cutler, Lawler-Sagarin, & Matuszewich, 2009).

Another survey of BDSM practitioners on Fetlife.com – a leading BDSM community website – measured relationship satisfaction for BDSM practitioners using the Revised Dyadic Adjustment Scale (RDAS) (Rogak & Connor, 2018). The authors of this research placed advertisements and links to their study on two popular websites targeted at BDSM practitioners for a period of 18 weeks. All of the participants (n=163) were required to be in a committed relationship or marriage to be included in the study, and were asked to self-identify their degree of involvement in BDSM, with answers ranging from "Only in the Bedroom" to "I live the lifestyle 24/7" (Rogak & Connor, 2018, p. 459). RDAS scores of 48 and above are considered non-distress, and scores of 47 and below are considered distressed (Crane, Middleton, and Bean, 2000). The mean score for this sample was 50.3 (SD = 7.2) indicating that the majority of the sample scored above the RDAS cutoff for clinical distress of 48. No difference was found between genders. Althought the authors cited inclusivity as a reason for not excluding participants based on reports of sexual orientation, this may also be a limitation in that it does not parse the potential influence of the norms of other minority sexual cultures such as LGBQ-related cultures on relationship satisfaction.

Elsewhere, Hébert and Weaver (2015) interviewed 21 self-identified adult BDSM practitioners of both dominant and submissive roles to explore their perceptions of the benefits and challenges of BDSM relationships. The participants described the general benefits of BDSM

as "…personal growth, improved romantic relationships, community, [and] psychological release…" with submissives describing dominant partners as "empathic, nurturing, desiring and able to take control, and attentive and responsible" (pg. 49). These responses align with generalized notions of the importance of open communication and dyadic empathy to romantic relationship satisfaction (Busby & Gardener, 2008; Fletcher, 2002; Gottman, 1994; Kimmes, Edwards, Wetchler, & Bercik, 2014). Notably, both dominants and submissives cited "stigma" as a challenge or barrier for BDSM relationships.

In a similar study, 146 people self-reported living in committed "24/7" master/slave relationships (Dancer, Kleinplatz, & Moser, 2006). One of the major distinguishing themes derived from this study is that the relationship is structured to safeguard the slave – 51% of the respondents said that they had established limits and safe-words with their dominants, with many of the remaining half indicating that they trusted their dominants to know their limits and therefore did not need further safeguards. Moreover, 88% of respondents indicated that they were satisfied or completely satisfied with their current relationships, and 71% indicated that the relationship was more satisfying or significantly more satisfying now than when it had begun.

In a survey of BDSM practitioners, distress in sexual functioning was shown to be significantly lower for men when they were in BDSM contexts versus non-BDSM contexts, except in the case of premature orgasm or anorgasmia (Monteiro Pascoal, Cardoso, & Henriques, 2015). For women, the researchers found no significant difference in sexual functioning distress in BDSM versus non-BDSM contexts except in the case of maintaining arousal. Interestingly, the researchers found no significant differences in sexual satisfaction between BDSM and non-BDSM contexts for men or women.

Given that CFTs are trained to operate with a lens of cultural competency when approaching diverse sexual lifestyles, they are particularly well-suited to developing research and clinical guidelines for attending to the complex and atypical relationship dynamics of BDSM practitioners. In addition, this work would expand the overall breadth of knowledge and cultural competency across the disciplines of mental health. At the current time, it is highly problematic that CFT and other mental health training disciplines do not have guidelines with which they can properly train their future clinicians to work these couples, especially those clients for whom this is an identity and major component of their lifestyle.

Psychotherapy with BDSM Practitioners

Currently there is little extant research on the application of psychotherapy to BDSM practitioners. In their comprehensive literature review, Dunkley and Brotto (2018) declare that BDSM practitioners appear to differ only minimally from the general population in terms of psychopathology (as shown above), and suggest therapists be aware of six unique clinical considerations when working with BDSM practitioners. These considerations are: (1) The use of the therapist's discretion in deciding whether to ignore the client's BDSM lifestyle or consider it as relevant to treatment; (2) Countertransference related to therapists' reactions to the BDSM lifestyle; (3) The possibility of clients' stigma-related anxiety leading to the non-disclosure of BDSM practice and therefore the disruption of therapy; (4) BDSM cultural competence; (5) Understanding of unique BDSM relationship dynamics in the context of common psychotherapeutic interventions; and (6) The ability to separate BDSM practice from domestic abuse and self-destructive pathology (Dunkley & Brotto, 2018).

In addition to these concerns, an earlier list of possible unique clinical considerations also included the need for therapists to be aware of BDSM "newbies" who seek out therapist approval

of their newfound kink and the potential pitfalls of bedroom play bleeding out into the rest of the relationship against the will of one or both partners (Nichols, 2006). Several of these potential clinical issues were echoed in a series of interviews with six couples that had one BDSM-identifying partner (Meyer & Chen, 2019). The implication of these findings is that therapists who are not aware of these clinical considerations may disrupt treatment and even cause harm to clients due to a lack of clinical and cultural competency.

These clinical topics are derived from the theories and findings of several disparate works, all of which are best collected and reviewed by Shahbaz and Chirinos in their book *Becoming a Kink Aware Therapist* (2016). By their definition, "kink-aware" therapists as those therapists who have a specific knowledge of kink concepts and have intentionally educated themselves on the kink lifestyle so as to support clients in BDSM or kink communities without pathologizing them unnecessarily (Shahbaz & Chirinos, 2016). Kolmes & Weitzman (2010) delineate between "kink aware" and "kink friendly," with the latter referring to therapists who are open and non-judgmental of kink concepts or lifestyles, but do not have the specific knowledge needed to appropriately address the types of considerations listed above. Although these writings make solid arguments for the depathologization of BDSM by therapists, the overall paucity of research on psychotherapy for BDSM clientele still makes it impossible to craft empirically supported guidelines. Instead, these works and others like them are forced to rely predominantly on anecdotal evidence to make their claims.

To my knowledge, only one study has directly investigated therapist approaches to and experiences with serving BDSM clientele. In the study, researchers performed 20 semi-structured interviews with therapists who had worked with at least three or more BDSM practitioners and then coded the interviews for themes reflecting what therapists believed to be

most important when working with this population (Lawrence & Love-Crowell, 2008). These themes included the importance of cultural competence as it relates to BDSM practices and values, a refusal on the part of the therapist to pathologize BDSM behavior, a utilization of supervision to process BDSM content, and a deliberate attempt to educate oneself on the complex process of clients' sexual identity formation (Lawrence & Love-Crowell, 2008). Moreover, the participants reported that BDSM is typically a background issue for their clients, and is often seen as a source of strength. When BDSM was discussed in therapy, the participants reported shame, guilt, and relationship concerns related to their clients' lifestyle choices to be the most pressing areas of distress, all of which supports the existing research on unique BDSM identity issues discussed earlier in this writing (Roush, Brown, Mitchell, & Cukrowicz, 2017; Bezreh, Weinberg, & Edgar, 2012).

Beyond available data, the clinicians' answers in the above study also tend to align directly with theoretical suggestions made by other authors (Lawrence & Love-Crowell, 2008; Shahbaz & Chirinos, 2016). This is unsurprising, however, given that the research was limited to therapists with experience working with BDSM clients and, as it turned out, with BDSM itself. All 20 therapists gave histories of personal BDSM experiences as a part of their answers to the sexual minority items on the demographic screener. As such, respondents also indicated that their own BDSM practice forced them to confront unique boundary concerns when working with BDSM clientele, including transference issues related to sexuality and power and countertransference issues related to revulsion, arousal, and inappropriate advocacy (Lawrence & Love-Crowell, 2008). These self-of-therapist issues are echoed in a review of clinical boundary issues when working within the BDSM community (Bettinger, 2002). Although Lawrence and Love-Crowell's (2008) research remains an interesting qualitative exploration of how therapists

are approaching theoretical best practices for working with BDSM clients, its homogenous sample does not provide any insight into how the majority of therapists approach working with BDSM clientele.

Another way of understanding psychotherapy with BDSM practitioners is to survey client experiences. Survey data and open-ended short answer data collected from 175 self-identified BDSM practitioners from 40 states in the United States showed 118 reports of poor care and 113 reports of good care (Kolmes, Stock, & Moser, 2006). Reflecting on poor outcomes, BDSM practitioners reported working with therapists who had inaccurate BDSM information, were uncomfortable with the topic, used unhelpful or unethical practices, or pathologized inappropriately (Kolmes, Stock, & Moser, 2006). Specific categories of reported bias included: (1) Therapists saying they felt BDSM was bad for the client; (2) Therapists requiring clients to give up BDSM as a requirement for continuing treatment; (3) Therapist confusing BDSM for abuse; (4) Clients feeling like they had to constantly educate their therapists on BDSM; (5) Therapists assuming that BDSM interests were the result of past family trauma; and (6) Therapists misrepresenting themselves as kink-aware when they were not (Kolmes, Stock, & Moser, 2006).

