The Impact of Client Engagement in BDSM Practices on Psychotherapist Clinical Judgment

By

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Abstract

Despite the absence of strong evidence for an association between consensual practice of BDSM (i.e. bondage, domination, sadism, masochism) and psychopathology (Connelly, 2006), anti-BDSM stigma persists in various social domains, including law (Onoma, 2017), media (Weiss, 2014; Wilkinson, 2009), medicine (Wright, 2018) and perception among the general public (Stockwell et al., 2010). Whether this stigma against BDSM is present among psychotherapists, and how it may manifest in treatment of clients who engage in BDSM, is not as well understood. The current study investigated whether client engagement in BDSM affected psychotherapists' diagnostic impressions of clients using a two-group experimental design, wherein participants (licensed psychotherapists, $N = 93$) were randomly assigned to watch one of two equivalent vignettes that differed only with regard to the depicted client's engagement in BDSM. Participants were then asked to assess client functioning, estimate salience of various clinical issues to the case and determine which DSM-5 diagnoses to consider during differential diagnosis. The current study also investigated whether psychotherapists' explicit attitudes about sex and BDSM, personal familiarity with BDSM and number of clinical training hours related to sex-positivity predicted pathologization of a hypothetical client who engages in BDSM. Findings were mixed, with participants characterizing the client who engages in BDSM as higher functioning and presenting with fewer clinical issues in several domains, but more likely to have two paraphilic disorder diagnoses. No relationships between psychotherapist characteristics of interest and pathologization of the BDSM-engaged client were found. Several possible explanations for these results are explored, and implications for researching bias among mental health practitioners, mental health care for individuals who engage in BDSM are discussed.

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Chapter 1: Introduction

While various helping professions have served as culturally endemic forms of healing throughout human history, they have also played a role in shaping and maintaining the social norms of the cultures in which they are embedded. The emergence of psychotherapy as a widespread healing practice in Western cultures in the 19th and 20th centuries is no exception to this reality. Indeed the field as a whole has been criticized as a vehicle for the imposition of a specific set of cultural values (Feltham, 1999; Isack & Hook, 1995; Moodley & West, 2005) and some researchers have identified a shift in client values to align with clinician values as an unintended outcome of psychotherapy (Tjeltveit, 1986). Although many writers who acknowledge these critiques as valid concerns contend that the practice of psychotherapy can be effective, despite the practice's unintended function as a gatekeeper of socially acceptable behavior (Feltham, 1999; Moodley & West, 2005), it is important for psychotherapists to remain vigilant in identifying how the field may be reinforcing cultural values in ways that have a deleterious impact on the well-being of clients, particularly clients who find themselves at odds with hegemonic cultural values.

Sexual behavior is a domain where American social norms have shaped, and been shaped by, trends in the related fields of psychology, psychiatry, and counseling. Critiques from within and outside these fields have explored the impact of cultural values surrounding sex on what mental health professionals consider "normative" and "pathological" sexual practices, noting that the clinical definitions of sexual pathology have changed considerably over time and tend to mirror cultural values related to the perceived morality and/or safety of different sexual behaviors, as well as social norms surrounding the kinds of sexual behaviors deemed acceptable for people of different gender identities (De Block & Adriaens, 2013; LoPiccolo & Heiman,

1977). Policing of sexual behavior in Western cultures had largely been left to religious institutions prior to the advent of modern psychiatry and psychotherapy, with Judeo-Christian traditions determining what was considered normal and what was considered "perversion" in the eyes of the divine (De Block & Adriaens, 2013). The stances of physicians and psychiatrists on what constituted "normal" sexuality during the early emergence of psychotherapy as a healing practice were heavily informed by religious beliefs that identified promiscuity, masturbation and non-procreative sex as sinful (De Block & Adriaens, 2013). When psychological explanations for deviation from sexual behavior deemed socially acceptable became more widely accepted during the 18th and 19th centuries, the definitions of sexual dysfunction and disorder offered by psychiatrists and prominent social scientists often mirrored those that were punishable by law. For example, anal sex and same-sex attraction were seen both as perversions of innate sexual drives, as well as designated sexual crimes during the 18th century (De Block & Adriaens, 2013).

The helping fields have not merely acted as an expression of cultural values surrounding sex, but have also likely contributed to how norms related to sex have changed over the course of American history. Early psychiatrists' definitions of normative sexual desires for men and women reflected and strengthened cultural norms in the West related to traditional gender roles, with different sexual "perversions" being associated with different sexes due to the perception that such "perversions" were due to deviation from masculinity in men and femininity in women (De Block & Adriaens, 2013). In the mid 20th century, prominent institutions in the fields of psychology, psychiatry and counseling codified the idea that non-mainstream sex-practices are pathological in nature through the inclusion of sexual behaviors considered to be deviant in texts used to diagnose mental disorders (De Block & Adriaens, 2013). Examples of this include the characterization of sexual deviations as "sociopathic personality disturbances" in the first

iteration of the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 1952), and the specific inclusion of 8 sexual deviations as "non-psychotic mental disorders" in the second iteration of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II;American Psychiatric Association, 1968). This stance among mental health professionals had implications for how non-normative sex behaviors were perceived in other social domains, as demonstrated in the United States Supreme Court case *Boutilier v. Immigration and Naturalization Service*, wherein a gay Canadian native was deported by the United States due to same-sex attraction being characterized as a "psychopathic personality," a label that disqualified him from residency in the United States at the time.

Depathologization of sex behaviors and sexual identities deemed outside of the mainstream within fields related to mental health have been hard won, and have often required sustained political action. For example, pressure from LGBT activist groups was instrumental in prompting the American Psychological Association (APA) to remove "homosexuality" as a mental disorder diagnosis in the 1970s that (De Block & Adriaens, 2013), ultimately resulting in the release of the DSM-III-R in 1987, the first iteration to of the DSM to include no references to same sex-attraction as a mental disorder. It cannot be overemphasized that the decision to remove homosexuality from the DSM as a mental disorder diagnosis was not one entirely based on the extant research literature at the time, but one due, in large part, to shifts in political and social forces. Indeed, prominent figures in the field of clinical psychology have stated that other non-normative sex practices remain designated in the DSM as diagnostic criteria for mental disorders due to the relative absence of sustained advocacy for their removal (De Block & Adriaens, 2013).

It should be noted that research and policy changes in the fields of psychology and psychiatry have also been instrumental in expanding the range of sexual behaviors considered socially permissible. While the work of Alfred Kinsey and colleagues (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953) was poorly received by the greater community of psychiatrists at the time of its release, it is widely considered to be some of the most socially influential work on human sexuality, particularly with regard to its characterization of sexual practices that fall outside of what was then considered mainstream as natural expressions of the diverse range of healthy human sexuality (Bullough, 1998; De Block & Adriaens, 2013). Furthermore, the work of Evelyn Hooker (1957) demonstrating no significant differences in psychological adjustment between gay and heterosexual male participants played a critical role in the depathologization of same-sex attraction within the fields of psychology and psychiatry. The subsequent removal of references to same-sex attraction as a type of psychopathology in the DSM-III-R has been regarded as having a facilitative impact on movements to extend civil rights protections (e.g. marriage equality) to individuals in same sex-relationships through depathologization of same-sex attraction (Drescher, 2012, 2015), and has prompted similar calls for depathologization of other forms of sexual expression in the field and beyond (e.g. non-mainstream sex practices considered "paraphilias"; Kleinplatz & Moser, 2006; Moser & Kleinplatz, 2006; Shindel & Moser, 2011).

Thus, psychotherapy as a profession, and related fields that shape the standards of care in that profession, are far from an objective arbiters of "normal" sexuality. They are rather institutions that reflect contemporary attitudes about sex and act as gatekeepers for acceptable sexual expression. It is therefore imperative that researchers expand the existing body of literature on how mental health professionals interact with individuals whose sexual expression

falls outside of mainstream sexual practices so that the profession of psychotherapy can rise to its more recently stated aspirations of being a form of healing that respects the individual differences of those it aims to help (American Psychological Association, 2010; Sue & Sue, 2012). This dissertation and the associated research project will investigate how mental health professionals perceive and interact with individuals who engage in BDSM, a specific subset of consensual non-normative sexual behaviors that eroticize differences in power.

Definitions

Before discussing the details of the research project associated with this dissertation, it is important to ground that discussion in an operationalization of BDSM and related constructs. BDSM is an acronym for (b)ondage, (d)omination, (s)adism and (m)asochism, and is widely used as an umbrella term that encompasses a range of sexual and non-sexual practices that eroticize differences in power (Jozifkova, 2013). These include bondage—the erotic practice of restricting a partner's movement through rope or other restraints; pet play—a variant of erotic roleplay wherein participants play the roles of a domesticated animals and "handlers"; impact play—the use of various implements to inflict erotic pain; eroticization of humiliation; and dominant/submissive dynamics—the erotization of hierarchical relationships (e.g. master and slave, etc.), among others. The degree of a given individual's identification with and engagement in BDSM can vary widely (Bezreh, Weinberg, & Edgar, 2012), and can be confined to the sexual expression of the individual, exist as a feature of relationship dynamics between two or more people, or be a commonality within communities of interest. Although not every practitioner of BDSM chooses to be a part of a community of interest centered around BDSM, many practitioners of BDSM have identified a heightened sense of community and belonging as one of the benefits of engaging in BDSM (Hébert & Weaver, 2015; Yost & Hunter, 2012).

There are several common synonyms for BDSM that are widely used among those who engage in BDSM practices. The related terms “sadomasochism” or “S&M” were more commonly used during the 1960s and 1970s to describe practices associated with the current understanding of BDSM (as in Rubin, 1982), but are sometimes used to specifically denote sexual practices that eroticize inflicting pain (i.e. sexual sadism) or experiencing pain (i.e. sexual masochism). Another set of related terms is “kink” and “kinky,” which are used to describe practices that fall outside of the set sexual practices considered to be mainstream. The term “kinky” is often contrasted with “vanilla”, a term which denotes mainstream sex practices. Although “kink” can technically be used to refer to practices that do not eroticize power differences, such as fetishism (i.e. the taking of a sexual object other than another human being), and may thus be considered a broader categorical term, it is often used synonymously with BDSM.

It should be noted that BDSM and kink are characterized not only by the nature of the behaviors associated with those terms, but also by the emphasis that practitioners of BDSM place on consent and minimization of associated physical and psychological risks (Lindemann, 2013). This emphasis on consent and risk control is widely considered by practitioners of BDSM to be what distinguishes kink behaviors from sexual abuse (Jozifkova, Bartos, & Flegr, 2012; Pitagora, 2013), and is reflected in two acronyms that are commonly used among communities that have formed around BDSM: SSC (safe, sane and consensual) and RACK (risk aware consensual kink) (D. J. Williams, Thomas, Prior, & Christensen, 2014). Terminology within kink oriented communities continues to evolve and diversify around the issues of consent and risk mitigation, with some newer frameworks emerging that focus on what is known as the “4 Cs”—caring, communication, consent and caution (D. J. Williams et al., 2014).

The term “paraphilia” was introduced to the English lexicon in the early 20th century by Friedrich Salomon Krauss, a sexologist and contemporary of Sigmund Freud who studied non-mainstream sexual practices, and has been used among mental health professionals to describe sexual practices that fall outside of those prescribed by social norms or those presumed to be “normal.” Although this term has demonstrated remarkable longevity as a descriptor of non-mainstream sex practices among mental health professionals, and is still used as a diagnostic term in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), many individuals who engage in non-mainstream sex behaviors and mental health professionals have identified the term as a pejorative (Moser & Kleinplatz, 2006b; Shindel & Moser, 2011). Furthermore, the term “paraphilia” only denotes interest and participation in particular behaviors, and does not specify whether those behaviors are engaged in consensually. Consequently, the term does not distinguish consensual and non-consensual engagement in non-mainstream sexual behaviors. Some researchers have also noted that the definition of “normative” sexual behavior has shifted over time, and thus what is considered “paraphilic” has similarly shifted due to the nature of the term “paraphilia” as one that is defined in opposition to what is considered “normal” (De Block & Adriaens, 2013; LoPiccolo & Heiman, 1977; Moser & Kleinplatz, 2006b). Thus, in the interest of specificity and avoiding the mischaracterization of BDSM practices and those who engage in them, the term “paraphilia” will not be used in this document to describe BDSM-related behaviors, and will only be used in descriptions of historical and contemporary perspectives on BDSM that use the term as their primary descriptor of non-mainstream sex practices. Instead, given the considerable overlap in the use of the terms “BDSM”, “kink” and “sadomasochism” among individuals and communities that engage in consensual BDSM practices, these terms will be used interchangeably in this document to refer generally to non-

mainstream consensual sexual and non-sexual practices that eroticize power differences in a sexual relationship or encounter in the vast majority of this document.

