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Clinical Considerations in Treating BDSM Practitioners: A Review

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ABSTRACT

BDSM is an overlapping acronym referring to the practices of bondage and discipline, dominance and submission, and sadism and masochism. This article reviews the psychological literature on BDSM practitioners and discusses issues concerning BDSM that are relevant to clinicians and sexual health-care providers. The literature concerning the psychological health of BDSM practitioners and clinical issues in treating BDSM practitioners was exhaustively reviewed. BDSM practitioners differ minimally from the general population in terms of psychopathology. Six clinical considerations emerged: ignoring versus considering BDSM; countertransference; nondisclosure; cultural competence; closer relationship dynamics; BDSM, abuse, and pathology.

Sexual sadism and sexual masochism describe behaviors that fall under the paraphilia umbrella and are often accepted as variations of "typical" sexual behaviors. Given the proliferation of sadomasochistic themes in sexually explicit media (Weiss, 2006a), sadomasochism may represent a more common sexual expression among individuals than was previously assumed (e.g., Moser & Levitt, 1987; Richters, de Visser, Rissel, Grulich, & Smith, 2008), with an estimated 10% of adults in the general population having engaged in some form of BDSM activity (Moser & Kleinplatz, 2006a). Light forms of sadomasochistic sexual activity, such as spanking, biting, and hair pulling, are not uncommon among individuals with more conventional sexual proclivities, with a minority of the population reporting engagement in more intense forms of sadomasochism, such as whipping, paddling, and bondage (Moser & Kleinplatz, 2006b). Despite ostensibly high human interest in alternative sexual behavior, the peer-reviewed academic literature surrounding unusual sexual activities and preferences remains relatively sparse. This review article aims to (a) provide a brief review of the history of the diagnosis of paraphilia; (b) present an overview of psychological- and personality-based literature on individuals who engage in alternative sexual practices; and (c) discuss issues concerning alternative sexuality relevant to clinicians and sexual health-care providers.

In recent years, BDSM—an overlapping acronym referring to the practices of bondage and discipline, dominance and submission, and sadism and masochism—has garnered an increasing amount of attention (Newmahr, 2010; Weiss, 2006b). Bondage and discipline involves using psychological or physical restraints, domination and submission involves the exchange of power and control, and sadism and masochism (or sadomasochism) involves taking pleasure in one's own, or another's, pain or humiliation (Hébert & Weaver, 2014). Fetishism is also considered to be part of the BDSM community (Nichols, 2006) and may be colloquially understood as a strong interest in or preference for certain activities, tools, fabrics, or clothing. Together, the practices comprising BDSM are often referred to as "kink" (Nichols, 2006). BDSM involves the consensual use of physical or psychological stimulation, often in combination

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with the eroticization of pain and/or power, to produce arousal and satisfaction (Wiseman, 1996). This article uses the term *BDSM* when discussing the diverse practices associated with its broader label, and *SM* (sadomasochism) when referring specifically to sadism and/or masochism.

Despite the increased visibility of BDSM, stigma attached to the practice is widespread, and misconceptions about BDSM practitioners are common (Newmahr, 2010; Silva, 2015). Over the last few decades there has been a sociological shift in how BDSM is conceptualized. Diagnostic changes to the *DSM-5* were made, with the intention of reducing stigma. The *DSM-5* (American Psychiatric Association [APA], 2013) and *DSM-IV-TR* (APA, 2000) criteria for paraphilia, sexual sadism, and sexual masochism are shown in Table 1. These changes clarify that nonconventional sexual interests and behaviors are not evidence of psychopathology. Consensual sadism and masochism no longer warrant a diagnosis unless significant clinical distress about their interest, not due to societal disapproval, is present.

Kink-aware and kink-friendly therapists

Kolmes and Weitzman (2010) highlight the differences between a kink-aware and a kink-friendly therapist. According to these authors, a kink-aware therapist recognizes BDSM as a normal part of sexual expression, is able to distinguish healthy BDSM from nonconsensual abuse, is aware of what constitutes safe versus unsafe BDSM, has a general understanding of the intricacies of BDSM, and is aware of kink-specific issues that might come up in therapy, such as the coming-out process, communication about BDSM interests with nonkinky partners, negotiation of boundaries within and outside of the relationship, and the stress experienced in keeping the practice of BDSM secret. A kink-friendly therapist is one who may not have educated himself or herself on BDSM, but is able to maintain an open mind and can refrain from judging kinky clients negatively on the basis of their interests.