Several BDSM practitioners also reflected on positive experiences, including: (1) Therapists reading up on the BDSM lifestyle; (2) Therapists showing comfort when discussing BDSM topics, (3) Therapists specifically promoting consent via the concepts of "Safe, Sane, Consensual" (SSC) and "Risk Aware Consensual Kink" (RACK); (4) Therapists asking questions but not expecting clients to do all the educating; (5) Therapists being open-minded and helping clients overcome BDSM-related stigma; (6) Therapists showing an understanding of the difference between BDSM and abuse; and (7) If possible, a BDSM-practicing therapist (Kolmes,

Stock, & Moser, 2006). Comparable responses were also found in previous studies (Kolmes, 2003).

In light of these categories, it is important to note that 74.9% of the clients in the Kolmes, Stock, and Moser (2006) sample reported that the issues they brought to therapy were not BDSM-related, although 11% said they were tangentially BDSM-related and 12% said that their issues were expressly BDSM-related. These findings align directly with the qualitative reports from clinicians (Lawrence & Love-Crowell, 2008), and provide insight into why 59.4% of the sample reported that they had not sought a specifically kink-aware therapist. Still, 65.1% chose to disclose their BDSM practice, only to develop the concerns listed above (Kolmes, Stock, & Moser, 2006).

In general, these findings suggest that even when clients do not come to therapy with BDSM-specific issues, there are still BDSM-related competencies and unique clinical considerations that should be considered when working with BDSM clients. Moreover, stigma faced by BDSM clients may be magnified in a culturally incompetent therapeutic environment and significantly disrupt therapeutic treatment, leading to reduced quality of therapy and a continuation of bias against alternative sexualities that culminates in poorer health outcomes (Hoff & Sprott, 2009; Kolmes, Stock, & Moser, 2006; Kolmes & Witherspoon, 2012; Shelton & Delgado-Romero, 2011). However, little research has been done to empirically support the development, dissemination, and implementation of specific training strategies.

Interestingly, some theorists have considered the possibility of BDSM practice being accepted as an intentional therapeutic tool, deriving this position from writings and research on the apparent intrinsic therapeutic benefits of BDSM scenes for practitioners. Dunkley, Henshaw, Henshaw, and Brotto (2019), for instance, theorize that the experience of pain in the consensual

context of BDSM can bring about altered states of consciousness that may be similar to what occurs during mindfulness meditation. For submissives, this state is commonly colloquially referred to as "subspace." The authors' hope is that further research in this area may demystify the mechanism by which pain becomes pleasure and thereby destigmatize BDSM practice (Dunkley, Henshaw, Henshaw, & Brotto, 2019). Relatedly, in interviews with 70 self-identified kinksters, descriptions of spiritually connective, transcendental, and cathartic experiences were discussed in the sample's recollections of their BDSM practices (Fennell, 2018). Cultural competence regarding BDSM would include an understanding of the spiritual connection many BDSM practitioners have with their activities and the important therapeutic role they believe in plays in their lives – invalidation of this belief could lead to further bias.

There is some data to suggest that BDSM practitioners view or even use these processes for explicitly therapeutic means. In a series of qualitative interviews with 66 professional dominatrices (or "dommes") – women who receive money to physically, verbally, and mentally dominate submissive and usually male clients – researchers unexpectedly found that dommes consistently referring to themselves as "therapists" performing their own brand of psychological treatment (Lindemann, 2011). The four themes of psychotherapeutic value that emerged were: (1) BDSM scenes being used as an alternative to sexual repression, or, as a release valve for socially undesirable sexual needs; (2) BDSM scenes being used as atonement rituals for clients who seek revitalization through shame, humiliation, and penance; (3) BDSM scenes being used as a mechanism by which clients can regain control over their past traumas by reliving them in role-plays that they have loosely scripted and consented to beforehand; and (4) BDSM scenes being used by clients to outsource the intimate physical and emotional needs that are traditionally reserved for intimate partners but are currently absent in their lives (Lindemann, 2011). This

latter piece is not unique to pro-domme BDSM practice and shares a lot in common with the existing therapeutic concept of sexual surrogacy (Brown, 2008), although in the domme interviews the clients discussed were frequently able-bodied, married men.

Most recently, as a part of a larger ethnographic study, Hammers (2019) interviewed BDSM practitioners who reported using BDSM scenes explicitly for the purpose of reconstructing and re-assessing their sexual traumas. Specifically, the practitioners create "reenactments as opposed to replications" (Hammers, 2019, p. 1) of their traumas, and use fantasy to rework these traumas into something more bearable. For these people, the reenactments go beyond the recounting or witnessing of traumas often seen in other forms of therapy by utilizing the body in a holistic psychosomatic and psychotherapeutic process. No research currently exists that can empirically support the efficacy of these interventions for any population, and as Lindemann (2011) notes, there are many ethical issues to consider in this context. However, these studies do represent further unique cultural competency considerations for therapists working with BDSM practitioners who may have strongly held convictions about the positive therapeutic value of their practice.

Therapists' Attitudes and Perceptions of Competence

An important early step in expanding our understanding of the relationship between BDSM and psychotherapy is to form a baseline for therapist's attitudes toward BDSM and their perceived competence in working with this population. To date, only two studies have approached this issue.

First, regarding attitudes only, a small study (*n=21*) assessed the implicit and explicit attitudes of graduate psychology students and practicing clinicians toward mainstream and BDSM sexual terms by administering the Implicit Relational Assessment Procedure (IRAP) to

measure implicit responses to BDSM stimuli (Stockwell, Hopkins, & Walker, 2017). The researchers also administered several questionnaires surveying opinions about BDSM and observed therapist participants' behavior during sessions with confederate BDSM and non-BDSM clientele. Overall, responses to the IRAP showed an acceptance of mainstream sexual terms and unfavorable responses to BDSM terms, whereas the Likert-style questionnaire responses showed favorable attitudes toward people who practice BDSM. Interestingly, participants who showed anti-BDSM responses on the IRAP stimuli smiled significantly less when interviewing BDSM confederates versus non-BDSM confederates (Stockwell, Hopkins, & Walker, 2017). However, no other differences in interviewing behavior were observed, and participants overall appeared to provide positive treatment to confederates regardless of label. This suggests that the IRAP may not be a good predictor of therapist behavior in this context, and more importantly, draws into question the influence of attitudes toward BDSM on therapeutic competence. It is possible that the unfavorable attitudes captured in the IRAP could influence therapy in the long term (as opposed to these short interviews), or at other levels of clinical practice (e.g., case conceptualization and diagnosis), but more study is needed to explore these ideas. Notably, the study only had 20 participants, which under-powers the study and limits the generalizability of these findings.

One larger study represents the only available research specifically focused on the attitude and experiences of psychotherapists working with BDSM clients (Kelsey et al., 2013). Participants in this study were doctoral-level (PhD, PsyD, or EdD) clinicians in the United States with listings searchable via the APA clinical directory and noted specialties in clinical psychology, counseling psychology, or sexuality. The final sample consisted of 766 licensed psychotherapists who were overwhelmingly "European American" (93.6%). Data was procured

via internet survey. Contrary to the researchers' hypothesis that clinicians would unnecessarily pathologize and discriminate against BDSM practitioners – which itself was based on existing data detailing these as major practitioner concerns (Kleinplatz & Moser, 2004; Lawrence & Love-Crowell, 2008; Nichols, 2006) – 68% of clinicians endorsed the idea that people can engage in BDSM without experiencing emotional problems as a direct result. Approximately 70% of clinicians agreed that they would not target BDSM activity for reduction if that was not the stated goal of the clients. In spirit, these responses align with the existing recommendations by BDSM experts of how clinicians should interact with BDSM clientele (Shahbaz & Chirinos, 2016), but does not match the degree of negative interaction reported by BDSM practitioner clients in Kolmes, Stock, and Moser's (2006) findings. What does meet expectations more closely is the low perceived competence of clinicians – only 48% of the therapist perceived themselves to be competent in working with BDSM practitioners, which is especially concerning given that 76% of the participants reported having treated at least one client who disclosed engaging in BDSM (Kelsey et al., 2013).

Again, these findings call into question whether therapists with BDSM clients are achieving the ethical standards set by their given licensing bodies to provide culturally competent care. The research also suffered from a low response rate (9%) and limited breadth (Kelsey et al., 2013). The low response rate suggests a selection effect in which only clinicians with an interest in this topic area responded to this study, much like the results from Lawrence and Love-Crowell (2008). This raises even more concern over the 48% competency rating – if less than half of the 9% of therapists who responded do not feel competent, and we assume that these respondents may consist of a portion of the overall clinician population that has an existing interest or specialty in BDSM, then it's possible that overall perceived clinical competence with

BDSM practitioners is considerably lower. Moreover, the restriction of the research to doctoral-level APA-credentialed clinicians means that the significantly larger number therapists at the Master's level – and those from other disciplines such as CFT – were not studied. Given that sexual and gender diversity is discussed only minimally in many psychological training programs (Glyde, 2015), and BDSM specifically is not sufficiently covered, if at all (Barker, Iantaffi, & Gupta, 2007), it's possible that research designed to capture a more diverse group of clinicians may reveal even lower scores on attitudes and perceived competence. In the case of the present study, research into the attitudes and perceived competence of CFTs could result in completely different findings.