The current prevalence of BDSM and non-mainstream sexual practices

The historical stigmatization of non-mainstream sex practices by society and social scientists, and the resulting stigma and motivation to conceal engagement in these activities, has hindered efforts to assess the prevalence of sexual behaviors that fall under the BDSM umbrella. However, an increasingly robust body of literature suggests that forms of sexual expression that lie outside of mainstream sexual practices are far from statistical anomalies, and feature in the sexual fantasies and behaviors of a considerable portion of the general population.

Research on sexual fantasies has yielded results suggesting that sexual fantasies involving BDSM-related themes (e.g. sadism, masochism, humiliation, dominance/submission, bondage, etc.) are present in sizable portions of the general population. A pair of studies conducted by Williams and colleagues (2009) investigating the content of sexual fantasies among American college-aged men found that 52-62% of respondents reported fantasizing about bondage (either being tied up or tying up others). Additionally, 62-65% of respondents in the same study reported fantasizing about performing sadistic sexual acts. A study investigating the status of BDSM in Belgium yielded an even higher estimate, with 68.8% of respondents reporting having experienced BDSM related fantasies that they either have or have not acted upon (Holvoet et al., 2017).

While some researchers have warned that fantasies are a poor predictor of sexual desire and actual engagement in sexual behavior in non-clinical and non-incarcerated populations (Joyal, 2015; K. M. Williams et al., 2009), there is some evidence that this may be due to fear of perceived negative social consequences in the case of individuals who fantasize about engaging

in non-mainstream sexual practices. For example, a large proportion of surveyed male and female college students indicated that they would engage in voyeurism if they could be assured that they would not face negative consequences (Rye & Meaney, 2007). Given the stigma that BDSM practitioners report experiencing related to their sex practices (Bezreh et al., 2012), and high rates of experiences with discrimination among individuals who practice BDSM (Wright, 2006, 2018), it is perhaps possible that more individuals would act on their desires and engage in consensual BDSM if it were viewed more favorably by society.

Estimates of the prevalence of kink-related desire and actual engagement in BDSM-related activities vary considerably. Some studies suggest that individuals who actually engage in BDSM may not constitute a large enough portion of the general population for BDSM behaviors to be considered "typical." Only 2.2% of sexually active men and 1.7% of sexually active women in an Australian sample of 19,307 individuals reported engagement in sexual acts related to bondage and discipline and/or sadomasochism in the year previous to the study (Richters, Grulich, De Visser, Smith, & Rissel, 2003; Richters, Visser, Rissel, Grulich, & Smith, 2008). In a study involving a representative sample of 1070 Canadian individuals, however, Joyal and Carpentier (2017) found that 23.8% of participants reported a desire to engage in masochistic sex acts and 7.1% of those surveyed reported a desire to engage in sadistic sex acts. The same study found that 19.2% of respondents had actually engaged in sexual masochism at least once in their lifetime, while 5.5% had engaged in at least one sadistic sexual behavior prior to the study. Another large scale study based on a non-clinical sample of Belgian participants yielded even higher estimates for the prevalence of BDSM participation, with approximately 46.8% of the sample reporting participation in at least one of the BDSM-related activities identified by researchers during their lifetime (Holvoet et al., 2017). Thus, there is little corroborating

evidence to suggest that participation in BDSM can be understood as statistically rare (i.e. present in less than 2.2% of the general population) or even unusual (i.e. present in between 2.3% of the population and 15.9% of the general population). Furthermore, given the high prevalence of sexual fantasies containing BDSM-related themes, and the possible role of societal stigma in suppressing the expression of such fantasies and desires, it is likely that BDSM-related practices can be understood as natural variants of human sexuality that manifest in a considerable portion of the general population. However, it should be noted that each of the existing large scale studies investigating the prevalence of BDSM behaviors have been largely conducted against a single cultural backdrop. As cultural values surrounding sex have been shown to impact the prevalence of different kinds of sexual expression (Hogan, 1982), the results of such studies are not generalizable to populations not represented by the respective samples of each study, and should be interpreted with caution.

Although research on the content of fantasies, strength of desire and engagement in behavior constitutes most of the research on the prevalence of BDSM, an emerging body of research has acknowledged that some individuals who engage in BDSM practices also integrate the practices into their sense of self. While there is little research on the prevalence of BDSM identities in the United States, a study on the prevalence of BDSM within the general population in Belgium found that 7.6% of the overall sample considered BDSM as an integral part of their identity (Holvoet et al., 2017). Additional research on the prevalence of kink identities in different communities, and how individuals who hold these identities differ from those who incidentally engage in BDSM, is warranted to further elucidate the breadth and depth of BDSM involvement among the general population.

While estimates of the prevalence of engagement in BDSM vary, it is clear that the phenomenon is common enough for a considerable number of psychotherapists to have had contact with clients who engage in kink behaviors or hold kink-related social identities. Seventy-six percent of a sample of 766 American psychologists reported having seen at least one client who had disclosed engagement in BDSM in during their career (Kelsey, Stiles, Spiller, & Diekhoff, 2013). Although mental health practitioners are called upon to provide effective and ethically sound treatment to individuals informed by thoughtful consideration of various domains of client functioning, including sexuality (American Psychological Association, 2009, 2010), prevalent stereotypes that associate BDSM and pathology in American society (Stockwell, Walker, & Eshleman, 2010) that persist despite the absence of strong research evidence that supports them (Connolly, 2006; Richters et al., 2008) may present a barrier to the provision of such treatment. As the internalization of stereotypes and stigma related to sexual identities has been identified as a source of prejudice against individuals who hold those identities (Herek, 2007), it is possible that internalization of negative stereotypes associated with BDSM by mental health professionals interact with kinky clients. An area where this may be particularly impactful is diagnostic and clinical decision making, which has been shown to be adversely impacted by stereotyping (McLaughlin, 2002). Unfortunately, research on how sexual prejudice against BDSM practitioners manifests among mental health practitioners specifically has been limited in both scope and methodology, necessitating additional research on whether and how sexual prejudice surrounding BDSM manifests among individuals working in mental health fields, particularly with regard to clinical judgment. The current study is a contribution to the research literature in this area, and investigated the relationship between client engagement in BDSM sex practices, mental health practitioner characteristics, and clinical decision making.

Chapter 2: Literature Review

This chapter reviews the extant literature pertaining to the theoretical, historical, social and psychological underpinnings of the stigma that surrounds BDSM, and how that stigma may be reflected in how mental health professionals treat clients who practice BDSM. Specifically, this synthesis of the literature explores the cultural origins of negative beliefs about non-normative sex practices in the United States, outlines the current treatment of BDSM by American social institutions, critically examines the evidence for and against pathologization of BDSM, and discusses how anti-BDSM stigma may manifest within the general population and among mental health professionals.

Theorized mechanisms of stigma and prejudice

Seminal theories surrounding the function and mechanisms of the related constructs of prejudice—negative attitudes and emotions associated with an outgroup (Allport, 1954)—and stigma—the pervasive devaluing of behaviors or personal characteristics associated with a marginalized group in society (Durkheim, 1895; Goffman, 1963)—have characterized these phenomena as ways that individuals and groups respond to perceived threats. Realistic conflict theory (Campbell, 1965; Sherif, Harvey, White, Hood, & Sherif, Carolyn, 1961) characterizes prejudice as a hostile response to outgroups that are perceived to be either a direct physical threat to the ingroup or a competitor for a shared pool of scarce resources. The originators of Social Identity Theory (Tajfel & Turner, 1979) expanded on the this understanding of perceived threat as the foundation of prejudice by asserting that threats to the ingroup need not be physical or material in nature to engender prejudice. Tajfel and Turner (1979) posited that social identity—affiliation with and emotional attachment to one's ingroup—is an important component of an individual's self-concept, and that humans' inclination to maintain a positive self-concept leads

them to favor and protect the integrity of their ingroup. This results in hostile responses to symbolic threats to the ingroup, such as individuals who violate ingroup norms (Tajfel & Turner, 1979).

Theories of learning and development provide a general framework of how group responses to stigmatized outgroup members become adopted by individuals. Social learning theory (Bandura, 1969, 1978; Bandura & Walters, 1977) suggests that direct experience of threat is not necessary for individuals to adopt prejudicial attitudes towards outgroup members, as humans internalize cognitive frameworks through vicarious learning and imitation. The attitudes and behaviors of similar or significant others in an individual's immediate environment are therefore often sufficient to spur the development of similar attitudes and behaviors in that individual (Rodríguez-García & Wagner, 2009). Moreover, Bronfenbrenner's ecological model of development (1979) maintains that the behaviors and attitudes of others in an individual's immediate proximity are shaped by interactions with social institutions, which are in turn shaped by broader cultural values. Thus, prejudice can be understood not only as something acquired through personal experiences with individuals who violate ingroup norms, but through exposure to stigmatizing messages associated with those individuals in one's environment. The understanding of the relationship between stigma and prejudice outlined by these theories is reflected in how social scientists have come to understand stigma against individuals who violate sexual norms, and how that stigma is expressed as prejudice against those individuals (Herek, 2007; Herek & McLemore, 2013), and provides a foundation for the current investigation of how sexual stigma surrounding BDSM may be reflected in prejudice among mental health practitioners towards clients who engage in BDSM.

Sexual stigma and prejudice. Although no framework has yet been developed for understanding the mechanisms that underlie prejudice against individuals who practice BDSM specifically, the theoretical literature related to discrimination against other groups that are marginalized on the basis of sexual expression serves as a potentially useful analogue for the theoretical underpinnings of the current study. One such framework proposed by Gregory Herek characterizes sexual prejudice—the negative evaluation of others based on sexual expression—as rooted in cultural beliefs that value some forms of sexual expressions over others, and the internalization of those norms by individuals' whose sexual expression conform to dominant views on acceptable sexual expression (Herek, 2007; Herek, Gillis, & Cogan, 2009; Herek & McLemore, 2013). Herek's framework of sexual prejudice posits that cultural norms in the United States characterize some forms of sexual expression as normal and good, while imposing sexual stigma—pervasive negative regard and diminished social power associated with forms of sexual expression that violate sexual norms—on others. Herek goes on to state that sexual stigma is expressed and maintained through three interrelated constructs: (1) enacted stigma, (2) felt stigma and (3) internalized stigma. Enacted sexual stigma involves systematic differences in treatment by social institutions and individuals, which can include ostracizing, attacking, and/or denying full participation in society to individuals with stigmatized sexual identities. Felt sexual stigma refers to the collective societal understanding of sexual stigma, and expectations surrounding what sexual expressions are stigmatized and how that stigma will be enacted. Internalized sexual stigma is understood as the adoption of cultural values surrounding sex as one's own and the incorporation of sexual stigma into one's own internal framework for evaluating self and others. Herek (2007) notes that internalized stigma takes divergent forms based on the degree to which an individual conforms to cultural norms surrounding sex. Whereas

the internalization of sexual stigma by members of a stigmatized group manifests as self-loathing, internalization of those same cultural values leads non-stigmatized individuals to harbor negative views of those who carry sexual stigma. Sexual prejudice in Herek's framework is therefore understood not as originating in or maintained by individuals, but rather as an expression of internalized sexual stigma.