Psychological and personality characteristics of BDSM practitioners

The available research suggests that BDSM practitioners differ minimally from the general population in terms of psychopathology. Compared to nonpractitioners, research has found BDSM practitioners to have the same rates of mental illness and psychological adjustment (Connolly, 2006; Cross & Matheson, 2006), as well as psychological distress (Richters, de Visser, Rissel, & Smith, 2006). Another study on personality characteristics found BDSM practitioners to be less neurotic, more extroverted, more open to new experiences, more conscientious, and less agreeable compared with nonpractitioners (Wismeijer & Assen, 2013). Weinberg (2006) reviewed the literature on BDSM spanning three decades and found the empirical research to suggest that BDSM practitioners are psychologically and socially well adjusted. Together, these studies highlight the relative good psychological health of BDSM practitioners (Gosselin & Wilson, 1980; Moser, 1999; Moser & Levitt, 1987; Richters et al., 2008). Findings such as these have led several authors to conclude that BDSM is best regarded as a recreational leisure activity, as opposed to the manifestation of psychopathology (e.g., Newmahr, 2010; Williams, 2009; Williams, Prior, Alvarado, Thomas, & Christensen, 2016).

Clinical considerations and recommendations

Although nondistressing sexual sadism and sexual masochism are no longer deemed to be mental disorders according to the *DSM-5* (APA, 2013), many clinicians remain uninformed of this. Awareness of gender and sexual diversities is only minimally discussed in most psychological training programs (Glyde, 2015). This lack of awareness creates the potential for doing harm to sexual-minority clients. The available research suggests that many therapists have inadequate or inaccurate information on BDSM practices, are uncomfortable working with BDSM clients, use unhelpful or even unethical practices with BDSM clients, and inappropriately pathologize BDSM practices (Ford & Hendrick, 2003; Kolmes, 2003; Lawrence & Love-Crowell, 2008). For example, in a study examining the therapeutic experiences of self-identified BDSM practitioners, some participants reported that their therapists went as far as requiring them to give up their involvement with BDSM as a condition to continuing therapy (Kolmes, 2006).

Table 1. The *DSM-5* (APA, 2013) and *DSM-IV-TR* (APA, 2000) criteria for Paraphilia, Sexual Sadism, and Sexual Masochism.

DSM-IV-TR	*DSM-5*
Paraphilia The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months (Criterion A). The diagnosis is made if the person has acted on these urges with a nonconsenting person or the urges, sexual fantasies, or behaviours cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B).	**Paraphilia & Paraphilic Disorder** The term *paraphilia* denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners. A *paraphilic disorder* is a paraphilia that is currently causing distress or impairment to the individual or paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others. A paraphilia is necessary but not a sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily justify or require clinical intervention. In the diagnostic criteria set for each of the listed paraphilic disorders, Criterion A specifies the qualitative nature of the paraphilia, and Criterion B specifies the negative consequences of the paraphilia. In keeping with the distinction between paraphilias and paraphilic disorders, the term *diagnosis* should be reserved for individuals who meet both Criteria A and B. If an individual meets Criterion A but not Criterion B for a particular paraphilia, then the individual may be said to have a paraphilia but not a paraphilic disorder.
Sexual Masochism A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer. B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupation, or other important areas of functioning.	**Sexual Masochism Disorder:** A. Over a period of at least 6 months, recurrent and intense sexual arousal from the act of being humiliated beaten, bound, or otherwise made to suffer, as manifested by fantasies, urges, or behaviors. B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Specify* if: **With asphyxiophillia**: If the individual engages in the practice of achieving sexual arousal related restriction of breathing. *Specify* if: **In a controlled environment**: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in masochistic sexual behaviors is restricted. **In full remission**: There has been no distress or impairment in social, occupational, or other areas of function for at least 5 years while in an uncontrolled environment.
Sexual Sadism A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person. B. The person has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.	**Sexual Sadism Disorder** A. Over a period of at least 6 months, recurrent, and intense sexual arousal from the physical or psychological suffering of another person, as manifested by fantasies, urges, or behaviors. B. The individual has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Specify* if: **In a controlled environment**: This specifier is primarily applicable to individuals living in institutional or other settings where opportunities to engage in sadistic sexual behaviors are restricted. **In full remission**: The individual has not acted on the urges with a nonconsenting person, and there has been no distress or impairment in social, occupational, or other areas of functioning, for at least 5 years while in an uncontrolled environment