Couple and Family Therapy

As Dermer and Bachenberg (2015) argued, improving education and training in sexual health and expression is crucially important for anyone practicing couple, marriage, or family therapy to develop diverse cultural competencies. This is predicated on the continued development of guidelines with which to train therapists in different areas of sexual diversity, including BDSM. Regarding CFT, the systemic theory and treatment philosophies that underpin both the discipline and its many treatment models (Nichols, 2017; Gehart, 2016) offer a fertile ground on which researchers and clinicians could explore working with BDSM clients. Many of the classic CFT models operate on concepts related to interpersonal communication, family/relationship structure, and power dynamics, all of which have been discussed above as core components of the BDSM lifestyle. The possibilities for interesting permutations on clinical concepts are abundant, with some examples described below.

For instance, Salvador Minuchin's Structural Family Therapy (Nichols, 2017; Gehart, 2016; Minuchin, 1974) operates on the philosophy that there is no objectively viable family

structure, and that the work in therapy is to help clients define the structure that works best for them. Though this model is often used for re-structuring traditional parent/child family systems, it would be interesting to see its effectiveness as applied to the non-traditional family structures of BDSM practitioners, especially those that operate in extended BDSM family clans or in the often intersecting sexual subculture of CNM (Orion, 2018; Conley, Moors, Matsick, & Ziegler, 2013).

Murray Bowen's Family Systems theory operates on the central concept of the differentiation of self from the family of origin, while considering the impacts of several other factors, including the intergenerational transmission of anxiety and lifestyle messages, interpersonal structures such as triangles, sibling position, and more (Nichols, 2017; Gehart, 2016; Bowen,1978). Again, approaching BDSM through the lens of these concepts leads to some interesting questions for theorists and practitioners. For instance, what is the role of differentiation during the identity formation of a BDSM practitioner, especially given that BDSM is most likely labeled as a transgressive act by a practitioner's family/culture of origin? Moreover, how do roles and rules in 24/7 BDSM relationships interact with Bowen's theories on triangling and intergenerational transmission? What unique transmissions do BDSM practitioners send to their children, if any?

Elsewhere, post-modern approaches such as Narrative Therapy draw upon notions of the influences of macro social narratives and micro power dynamics between individuals to help clients craft new stories for their lives (Nichols, 2017; Gehart, 2016; White, 2007). Considering all of the negative societal narratives that surround BDSM and the unique role of power in BDSM relationships, it would be interesting to investigate how narrative therapists approach developing life stories with BDSM practitioners. For example, how do dyadic psychotherapy

outcomes for BDSM couples in Narrative Therapy compare to outcomes for couples in Cognitive-Behavioral Couples Therapy? What is the impact of the witnessing stage of Narrative Therapy on BDSM practitioners for whom secrecy and concealment have been an important part of their lifestyle?

These and many more questions could be studied, and eventually, shape therapeutic practice with BDSM clients and couples First, however, a baseline must be set for how current CFTs perceive BDSM practices and their competence in working with BDSM practitioner clients.

Current Study

Aside from the research of Kelsey et al. (2013) and Lawrence & Love-Crowell (2008), there is no existing data on the attitudes of any mental health professionals toward BDSM or the perceived competence of mental health professionals in working with BDSM practitioners. Moreover, there is no existing data on the attitudes of CFTs toward BDSM, the perceived competence of CFTs in working with BDSM practitioners, and what might be associated with these beliefs. Given that cultural competence is a crucial component in providing ethical mental health care to clients of diverse sexualities (Hoff & Sprott, 2009; Kolmes, Stock, & Moser, 2006; Shelton & Delgado-Romero, 2011) and that the prevalence of BDSM practice appears to be widely underreported, it is important that we begin to understand the attitudes and perceived competence of therapists working with this population as the first step in developing better services. Therefore, the current study explores CFTs' attitudes towards BDSM, their perceived competence in working with clients who practice, identify with, or fantasize about BDSM, the relationship between these factors, and other professional factors that may be related to these attitudes and competencies.

Conceptual Model

For this cross-sectional study, I conceptualize CFTs' BDSM attitudes and perceived competence serving BDSM practitioners as two variables that are hypothesized to be associated with one another. Moreover, I hypothesized that there were at least six professional factors associated with both BDSM attitudes and perceived competence (Figure 1).

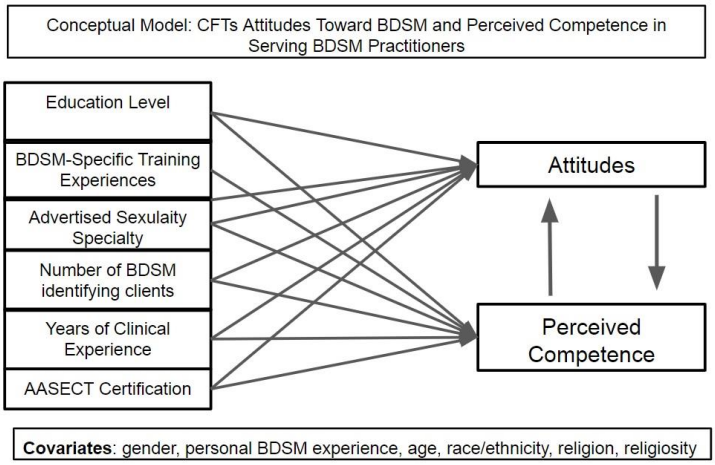

Figure 1. Conceptual Model

Research Questions

The research questions for this study are: (1a) What are CFTs' self-reported attitudes toward BDSM and perceived competency in working with BDSM practitioners? (1b) Furthermore, what is the association between BDSM attitudes and perceived competency? and (2) What is the relationship between CFT's specific professional experience (e.g., education level, years of clinical experience, BDSM-specific training experience, AASECT certification, number of BDSM-identifying clientele, and an advertised specialty in BDSM, CNM, LGBTQ, or other alternative sexuality populations) and their self-reported attitudes and perceived competency in working with BDSM practitioners?

Hypothesis

For research question one, I hypothesized that participants' overall mean scores on our measure of BDSM attitudes would indicate neutral to mild agreement with negative BDSM attitudes, and that mean scores on our measure of perceived competency would indicate moderate to low perceived competence with the BDSM population. I also hypothesized that there would be a negative association between BDSM attitudes and perceived competence in working

with BDSM practitioners, whereby those with more positive attitudes toward BDSM would report higher perceived competence. The hypotheses are mostly consistent with the findings of Kelsey et al (2013), although I hypothesized higher negative BDSM attitudes as I expected to get a more diverse sample.

For research question two, I hypothesized that hours of BDSM-specific training, AASECT certification, numbers of BDSM-identifying clients served, and specialty expertise in alternative sexuality would be positively associated with positive attitudes toward BDSM and greater perceived competence in working with BDSM clientele due to exposure. I also hypothesized that education levels and years of clinical practice would be unrelated to attitudes and perceived competence, given that the do not imply any specific exposure to this population or issues unique to BDSM culture.

Methods

Sample

Primary data was collected via an online self-report survey that recruited CFTs through a combination of targeted purposive and snowball sampling. Eligible participants needed to be a CFT with a full license (LCMFT, LMFT, etc.), a provisional license (LGMFT, Tier 1 MFT, etc.), or any CFT who has completed their Master's degree/training and was working toward their provisional license. Participants were eligible for the study if they received their training from a Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) accredited graduate CFT or Marriage and Family Therapy (MFT) program. AAMFT clinical directories, regional CFT clinician email listservs, CFT graduate program alumni listservs, and various online psychotherapist directories were used to collect email contact information for potential participants. Recruitment posts were made in online CFT forums, such as those available on the AAMFT website and in regional CFT Facebook groups. To facilitate snowball sampling, the questionnaire ended with a forwarding request to other CFTs. In total, 192 people initiated the survey, n = 132 completed the survey. For analysis of the survey data, we restricted our sample to include only those participants who completed the survey (n = 132).

The self-report survey was developed to assess BDSM-related attitudes, perceived competence working with BDSM practitioners, associated professional factors, and sociodemographic covariates. The anonymous survey was hosted on Qualtrics, and took between 10-20 minutes to complete. Participants could stop the survey at any time, skip questions, or select “I prefer not to answer.” Those who completed the survey were given the opportunity to win one of four $25 Amazon gift cards.

BDSM Attitudes

There remain limited standardized measures for assessing attitudes toward BDSM. For this study, I used the Attitudes About Sadomasochism Scale (ASMS) developed by Yost (2010) to measure BDSM attitudes (α = .96). The measure has 23 items measured on a seven-point Likert scale from "Disagree Strongly" (1) to "Agree Strongly" (7). The scale items were summed and averaged so that higher scores reflect more negative BDSM attitudes.

Yost (2010) validated the ASMS with an initial confirmatory analysis (n = 258) of the subscales. Analysis also showed the ASMS was positively correlated with other measures of social and sexual conservatism but still constituted a unique attitudinal construct (n = 471). Further, analysis revealed that participants who had prior knowledge about SM, participated in SM, or had friends who participated in SM scored more positively on the ASMS. The measure is listed in Appendix A. Based on my hypothesis I expected means scores on the ASMS to be between 4 and 5, indicating neutral to mild agreement with negative BDSM attitudes.