Empirical support for the relationship between sexual prejudice and sexual stigma has largely emerged from its application in studying sexual prejudice towards individuals who hold lesbian, gay and bisexual (LGB) identities. These studies have largely focused on how LGB identities violate internalized values related to heteronormativity—the cultural assumption that heterosexuality is normal and correct (Rich, 1980; Warner, 1991). In a study on anti-gay attitudes, Minnigerode (1976) found that endorsement of sexually conservative attitudes and opposition to feminist challenges to traditional sex roles predicted anti-gay attitudes in a sample of 104 participants. A study by Herek (1988) yielded similar findings, with endorsement of traditional religious values, endorsement of traditional American beliefs regarding family roles for men and women, and perceived anti-gay attitudes among peers emerging as predictors of anti-gay attitudes. Olatunji (2008) found that the affective response of disgust towards gay men in individuals that endorse anti-gay attitudes was partially mediated by sexually conservative attitudes and religiosity, even when fear of contracting HIV/AIDS, another possible source of disgust reactions based in anti-gay stereotypes, was controlled for.

Other research has identified the internalization of heteronormative values as the underlying mechanism behind other predictors of attitudes towards LGB people. Whereas research on the role of attributions (i.e. beliefs about the origin of behavior) in determining prejudicial attitudes towards gay men in the United States has linked anti-gay attitudes with

beliefs that same sex attraction is controllable (Haider-Markel & Joslyn, 2008), the results of more recent studies indicate that this relationship is fully mediated by the belief that gays and lesbians violate cherished American cultural values (Reyna, Wetherell, Yantis, & Brandt, 2014). Thus, people who believe that same-sex attraction is a choice may hold negative views towards LGB people because they believe that LGB individuals are choosing to violate values that could easily be conformed to. Other research in the field of public policy has yielded corroborating evidence for the notion that internalized cultural values inform the attributions of choice that predict sexual prejudice. Lewis (2009) found that groups that were most likely to be exposed to scientific evidence debunking the idea that sexual orientation is a preference were no more likely to change their beliefs surrounding the origin of LGB identities (i.e. whether those identities are innate or the result of personal choice). Instead, he found that religious ideology was a strong predictor of beliefs that LGB identities are the product of personal preference, and that this relationship was fully mediated by moral judgment (Lewis, 2009). Taken together, these findings indicate that attributions about the controllability of non-mainstream sexual expression do not predict sexual prejudice in isolation, but are rather intertwined with or based in an individual's internalized cultural values surrounding sex.

As this body of literature does not pertain to sexual stigma surrounding BDSM specifically, more research is required to determine whether sexual stigma surrounding non-mainstream sexual practices like BDSM in the United States manifests as prejudice in ways similar to those established by the literature on sexual stigma towards LGB identities. However, while the content of negative stereotypes and prejudiced beliefs about BDSM may not completely mirror those explored in the literature on sexual stigma against LGB identities, Herek's model presumes that the existence of sexual stigma of any kind will generate some form

of prejudice at the individual level in non-stigmatized individuals. Given the current and historical status of BDSM as a non-mainstream sexual practice in the United States, Herek's model should predict that the stigma against BDSM in the United States will engender prejudicial thinking or negative stereotyping regarding BDSM at the individual level of some kind.

Foundations of anti-BDSM stigma

If sexual prejudice is to be understood as the internalization of sexual stigma, it is important to ground any investigation of current prejudice against BDSM within the helping professions in the United States in an understanding the historical antecedents of those prejudices. Thus, a consideration of the cultural milieu in which anti-BDSM attitudes developed and how cultural beliefs about sadomasochistic sexual behavior have shifted over time is warranted. Sexual stigma surrounding BDSM can be understood as having origins in three different social domains: religion, early psychiatric perspectives on sexuality and anti-sex social movements, which characterized deviation from socially acceptable forms of sexuality as moral failing, aberrations of development and recapitulation of harmful social dynamics, respectively.

Sexual deviance as a moral failing: religious perspectives. English Puritanism in the 17th and 18th century undeniably shaped the American cultural attitude towards sex, and, as such, has guided the development of attitudes towards specific sexual behaviors, including those that fall under the BDSM umbrella. The religious philosophy of Puritanism, which served as a moral code for many of the groups that participated in the colonization of what would later become the United States, emphasizes hard work and spiritual purity as requisite to spiritual salvation. Among the precepts of this worldview was the belief that sex should be restricted to a

heterosexual dyad joined by church-sanctioned marriage, and the belief that sex not directed towards procreation was to be avoided (Uhlmann & Sanchez-Burks, 2014).

While strict adherence to Puritanism as a religious philosophy has declined since the 17th century, research indicates that the puritan value system that stigmatized sex outside of wedlock or sex for purposes other than procreation has persisted, and continues to inform contemporary anti-sex attitudes (Uhlmann & Sanchez-Burks, 2014). Uhlmann and colleagues (2011) found that Americans who are not primed to engage in deliberate thinking tend to show greater implicit disapproval of promiscuity and non-procreative sex outside of a traditional heterosexual marriage dyad. They found that this relationship was particularly strong when American identity was primed in American participants, and failed to find the same pattern in participants from other cultures. These findings point to the existence of a lasting cultural legacy of puritanism—an association between non-procreative sex and immorality—that has likely shaped prevailing views towards all non-procreative sex practices. As BDSM practices are practiced both within and outside of heterosexual marriage, and are also by their nature not directed towards procreation, they naturally violate the enduring moral prescriptions surrounding sex in American society that are based in the Puritan philosophical tradition, setting the stage for stigmatization of individuals who engage in those practices.

Sexual deviance as aberrant development: early psychiatric perspectives. Influential secular perspectives on alternative sexual practices have characterized behaviors that fall under the BDSM umbrella not as moral violations, but as manifestations of pathology. Specifically, early psychiatric perspectives that influenced the development of psychological theories of sexual deviance viewed sadomasochistic sex practices as aberrations of innate sexual drives and/or manifestations of sexual trauma.

Early psychiatric views of sadomasochistic sexual practices were heavily shaped by the work of Richard Von Krafft-Ebing, a Viennese psychiatrist and regular correspondent to Freud, who composed *Psychopathia Sexualis*, a treatise on sexual dysfunction. Krafft-Ebing classified many of the sexual practices that currently fall under the BDSM umbrella as "paraesthesias", or manifestations of the sexual drive that deviate from what he saw as the natural purpose of sexual activity: procreation (De Block & Adriaens, 2013). Although this understanding of non-procreative sex as aberrant mirrors that of contemporary religious views, it represents a critical departure from views of non-mainstream sexual acts as moral failings, and resulted in a shift towards a cultural understanding of non-mainstream sexual expression as originating in personality differences. (De Block & Adriaens, 2013).

Krafft-Ebing's work would influence the views of one of the most prominent figures in the psychoanalytic school of thought and an individual who had an undeniable impact on the development of the helping professions in the United States: Sigmund Freud. As the work of Sigmund Freud emphasized the importance of the sexual drive as a central feature of the human experience, it is perhaps unsurprising that he took interest in sex behaviors that were deemed deviant, and that his conclusions about such behaviors would go on to influence prevailing views about sexuality in cultures impacted by his writings. While Freud's earlier work on sexual behavior acknowledged that children have the potential to develop a diverse range of sexual expressions, and that procreative sex was one of many possible expressions of the sexual drive, procreative sex with an adult remained at the center of his definitions of "normal" and "pathological" sex (Freud, 1905). He posited that sexual interest in humiliation, punishment, bondage and other "perversions" that fall under the BDSM umbrella were only pathological when they interfered with, or were engaged in exclusive of, procreation-oriented sexual activities

(De Block & Adriaens, 2013). However, he would later characterize "perversions" that persisted into adulthood as a pathological way of reenacting interpersonal trauma experienced in childhood (Freud, 1961). He also presumed that interest and engagement in sexual masochism would abate once the underlying trauma had been addressed through psychoanalytic therapy, a belief that persists even in some contemporary psychoanalytic writings (Levy, 2000; Metzl, 2004).

Given the undeniable impact of Kraft-Ebbing and Freud on cultural understandings of psychopathology in the United States, it is likely that their characterizations of sexual sadomasochism as an aberration of normal human developmental processes or a product of trauma has impacted American cultural values surrounding non-mainstream sex practices. Indeed, despite the recent emergence of calls for the depathologization of consensual BDSM practices from within the helping professions (Shindel & Moser, 2011), the perception of BDSM as a pathological reliving of childhood trauma persists within the field (e.g. Grossman, 1991; Southern, 2002).

BDSM as gender oppression: anti-sex feminist perspectives.

Prominent feminist perspectives in the 1970s and 1980s characterized BDSM, particularly sadomasochistic acts enacted in partnerships or interactions involving women, as expressions of misogyny inherent in a patriarchal society that further serve to reinforce social norms that subjugate women (e.g. Hoagland, 1982; Russell, 1982). This subset of feminist thinkers thus put forth the notion that sadomasochistic sex acts are inherently damaging to women, even when engaged in with the full consent of all individuals involved (Hoagland, 1982; D. E. H. Russell, 1982). This sentiment was so prevalent among influential feminists in the 1970s and 1980s that women who practiced BDSM were denounced in a resolution issued by the

National Organization for Women (NOW), the largest and most prominent group of feminist activists at the time (Wright, 2006). This stance on BDSM propagated by anti-BDSM feminists contributed to the stigmatization of practices related to BDSM in a manner different than that of early psychiatric perspectives on BDSM; rather than arguing from the premise that sexual sadomasochism emerges out of individual pathology and harms the individual, anti-sex feminism characterized sexual sadomasochism as having a cultural origin and a broader negative cultural impact.

It is worth noting that some prominent feminists of the 1980s took a markedly different stance on BDSM and challenged the aforementioned view of BDSM eroticism as inherently oppressive to women. Rather than characterizing BDSM as a way of perpetuating hierarchies of power that privilege men, these sex-positive feminist thinkers, and those who would later become known as the early queer theorists, conceptualized BDSM as a way to challenge gender norms and systems of power through sexual difference (Califia, 1994; France, 1984). Furthermore, many of them criticized the anti-BDSM attitudes in certain feminist circles as reflections of the puritan attitudes prevalent in American society that equate sex with moral inferiority (Rubin, 1982). Sex-positive feminism and queer theory thereby characterize engagement in BDSM as one of many radical responses to the societal trauma that results from gender and sexuality-based oppression, while refusing to pathologize BDSM eroticism itself (Califia, 1994; France, 1984; Rubin, 1982). While this branch of feminist thought champions the idea that BDSM eroticism is one of many healthy and adaptive forms of sexual expression, the legacy of anti-sex feminist views on BDSM is a persistent one, with some writers continuing to assert that engagement in BDSM, particularly as a woman playing a submissive sexual role, is the result of internalizing harmful gender roles (Deckha, 2011).

Stigma surrounding BDSM in social institutions

The historical pathologization of BDSM is reflected in the treatment of BDSM eroticism within contemporary societal institutions. The devaluing of and negative regard towards BDSM in the media, medical models of mental health, and the law can be understood as the enacted stigma that Herek alludes to in his model of sexual stigma (Herek, 2007, 2009; Herek & McLemore, 2013), and functions as part of the wider societal devaluing of BDSM that is internalized by individuals .

Representation in the media. While research on BDSM representation in the media remains sparse, the extant research literature suggests that pathologizing views continue to inform how BDSM eroticism is portrayed in the public sphere. Some analyses of popular portrayals of BDSM have noted the persistent emphasis on BDSM as taboo or pathological in popular media, utilizing BDSM themes as a way to connote edginess or danger (Wilkinson, 2009). While representation of BDSM has become more common in the media, and has at times been less explicitly pathologizing of BDSM practices that are more widely known amongst people outside of the BDSM community (e.g. bondage, spanking, etc.), even non-pathologizing depictions of BDSM are often derisive and devaluing (Weiss, 2014; Wilkinson, 2009). Other analyses of popular media portraying BDSM has criticized those depictions for treating BDSM as an impediment to traditional goals of romantic love (e.g. marriage) and thus positioning BDSM as a societal ill (Downing, 2013). Additionally, depictions of relationships or dyadic interactions involving BDSM often prompt audiences to empathize with individuals that take a submissive or masochistic role while casting them as victims (Weiss, 2014) while failing to acknowledge BDSM community's emphasis on consent as the cornerstone of sexual play

(Harper & Yar, 2013). Together, these depictions both reflect and perpetuate a cultural devaluing of BDSM sex practices, and bolster the perception of BDSM as akin to sexual violence or abuse.