Table 2. Clinical issues to consider in the treatment of BDSM practitioners.

Clinical Consideration	Description
Ignoring vs. considering BDSM	The problem the client is seeking help with may not be related to BDSM involvement, and in such cases, BDSM should not be made a central issue in his or her treatment.
Countertransference	The psychologist being aware of his or her own emotional reaction to the client's involvement in BDSM.
Nondisclosure	Fear of negative evaluations may prevent BDSM practitioners from disclosing their sexual preferences to mental health professionals.
Cultural competence	Having a general working knowledge of BDSM practices, cultural values, and associated phenomena.
Close relationships dynamics	Awareness of the issues BDSM practitioners commonly face with respect to the development and maintenance of interpersonal relationships.
BDSM, abuse, & pathology	Being able to distinguish BDSM from abuse and pathology, as well as identify abuse in a BDSM relationship when present.

Further, BDSM practitioners have lost jobs, housing, and custody of their children based on the legal testimony of psychiatric consultants' pathologization of BDSM (Kleinplatz & Moser, 2006; National Coalition for Sexual Freedom [NCSF], 2011; Wright, 2006).

Based on the reported experiences of BDSM practitioners, it is not uncommon for some mental health professionals to make negative comments about BDSM in a way that is considered unacceptable with respect to other areas of sexuality (Hudson-Allez, 2005). The association between BDSM-identification and social stigma is concerning in light of research that has documented the negative impact on healthcare usage when people experience stigma from medical professionals (Chesney & Smith, 1999). Three of the most common examples of biased, inadequate, or inappropriate care in the treatment of BDSM practitioners are confusing consensual BDSM with abuse, assuming that BDSM interests are indicative of a history of abuse, and deeming BDSM unhealthy (Kolmes, Stock, & Moser, 2006). BDSM participants who completed an Internet-based survey concerning their experiences with psychotherapy frequently reported that they had to correct misconceptions about BDSM held by their therapists (Kolmes, 2003). A follow-up study involving 175 BDSM practitioners reporting on their experience with therapy revealed 118 distinct incidences of therapists providing poor care to BDSM clients (Kolmes et al., 2006). Another study found that 32% of a sample of BDSM practitioners who had sought counseling reported that the counselor was insensitive to their sexual identity (Brame, 1999).

In an Internet-based survey of therapists' attitudes toward BDSM, 76% of therapists reported having treated at least one client involved in BDSM, while only 48% of therapists perceived themselves to be competent in this area (Kelsey, Stiles, Spiller, & Diekhoff, 2013). Prevalence estimates of BDSM practitioners are comparable to the number of adults involved in same-sex activity, suggesting that therapists can expect to encounter clients who practice BDSM as often as they encounter lesbian, gay, and bisexual clients (Lawrence & Love-Crowell, 2008). This comparison has important implications, as one study found practicing therapists reported being significantly more uncomfortable treating clients who practiced BDSM than with clients who engaged in same-sex or group-sex activity (Ford & Hendrick, 2003). Several authors have written about clinical issues in the treatment of BDSM practitioners, the primary themes of which are discussed below and summarized in Table 2.