Perceived BDSM Competency

To the author's knowledge, there are no existing measures that assess therapist's perceived competency in working with BDSM practitioners. For this study, an adapted version of the Sexual Orientation Counselor Competency Scale (SOCCS) (α = .90) (Bidell, 2005) was used to measure therapist competency, which we are calling the BDSM-Perceived Counselor Competency Scale, or BDSM-PCoCs. There is precedence for these types of alterations, as Carlson, McGeorge, and Toomey (2013), Nova, McGeorge, and Stone-Carlson (2013) and later McGeorge, Carlson, and Toomey (2015) modified the SOCCS to include items better-suited to graduate CFT training programs, along with additional questions about bisexuality and spirituality. The SOCCS was found to be reliable and valid after these modifications.

For the BDSM-PCoCS, the questionnaire was altered by replacing terms such as "LGB," "gay," "lesbian," and "bisexual" with relevant terminology such as "BDSM" and "BDSM practitioner." The adaptation of this scale required minimal changes given that the SOCCS items are comprised of simple self-evaluations such as "At this point in my professional development, I feel competent, skilled, and qualified to provide therapy to LGB clients," which was altered to, "At this point in my professional development, I feel competent, skilled, and qualified to provide therapy to clients who are BDSM practitioners." Other alterations are supported by existing research previously cited in this paper. For instance, "I am aware of institutional barriers that may inhibit LGB people from using mental health services" was changed to "I am aware of institutional barriers that may inhibit BDSM people from using mental health services", which in consistent with previous research regarding stigma and unnecessary diagnosis for BDSM practitioners (Simula, 2019b; Sprott, et al., 2017; Joyal, 2015; Nichols, 2006). One question in the SOCCS skills section regarding therapists' opportunities to work with male or female bisexual clients was dropped from the final version of the BDSM-PCoCS because it was redundant with prior questions about opportunities to work with male and female BDSM clientele after measure modification. The full list of alterations can be found in Appendix B. Response are recorded on 7-point Likert scale ranging from "Not at All True" (1) to "Totally True" (7). The combined modified Knowledge and Skills subscale score was used to represent therapists' perceived competence. Items were summed and averaged so that higher scores reflect greater perceived BDSM competence. Based on my hypothesis that perceived competence would be low to moderate, I expected means scores on the BDSM-PCoCs to be between 2 and 3, representing low to mild agreement with statements about participants' skills and knowledge related to therapy with BDSM practitioners.

Professional Factors

I assessed six professional factors: CFT's education level, years of clinical practice, hours of BDSM-focused psychotherapeutic training experience, AASECT certification, number of BDSM-identifying clients they have seen in clinical practice, and professional advertisement of a therapeutic specialty with BDSM or other alternative sexualities.

Education level asked participants to indicate their highest levels of education and where they received their degrees. Participants were provided three options, including CFT/MFT master's programs (1), CFT/MFT doctoral programs (2), other doctoral programs (3) and were prompted to write in their given alma mater. *Years of clinical practice* was assessed numerically in years. Participants provided *hours of BDSM-specific psychotherapeutic training* across six separate training categories: Course work during CFT master's programs, course work during CFT doctoral programs, continuing education via workshops or seminars, informal guidance from supervisors or mentors, independent research, and other. Participants could select from a range of 0 to 100 hours in all categories. Items were summed and averaged to create a composite measure of professional BDSM training. Given a floor effect in the data distribution and based on post-hoc sensitivity analysis, the training hours variable was recoded to reflect whether participants had three or more hours of BDSM-specific training (less than three hours = 0, three or more hours = 1).

Participants also reported whether or not they were *AASECT certified* (AASECT certified or in the process for AASECT certification = 1, not AASECT certified = 2). The number of *BDSM-identifying clients that therapists have seen* in their clinical practice was assessed as a continuous numeric value. I also assessed whether professionals *advertised BDSM or other alternative sexualities* as an area of specialty. Participants could select one or multiple responses

including BDSM practitioners, otherwise kink-identifying clientele, consensually non-monogamous clientele, LGBTQ clientele, and prefer not to answer). A coding mistake in Qualtrics resulted in a forced response for this particular question, which also lacked an option of "none." If participants did not advertise a specialty, they would have been forced to select "prefer not to answer." Therefore, we recoded this variable to reflect clinicians who reflect groups of: none or declined response = 0, BDSM, kink, or CNM = 2, LGBTQ = 3, and any combination of BDSM, kink, CNM, and LGBTQ specialization = 4.

Covariates

Covariates for the current study include age, gender, race/ethnicity, religion/faith, religiosity, and self-identification as a BDSM practitioner. Age was assessed with a numeric drop-down value ranging from 0 to 99. Gender was assessed with a single multi-response item (male/man, female/woman, transgender male/man, transgender female/woman, nonbinary/genderqueer/gender non-conforming, other gender, or prefer not to answer). Given the distribution of responses, gender identity was recoded into three categories reflecting responses of male/man = 1, female/woman = 2, transgender/gender nonconforming/intersex = 3 (see Bauer, Braimoh, Scheim, Dharma, & Dalby, 2017).

Race/ethnicity was collected as a multi-response multiple choice question offering nine options (American Indian/ Alaskan Native, Native Hawaiian/ Other Pacific Islander, Asian/ Asian American, White, Black/ African American, Bi-/Multi-Racial, Hispanic/ Latinx Origin, Other). Given the overwhelming majority of White respondents (n = 92), the variable was recoded to reflect participants who were White = 1 and Other Race/PoC = 2, the latter of which includes those who indicated any non-White racial/ethnic category as well as multiracial/ethnic responses. Religion/faith data was collected in a multiple choice format with 15 options (e.g.,

Protestant, Catholic, Jewish, Muslim, Atheist, Other Religion/ Faith, etc). Responses were recoded as: Christian = 1, Jewish = 2, Atheist, Agnostic, Unaffiliated, or unsure = 3, Other religion/faith/spirituality = 4. Religiosity was measured on a Likert scale from "Not Religious" (1) to "Very Religious" (4). Finally, therapist self-identification as a BDSM practitioner was measured with a single item response option, yes = 1, no = 2.

Analytic Strategy

All data management and analysis was conducted in Stata 15.1 (StataCorp, 2017). The first step was to estimate descriptive statistics (frequencies, means, and standard deviations) for all variables. For research question one, we estimated the association between mean scores on the ASMS (i.e., BDSM attitudes) and mean scores on the BDSM-PCoCS (i.e., perceived BDSM competence) using a Pearson correlation. For research question two, we tested the bivariate associations between professional factors, sociodemographic variables, and both outcomes (BDSM attitudes and perceived competence) using analysis of variance (ANOVA) for categorical predictors and covariates and Pearson correlations for continuous predictors and covariates. For ANOVA models, post-hoc pairwise comparisons of mean attitudes and competencies were assessed using Bonferonni corrections at $p < .05$. Finally, we used multivariate regression to test the influence of all professional factors on BDSM attitudes and perceived competence adjusting for sociodemographic covariates. Multivariate regression allows models to estimate two simultaneous outcomes, which is particularly useful when dependent variables are hypothesized to be correlated. The resulting estimates (betas) reflect the unique variance between a given predictors and outcome.

Results

Sociodemographic Characteristics

Sample sociodemographic characteristics are presented in Table 1. Sample size was *n* = 132. Roughly 65.15% of participants indicated that they held a full CFT or MFT license, and 34.85% participants indicated they held provisional licenses. Approximately 87% of the sample held a CFT or MFT master's degree, 8.33% held a CFT or MFT doctoral degree, and 4.55% earned a doctoral degree in related field. The average years of clinical practice for participants was *M* = 8.72 (SD = 6.31). Average hours of BDSM-specific training were *M* = 8.87 (*SD* = 9.10). Roughly 13% of participants were AASECT certified or currently in training to be certified. Participants averaged a total of *M* = 14.31 (*SD* = 24.38) clients who identified as BDSM practitioners. Regarding advertisement of a specialty with an alternative sexuality, 24.43% reported none/prefer not to answer; 7.63% indicated advertising a specialty in BDSM or kink or CNM, 21.37% reported advertising a specialty in LGBTQ populations, and 46.56% indicated that they advertised a combination of specializations in combination of BDSM, kink, CNM, and/or LGBTQ.

Average age of participants was *M* = 38.98 (*SD* = 11.44). For gender, 15.27% of participants selected male/man, 76.34% selected female/woman, and 8.40% selected transgender male or female, gender non-conforming, or intersex. For religion, 17.74% were Christian, 10.48% as Jewish, 43.55% as Atheist, Agnostic, unspecified faith, or unsure, and 28.23% as other religion, faith, or spirituality. Average religiosity of participants was *M* = 1.65 (*SD* = 0.95), indicating somewhat to no religiosity for most of the sample. Nearly 35% of participants indicated that they identified as a BDSM practitioner.

CFTs' Attitudes, Perceived Competence, and their Relationship

The first research question asked what CFTs' attitudes toward BDSM are and what their level of perceived competence is providing well-informed culturally competent care for clients who identify as BDSM practitioners and/or participate in some BDSM activities or fantasies. Average overall scores on BDSM attitudes were M = 1.89 with a standard deviation of (SD) = 0.66, indicating generally positive BDSM attitudes in the sample (on ASMS Likert scale, 1 = Disagree Strongly and 2 = Disagree Moderately with prejudicial BDSM statements). Average overall scores of perceived competence were M = 4.07 (SD = 1.33), indicating moderate perceived competence in working with BDSM practitioners in the sample (on BDSM-PcOCS Likert scale, 4 = "Somewhat True" regarding questions about experience, education, and self-reported competence).