DSM-5 Classification. Diagnostic criteria that pathologize BDSM sexual behaviors are another potential way that stigma is enacted through American medical and mental health institutions. Forms of sexual expression that fall under the BDSM umbrella are characterized as "paraphilias" in the current iteration of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), which characterizes paraphilias as the desire to engage in behaviors that fall outside of "genital stimulation" and "preparatory fondling" and/or attraction towards anything other than an adult human. More specifically, any persistent and intense sexual arousal related to experiencing physical or psychological suffering or inflicting that suffering on others for a period longer than 6 months would result in an individual meeting partial criteria for either sexual masochism disorder or sexual sadism disorder, respectively (Criterion A of sexual masochism disorder and sexual sadism disorder; American Psychiatric Association, 2013).

While the DSM-5 specifies that the presence of this kind of arousal does not necessarily imply the presence of disordered psychological functioning and that the presence of distress or impairment is necessary for a paraphilic disorder diagnosis to be made (American Psychiatric Association, 2013), the degree to which an individual's subjective experience of their own engagement in sadomasochistic sex practices factors into a clinical determination of distress/impairment is not clearly specified by the DSM-5 and may vary based on factors related to the attending clinician and/or the medical/mental health institution serving the individual. It is therefore important to acknowledge the possibility that consensual engagement in BDSM practices may be interpreted as causing an individual egosyntonic harm and/or impairment by a

clinician or institutions that hold a priori negative perceptions of BDSM. This possibility is particularly salient, given the persistence of beliefs linking BDSM and psychopathology in some schools of psychotherapy (Levy, 2000; Metzl, 2004).

Additionally, the inclusion of the paraphilic disorders in various iterations of the DSM, and the diagnostic criteria for sexual masochism disorder and sexual sadism disorder in particular, have been criticized as more indicative of anti-BDSM attitudes among clinicians and the general population than actual evidence linking engagement in BDSM practices with pathology or distress (Kleinplatz & Moser, 2006; Shindel & Moser, 2011; see section on evidence for and against stereotypes of BDSM for a more thorough review of the literature on levels of psychopathology in the BDSM community). Some have also argued that the distress and impairment that is assumed to result from engagement in BDSM has been poorly operationalized by writers and editors of the DSM-5 and that distress associated with accepting one's own BDSM identity and incorporating it into one's lifestyle in an adaptive way could be better captured by other existing diagnoses that do not specifically pathologize sexual expression (Shindel & Moser, 2011).

Treatment of BDSM in the law. As the law is both a reflection of and powerful influence on societal attitudes, particularly with regard to individuals perceived as falling outside of what is considered psychologically "normative" (Sales & Kahle, 1980), the legal system's treatment of BDSM-related behaviors can serve as an indicator of cultural perceptions of BDSM eroticism in the general population and act as a form of enacted sexual stigma.

Laws and rulings related to sexual and physical violence suggest that legal institutions often conflate consensual BDSM with violence. There is no specific exclusion for consensual BDSM under laws concerning assault and battery (Onoma, 2017), and a Virginia district court

ruled in *Doe v. George Mason University* (2016) that individuals' right to sexual liberty does not extend to BDSM related activities, citing states' obligation to protect "vulnerable persons." This association between BDSM and violence in the eyes of the law is far from an exclusively American legal phenomenon. In the United Kingdom, the case *R v. Brown* (1993) two men were charged with "unlawful and malicious wounding" and "assault occasioning bodily harm" related to consensual BDSM practices. When the accused asserted that their participation in these practices had been consensual, the court characterized BDSM as bodily harm and thereby rejected the notion that an individual could consent to engage in BDSM (*R v. Brown*, 1993). These legal realities contribute to the stigmatization of BDSM and increase the likelihood that BDSM practitioners will have negative, and potentially life altering, encounters with the legal system as a result of engaging in consensual forms of sexual expression. Furthermore, some evidence suggests that perceived hostility towards BDSM lifestyles, identities and practices within legal institutions may de-incentivize reporting of sexual violence in relationships where members are engaging in BDSM behaviors due to fear of legal and social repercussions unrelated to the actual instance of violence (Haviv, 2016; Pitagora, 2016).

The failure of the law to protect BDSM practitioners from discrimination on the basis of sexual expression is another way that the law reflects and reinforces social stigma surrounding BDSM. As federal anti-discrimination regulations established under Civil Rights Act of 1964 do not explicitly prohibit discrimination based on an individual's sexual expression or behavior, practitioners of BDSM are often subjected to discrimination in legal institutions and proceedings as well as in domains where stronger anti-discrimination law would otherwise protect them. This is evident in child custody cases where an individual's engagement in BDSM-related activities is used to cast doubt on their fitness as a parent (Klein & Moser, 2006) and practitioners' fears

about loss of employment due to disclosure of their kinky activities or identities (Bezreh et al., 2012). Research suggests that BDSM practitioners' fears are not without cause and that lack of protection for non-mainstream sexual behaviors under current anti-discrimination legislation produces demonstrable disparities in treatment in the domain of work; the results of some surveys suggest that up to 30% of kink identified individuals have experienced employment discrimination related to their engagement in BDSM (Wright, 2006).

Moreover, it is important to note that the way that BDSM practices are perceived within legal institutions is heavily influenced by the characterization of those practices by the helping professions due to the role that mental health care professionals often play in legal proceedings as expert witnesses and the power that information related to litigant mental health holds in swaying juror opinion (Garb, 1992). Indeed, Wright (2018) found that in the years following the introduction of less pathologizing language surrounding BDSM practices in the DSM-5, there was a precipitous decrease the number cases involving children being removed from the custody of parents who engages in consensual BDSM. This finding demonstrates that the impact of anti-BDSM stigma is not siloed within separate social institutions, and that the expressions of this stigma across social institutions inform and compound upon one another in ways that negatively impact kinky individuals' ability to participate in society.

Internalized anti-BDSM stigma

Anti-BDSM prejudice in the general population. Research conducted on implicit and explicit attitudes towards BDSM at the individual level has yielded results suggesting that non-kinky individuals have internalized the pervasive societal stigma surrounding BDSM and endorse pathologizing views about BDSM. Using the Implicit Relational Assessment Procedure (IRAP), a test of implicit bias, Stockwell and colleagues (2010) compared the speed with which

participants paired words related to BDSM and mainstream sexual practices with the terms "healthy" and "sick," and calculated whether response times would differ based on whether participants endorsed a kinky identity. They found that non-BDSM identified students took longer to associate BDSM-related terms with health and were quicker to associate BDSM-related terms with illness than their BDSM-identified counterparts, suggesting pathologization of BDSM among those who do not engage in kinky sex practices. Furthermore, the same researchers found that implicit anti-BDSM attitudes were correlated with explicit anti-BDSM attitudes measured by self-report measures; when participants were asked to rate terms related to mainstream and BDSM sex practices on a continuous scale (visual analogue scale: VAS) with endpoints labeled "healthy" and "sick," their responses tended to align with their implicit attitudes towards BDSM, as indicated by their latent response times on the IRAP task. This suggests that pathologization of BDSM occurs at an implicit as well as explicit level among individuals who do not practice BDSM, and that these two types of bias are related.

Anti-BDSM prejudice among mental health practitioners. Although the limited empirical research on societal beliefs surrounding BDSM in the general population appears to suggest that anti-BDSM prejudice exists among non-kinky lay people, the question of whether this same prejudice exists among mental health professionals has been more difficult to answer. As research suggests that psychotherapists tend to endorse a similar set of values (Mahalik, 1995; Mahalik, Worthington, & Crump, 1999), and that these values may differ from those of the general population (Mau & Pope Davis, 1993), it is possible that mental health professionals may not share the same anti-BDSM prejudices observed among members of the general population. The extant research in this area has produced conflicting conclusions, potentially due to issues related to research methodology.

Much of the research investigating whether anti-BDSM bias or prejudice exists among mental health professionals has involved the use of self-report or qualitative analysis of clinician generated narratives. This research seems to suggest that mental health practitioners are less likely to hold negative views of individuals who practice BDSM, with one study indicating that developing psychotherapists in clinical training programs may be less likely to express negative attitudes towards BDSM practitioners than members of the population without clinical training in a mental health field (Stockwell, Hopkins, & Walker, 2017). A study conducted by Kelsey and colleagues (2013) also provided some evidence that many clinicians endorse the belief that BDSM can be part of a healthy long-term relationship (67% of clinicians sampled), and reject the idea that BDSM should be eliminated through psychotherapy (70% of clinicians sampled). A qualitative analysis of interviews with 14 therapists yielded themes of a focus on cultural competence surrounding BDSM and refusal to pathologize BDSM practices (Lawrence & Love-Crowell, 2008).

At first glance, it would seem that the extant literature supports the conclusion that mental health professionals hold a more affirming stance towards non-mainstream sexual practices than the general public. However, this conclusion contrasts sharply with the findings of qualitative research investigating the therapy experiences of kinky clients, which provide indirect evidence of anti-BDSM bias among mental health professionals and its expression as differences in clinical judgment. Hoff and Sprott (2009) conducted a content analysis of BDSM identified participants' responses to open ended survey items regarding psychotherapy experiences, and found that a considerable number of participants had experienced premature termination of therapy services or frequent pathologizing statements about clients' sex practices upon disclosing their participation in BDSM related activities. Approximately half of the participants in another

qualitative study of BDSM-identified individuals' experiences in therapy reported personally experiencing or knowing someone who had experienced biased mental health care characterized by therapist behaviors such as characterizing BDSM as unhealthy, assuming that BDSM-related practices are indicative of a sexual/physical abuse history, attempting to coerce the client into abandoning their BDSM behaviors under threat of withdrawing treatment, and conflating consensual BDSM practices with sexual or physical abuse (Kolmes, Stock, & Moser, 2014). The discrepancy between therapists' self-reported competence surrounding work with BDSM-identified individuals and client reports of biased care in the research literature is alarming, and points to potential limitations of the methodologies used to assess anti-BDSM bias among mental health practitioners thus far.

It should be noted that the studies investigating therapist attitudes towards BDSM practitioners that fail to detect anti-BDSM bias are largely based on self-report measures where the construct being measured is readily perceivable to participants (e.g. Kelsey et al., 2013; Stockwell et al., 2017). In light of well-established lines of research that identify social desirability response bias as a threat to the validity of self-response measures in a variety of domains (e.g. occupational assessments: Arnold & Feldman, 1981; subjective experience of pain: Deshields, Tait, Gfeller, & Chibnall, 1995; eating habits: Hebert, Clemow, Pbert, Ockene, & Ockene, 1995; and prejudice: Plant & Devine, 1998), it is important to consider the possibility that social desirability motivations may have prevented therapists from expressing pathologizing views of BDSM explicitly in these studies. This is an especially important consideration when studying prejudice among mental health practitioners, given the increasing emphasis on social justice, multicultural competence and sensitivity to social identities among clinical training

programs in the United States (Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009), which may enhance social desirability motivations to present as non-biased or lacking in prejudice.

Research has shown that a perceived emphasis on social justice within a training environment predicts more favorable self-assessment of social justice orientation among clinical trainees (Beer, Spanierman, Greene, & Todd, 2012) and there is evidence that social desirability predicts a considerable portion of the variance observed in scores on self-report measures of multicultural competency among graduate trainees in mental health professions (Beer et al., 2012). However, self-assessment of multicultural competence does not seem to be a reliable predictor of actual ability to practice in a multiculturally competent manner, as there is no observed relationship between self-assessment of multicultural competence and observer ratings of a clinician's ability to integrate cultural factors into their conceptualizations of clients once researchers controlled for social desirability (Constantine & Ladany, 2000).