Ignoring versus considering BDSM

More often than not, BDSM practitioners come to therapy for reasons separate from their involvement in BDSM (Nichols, 2006), such as depression, anxiety, or relationship issues (Connolly, 2006). Indeed, 74.9% of practitioners in the Kolmes et al. (2006) study reported that the issues that brought them to therapy were in no way related to their BDSM interests, while only 12% reported that their BDSM interests were related to their reasons for seeking therapy, and 11% reporting that it was tangentially related. In a qualitative study on psychologists experienced in working with BDSM practitioners, therapists highlighted the importance of being able to keep BDSM from becoming a central issue in therapy when it is peripheral to the client's presenting concerns (Bezreh, Weinberg, & Edgar, 2012). Clinicians can demonstrate acceptance and understanding of BDSM by not focusing on their client's involvement with BDSM.

It is important to stress that this point stands even if the desire to discuss the client's sexuality is driven by curiosity rather than by disapproval or judgment (Nichols, 2006).

With this in mind, it is equally important to consider the potential impact of BDSM involvement on seemingly unrelated issues. BDSM practitioners are often not open about their BDSM activities in all areas of life; many individuals hide their BDSM involvement from family, colleagues, and friends. In such cases, the fear of being "outed" or exposed represents a real concern with the potential for life-altering consequences. Being exposed could negatively impact a client's career and close relationships, as well as have negative repercussions with respect to divorce and child rearing (Nichols, 2006). Clinicians must be aware of these connections in order to validate clients' experiences and fears, as well as to assist them in overcoming associated barriers.

Countertransference

A salient issue that must be considered when working with BDSM practitioners is that of countertransference, a psychodynamic term that captures the emotional reaction of the mental health provider to the client. Lawrence and Love-Crowell (2008) conducted a qualitative study of 14 psychotherapists experienced in working with BDSM practitioner clients to identify treatment characteristics needed to provide psychological services. Issues around countertransference emerged as an important feature of treating BDSM practitioners. Countertransference was found to involve a range of experiences among therapists in this study, including revulsion, sexual arousal, and advocacy. Emotions and behaviors that are normally construed as unhealthy, such as powerlessness and shame, are normalized and eroticized in the context of BDSM (Pillai-Friedman, Pollitt, & Castaldo, 2015). To clinicians with little experience with this topic, countertransferential feelings such as shock, fear, disgust, anxiety, and revulsion are common (Nichols, 2006). These feelings can produce a deep-seated conviction that the client's behavior is self-destructive, often without tangible reasons to justify the resolve of this conviction. Countertransference is likely present in instances where clinicians believe their client's pathology is clear in the absence of concrete evidence of harm. Scenes that involve superficial cutting or verbal humiliation represent relatively common BDSM activities that might lead an uninformed therapist to erroneously jump to negative conclusions through the projection of the therapist's own reactions.

In working with BDSM practitioners, clinicians must challenge their own mainstream value system, theoretical beliefs, practice orientation, and subjective biases about various aspects of BDSM (Pillai-Friedman et al., 2015). Nichols (2006) offers several suggestions for how therapists can process countertransference feelings toward BDSM. Adopting an attitude of detached observation may help one to objectively question adverse reactions or judgments, allowing for a neutral way of analyzing countertransferential feelings (Nichols, 2006).

Nondisclosure

Many BDSM practitioners who seek therapy choose to not disclose their sexual preferences to their therapist for fear of negative evaluations (Nichols, 2006). In a study of 115 BDSM practitioners, fewer than half were "out" to their health-care providers, despite most participants expressing a preference for openness in order to receive more individualized care (Waldura, Arora, Randall, Farala, & Sprott, 2016). In this study, the most common reason for not coming out was a fear of stigma. Kolmes et al. (2006) examined 175 BDSM practitioners' experiences with therapy, and one third of the sample reported choosing not to disclose their BDSM involvement in therapy (Kolmes et al., 2006). Many of these participants attributed their reason for nondisclosure to concern over being judged negatively by their therapists. In addition to fears of negative appraisal, participants expressed concerns about counselors breaking confidentiality based on erroneous assumptions about others being at risk for harm due to BDSM activities. Concern over stigmatization was also found to have a censoring effect on some BDSM clients in a study by Hoff and Sprott (2009), who analyzed the therapy experiences of 32 BDSM-identified couples. Nondisclosure of sexual preferences may not interfere with therapy if the client's issues are unrelated or if the therapy is short-term; however, withholding such information has the potential to compromise therapy if the client's issues involve sexual or relationship problems (Nichols, 2006). Long-term therapy may also be negatively affected by nondisclosure, as important information concerning meaningful aspects of the client's life may be withheld.