Pearson correlation testing the association between BDSM attitudes and perceived competence showed a significant negative correlation between the two variables (r = -.55, p<0.001), indicating that more positive BDSM attitudes are associated with higher perceived competence.

Bivariate Associations between Professional Factors and BDSM-related Attitudes and Competence

My second research question tested the relationship between five professional factors and CFTs' BDSM attitudes and perceived competence. Bivariate analysis testing the relationship between categorical independent variables and covariates with BDSM attitudes and perceived competence are displayed in Table 2. Bivariate correlations testing these associations for continuous variables are presented in Table 3.

There was no statistical relationship between level of education and BDSM attitudes (F = 2.35; p = .100), or perceived competence (F = 0.08, p = .926). Participants who were AASECT certified or in the process of obtaining AASECT certification had significantly more positive BDSM attitudes (M = 1.40) than whose without AASECT certification (M = 1.95), F = 10.25; p = .002. AASECT certified clinicians also reported greater perceived competence (M = 5.75) than those without (M = 3.83), F = 41.53; p < .001.

There were significant differences in BDSM attitudes (F = 19.21; p < .001) and perceived competencies (F = 45.64; p < .001) as a function of whether or not clinicians advertised specialties with diverse sexualities. Participants who selected only BDSM, kink, or CNM as an advertised professional specialty had more positive BDSM attitudes (M = 1.61) and higher perceived competence (M = 4.41) than those who declined to answer (M = 2.38 for attitudes and M = 2.81 for competence, respectively). Participants who selected only LGBTQ as an advertised professional specialty had more negative BDSM attitudes (M = 2.18) than those who only selected BDSM, kink, or CNM (M = 1.61). Those who exclusively advertised LGBTQ specific specialties had higher perceived competence (M = 3.39) than those who declined to answer (M = 2.81), but lower perceived competence than to those who selected exclusively BDSM, kink, or CNM (M = 4.41) specific specialties. Participants who selected a combination of advertised professional specialties (e.g., BDSM and LGTBQ) had more positive BDSM attitudes (M = 1.52) than those who declined to answer or had none (M = 2.38) and those who exclusively selected LGBTQ (M = 2.18), and higher perceived competence (M = 5.00) than those who declined to answer or said none (M = 2.81) and those who selected only LGBTQ (M = 3.39).

There was no statistical association between years of clinical experience and BDSM attitudes (r = .01, p = 0.92), however, there was a significant but weak positive correlation between years of experience and perceived competence (r = .19, p < .05), indicating that participants with greater years of experience had higher levels of perceived competence. There was a significant moderate negative association between the number of BDSM-identifying clients CFTs had seen in their practice and their BDSM attitudes (r = -.36, p < .001) and significant and strong positive correlation with perceived competence (r = .56, p < .001). Clinicians who reported three or more of BDSM-specific training also had moderately more positive BDSM attitudes (r = -0.48, p < .001) and higher perceived competence (r = .66, p < .001) than those who reported less than three hours of BDSM specific training.

Bivariate Analysis – Covariates

Age was uncorrelated with BDSM attitudes (r = -.10, p = .246), but positively correlated with perceived competence (r = -.40, p = .003). Gender was also unrelated to BDSM attitudes (F= 1.73; p = .181) but was significantly associated with perceived competence (F = 4.42; p = .014). Specifically, transgender/ gender non-conforming/ intersex participants had significantly higher perceived competence (M = 5.51) than cisgender male (M = 3.79) and female (M = 4.02) clinicians.

Race/ ethnicity was unrelated to BDSM attitudes (F = 2.50; p = .116) or perceived competency (F= 2.20; p = .140). Religion / faith had a significant association with BDSM attitudes (F = 6.25; p = .001). Participants who were atheist, agnostic, had an unspecified secular outlook, or were unsure had significantly more positive BDSM attitudes (M = 1.68) than Christian participants (M = 2.36). Moreover, participants from other religions, faiths, or spiritualties (e.g., Buddhists, Muslims, Hindus) were also found to have significantly more

positive attitudes (*M* = 1.82) toward BDSM than Christian participants *(M* = 2.36). Religion / faith was also found to have significant associations with perceived competency (*F* = 5.93; *p* < .001). Again, participants who were atheist, agnostic, had an unspecified secular outlook, or were unsure indicated significantly higher perceived competence (*M* = 4.52) in working with BDSM clients than Christian participants (*M* = 3.31) and Jewish participants (M = 3.36). Additionally, participants from other religions, faiths, or spiritualties were found to have significantly higher perceived competence (*M* = 4.03) than Christian participants *(M* = 3.31). A significant positive correlation was found between religiosity and BDSM attitudes (*r* = 0.34, *p* < .001), indicating BDSM attitudes became more negative as religiosity went up. Similarly, a significant negative correlation was found between religiosity and perceived competency (*r* = -0.40, *p* < 0.001).

Participants who self-identified as BDSM practitioners were found to have significantly more positive BDSM attitudes (*F* = 30.72; *p* < .001) and significantly more perceived competence (*F* = 43.59; *p* < .001).

Multivariate Regression – Main Outcomes, Professional Factors, Covariates

Results from multivariate regression are presented in Table 4. Level of education and hours of BDSM-specific training were the only variables uniquely associated with BDSM attitudes after accounting for the shared variance between BDSM attitudes and perceived competence. Specifically, compared to those with a CFT Master's degree, participants whose highest level of education was a non-CFT doctoral degrees had higher levels of negative BDSM attitudes (*b* = .054, *se* = .261, *p* = .043); whereas those with a CFT Master's or doctoral degree did not differ. Participants with more than three hours of BDSM-specific training experience had more positive BDSM attitudes (*b* = -.16, *se* = .16, *p* = .03) than those with less than three hours

of BDSM-specific training experience. All other main effects and covariate effects were unrelated to BDSM attitudes.

Hours of BDSM-specific training experience, AASECT certification, and the advertisement of a specialty in BDSM or other diverse sexualities were significantly associated with perceived competence, after accounting for associations with BDSM attitudes. Specifically, participants who had more than three hours of BDSM-specific training had higher levels of perceived competence (b = .73, se = .22, p < .001) than those with less than 3 hours of BDSM-specific training experience. Moreover, compared to those without AASECT certification, participants who had AASECT certification or were in the training process for AASECT certification had higher levels of perceived competence (b = .60, se = .28, p = .033). The advertisement of a specialty in BDSM or other diverse sexualities was also significantly related to perceived competence: Compared to those that do not advertise a specialty in an alternative sexuality, those that advertise a specialty in BDSM, kink, or CNM had significantly higher perceived competence (b = .73, se = .37, p = .050), as did those who advertise both a specialty in BDSM, kink, or CNM and a specialty in LGBTQ issues (b = 1.04, se = .29, p < .001). All other main and covariate effects were non-significant.

Discussion

Main Findings

The purpose of the current study was to explore CFTs' attitudes toward BDSM and perceived competence in providing psychotherapy for BDSM practitioners. Before reviewing the data, it is important to note that a selection bias likely occurred in this study. More than half the sample indicated that they advertised a specialty in BDSM, kink, or CNM, and 35% of the sample self-identified as BDSM practitioners. This means that our sample was weighted toward therapists with a predisposed interest in or exposure to BDSM that would skew their scores toward positive attitudes and higher perceived competence. When reviewing these findings, it is important to take this into account and consider how these scores may change if the sample was more diverse.

Results showed that although CFTs reported positive BDSM attitudes, they also perceive only moderate competence in providing services for BDSM practitioners. Attitudes were more positive than hypothesized (mean scores of $M = 1.98$ equates to moderate disagreement with prejudicial statements on the ASMS vs. the hypothesized mean score of 4 to 5 equating to neutral to moderate agreement with prejudicial statements on the ASMS) and perceived competence was slightly higher (mean scores at $M = 4.07$ equated to moderate perceived competence vs. the hypothesized mean score of 2 to 3 equating to mild to moderate perceived competence). As hypothesized, BDSM attitudes and perceived competence were also negatively correlated, meaning that participants with more positive BDSM attitudes had higher perceived competence. These findings mirror those of Kelsey et al, (2013), wherein despite positive BDSM attitudes overall, only 48% of doctoral-level psychologists felt competent to work with clients who identified as BDSM practitioners. What we can infer from the findings in both studies is that

although therapists in these mental health disciplines are likely to not hold negative attitudes toward BDSM or BDSM practitioners, they do not feel well-prepared to work with this population either.

This is complicated by the fact that the many participants in the current sample had worked with BDSM practitioner clients: In fact, the therapists in this sample had an average of approximately 14 BDSM practitioner clients, perhaps owing again to the potential selection bias. For comparison, the larger sample of doctoral-level psychologists (*n* = 766) in Kelsey et al., (2013) reported having worked with an average of 6.7 clients reporting BDSM involvement. To broaden this picture, prevalence data suggests that anywhere from 2% to 25% of the population may be practicing BDSM regularly (Holvoet et al., 2017; Richters, de Visser, Rissel, Grulich & Smith, 2008; Simula, 2019b), and that up to 65% of the population has at least fantasized about participating in BDSM-related activities (Joyal & Carpentier, 2017; Joyal, Cossette, & Lapierre, 2015; Renaud & Byers, 1999). Given that many clients choose not to share their BDSM practice for fear of therapeutic bias (Hoff & Sprott, 2009; Kolmes, Stock, & Moser, 2006), these findings, in conjunction with those of research question one, suggest that therapist may be encountering more BDSM practitioners than they realize during their years of practice while not feeling competent to service BDSM-identifying clients. This lack of perceived competence likely extends to how the therapists create space – or do not create space – for BDSM practitioners to disclose. For instance, previous research has shown that LGB clients are unlikely to disclose their sexual orientation to their psychotherapists in the absence of a sexual history assessment or other culturally-informed model of disclosure that the therapist might facilitate (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015). Many BDSM practitioner clients may encounter a similar problem, thereby disrupting therapy and leading to poorer outcomes.