Taken together, these findings indicate that self-report measures may be inadequately sensitive to bias against certain marginalized identities when studying mental health professionals and trainees due to social pressure to conceal prejudicial attitudes in training/practice environments that emphasize multicultural competence. These findings converge with those of a systematic review of studies investigating implicit and explicit bias among mental health professionals along the dimensions of race and sexual orientation, which found no evidence for bias when bias was measured via self-report, but found evidence for implicit bias (Boysen, 2009). Anti-BDSM prejudice among mental health practitioners may therefore not be best assessed via asking mental health practitioners about their explicit attitudes towards kink, but rather by assessing for differences in treatment of kinky and non-kinky clients. Thus, it may be important to use methods other than self-report to assess potential prejudice

among mental health practitioners towards BDSM-identified clients in order to mitigate the impact of social desirability biases on participant responses. To this end, the current study utilized a vignette-based experimental design to assess whether mental health professionals' clinical impressions of clients differs according to manipulated case material related to a client's level of engagement in BDSM.

Evidence for and against stigmatizing stereotypes related to BDSM

Even if mental health professionals clinical impressions of kinky and non-kinky clients are found to differ, the conclusion that these differences represent bias or prejudice, rather than sound clinical judgment, cannot be drawn without first establishing whether any link between consensual BDSM engagement and psychopathology actually exists. Therefore, it is important to critically examine the scientific basis for stigmatizing beliefs surrounding non-mainstream sexual practices that fall under the BDSM umbrella. Despite the longevity and persistence of narratives in popular media that pathologize BDSM, systemic pathologization of sadomasochistic sexual practices within widely used diagnostic texts, criminalization of BDSM practices under the law, and negative perceptions among the general population, there is little evidence in the scientific literature to suggest that consensual engagement in practices associated with BDSM leads to increased psychopathology or dysfunction. In fact, what little research has been done on the mental health of individuals who engage in consensual BDSM suggests that kinky individuals differ very little from their non-kinky counterparts with regard to developmental trajectory and various domains of functioning, or are more likely as a group to exhibit qualities associated with higher functioning in those domains (Connolly, 2006; Monteiro Pascoal, Cardoso, & Henriques, 2015; Richters et al., 2008; Wismeijer & van Assen, 2013).

Strength of the evidence surrounding BDSM as a correlate of psychopathology. As there has been little research on the mental health of individuals who engage in consensual BDSM, much of the literature linking behaviors associated with BDSM and psychopathology has involved studies that examine the correlates of these behaviors in incarcerated (e.g. Kingston, Seto, Firestone, & Bradford, 2010; Mokros, Schilling, Weiss, Nitschke, & Eher, 2014; Richards & Jackson, 2011) and/or clinical populations (Hopkins et al., 2016). While these studies appear to support the conclusion that activities associated with BDSM are associated with various forms of psychopathology, the studies are often conducted without an appropriate comparison group, operationalize sadomasochism using definitions that assume pathology, or fail to distinguish between non-consensual and consensual engagement in sadomasochistic sex acts. Moreover, these studies often assume causation from correlation by failing to adequately consider how characteristics specific to clinical and incarcerated populations may better explain the relationship they observe between sexual sadomasochism and psychopathology. Thus, it is neither possible to generalize these findings to individuals who engage in consensual BDSM, nor to make causal claims about the impact of engagement in sex behaviors associated with BDSM on mental health based on these studies alone.

Although there is a paucity of research on mental health correlates of consensual BDSM, a study conducted by Connolly (2006) provides insight into the assumed relationship between consensual sadomasochism and mental illness symptomology. As the magnitude of distress experienced by an individual is an important consideration when determining mental disorder status, it is important to consider the degree of subjective distress reported by BDSM practitioners. Connolly (2006) found that only 0.8% of surveyed individuals who participate in consensual BDSM found their participation distressing in any way. Concerns about possible

negative impact of disclosure of one's BDSM identity to others appeared to be more common amongst respondents, with a considerable proportion of those surveyed (65.9%) indicating that they could not be fully open about their identities in all relationships and contexts.

With regard to the presence of symptoms specific to particular psychological disorders, the same study found no evidence of elevated scores on measures of depression, anxiety, or OCD symptomology in kinky participants when their scores were compared to those of a non-BDSM identified comparison group. It should also be noted that kinky participants did not consistently exhibit scores on the aforementioned measures greater than median scores calculated based on the general population. Although the experience of trauma related phenomenon was higher than the standardization mean for the measure used to assess trauma experiences in this study's sample, there was no evidence for elevated post-traumatic stress disorder (PTSD) symptomology.

Furthermore, Connolly's findings (2006) also suggest that endorsing a BDSM identity is not related to clinically elevated levels of maladaptive personality traits, such as psychological sadism, psychological masochism, paranoia or traits related borderline personality disorder (BPD). These findings contradict research on clinical populations linking sexual masochism with BPD (Frías, González, Palma, & Farriols, 2017) and research involving male sex offenders linking sexual sadism with correlates of psychological sadism (e.g. lack of empathy; Robertson & Knight, 2014). This discrepancy in the literature indicates that consensual BDSM and the sadomasochistic behaviors exhibited by clinical and/or criminal populations may be distinct and have divergent implications for mental health and well-being. While the study conducted by Connolly (2006) found that the BDSM identified portion of the sample exhibited slightly elevated scores on subscales of the Minnesota Multiphasic Personality Inventory (MMPI-2)

related to narcissism, the measure did not yield personality profiles consistent with pathological narcissism in a meaningful number of BDSM affiliated participants, suggesting that these elevations may be indicative of normal variation within the general population or even personality strength among BDSM participants.

Suicide. Suicidality is a notable domain where the research surrounding the mental health correlates of consensual BDSM practices appears more mixed. The recent research involving suicidality within the BDSM community centered around constructs related to the interpersonal theory of suicide (i.e. perceived burdensomeness, thwarted belongingness and capacity for suicide; Van Orden et al., 2010) suggests that engagement in sexual behaviors associated with BDSM may increase one's tolerance for pain and, in turn, increase one's capacity for and likelihood of attempting suicide (Brown, Roush, Mitchell, & Cukrowicz, 2017). However, it should be noted that the effect sizes for this study that supported this conclusion were small, and analyses did not yield a significant direct effect of BDSM behaviors or endorsement of BDSM identity on suicide attempt status, limiting the causal inferences that can be made based on these results. The results of a study investigating the relationship between suicidal ideation in BDSM practitioners, theoretical predictors of suicidal ideation and feelings of guilt and shame point to an alternative explanation for suicidality within the BDSM community: the stigma associated with BDSM identity (Roush, Brown, Mitchell, & Cukrowicz, 2017). The authors of this study found that the societal stigma associated with BDSM may result in diminished feelings of social connection and intensified feelings of being a burden to others, two constructs that predict the frequency and intensity of suicidal ideation. This finding resonates with those of qualitative studies investigating the experiences of individuals who engage in consensual BDSM, which identified themes related to distal and proximal stressors associated with societal stigma against

BDSM including feelings of shame, motivations to conceal one's engagement in BDSM, and fear of rejection from others (Hoff & Sprott, 2009; Kolmes et al., 2014; Nichols, 2006). However, other qualitative studies have identified benefits of engaging in BDSM sex practices and involvement in BDSM communities that may act as potential buffers against thwarted belongingness, and thus suicidality, including improved romantic relationships and a sense of community (Hébert & Weaver, 2015). The link between engagement in BDSM and suicidality is therefore unclear, and more research is required to determine the relative contributions of anti-BDSM stigma, secondary effects of BDSM-related sex practices, and protective factors to overall levels of suicidality within the BDSM community.

Strength of the evidence for BDSM as correlated with antecedents of distress. While some writers have posited that engagement in BDSM is correlated with traits or experiences that increase an individual's susceptibility to developing psychopathology such as maladaptive personality (Krafft-Ebing, 1901), childhood sexual trauma (Southern, 2002) and insecure attachment (Taylor & Ussher, 2001), empirical studies surrounding individuals who participate in consensual BDSM have found little evidence to suggest that this is the case. In a study conducted involving 902 BDSM identified participants and 434 non-BDSM identified participants from the Netherlands, Wismeijer and van Assen (2013) found that BDSM identity may be associated with higher levels of extraversion, more openness to experience, less neuroticism and higher levels of conscientiousness. This finding is particularly notable, that higher levels of extraversion and lower levels of neuroticism were shown to predict greater subjective well-being in the same sample (Wismeijer & van Assen, 2013). While personality structure may differ systematically by sexual role preference within the BDSM community (Hébert & Weaver, 2014; Wismeijer & van Assen, 2013), it should be noted that BDSM

practitioners were found to be more extraverted and less neurotic regardless of sexual role preference (Wismeijer & van Assen, 2013). These findings challenge the notion of BDSM as an indicator of a pathological personality structure, and in fact suggest that BDSM identity may be linked to personality traits that are associated with enhanced well-being. Rates of childhood sexual assault and lifetime exposure to sexual coercion also do not appear to differ based on BDSM identification or engagement in BDSM sex behaviors (Richters et al., 2008), and some research indicates that BDSM practitioners may be significantly more likely to exhibit secure attachment than their non-kinky counterparts, regardless of gender and/or whether they prefer to play a dominant or submissive sexual role (Wismeijer & van Assen, 2013). Thus, the research literature appears to suggest that BDSM is unrelated to internal and external factors that are assumed to underlie the development of psychopathology.

Evidence for BDSM as facilitative of psychosocial functioning. The extant literature does not merely suggest the absence of elevated psychopathology among individuals who engage in consensual BDSM; it also identifies ways in which engagement in consensual BDSM may facilitate psychological health rather than impede functioning.

Qualitative research on kinky individuals' subjective understanding of their own participation in BDSM has identified a variety of ways that individuals may use kinky practices to promote psychological well-being: as a means of coping with daily stressors, as a form of authentic self-expression, as a way of releasing psychological tension, and as a vehicle for personal growth and interpersonal closeness (Hébert & Weaver, 2015). Other qualitative research suggests that the altered mental states that some submissive partners report achieving while engaging in BDSM practices may reduce stress and increase feelings of intimacy (Pitagora, 2017).

Quantitative research on non-heterosexual members of the BDSM community suggests that membership in BDSM communities may help individuals cope with discrimination and internalized stigma related to the other marginalized sexual identities that they hold. Tatum (2016) found that gay men associated with the BDSM sexual subculture were less concerned about rejection based on their sexual orientation, less motivated to conceal their sexual orientation and demonstrated less internalized homophobia, and attributed this trend to the social support that many BDSM practitioners experience via participation in a community that affirms their sexual identities.

Furthermore, individuals who report an interest in unconventional sex practices may be more likely to appraise their bodies as acceptable to others and less likely to engage in rigid thinking around body image (Swami, Weis, Barron, & Furnham, 2017). Since body dissatisfaction and rigidity surrounding acceptable body types have been identified as predictors of negative mental health outcomes, including low self-esteem (Tiggemann, 2005), depressive symptomology (McCaulay, Mintz, & Glenn, 1988) and disordered eating (Hill, Masuda, & Latzman, 2013), it is possible that engagement in unconventional sex practices may have an indirect positive impact on mental health or be associated with traits that facilitate adaptive psychological functioning and positive self-concept.

Despite the characterization of BDSM as a form of sexual dysfunction or harmful sexual deviance in popular media (Weiss, 2014), the extant research literature suggests that individuals who engage in consensual kink may experience a similar or lesser degree of disruption in their sexual and romantic relationships when compared with their non-kinky counterparts. In a phenomenological study of narratives surrounding optimal sexual experiences across the lifespan, Kleinplatz and her colleagues (2013) found that coders were unable to reliably

distinguish between transcripts of responses from BDSM practitioners and those of individuals who do not identify as members of the BDSM community, suggesting that there is considerable overlap between the two groups with regard to the kinds of sexual experiences that they seek.