Clinicians can encourage self-disclosure through indirect ways, such as having a rainbow flag visible in the office, literature on sexual minorities or BDSM on the bookshelves, and including questions about BDSM on client questionnaires. A clinician can also intentionally bring up BDSM indirectly over the course of therapy; for example, by mentioning the exceptional communication skills of people who practice BDSM (Nichols, 2006). During the intake interview, a clinician may facilitate disclosure by asking about the client's sexual history in an open-ended and encompassing fashion. Based on the positive feedback of BDSM practitioners, Waldura et al. (2016) recommend asking, "What else would you like me to know about your sexuality, so I can take best possible care of you?"

If a client discloses BDSM practice, the clinician may adopt a psychologically neutral and nonjudgmental therapeutic stance. A gentle curiosity and open mind toward discussion of BDSM is encouraged. Depending on context, the clinician may decide to withhold probing questions about safety and consent until the client is more comfortable discussing his or her practice of BDSM in therapy. When these potentially sensitive subjects are broached, the clinician should be careful not to display signs of negative evaluation or judgment; Jozifkova (2013) provides advice on how consent and safety can be nonjudgmentally inquired about. In addition to watching one's language, clinicians should pay particular attention to their nonverbal behaviors in order to avoid subtle nonverbal messages conveying disapproval or discomfort with BDSM, such as frowning, stiffening of the posture, or pushing the chair farther from the client (Waldura et al., 2016). If the client only mentions BDSM involvement in passing and not as a focus of discussion, the clinician is advised not to tirelessly pursue the subject. Any disclosure of BDSM involvement should be followed up by independently educating oneself on the subject.

Cultural competence

Of the 14 therapists interviewed in Lawrence and Love-Crowell's (2008) study, all unanimously emphasized the importance of cultural competence in conducting effective therapy with BDSM clients. Cultural competence was described in this context as portraying an open and accepting attitude toward BDSM clients and their activities, as well as having a general working knowledge about BDSM practices, cultural values, and associated phenomena (e.g., polyamory)—the latter being a significant requirement above and beyond just adopting a nonjudgmental and open approach. Therapists in this study also expressed that it was crucial not to pathologize BDSM involvement and not to regard practicing BDSM as indicative of a mental disorder. The importance of seeking out supervision and consulting with fellow mental health professionals was also discussed. Nichols (2006) similarly highlighted the need for a greater professional understanding of BDSM, and Kolmes et al. (2006) argued that clinicians should not provide services outside of their areas of education and training as a matter of ethics, and that any psychologist treating a client that practices BDSM has a professional responsibility to cultivate a greater understanding of BDSM. Kolmes et al. (2006) further advised that BDSM practitioners represent a distinct subculture and that specialized training is needed for ethical treatment of this population. These authors suggest that there is a need for specific guidelines to aid therapists working with kinky individuals, to educate practitioners on the complexity of BDSM, and to enable therapists to better distinguish between behaviors constituting a healthy expression of SM versus abuse. Kleinplatz and Moser (2004) provide preliminary guidelines for providing therapy to kinky clients that include many of the considerations discussed here.

The American Psychiatric Association guidelines for working with LGBT clients, which emphasize refusal to pathologize and the importance of seeking consultation when appropriate, can also be applied to the treatment of clients who practice BDSM (APA, 2013). To increase competency in providing treatment for BDSM practitioners, clinicians are encouraged to explore information describing BDSM practices. (See Table 3 for a collection of BDSM community literature resources.) The National Coalition for Sexual Freedom (NCSF; ncsfreedom.org) is an organization dedicated to creating a political, legal, and social environment in the United States that advocates for people involved in alternative sexual and relationship expressions, and offers many online resources for practitioners and clinicians alike.

Close relationship dynamics

Involvement in BDSM can have significant implications on the development and maintenance of close relationships. Stress often results from being "closeted," as the concealment of BDSM activities from friends, family, and colleagues can be challenging (Nichols, 2006). Stiles and Clark (2011) discuss the

Table 3. BDSM community literature resources.