The second research question in this study explored the association of various professional factors in psychotherapy with BDSM attitudes and perceived competence. In my study's final model, we found that a few measures of area-specific training were significantly associated with our outcome variables. Although there was an additional significant effect with the level of education – in which those with a non-CFT doctoral degrees had more negative BDSM attitudes relative to master's level CFTs – it is hard to draw meaningful conclusions from this because there were so few of these participants in the sample (n = 7). Moreover, these participants had to have graduated from a COAMFTE-approved program in order to meet inclusion criteria (likely their master's-level training), so the only conclusions that could potentially be drawn from this is that more research must be done in order to discern if these differences in training are, in fact, related to BDSM attitudes.

The remaining significant effects were related to therapists' BDSM-specific exposure and education. Having three or more hours of BDSM-specific training experience (relative to less than three) was the only other variable significantly associated with more positive BDSM attitudes. Having three or more hours BDSM-specific training experience (relative to less than three hours), AASECT certification or training (relative to none), and professional advertisement of a specialty in BDSM, kink, CNM, or a combination of any of those with LGBTQ (relative to no reported specialization or specializing only with LGBTQ) were positively and significantly associated with perceived competence.

Although these findings support my hypothesis for research question two that BDSM-specific training hours, AASECT certification, and advertisement of a specialty with alternative sexualities would be significantly associated with both more positive BDSM attitudes and higher perceived competence, there is more to unpack. These three variables are all, at their core,

related to training. Those with AASECT certification by definition have more extensive training in various typical and diverse sexualities. Additionally, a post-hoc regression analysis of the advertisement variable showed that those who advertise a specialty with BDSM, kink, and/or CNM had approximately 12 more hours of BDSM-specific training than those who declined to answer or said no ($p < .001$), and 10 more hours of BDSM-specific training than those who only advertise a specialty in LGBTQ issues ($p < .001$). This indicates that advertisement of a specialty in one or more alternative sexualities is another way of establishing if therapists have more hours of area-specific training.

Crucially, our results showed that those with three or more hours of BDSM-specific training were $b = .73$ units higher perceived competency than those who had less than three. As the beta for AASECT certification was nearly the same ($b = .60$), I performed post-hoc sensitivity analysis testing the independent effects of AASECT training and BDSM-specific training on perceived competency. Results suggested that these professional factors are distinct constructs. In other words, even if CFTs do not get AASECT training, having three or more hours of BDSM-specific training still equates with $b = .73$ higher perceived competence.

Given that CFTs in my sample had relatively positive BDSM attitudes but only moderate perceived competence, it may be that the culturally competent lens taught in existing training programs help CFTs to be non-prejudicial or "kink friendly" when working BDSM clientele, but do not teach the necessary skills to help them feel confident when offering direct services to this population. Findings here suggest that three or more hours of BDSM-specific training could increase perceived competence by a full unit (e.g., statements regarding their skills and knowledge rising from "Somewhat True" to "Mostly True"), increasing the likelihood of more culturally competent – and therefore more ethical and effective – care. As such, it could be

suggested that three or more hours of BDSM-specific training be integrated into CFT programs to help increase CFTs' perceived competence in working with BDSM practitioners. This could also address the cultural insensitivities raised by BDSM practitioners in previous studies who felt that their negative experiences with therapy were often caused by the therapists not having a basic understanding of BDSM culture or lifestyle (Kolmes, Stock, & Moser, 2006; Kolmes & Weitzman, 2010).

Several researchers have already made the argument that "kink aware" therapists – those who have developed positive BDSM attitudes and high perceived competence due to professional education, training, exposure, and/or experience – are necessary in order for this population to receive efficacious services. "Kink friendly" therapists, who may have positive BDSM attitudes but low, moderate, or no perceived competence due to a lack of professional education, training, exposure, and/or experience, presumably cannot provide the same quality of care (Kolmes & Weitzman, 2010; Shahbaz & and Chirinos, 2016). This idea is further supported by Lawrence and Love-Crowell's (2008) finding that professionally developed BDSM cultural competence and continuing education on BDSM sexuality were considered by many therapists to be among the most crucial components of ethical and effective psychotherapy for this population. In another study, BDSM practitioners referenced their therapists' lack of knowledge about BDSM and discomfort discussing the topic as areas of bias that led to poor therapeutic outcomes (Kolmes, Stock, & Moser, 2006). Additionally, Dunkley and Brotto (2018) have pointed to BDSM cultural competence and awareness of countertransference as among the most important considerations therapists should make when working with BDSM practitioners. As such, these competencies, or lack therefore, are ripe for clinical and training implications.

Clinical Implications

The research findings presented here have practical implications for CFT clinical practice and education. First, as noted, the findings suggest that many CFTs today may be "kink friendly," meaning the training they received through their graduate CFT programs has prepared them to be open-minded toward BDSM practitioners and the BDSM lifestyle, but not explicitly knowledgeable or "kink aware." This suggests that BDSM practitioners are less likely to encounter actively prejudicial therapists if they work with CFTs, but it does not mean that therapists are providing the most ethical possible care for clients in their clinical practices. As shown by Kolmes, Stock, and Moser (2006), BDSM practitioners who have experienced negative outcomes in therapy reported that their therapists' lack of knowledge about BDSM, discomfort with the topic, sharing of false information, and other actions showcasing cultural incompetence around BDSM were all factors that influenced or led to negative clinical outcomes. CFTs may be inadvertently treating clients from a biased stance or otherwise contributing to a negative therapeutic experience and outcome. Clinicians should be aware of this possibility and, if they do not have competence in this area, seek out education to increase their knowledgebase.

Outside of graduate training programs, most states require therapists to get a few hours of continuing education credits every year, but the topics of these credits are usually not regulated (e.g., Maryland state law only requires that some hours be in person) (Maryland Board of Professional Counselors and Therapists, 2020). Another way of addressing the competency knowledge gap would be to require that yearly continuing education credits feature some cultural competency courses in order to continue helping CFTs expand their aptitudes with diverse groups. This could drive more CFTs toward existing BDSM seminars and spur others to generate

new seminars on working with BDSM practitioners that, based on this research, should be at least three or more hours. Increasing the number of CFTs with three or more hours of BDSM specific training could increase the overall quality of care for their clients.

From an educational perspective, this lack of "kink aware" therapists could be curbed by introducing more BDSM-specific training into graduate CFT training programs. Specifically, the findings of this study suggest that having three or more hours of BDSM-specific training will help to increase therapists' positive attitudes and perceived competency. Minimally, this could be one or two class periods during a graduate sex therapy or couple therapy course, although more training may breed even more competence. As mentioned previously, CFT as a field is specially predisposed to exploring and understanding the unique and diverse relationships of BDSM practitioners and defining what specific knowledge (e.g., consent culture and developmental milestones) and interventions may be most useful for therapists to know before working with this population. A dedication to this population and topic by researches in the CFT field and the infusion of what is learned into graduate training would improve CFTs' competence and help develop CFT as the premier discipline for those interested in this issue.

Limitations and Future Directions

There are a few important limitations to note for this study. To start, the sample size was fairly small (n = 132), overwhelmingly White and female, and limited to CFTs. A larger and more representative sample might have produced different results, and a sample that consisted of therapists beyond the CFT discipline could have provided important cross-discipline comparison groups from which to draw inferences about CFTs or other licensed mental health professionals. Moreover, I was not able to explore temporality in this study, so we do not yet have a clear picture of the possible cause and effect relationship between earlier experiences and later

attitudes or perceived competence. For example, it is unlikely that advertising oneself as a therapist with BDSM-specific expertise increases their perceived competence, but may be bidirectional in that more exposure to BDSM clients likely increases therapists' perceived competency in working with this population. In addition, the programming error that occurred on the survey with our specialty advertisement variable affects the accuracy of the data related to this question. Approximately 25% of the sample selected "I prefer not to answer," but it is unclear which of these participants intended to not answer and which participants wanted to say they did not advertise a specialty with any of the options. Collapsing these together allows us to make inferences about this variable but those inferences are lower in resolution due to the error.

Another notable limitation is the possibility of a confounding effect between some of the items in the skills subscale of the BDSM-PCoCs and the measure of BDSM-specific training hours. Questions such as, "I have received adequate clinical training and supervision to provide therapy to clients who are BDSM practitioners," and "I have received course work that focused on BDSM issues in family therapy," may be measuring hours of training rather than perceived competence, as the difference between a raw number of hours and the subjective impression of having received enough training to feel prepared may be too subtle to parse. In future research, sensitivity testing for these variables or slight alteration to the questions may reduce the possibility of confounding variables.