Quantitative research surrounding sexual functioning and relationship satisfaction among BDSM practitioners also provides evidence against the common belief that engagement with BDSM arises from or causes dysfunction in sexual and/or romantic relationships. Monteiro Pascoal, Cardoso and Henriques (2015) assessed sexual distress in 68 kinky and non-kinky adults and found that participants demonstrated similar rates of sexual concerns in several domains (i.e. arousal difficulties, premature orgasm, orgasm inhibition, and lack of orgasm) regardless of engagement in BDSM or gender. Furthermore, kinky and non-kinky participants reported statistically indistinguishable patterns of overall sexual satisfaction (Monteiro Pascoal et al., 2015). When analyses yielded group differences in this study, the differences favored participants who engaged in consensual BDSM, with kinky male participants reporting less distress related to sexual desire and kinky female participants reporting less distress related to maintaining arousal than their non-kinky counterparts (Monteiro Pascoal et al., 2015). These findings resonate with earlier findings from Richters and her colleagues (2008), who found that BDSM participants were no more likely than non-kinky individuals to experience disinterest in sex, orgasm related difficulties, painful intercourse, lack of pleasure during sex, sexual performance anxiety and/or negative body image during sex.

Research on BDSM practitioners' functioning in romantic/sexual dyads supplements the aforementioned research surrounding sex-related distress, and further challenges the notion that BDSM is antithetical to healthy romantic/sexual functioning. Rogak and Connor (2017) found

that the distress that BDSM practitioners experience within their sexual/romantic relationships falls well within the range observed in non-clinical samples of the general population.

Despite the frequent conflation of consensual BDSM and sexual violence in the public eye, recent research has yielded results suggesting that members of the BDSM community may endorse fewer beliefs that perpetuate cultural norms around sex that normalize rape and sexual assault (i.e. "rape culture"). Klement, Sagarin, and Lee (2017) compared responses to measures of rape-supportive beliefs from a group of 57 members of the BDSM community, a group of 60 non-kinky identified college students and a group of 68 non-kinky identified adults. BDSM identified participants were less significantly less likely to endorse rape myths (e.g. "if a girl goes to a room along with a guy at a part it is her own fault if she is raped"), blame victims of sexual assault and hold beliefs related to benevolent sexism (e.g. "women should be cherished and protected by men") than participants in the non-kink identified groups. As the extant literature has established a relationship between the endorsement of rape-supportive beliefs and the likelihood of both perpetrating (Truman, Tokar, & Fischer, 1996) and experiencing (Kalof, 1993) coercive sexual behavior, the findings of Klement, Sagarin and Lee suggest that sexual cultures that explicitly centralize the concept of affirmative consent, such as the BDSM subculture, may actually foster sexual norms and beliefs that discourage anti-social behavior, such as sexual assault. Given that operational definitions of psychopathology and impaired psychosocial functioning often include anti-social behavior and aggression towards others (American Psychiatric Association, 2000; Harkness, McNulty, & Ben-Porath, 1995), this finding stands in contrast to the lay association between BDSM and "sickness" (Stockwell et al., 2010), as it demonstrates ways in which BDSM practitioners may be less likely to exhibit behaviors associated with psychopathology in a specific domain (i.e. aggression).

Absence of support for BDSM stereotypes related to psychopathology. Taken together, the research literature on BDSM indicates a lack of strong support for stereotypes of BDSM that associate consensual sadomasochistic sex practices with psychopathology. The findings reviewed above indicate that interest and participation in consensual BDSM practices is likely a natural variant of the broad spectrum of human sexuality, and not an undesirable anomaly that emerges from or causes disruption in an individual's psychosocial development or functioning. Therefore, this body of literature suggests that any pathologizing of practitioners of consensual BDSM above and beyond members of the general population, all other factors being equal, cannot be understood as an instance of accurate clinical assessment, and may instead be an expression of sexual stigma surrounding BDSM. Moreover, the aforementioned findings linking engagement in BDSM and correlates of psychological well-being suggest that any over-pathologization of BDSM by mental health practitioners may be incongruent with the ways in which engagement in BDSM is facilitating, rather than impeding, overall functioning. Therefore, it is important to explore whether the sexual stigma surrounding BDSM has been internalized by mental health practitioners and, if so, how that stigma shapes mental health practitioners' clinical judgment when working with clients who engage in BDSM.

Clinical judgment

In light of the pervasive stigma surrounding BDSM and its incongruence with research findings showing no appreciable link between BDSM and psychopathology, it is important to acknowledge the possibility that any internalization of that stigma by psychotherapists may hinder their ability to exercise clinical judgment. Given the negative perceptions about BDSM held by many non-BDSM affiliated individuals (Stockwell et al., 2010), it is possible that psychotherapists have also internalized negative stereotypes of BDSM in ways that shape their

clinical impressions of kinky clients and impede their ability to accurately assess the severity and/or etiology of kinky clients' concerns. While this possibility has not been extensively investigated to date in the extant research literature, research on psychotherapists' clinical impressions of clients with other marginalized sexual identities has focused on how mental health care providers' sexual prejudice may impact clinical judgment in three areas: overall perception of psychopathology, perceived relevance of specific clinical concerns and diagnosis.

Perceptions of overall psychopathology. The little research that exists on how anti-BDSM stigma may shape mental health professionals' perceptions of client psychopathology suggests that mental health professionals may perceive BDSM sex practices as more pathological than mainstream sex practices. Stockwell and colleagues (2017) found evidence for implicit negative bias towards BDSM sex behaviors among graduate psychology students in clinical training programs, with participants being more quick to associate BDSM sex practices with being "sick" on an implicit relational assessment procedure (IRAP). This study did not, however, go on to explore how this implicit bias may shape mental health practitioners' assessment of client psychopathology. Unfortunately, the research literature on mental health professionals' perceptions of clients who identify as a member of other sexual minority groups has produced mixed results, making it difficult to extrapolate from those findings how client engagement in BDSM may impact psychotherapists' assessment of clients' psychological functioning.

Some studies appear to point to a link between clients' stigmatized sexual identities and elevated levels of perceived psychopathology among mental health practitioners. In a vignette study, Hayes and Erkis (2000) found that mental health professionals were more likely to rate hypothetical male clients with HIV as lower functioning when they presumed that the client was gay or bisexual. Furthermore, psychotherapist homophobia also predicted more unfavorable

perceptions of HIV-positive clients' psychosocial functioning, suggesting the role of sexual stigma in shaping mental health practitioners' clinical impressions of clients. Similarly, a study conducted by Barrett and McWhirter (2002) found that trainee psychotherapists who exhibited higher levels of homophobia were less likely to attribute positive adjectives to gay and lesbian clients based on clinical case descriptions.

More recent studies, however, have found no evidence that sexual orientation impacts mental health practitioners' overall assessment of client functioning. Thompson, Chin and Kring (2019) found that lesbian sexual identity had no significant impact on mental health practitioners' perception of client psychopathology, as measured by participants ratings of clients on adapted scales of anxiety and depressive symptomology. Bowers and Bieschke (2005) similarly found no effect of client sexual orientation on mental health practitioners' assessment of clients' overall level of psychopathology using the global assessment of functioning (GAF). Another study on the impact of bisexuality on clinical judgment also found no impact of client bisexual identity on GAF scores (Mohr, Weiner, Chopp, & Wong, 2009).

Explanations for these findings include the understanding that psychotherapists' perceptions of stigmatized groups are shaped according to the specific stereotypes associated with those groups, rather than the blanket belief that sexual minorities exhibit more psychopathology (Mohr et al., 2009). However, given the evidence that pervasive anti-BDSM stereotypes include an association of BDSM with psychopathology (Stockwell et al., 2010; Wright, 2006), the status of the paraphilias in current and previous iterations of the DSM (American Psychiatric Association, 2013; Moser & Kleinplatz, 2006a) and evidence for an implicit view of BDSM sex practices as "sick" among psychotherapists (Stockwell et al., 2017),

the possibility that psychotherapists will pathologize kinky clients above and beyond their non-kinky counterparts merits exploration.

Measuring perceptions of psychopathology. Although some methodologies have utilized specific symptom inventories or screeners to measure mental health professionals' assessment of psychopathology when studying clinical bias (e.g. Thompson et al., 2019), many researchers have favored the global assessment of functioning (GAF; American Psychiatric Association, 2000) for its ability to parsimoniously summarize a psychotherapist's clinical impressions of a client (Davis-Coelho, Waltz, & Davis-Coelho, 2000; Gamst, Dana, Der-Karabetian, & Kramer, 2000; Hayes & Erkis, 2000; Lilling & Friedman, 1995; Mohr et al., 2009). This measure has been used in previous research to assess the impact of various client characteristics on mental health professionals' perceptions of client's overall degree of psychopathology, including the gender of a client's partner (Lilling & Friedman, 1995), weight (Davis-Coelho et al., 2000), sexual orientation (Hayes & Erkis, 2000; Mohr et al., 2009) and ethnicity (Gamst et al., 2000).While the GAF has been criticized for having low interrater reliability in clinical settings (r = .39 to r = .59; Vatnaland, Vatnaland, Friis, & Opjordsmoen, 2007), some research has found that the GAF demonstrates adequate interrater reliability when used during initial screening of psychotherapy clients (r = .81; Söderberg, Tungström, & Armelius, 2005). Furthermore, some researchers have argued that the subjective nature of the GAF increases its sensitivity to mental health professionals' latent biases surrounding clients, making it an appropriate way to measure how those biases translate into clinical decision making (G. L. Russell, Fujino, Stanley, Cheung, & Snowden, 1996).

Perceived salience of clinical issues. Other research suggests that sexual stigma manifests as overestimation of the salience of clinical issues that are associated with stereotypes

(Mohr, Israel, & Sedlacek, 2001; Mohr et al., 2009) or differences in diagnosis (Eubanks-Carter & Goldfried, 2006). Mohr and colleagues (2009) found that while client bisexual identity did not result in elevated perception of overall psychological dysfunction, it prompted clinicians to overestimate the relevance of clinical issues that aligned with stereotypes related to bisexuality (e.g. sexual orientation, intimacy, sexual dysfunction, and identity development). Moreover, the same study found that endorsement of stereotypes surrounding bisexuality (e.g. the belief that bisexual individuals are sexually confused) mediated this effect (Mohr et al., 2009). In a study on the impact of patient race on health providers' willingness to prescribe HIV anti-retroviral pre-exposure prophylaxis (PrEP), researchers found that stereotypes that hypersexualize Black men or portray them as sexually irresponsible led clinicians to overestimate risky sex behaviors in Black men who have sex with men (relative to White men who have sex with men) and resulted in a diminished willingness to provide Black patients with a prescription for PrEP (Calabrese, Earnshaw, Underhill, Hansen, & Dovidio, 2014). The authors attributed these findings to pervasive stereotypes of African American men, and particularly African American men who have sex with men, as hypersexual and less sexually responsible (Bowleg, 2013; Valentine, 2008).

Diagnostic bias. Sexual stigma may not only influence mental health practitioners' understanding of the clinical issues relevant to a client's case, it may also prompt them to give diagnoses that align more with sexual stereotypes. A study conducted by Eubanks-Carter and Goldfried (2006) found that psychotherapists presented with diagnostically ambiguous case material were more likely to provide a diagnosis of borderline personality disorder (BPD) when they perceived the client to be gay or bisexual. The authors were careful to note two potential explanations for this finding: the historical association between same sex-attraction in men and

borderline personality traits within influential theoretical approaches to therapy, and stereotypes associating men who have sex with men with women, another group that is disproportionately associated with BPD diagnoses (Eubanks-Carter & Goldfried, 2006). Another notable finding of this study was that the diagnostic bias was detected in a sample of participants who overwhelmingly reported positive explicit attitudes towards the LGBTQ community, as measured by expressed support for same-sex marriage (Eubanks-Carter & Goldfried, 2006). This further highlights the limitations of self-report measures of prejudice when researching the impact of sexual stigma on mental health professionals, and demonstrates that psychotherapists' diagnostic choices may be a more reliable indicator of bias among psychotherapists than self-report. As the existence of systematic diagnostic bias among psychotherapists who encounter kinky clients has not yet been confirmed or disconfirmed by the extant literature, the current study hopes to contribute to the literature on how client identities impact diagnostic decision making by determining if engagement in BDSM impacts the diagnoses that psychotherapists consider during their initial assessment of a client.