Author(s)	Title
American Psychiatric Association (2013)	*Diagnostic and Statistical Manual of Mental Disorders* (5th ed.)
Bannon (1992)	*Learning the Ropes: A Basic Guide to Safe and Fun S/M Lovemaking*
Easton and Hardy (2001)	*The New Bottoming Book*
Easton and Hardy (2003)	*The New Topping Book*
Easton and Liszt (2015)	*When Someone You Love Is Kinky*
Fulkerson (2010)	*Bound by Consent: Concepts of Consent Within the Leather and Bondage, Domination, Sadomasochism (BDSM) Communities*
Harrington and Williams (2012)	*Playing Well With Others: Your Field Guide to Discovering, Exploring and Navigating the Kink, Leather and BDSM Communities*
Henkin and Holiday (1996)	*Consensual Sadomasochism: How to Talk About It and How to Do It Safely*
Kleinplatz and Moser (2004)	"Toward Clinical Guidelines for Working With BDSM Clients"
Masters (2008)	*This Curious Human Phenomenon: An exploration of some uncommonly explored aspects of BDSM*
Miller and Devon (1995)	*Screw the Roses, Send Me the Thorns: The Romance and Sexual Sorcery of Sadomasochism*
Morpheous (2008)	*How to Be Kinky: A Beginner's Guide to BDSM*
National Coalition for Sexual Freedom (2012–2017)	ncsfreedom.org
Nichols (2006)	"Psychotherapeutic Issues With "Kinky" Clients: Clinical Problems, Yours and Theirs"
Ortmann and Sprott (2012)	*Sexual Outsiders: Understanding BDSM Sexualities and Communities*
Taormino (2012)	*The Ultimate Guide to Kink: BDSM, Role Play and the Erotic Edge*
Williams (2006)	"Different (Painful$_i$) Strokes for Different Folks: A General Overview of Sexual Sadomasochism (SM) and Its Diversity"
Wiseman (1996)	*SM 101: A Realistic Introduction*

various reasons for concealment of BDSM involvement, levels of concealment and social disclosure, the use of cover stories, and concealment strategies to improve psychological outcomes. Nichols (2006) discussed the various issues that can arise with one's partner and family that are specific to BDSM clients. Some individuals repress their SM desires and do not disclose their interests to romantic partners. In such cases, a therapist may be asked to facilitate disclosure, or be sought out specifically to help process the aftermath of disclosure or accidental discovery of BDSM interests.

In addition to problems associated with the "coming-out" process, there are important considerations that must be taken into account when treating clients involved in kinky partnerships. For example, polyamory and various other forms of consensual nonmonogamy are common in the BDSM community; thus, knowledge of such relationship styles is important when working with this population (Lawrence & Love-Crowell, 2008). A basic understanding of relationships involving power exchange represents another area in which therapists working with BDSM clients should familiarize themselves. Such knowledge is especially important when treating clients who are involved in "lifestyle" BDSM relationships, wherein dominance and submission transcends sexual activity and is interwoven throughout many or all aspects of the relationship (Lawrence & Love-Crowell, 2008). Lawrence and Love-Crowell (2008) found relationship concerns to be the most common presenting issue of BDSM clients, according to therapists who work with this population. In this study, therapists noted that their BDSM clients often express difficulty in finding partners who share their interests. Disparate levels of interest in BDSM within established partnerships represent another common relationship problem reported by BDSM clients.

If a client is suffering from the burden of hiding or disclosing their sexual interests to an unaware partner, the book entitled *When Someone You Love Is Kinky* (Easton & Liszt, 2015) could be recommended. This book aims to help loved ones understand and accept a partner's interest in BDSM.

BDSM community membership

Clinicians working with BDSM practitioners should be aware of the potential ways organized BDSM communities may promote positive outcomes for members. The BDSM community represents a social network of advocacy and support groups, events, and safe spaces for like-minded people to discuss and engage in BDSM activities. In addition to regulating community norms of safety and consent, the

BDSM community fosters a sense of belonging among members, provides opportunities to socialize and meet partners, and offers various functional resources, which has particular relevance for clients seeking therapy.