Similar to concerns raised in previous research (Kelsey et al., 2013; Lawrence & Love-Crowell, 2008), there is a high probability of selection bias in the current study. Over 50% of the current sample indicated that they advertise a specialty with BDSM, kink, and/or CNM. This means that many participants who chose to take part in the study may have already been intrinsically interested and/or trained in this topic. Collecting data from a range of participants

with more diverse experiences and exposures would help give us a better sense of which factors and covariates are related to CFTs' attitudes about this population. For instance, it's possible that religion and religiosity, which were shown to be significant at the bivariate level but not at the multivariate level, could be significant at the multivariate level with a larger, more diverse sample. That said, if there was a selection bias in this study favoring CFTs who are already intrinsically accepting of the BDSM community and/or lifestyle, the fact that the sample's perceived competence scores were so moderate provides further evidence of the need for more extensive training, as "kink friendly" therapists cannot provide the same quality of care as "kink aware" therapists (Kolmes & Weitzman, 2010; Shahbaz & and Chirinos, 2016). This training could occur in graduate-level sex therapy classes, continuing education credits, and beyond.

Future research should explore the attitudes and perceived competencies of therapists in other disciplines to broaden our understanding of how therapists feel when approaching clients who are BDSM practitioners. This information could also be used to assess which disciplines' therapists have the most positive attitudes and feel most prepared to deal with these issues in a culturally competent manner, and test whether the systemic lens of CFTs does better-prepare them to feel competent exploring the power dynamics of BDSM relationships. Moreover, it may be possible to reduce selection bias in future research on this topic by couching the target measures about BDSM within a larger survey collecting data about therapists' attitudes and competence regarding a variety of more typical sexual practice. Those who were dissuaded to participate because of the outward advertisement of the research as a study focused on BDSM may be more likely to fill out the questionnaires if the survey is advertised from a broader sex therapy perspective.

The development of a measure of BDSM knowledge and cultural competency for therapists could also be helpful for determining whether therapists meet a "kink aware" standard of competence. This is especially important considering that the misrepresentation of therapists as "kink aware" is a specific category of bias reported by BDSM practitioners who have experienced poor outcomes in psychotherapy (Kolmes, Stock, & Moser, 2006). Such a measure could also be used in several types of studies focused on different intervention methods for therapists working with BDSM practitioners, leading to a long term goal of developing standardized guidelines for therapeutic practice with BDSM practitioners. This knowledge measure could also be used to assess the quality and/or impact of BDSM trainings for therapists.

As a side note, more extensive and exact prevalence studies of BDSM practice and behavior will be crucial in providing evidence to support the delegation of time and resources to developing BDSM-focused programs for graduate students, therapist trainees, and seasoned therapists.

Conclusion

Despite the paucity of research on BDSM within the mental health field, there is a clear history of bias, unnecessary pathology, and cultural incompetence in the treatment of BDSM practitioners which is especially concerning given how large this misunderstood subculture may be. This was the first study to explore the attitudes of CFTs toward BDSM and their perceived competence providing psychotherapy for BDSM practitioners. Overall, I found that CFTs have more positive attitudes toward BDSM, but only a moderate sense of perceived competence, which mirrors findings from the only other study previously conducted on clinician attitudes and perceived competence in this area. The most important finding of this study indicates that three or more hours of BDSM-specific training plays a strong role in increasing positive BDSM attitudes and increasing perceived competence. This adds empirical support to the idea that more training is required in order for CFTs to provide ethical and culturally competent care for this population. Although not without its limitations, these results should be considered in future conversations about how to train CFTs and develop BDSM-focused training programs for therapists.

Tables

Table 1

Sample Demographic Characteristics and Descriptive Statistic (N = 132)

	n/M	(%/SD)	Range
ASMS Total			
	1.89	0.66	1.00 – 4.14
Perceived Competence			
	4.07	1.32	1.08 – 6.50
Highest Degree			
CMFT Master's	115	87.12	
CMFT Doctoral	11	8.33	
Other Doctoral	6	4.55	
Years of Clinical Experience			
	8.72	6.31	
BDSM Training Experience			
	8.87	9.10	
AASECT Certification			
Certified or In-Training	17	12.98	
Not Certified	114	87.02	
Number of BDSM-Identifying CLs			
	14.32	24.38	
Professional Advertisement of Specialty			
None or Declined	32	24.43	
BDSM, Kink, CNM	10	7.63	
LGBTQ	28	21.37	
Combination	61	46.56	
License			
LMFT / LCMFT	86	65.15	
Provisional	46	34.85	
Age			
	38.98	11.44	
Gender			
Male/man	20	15.27	
Female/woman	100	76.34	
Trans/GNC/Intersex	11	8.40	
Race/ Ethnicity			
White	92	69.70	

	n/M	(%/SD)	Range
Other Race/ PoC	40	30.30	
Religion/ Faith			
Christian	22	17.74	
Jewish	13	10.48	
Atheist, Agnostic, Unspecified, Unsure	54	43.55	
Other Religion, Faith, Spirituality	35	28.23	
Religiosity			
	1.65	0.95	
Self-Identification as BDSM Practitioner			
Yes	44	34.92	
No	82	65.08	

Table 2

Bivariate Associations (ANOVAs) between Discrete Professional Factors and Sample Demographic Characteristics and BDSM Attitudes and Perceived Competence (N = 132)

Variables	BDSM Attitudes			Perceived Competence		
	Margins	*F*	*p*	*Margins*	*F*	*p*
Degree		2.35	.100		0.08	0.926
Master's CMFT	1.85			4.08		
Doctoral CMFT	2.09			3.92		
Doctoral Other	2.41			4.03		
AASECT Certification		10.25	.002		41.53	< .001
Certified or In-Training	1.40_{a}			5.75_{a}		
Not Certified	1.95_{a}			3.83_{a}		
Professional Advertisement of Specialty		19.21	< .001		45.64	< .001
None or Declined	2.38_{ab}			2.81_{abc}		
BDSM, Kink, CNM	1.61_{ac}			4.41_{ad}		
LGBTQ	2.18_{cd}			3.39_{bde}		
Combination	1.52_{bd}			5.00_{ce}		
Self-Identification as BDSM Practitioner		30.72	< .001		43.59	< .001
Yes	1.47_{a}			4.96_{a}		
No	2.13_{a}			3.55_{a}		
Gender		1.73	.181		4.42	.014
Male/man	1.91			3.79_{a}		
Female/woman	1.91			4.02_{b}		
Trans/GNC/Intersex	1.51			5.15_{ab}		

Variables	BDSM Attitudes			Perceived Competence		
	Margins	*F*	*p*	*Margins*	*F*	*p*
Race/ Ethnicity		2.5	.116		2.2	.140
White	1.83			4.18		
Other Race/ PoC	2.04			3.81		
Religion/ Faith		6.25	.001		5.93	0.0008
Christian	2.36_{ab}			3.31_{ab}		
Jewish	2.07			3.62_{c}		
Atheist, Agnostic, Unspecified, Unsure	1.68_{a}			4.52_{ac}		
Other Religion, Faith, Spirituality	1.82_{b}			4.03_{b}		

Note. Values with the same subscripts denote statistical differences across groups at $p < .05$

Table 3

Bivariate Associations (Correlations) between Continuous Professional Factors and Sample Demographic Characteristics and BDSM Attitudes and Perceived Competence (N = 132)

Variables	1	2	3	4	5	6	7
1. Attitudes	-						
2. Perceived Competence	-.55***	-					
3. Age	-0.01	.26**	-				
4. Religiosity	.34***	-.39***	.27**	-			
5. Years of Experience	.01	.19*	.64***	-.15	-		
6. # of BDSM Clients	-.36***	.56***	.33***	-.28**	.44***	-	
7. Training Experience	-.48***	.66***	.19*	-.32***	.15	.37***	

Note: ***$p < .001$; **$p < .01$; *$p < .05$

Table 4

Multivariate Regression Model Testing the Associations between Professional Factors, Covariates, and BDSM Attitudes and Perceived Competence (N = 132)

	BDSM Attitudes			*Perceived Competence*		
	B	*SE*	*p*	*B*	*SE*	*p*
Degree						
Doctoral CMFT	0.08	0.22	0.71	-0.16	0.31	0.60
Doctoral Other	0.05	0.26	0.04	0.06	0.36	0.88
Training Hours						
	-0.16	0.16	0.03	0.73	0.22	0.00
AASECT Certification						
Certified or In-Training	-0.07	0.20	0.73	0.60	0.28	0.03
Number of BDSM Clients						
	0.00	0.00	0.45	0.01	0.01	0.14
Years of Experience						
	0.00	0.01	0.81	0.01	0.01	0.33
Professional Advertisement of Specialty						
BDSM, Kink, CNM	-0.39	0.27	0.15	0.73	0.37	0.05
LGBTQ	-0.07	0.18	0.71	0.31	0.24	0.20
Combination	-0.33	0.21	0.13	1.04	0.29	0.00
Self-Identification as BDSM Practitioner						
No	0.19	0.15	0.21	-0.16	0.21	0.43
Gender						
Female/woman	-0.04	-0.04	0.80	0.28	0.23	0.23
Trans/GNC/Intersex	0.06	0.06	0.81	0.64	0.35	0.07