Need for stereotype sensitive instrumentation. The aforementioned studies on the role that stereotypes play in how mental health practitioners make clinical decisions highlight how internalized sexual stigma against different groups impacts clinical judgment in ways that are specific to the stereotypes associated with each group (Mohr, Chopp, & Wong, 2013; Worthen, 2013). Instrumentation aimed at detecting clinical bias surrounding BDSM must therefore be developed with consideration of which clinical issues are associated with stereotypes related to BDSM. The dearth of research on the presumed or actual clinical presentations of kinky psychotherapy clients makes this process challenging, and necessitates an approach that draws upon the expertise of individuals with expert knowledge of mental health issues and the BDSM

community. The use of focus groups that include members of marginalized groups that are being studied has been emphasized as a way to ensure that marginalized communities have a hand in the development of research that has implications for their well-being, and to ensure that research instruments are culturally anchored and adequately sensitive (Hughes & DuMont, 1993). In line with these recommendations, consultation with subject matter experts within academia and the helping professions who also identify as members of the BDSM community was used to develop and adjust stimulus materials and instruments for this study.

Due to the relative lack of empirical research in this area, it is yet unclear whether negative stereotypes based in BDSM-related stigma will affect psychotherapists' perceptions of kinky clients' overall level of psychological dysfunction, or their judgment of which clinical issues are salient to a client's presenting concerns. However, in light of research that points to pervasive stereotyping of BDSM practitioners as "sick" among lay people (Stockwell et al., 2010), implicit negative bias surrounding BDSM among mental health practitioners (Stockwell et al., 2017) and client accounts of psychotherapists choosing inappropriate content areas for exploration based on a client's BDSM engagement (Hoff & Sprott, 2009; Kolmes et al., 2014), the current study was designed to explore both of these possibilities.

Psychotherapist characteristics

In addition to exploring whether client engagement in BDSM impacts clinical judgment among mental health professions, it is important to identify characteristics of mental health professionals that may predict any overpathologization of kinky clients. The extant literature on bias surrounding sexual minorities generally, and BDSM practitioners in particular, provide several potentially fruitful areas of exploration: explicit attitudes about BDSM, personal

familiarity with BDSM, sex-positivity training and demographic variables found to impact sexual prejudice.

Explicit attitudes. As Herek theorizes that prejudice is the result of internalization of stigma, it is possible that explicit attitudes surrounding BDSM specifically and sex more generally would predict the pathologizing clinical behaviors that this study aims to examine. While the relationship between negative attitudes surrounding a minority sexual identity and pathologization of clients who hold that identity has been investigated in with regard to other forms of sexual expression (e.g. gay and lesbian clients; Barrett & Mcwhirter, 2002; Hayes & Erkis, 2000), the extant literature has not established whether explicit anti-BDSM attitudes predict clinical impressions of kinky clients, leaving this as a fruitful area for exploration through the current study.

Studies that have identified a relationship between sexual attitudes more generally and attitudes towards BDSM specifically suggest that sexual conservatism may be another attitudinal construct of interest for the current study. Individuals that endorse right-wing political beliefs, negative attitudes about gay men and lesbians, sexually conservative attitudes, and belief in rape myths were also more likely to endorse anti-BDSM attitudes (Yost, 2010). This finding resonates with the findings of a study by Rye, Serafini, and Bramberger (2015), which yielded results suggesting a link between general avoidance of sexuality and negative views of BDSM. Furthermore, Swami, Weis, Barron, & Furnham (2017) found a link between sexually liberal attitudes and acceptance of BDSM and other non-conventional forms of sexual expression. These research findings suggest that negative attitudes towards BDSM may be associated with deeply held values related to sex more generally.

It will therefore be important to include both explicit attitudes toward sex and BDSM as predictor variables in the current study for several reasons. Firstly, the degree to which explicit prejudice is seen as socially acceptable differs systematically according to the target of that prejudice, with some stigmatized groups or characteristics being seen as more acceptable targets of overt discrimination (Crandall, Eshleman, & O'Brien, 2002). As there has been very little research done on if and how sexual attitudes are reflected in differences in behavior towards kinky individuals, inclusion of these predictor variables serves to clarify the strength of this relationship among mental health professionals. Morever, since anti-BDSM attitudes have been identified as a construct that is related to, but distinct from, sexual conservatism (Yost, 2010), it is important to include measures of both of these attitudinal constructs in the current investigation.

Additionally, including these predictor variables allows the current study to speak to the sensitivity of explicit measures of anti-BDSM prejudice in the event that the results of the analyses reveal systematic differences in clinical judgment on the basis of client engagement in BDSM. If such differences were to be found, it would be important to determine whether these differences can be predicted by mental health practitioners' explicit attitudes related to BDSM and sex, or if explicit measures of sexual prejudice are unreliable predictors of actual discriminatory behavior exhibited by this population. If explicit anti-BDSM attitudes were shown to correlate with greater pathologization and/or distorted diagnostic decision making, the current investigation would contribute to the literature confirming the predictive power of explicit measures of anti-BDSM prejudice. If no relationship or the inverse relationship were to be found, the results would call the predictive power of self-report measures of anti-BDSM bias into question.

Personal familiarity and contact. Various forms of personal familiarity with BDSM have been shown to correspond to positive attitudes towards BDSM, and were therefore considered in the current study. The research literature has identified three forms of personal familiarity with BDSM that may be salient when considering the impact of sexual stigma on psychotherapists' clinical judgment: personal engagement in BDSM practices, having significant interpersonal relationships with BDSM practitioners and previous experience working with kink-identified clients.

Personal engagement in BDSM. Perhaps unsurprisingly, positive personal experiences with BDSM and identification with BDSM practices has also been found to correspond with more positive implicit and explicit attitudes towards BDSM (Stockwell et al., 2010). Therefore, participant engagement in BDSM practices will be included in the analyses as a predictor variable for

Interpersonal relationships with BDSM practitioners. Having individuals who practice BDSM and/or identify as members of the BDSM community within one's social constellation has emerged as an important correlate of pro-BDSM attitudes, and must therefore be considered as a potential predictor of diagnostic bias among psychotherapists who encounter kinky clients. Prior knowledge of the BDSM community and having a friend who practices BDSM were both positively correlated with less pathologizing views of BDSM (Yost, 2010). This finding, coupled with research showing that attitudes towards BDSM do not respond to brief intervention (Rye et al., 2015), suggests that the formation of positive attitudes towards BDSM may require some form of interpersonal contact with BDSM practitioners and/or exposure to BDSM culture. This finding also converges with decades of research identifying positive direct and indirect intergroup contact as a key mechanism through which prejudice is reduced (Allport, 1954; Crisp

& Turner, 2012; Schiappa, Gregg, & Hewes, 2005). Thus, the presence of BDSM practitioners in participants' social and family networks will be included as a predictor variable in the current study.

Experience working with kinky clients. As the subjects of the current investigation will be mental health professionals, another form of personal familiarity with BDSM must be considered: past experience working with kinky clients. Research shows that experience working with clients who identify as members of other marginalized sexual groups (i.e. LGB identified clients) corresponds with increased self-reported competence around conducting psychotherapy with clients with those identities, and that perceived competence increased with the number of LGB clients a psychotherapist had worked with previously (Graham, Carney, & Kluck, 2012). The inferences that can be drawn about psychotherapists' interactions with kinky clients from these findings are limited due to potential differences between how LGB and kink identities are perceived, and the existence of research indicating that self-reported competence working with marginalized populations does not always translate to corresponding clinical behaviors (Hansen et al., 2006). Nonetheless, it is still important to investigate whether this form of personal familiarity with kink will predict any differences in clinical judgment that emerge in the current study given research suggesting that the number of kinky clients previously seen by a psychotherapist has a small but significant positive effect on psychotherapist attitudes towards BDSM (Kelsey et al., 2013).

Sex positivity training. As a study on psychotherapists' interactions with a stigmatized sexual minority group, this study is also situated within a larger context of a national conversation surrounding the need for increased psychotherapist training in the domain of sex-positivity—an umbrella term for attitudes towards sex that acknowledge a diverse range of

sexual desires and expressions as healthy while emphasizing the importance of consent and personal sexual agency (Cruz, Greenwald, & Sandil, 2017; Ivanski & Kohut, 2017; D. J. Williams, Prior, & Wegner, 2013). Research on the efficaciousness of sex-positivity training for mental health professionals suggests that such training reliably increases psychotherapist competence surrounding topics of sexuality (Graham et al., 2012; Hanzlik & Gaubatz, 2012; Harris & Hays, 2008), but there is little research on whether current modalities of sex-positivity training are effective at reducing the impact of bias and sexual prejudice on psychotherapists' clinical judgment more broadly. There is even less research on whether sex-positivity training is has an impact on psychotherapists' clinical decision making when working with kink-identified clients in particular. Despite calls from within the field for psychotherapist competence surrounding sexual issues and identities (American Psychological Association, 2010), there is evidence that training aimed at increasing clinician competence with regard to sex-related issues and reducing clinician biases has not been integrated into training for mental health professionals in the United States. In a survey of 25 counseling psychology departments in the United States, Burnes, Singh and Witherspoon (2017) found that only one of the departments investigated offered coursework that touched on sex positivity. The same study found that the vast majority of programs surveyed did not have mandatory coursework related to sexual issues, and that when sexuality related content was a part of the curriculum, it was often covered briefly as part of a course that covered individual differences more broadly or on an as-needed basis (Burnes et al., 2017). Thus, this contribution to the literature is aimed at providing additional clarity around whether sex-positivity training for psychotherapists predicts less biased clinical judgment when working with kinky clients, and informing future efforts to develop training modalities that help mitigate the impact of stigma surrounding diverse sexual expressions.

Demographic variables. Four psychotherapist characteristics—gender, transgender/nonbinary gender identity, sexual orientation and age, were also included in the current study as control variables in light of research evidence suggesting that sexual stigma in society may be internalized to different degrees across these dimensions.

Psychotherapist gender identity. Gender differences have been found in prejudice against other stigmatized sexual minority groups, with women reporting more favorable attitudes towards LGB populations (Herek, 1988; Parrott, 2009). These gender differences in the internalization of sexual stigma appear to manifest in clinical decision making as well, as demonstrated by the impact of psychotherapist gender on diagnostic judgments when working with sexual minority clients (Eubanks-Carter & Goldfried, 2006). While gender differences have not emerged in studies examining the anti-BDSM attitudes (Kelsey et al., 2013), it is yet unclear whether gender differences will emerge with regard to clinical judgment surrounding the concerns of kinky clients. Gender was therefore included as a control variable in the analyses of the current study.

Transgender and nonbinary identity have also emerged as demographic variables that may influence how individuals conceptualize sexuality and sexual behavior. Several studies have shown that cisgender and transgender respondents react differently to measures based on hegemonic understandings of sexual identity (Galupo, Davis, Grynkiewicz, & Mitchell, 2014; Galupo, Mitchell, & Davis, 2018), and BDSM power dynamics have emerged as a prominent theme in qualitative research about transgender individuals' understandings of their own sexual experiences. As such, transgender and nonbinary identity were also identified as an important control variable for this study.