Graham, Butler, McGraw, Cannes, and Smith (2015) examined the role, meaning, and function of BDSM communities from the perspective of self-identified BDSM practitioners. Three central themes emerged, each containing several categories. The first theme was social features. Participants spoke of the multifaceted ways they benefited from the interpersonal interactions with like-minded others enabled by community involvement. BDSM communities were reported to nurture both sexual relationships and platonic relationships that extend beyond BDSM. A sense of community was another strong social feature that emerged, referring to a broader sense of kinship and connection with a group of people. Acceptance represented another important social feature, with communities providing an environment where members' interests and identities are validated, celebrated, and shared. Newmahr (2011) similarly observed that BDSM communities are also more accepting of other forms of marginalization.

The second theme that arose was personal development in the form of self-improvement and self-actualization. BDSM communities were said to provide venues that encouraged sexual expression and personal growth. Participants also recognized various therapeutic elements to community involvement, as well as enhanced spiritual or philosophical knowledge. Other research supports the therapeutic benefits (Barker, Iantaffi, & Gupta, 2007; Pitagora & Ophelian, 2013; Williams, 2012) and spiritual elements (Nichols, 2006; Weiss, 2011; Westerfelhaus, 2007) of BDSM communities.

The functional resources offered by BDSM communities emerged as the final theme. Practitioners placed a high value on the sharing of educational knowledge and resources, as well as social support. A strong emphasis on safety and consent also arose as a prominent feature of BDSM communities. While results generally highlighted positive features, negative aspects of the community were also identified, such as internal conflict among members.

There are many kinds of events held by the BDSM community, and knowing where to start may be experienced as overwhelming or intimidated by novices. In such cases, a clinician might suggest the client search for a locally held *munch*, which is a public socialization venue that serves as a casual introductory space that people can visit to find entrance to the BDSM community and discuss topics related to BDSM.

The Internet has increased the visibility and accessibility of the BDSM community, and various websites provide an online platform for meeting and interacting with like-minded individuals. FetLife (www.fetlife.com), for example, is a worldwide, online social network comprising more than six million BDSM practitioners. It can be thought of as a Facebook for kinky people, and contains numerous resources for local events as well as online discussion forums. FetLife may represent another resource to which clinicians can direct their clients.

BDSM, abuse, and pathology

Without training in this area, it can be easy to confuse a loving, consensual BDSM relationship with an abusive relationship. A prominent fear among BDSM practitioners, especially women, is that kink activities will be confused with intimate partner violence or abuse (Waldura et al., 2016). However, it is important to recognize that real, nonconsensual abuse can occur within the confines of a BDSM relationship. Abuse in BDSM relationships can go beyond violations of physical or sexual boundaries, and involve partner manipulation, both financial and psychological. Clinicians working with BDSM practitioners must be able to differentiate healthy BDSM relationships from domestic violence and assault, as well as recognize abuse within BDSM relationships. In order to accomplish this, mental health professionals need to be educated on how boundaries are established and maintained in BDSM relationships (Kolmes et al., 2006). Jozifkova (2013) provides a useful guideline on how to identify abuse in BDSM relationships. In brief, markers distinguishing BDSM from violence include voluntariness, communication, a safe word or ability to withdraw consent, safer sex, and access to information about BDSM. Similarly, healthy BDSM relationships differ from abusive relationships based on the following: (a) the presence of fear versus feelings of safety distinguishes abuse from consensual BDSM; (b) the ability to use a safe word, rescind consent, and have the withdrawal of consent respected separates BDSM from abuse; (c)

in healthy BDSM relationships, partners are able to discriminate between BDSM activity and common everyday life; (d) in abusive relationships, the victim is often intentionally isolated from his or her friends and family; this is not the case in healthy BDSM relationships; (e) emotional highs and lows marked by periods of violence and reconciliation are common in abusive relationships, while healthy BDSM relationships do not exhibit this pattern; (f) a clear disparity in social hierarchy between partners exists in abusive BDSM relationships, and in some healthy BDSM relationships; the level of disparity in everyday life is the distinguishing factor, such that everyday hierarchy disparity is mild in functional healthy relationships; (g) respect for one another is present in healthy BDSM relationships, regardless of power dynamics; and (h) negotiation and communication are emphasized in healthy BDSM relationships, but are absent or disrespected in abusive relationships.