		BDSM Attitudes			*Perceived Competence*		
		B	*SE*	*p*	*B*	*SE*	*p*
Race/ Ethnicity							
	Other Race/ PoC	0.05	0.13	0.71	-0.12	0.18	0.51
Religion/Faith							
	Jewish	-0.08	0.23	0.73	-0.57	0.31	0.07
	Atheist, Agnostic, Unspecified, Unsure	-0.19	0.22	0.39	-0.33	0.30	0.28
	Other Religion, Faith, Spirituality	-0.26	0.20	0.21	-0.35	0.28	0.21
Religiosity		0.07	0.08	0.43	-0.14	0.11	0.23

Appendix A

Attitudes About Sadomasochism Scale (Yost, 2010, p. 90-91)

Attitudes about Sadomasochism Scale

Instructions: For each of the following statements, please note whether you agree or disagree, using the following scale:

1	2	3	4	5	6	7
disagree strongly	disagree moderately	disagree mildly	neither agree nor disagree	agree mildly	agree moderately	agree strongly

Use the following definitions when considering your responses:

Sadomasochism:	sexual practices that involve dominance and submission (the appearance that one person has control over the other), sometimes involve role-playing (such as Master–slave or Teacher–student), are always consensual (all partners participate willingly and voluntarily).
Sadomasochist:	someone who deliberately uses physical stimulation (possibly pain) and/or psychological stimulation and control to produce sexual arousal and to achieve sexual pleasure
Dominant:	someone who always or mostly is the person in control during an SM sexual encounter
Submissive:	someone who always or mostly is the person who does not have control during an SM sexual encounter

1. Sadomasochists just don't fit into our society.

2. Practicing sadomasochists should not be allowed to be members of churches or synagogues.

3. Sadomasochism is a perversion.

4. Sadomasochistic behavior is just plain wrong.

5. Sadomasochism is a threat to many of our basic social institutions.

6. I think sadomasochists are disgusting.

7. Sadomasochistic activity should be against the law.

8. Parents who engage in SM are more likely to physically abuse their children.

9. Sadomasochism is an inferior form of sexuality.

10. If I was alone in a room with someone I knew to be a Dominant, I would feel uncomfortable.

11. SM rarely exists in a psychologically healthy individual.

12. If I was alone in a room with someone I knew to be a Submissive, I would feel uncomfortable.

13. People who engage in SM are more likely to become involved in domestic violence.

14. A Dominant is more likely to rape a romantic partner than the average person.

15. A Dominant is more likely to rape a stranger than the average person.

16. A Dominant is more likely to sexually molest a child than the average person.

17. A variety of serious psychological disorders are associated with sadomasochism.

18. Sadomasochists are just like everybody else.

19. Sadomasochism is erotic and sexy.

20. Many sadomasochists are very moral and ethical people.

21. Sadomasochistic activity should be legal, as long as all participants are consenting adults.

22. Submissives are passive in other aspects of their lives (besides sex).

23. Dominants are aggressive and domineering in other aspects of their lives (besides sex).

Note. Items 18 through 21 should be reverse scored prior to computing subscale scores. To create the Socially Wrong subscale score, average Items 1 through 12; the Violence subscale, average items 13 through 17; the Lack of Tolerance subscale, average items 18 through 21; and the Real Life subscale, average items 22 and 23. A full scale score Tolerance subscale, average items 18 through 21; and the Real Life subscale, average items 22 and 23. A full scale score can be computed by averaging responses to all 23 items. 91

Appendix B

Item Modifications: BDSM-PCoCs Modification Questionnaire

Adapted from Bidell (2005), Carlson, McGeorge, and Toomey (2013), and McGeorge, Carlson, and Toomey (2015)

Original Items listed first, followed by the text for the revised items:

Knowledge and Skills Combined Subscales

1. **Original Item:** I have received adequate clinical training and supervision to provide therapy to lesbian, gay, and bisexual (LGB) clients.
    a. **Revised Item:** I have received adequate clinical training and supervision to provide therapy to clients who are BDSM practitioners.
2. **Original Item:** I know where to find resources to enhance my therapy skills when working with LGB clients by monitoring my functioning/competency—via consultation, supervision, and continuing education.
    a. **Revised Item:** I know where to find resources to enhance my therapy skills when working with BDSM practitioner clients by monitoring my functioning/competency—via consultation, supervision, and continuing education.
3. **Original Item:** I have had the opportunity to work with gay male clients in therapy.
    a. **Revised Item:** I have had the opportunity to work with male BDSM practitioners in therapy.
4. **Original Item:** At this point in my professional development, I feel competent, skilled, and qualified to provide therapy to LGB clients.

   a. **Revised Item:** At this point in my professional development, I feel competent, skilled, and qualified to provide therapy to clients who are BDSM practitioners.
5. **Original Item:** I have had the opportunity to work with lesbian or gay couples in therapy.
   a. **Revised Item:** I have had the opportunity to work with BDSM-practicing couples in therapy.
6. **Original Item:** I have had the opportunity to work with lesbian clients in therapy.
   a. **Revised Item:** I have had the opportunity to work with female BDSM practitioners in therapy.
7. **Original Item:** I am aware some research indicates that LGB clients are more likely to be diagnosed with mental illnesses than are heterosexual clients.
   a. **Revised Item:** I am aware some research indicates that clients who are BDSM practitioners are more likely to be diagnosed with mental illnesses than are clients who do not practice BDSM.
8. **Original Item:** I have received course work that focused on LGB issues in family therapy.
   a. **Revised Item:** I have received course work that focused on BDSM issues in family therapy.
9. **Original Item:** Heterosexist and prejudicial concepts have permeated the mental health professions.
   a. **Revised Item:** Prejudicial anti-BDSM concepts have permeated the mental health professions.

10. **Original Item:** I feel competent to assess the mental health needs of a person who is LGB in a therapeutic setting.
    a. **Revised Item:** I feel competent to assess the mental health needs of a person who is a BDSM practitioner in a therapeutic setting.
11. **Original Item:** I am knowledgeable about LGB identity development models.
    a. **Revised Item:** I am knowledgeable about BDSM identity development models.
12. **Original Item:** I have had the opportunity to work with bisexual (men or women) clients in therapy.
    a. **Revised Item:** *item removed*
13. **Original Item:** I am aware of institutional barriers that may inhibit LGB people from using mental health services.
    a. **Revised Item:** I am aware of institutional barriers that may inhibit BDSM practitioners from using mental health services.
14. **Original Item:** I am aware that therapists frequently impose their values concerning sexuality upon LGB clients.
    a. **Revised Item:** I am aware that therapists frequently impose their values concerning sexuality and sexual practice upon clients who are BDSM practitioners.
15. **Original Item:** Currently, I do not have the skills or training to do a case presentation if my client was LGB.
    a. **Revised Item:** Currently, I do not have the skills or training to do a case presentation if my client was a BDSM practitioner.

16. **Original Item:** I have done a therapeutic role-play as either the client or therapist involving a LGB issue.
    a. **Revised Item:** I have done a therapeutic role-play as either the client or therapist involving a BDSM issue.

Attitude Scale

1. **Original Item:** The lifestyle of a LGB client is unnatural and immoral.
    a. **Revised Item:** The lifestyle of a BDSM practitioner client is unnatural and immoral.
2. **Original Item:** Personally, I think homosexuality is a mental disorder or a sin and can treated through counseling or spiritual help.
    a. **Revised Item:** Personally, I think BDSM practice is indicative of a mental disorder or is a sin and can treated through counseling or spiritual help.
3. **Original Item:** When it comes to homosexuality, I agree with the statement: "You should love the sinner but hate or condemn the sin."
    a. **Revised Item:** When it comes to BDSM, I agree with the statement: "You should love the sinner but hate or condemn the sin."
4. **Original Item:** I believe that LGB couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine normal and traditional family values.
    a. **Revised Item:** I believe that BDSM couples don't need special rights (e.g. parental custody rights) because that would undermine normal and traditional family values.
5. **Original Item:** It would be best if my clients viewed a heterosexual lifestyle as ideal.

    a. **Revised Item:** It would be best if my clients viewed traditional sexual practices as ideal.

6. **Original Item:** I think that my clients should accept some degree of conformity to traditional sexual values.
    a. **Revised Item:** I think that my clients should accept some degree of conformity to traditional sexual values.
7. **Original Item:** I believe that all LGB clients must be discreet about their sexual orientation around children.*
    a. **Revised Item:** I believe that all clients who are BDSM practitioners must be discreet about their sexual orientation around children.*
8. **Original Item:** It's obvious that a same sex relationship between two men or two women is not as strong or as committed as one between a man and a woman.
    a. **Revised Item:** *item removed*
9. **Original Item:** I believe that being highly discreet about their sexual orientation is a trait that LGB clients should work towards.
    a. **Revised Item:** I believe that being highly discreet about their sexual practice is a trait that clients who practice BDSM should work towards.
10. **Original Item:** I believe that LGB clients will benefit most from counseling with a heterosexual counselor who endorses conventional values and norms
    a. **Revised Item:** I believe that clients who practice BDSM will benefit most from counseling with a counselor who endorses conventional sexual practices, values and norms.

All questions will utilize a six point Likert scale, with from 1 (indicating "Not at All True") to 6 (indicating "Totally True")

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