Physical indicators can also help distinguish consensual BDSM from abuse. Moser (2006) provides a list of physical differences between markers of abuse and BDSM for mental health professionals and physicians: (a) BDSM rarely results in facial bruising or defensive marks that are received on the forearms; (b) marks obtained during a BDSM scene usually have a pattern and are well defined, indicating that the bottom partner remained still—marks resulting from physical abuse are typically more random, and the soft-tissue bruising is unlikely to be focused in a single area; (c) the common areas for stimulation-based play are the buttocks, thighs, upper back, breasts, or the genitals (i.e., the fleshy parts of the body that can withstand intense stimulation)—marks involving the lower back, bony areas, eyes, and ears are unusual.

If confronted with a client who is engaging in SM but is practicing without the expressed consent of his or her partner, the client's behavior represents sexual or physical abuse and should be handled accordingly. If a client is engaging in Domination/submission (D/s) without the full consent of his or her partner, the client's behavior may constitute emotional or psychological abuse. If a client discusses sexual excitement over physically hurting or humiliating a *nonconsenting* person, psychopathology is likely present. It should be noted here that consensual nonconsent—such as role-playing sexual coercion—does not constitute psychopathology. Sadism in the context of BDSM can be differentiated from pathological sadism (as discussed in the *DSM-5*) in that sadistic behaviors in the absence of consent are not arousing or desirable to a sadist practicing consensual BDSM. Conversely, the lack of consent on the part of the victim represents a primary source of pleasure in cases of pathological sadism. The NCSF website offers community assistance guides for victims of sexual assault from within the BDSM scene.

Becoming a kink-aware practitioner

Specific training on treating BDSM-identified clients in therapy involves psychoeducation of accurate information about this sexual-minority group, awareness of cultural biases and the negative effects of stigma, and sensitivity to the intricacies presented by BDSM practitioners seeking therapy. Pillai-Friedman et al. (2015) offer a three-part training program to help mental health care professionals become kink-aware, which involves Sexual Attitude Reassessments (facilitated education on BDSM), independent reading, and skill development through supervision. Shahbaz and Chirinos (2017) have authored a book on becoming a "kink aware" therapist. Ortmann and Sprott (2012) provide a guide for clinicians seeking to gain competency in working with BDSM practitioners. The community-academic organization community-academic consortium for research on alternative sexualities (CARAS) created an instructional video for clinicians working with BDSM clients as part of their BDSM and Therapy project (https://carasresearch.org, Table 3). This project also articulates the possible risks of BDSM play, clarifies situations where BDSM play may not be healthy or helpful, and instructs clinicians on how to help BDSM practitioners process negative experiences unique to BDSM play (e.g., having limits pushed too far in a scene). The NCSF also maintains a network of kink-aware professionals and has website resources for clinicians. Kink-aware professionals who are interested in having people referred to them from the NCSF website may submit their name for consideration. Professionals listed on this platform "must believe that alternative forms of erotic play can be healthy and proper expressions of sexuality," and "agree that any form of consensual sexuality between adults can be considered healthy if practiced in a safe and responsible manner." National Coalition for Sexual Freedom. *How to Become a KAP professional*.

Conclusion

This literature review was intended to provide an up-to-date summary of the psychological characteristics and treatment of BDSM practitioners. Research suggests that BDSM practitioners are psychologically and socially well adjusted, and that the practice of BDSM may be best understood as a recreational leisure activity (Cross & Matheson, 2006; Hébert & Weaver, 2014; Moser & Kleinplatz, 2006a; Nichols, 2006; Weinberg, 2006). Despite its increasing visibility, stigma, discrimination, and misinformation concerning the practice of BDSM are common among mental health-care providers and the general public. Clinicians should be educated on the nuances of providing therapy to BDSM practitioners. It is hoped that this review will serve as a useful resource and referral guide for clinicians aiming to expand their scope of professional competence to include BDSM practitioners.

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