Sexual minority identity. Research has shown that inhabiting a minority sexual identity may be associated with more accepting attitudes of identities associated with sexual stigma. A 2020 meta-analysis of studies on the relationship between sexual orientation and "Big 5" personality dimensions conducted by Allen and Robson yielded results suggesting that gay/lesbian and bisexual populations exhibit elevated levels of openness to experience when compared to individuals who identify as heterosexual. As openness to experience has been found to have an inverse relationship with negative attitudes towards minoritized sexual identities (Shackelford & Besser, 2007), it is possible that non-heterosexual identity may also predict the degree to which participants pathologize clients that engage in BDSM. Sexual orientation and transgender identity was therefore identified as a demographic control variable to be included in the current study's analyses.

Psychotherapist age. Several studies have shown that older individuals tend to endorse more negative views of BDSM (Kelsey et al., 2013; Yang & Shih, 2017). This necessitates the addition of psychotherapist age as a demographic control variable for the current study.

Research question/study aims

Given the aforementioned findings that implicate stereotypes related to sexual identity as a predictor of distorted clinical judgment when mental health professionals treat clients with sexual minority identities, the lack of research on how clinical judgment may be affected by client engagement in BDSM is a significant gap in the current literature on clinical decision making processes. The current study was directed at addressing this gap in the research literature by investigating whether mental health professionals' assessment of clients' overall level of psychopathology and the clinical issues relevant to a case vary systematically with regard to client engagement in BDSM. Additionally, this study sought to investigate the degree to which

variability in clinical judgment concerning clients who engage in BDSM would explained by explicit attitudes surrounding sex and BDSM, personal familiarity with BDSM and prior sex-positivity training.

Hypotheses

Based on a review of the extant literature, the current study tested the following hypotheses:

Hypothesis 1: Participants will pathologize clients engaged in BDSM more than clients who do not engage in BDSM as indicated by lower scores on the GAF (Hypothesis 1a), and a greater number of mental disorder diagnoses considered (Hypothesis 1b).

Hypothesis 2: When asked to estimate the relevance of a list of clinical issues to a hypothetical client's concerns, participants will overestimate the clinical relevance of issues related to stereotypes associated with a client's engagement in BDSM when verbal and non-verbal indicators of BDSM engagement are present. This should be evident in higher ratings of relevance for clinical concerns determined to be related to BDSM stereotypes through consultation with a focus group of content experts.

Hypothesis 3 (exploratory): DSM-5 diagnoses that participants include in their differential diagnosis will differ along the dimension of client engagement in BDSM.

Hypothesis 4 (exploratory): The relationship between sexual conservatism, negative explicit attitudes towards BDSM, pathologization of clients who are involved in BDSM and appraisal of the relevance of clinical concerns associated with BDSM stereotypes will be explored.

Hypothesis 5 (exploratory): The relationship between personal familiarity with BDSM (i.e. personal history of engagement in BDSM practices, identifying as a member of the BDSM community, number of significant others who engage in BDSM, number of kinky clients seen),

pathologization of clients who engage in BDSM, and appraisal of the relevance of clinical concerns associated with BDSM stereotypes will be explored.

Hypothesis 6 (exploratory): The relationship between the number clinical training and continuing education hours devoted to the topic of sex positivity during a participant's graduate training and professional career, pathologization of clients who engage in BDSM, and appraisal of the relevance of clinical concerns associated with BDSM stereotypes will be explored.

Chapter 3: Method

Participants

The population of interest for this study was English-speaking licensed psychotherapists. Upon consenting to participate in the study, all participants were asked to confirm their status as licensed mental health practitioners who are currently engaging in clinical practice, which was operationalized for the purposes of this study as having seen at least one individual client or facilitated one therapy group in the 12 month period prior to participation in this study.

Participant recruitment. Prior to recruitment, a power analysis was conducted to inform participant recruitment goals for the study. This power analysis, which assumed a significance level of .05 and statistical power of .8, determined that a total sample size of approximately 200 participants would be necessary to detect mean differences representing a small to medium effect size (d = .4) using an independent samples t-test. Licensed mental health practitioners were recruited via direct emailing, listservs of professional organizations nationwide, and social media groups that serve mental health professionals. Email addresses of clinicians were obtained through public databases used by prospective clients to contact mental health providers, while permission to post recruitment information to listservs of professional organizations and social media groups was obtained by contacting listserv and social media group administrators. Geographic areas for recruitment via direct emailing of prospective participants were selected by randomly selecting a state from each United States census region and conducting a search through two mental health provider databases for all psychotherapists located within a 50 mile radius of the state's largest city. Recruitment was expanded to cities outside of these states later in the study in order to ensure that the sample size was sufficient to ensure adequate statistical power for study analyses. To avoid biasing the sample by oversampling from demographic

groups that have been shown to hold more liberal or conservative views surrounding sex and other social issues (e.g. people who hold non-heterosexual identities; Grollman, 2017; Schnabel, 2018), professional organizations and social media groups dedicated to supporting psychotherapists with specific cultural identities were not utilized to recruit participants.

Recruitment information included a brief description of study aims (i.e. to investigate mental health care providers' conceptualization of client concerns and clinical decision making) and a weblink that linked to a Qualtrics survey containing all study stimuli and measures. Recruitment materials were written to obscure the true nature of the study in order to prevent construct guessing. This was done by omitting information about the study's true constructs of interest (e.g. client engagement in BDSM and pathologization) and identifying the investigation of clinical decision more broadly as the study's overall purpose. All recruitment materials (e.g. email correspondence and an electronic flyer) were developed in consultation with, and approved by, the UW-Madison IRB before use. All recruitment materials can be found in Appendixes A and B.

Final participant sample. Although the study's initial recruitment goal was not met, recruitment was halted after several months due to time constraints for the study. When recruitment was suspended, the Qualtrics survey for this study had recorded a total of 152 responses. Of these, 59 responses were removed from consideration in the final analyses due to (a) the respondent indicating that they were not a licensed mental health practitioner, (b) no responses recorded past completion of informed consent documentation, (c) insufficient time spent watching the video vignette, and/or (d) responses to measures indicating a random or otherwise invalid response pattern (e.g. a participant responding to all Likert items with the scale

midpoint). After responses deemed invalid were excluded, a final sample of 93 complete and partial responses was used to test study hypotheses.

Gender identity. Of the respondents that comprised final sample, 24 participants identified as male (25.8%), 59 participants identified as female (63.4%) and 1 participant identified as nonbinary (1.1%). Nine participants declined to indicate their gender (9.7%). A large majority of participants included in the final sample identified as cisgender, with 81 respondents indicating that their current gender matched their gender assigned at birth (87.1%) and 3 respondents indicating that their gender does not match their gender assigned at birth (3.2%). Nine participants declined to indicate congruence or incongruence between their gender identity and their gender assigned at birth.

Sexual orientation. A majority of the sample identified as straight/heterosexual, with 62 respondents indicating that they were heterosexual (66.7%), 15 respondents identifying as bisexual, pansexual or omnisexual (16.1%), 4 respondents identifying as gay or lesbian (4.3%), 1 respondent identifying within the asexual spectrum of identities (1.1%) and 2 respondents indicating a sexual orientation outside of the choices provided (2.2%). Nine respondents declined to indicate their sexual orientation (9.7%).

Racial identity. Participants were asked to choose one or more of the following categories to describe their racial identity: Asian/Pacific Islander, Black/African origin, Latinx/e, Native American, White, and Other (participants were asked to specify further if they chose this category). The majority of the overall sample identified as White, with 67 (72.0%) participants endorsing an exclusively White racial identity. Latinx/e individuals comprised 4.3% of respondents with 4 participants endorsing only a Latinx/e identity. The sample also contained 1 participant that indicated their race as Black/African and one participant that endorsed an

Asian/Pacific Islander identity (1.1%, respectively). Three participants (4.3%) solely endorsed a racial identity that was not represented by the aforementioned categories. Of these, one participant identified as Middle Eastern, one participant identified as European and one participant declined to specify their race. Eight participants (8.6%) selected more than one of the available categories on the item pertaining to race. Although no participants endorsed a Native American racial identity exclusively, one participant among those who endorsed holding multiple racial identities indicated Native American as among the racial identities that they hold. One participant who endorsed multiple racial identities specified their race as White and Jewish. Nine participants did not indicate their racial identity (9.7%).

Age. The reported age of participants in the overall sample ranged from 25 to 74 years old, with a mean reported age of 41 (*SD* = 12.5). The median age for all participants in the sample was 38 years old.

Geography. The sample for this study skewed heavily suburban and urban, with only 9 participants (9.7%) indicating that they live in a rural community. 48 participants reported living in a suburban community (51.6%), and 26 participants reported living in an urban community (28.0%). Ten participants (10.8%) did not specify their community of residence.

Socioeconomic status. Reported household income for participants ranged from 0 to 300000 USD, with a mean income of 116189 USD, and a standard deviation of 63320.40. When asked to identify their social class from a list of pre-determined options (“working class”, “middle class”, “upper middle class”, and “upper class”), 4 participants indicated their social class as working class (4.3%), 40 endorsed a middle class identity (43.0%), 36 described themselves as upper middle class (38.7%), and 2 characterized themselves as upper class (2.2%).

Professional identity. The overall sample represented a diverse cross section of professional identities and theoretical orientation. Of the participants that reported their highest level of education, 34 (36.6%) indicated that they had attained their master's degree (e.g. M.A., M.S., Ed.M., etc.), while 49 (52.7%) indicated that they had attained their doctorate. Ten participants (10.8%) did not indicate their highest level of education. Thirty-three participants (35.5%) identified as clinical psychologists, 16 identified as licensed professional counselors (17.2%), 14 identified as counseling psychologists (15.1%), 10 identified as social workers (10.8%), 8 identified as marriage and family therapists (8.6%), and 2 held a professional identity outside of the aforementioned options (2.2%). Ten participants did not provide information about their professional identity (10.8%).

Study Design

The study utilized a two group (no reported client engagement in BDSM sex practices vs. reported client engagement in BDSM sex practices) experimental vignette-based design. Participants were randomly assigned to one of two conditions, watched a video vignette of a hypothetical psychotherapy client with characteristics that corresponded to the level of the manipulated independent variable (i.e. mention of client involvement in BDSM sex practices) associated with their assigned condition, rated the client on various dimensions of functioning and distress, and estimated the relevance of several clinical issues to the case presented in the vignette. Participants were also asked to identify what DSM-5 diagnoses that they would consider during differential diagnosis, complete scales assessing participants' explicit attitudes towards BDSM and sex more generally, and complete a demographic questionnaire.

Video vignette development. The scripts used for the video vignettes portraying the hypothetical client were developed based on vignettes used in prior research on clinician

perception of client psychopathology (Mohr et al., 2001, 2009; Thompson et al., 2019). The overall intention was to create two vignettes that differed only with regard to mention of the hypothetical client's engagement in BDSM practices, and minimized the influence of other types of bias on participants' perceptions of the hypothetical client.

The client in both clinical vignettes was depicted as a White adult male experiencing adjustment related distress related to a recent change in geographic location for work. As the goal of the study was to assess the impact of therapist bias on clinical and diagnostic judgment, the presenting concern of the hypothetical client in each vignette was identical across participant groups, and included feelings of sadness, sleep disturbances, anxiety about interpersonal relationships and feelings of isolation. Clinical content was written to portray a client who meets partial criteria for adjustment disorder, but was intended to represent no specific DSM-5 diagnosis.

The manipulation that distinguished the video vignettes associated with the two experimental conditions of this study was achieved through verbal and visual cues that signaled the hypothetical client's participation or non-participation in BDSM practices. Manipulated verbal content included differences in how the depicted clients described their sexual practices and social support network. The vignette depicting a kinky client included allusions to a dominant/submissive relationship (e.g. "it's so hard being away from someone who means everything to you and is also someone you feel deeply submissive to"), direct mention of engagement in BDSM practices (e.g. "you can't really get tied up or flogged over Skype") and mention of a engagement in a BDSM/kink community (e.g. "back home I was part of a pretty active kink community"). While the vignette depicting the non-kinky client contained no mention of BDSM relationships, practices or communities, corresponding statements related to

distress surrounding a long distance relationship (e.g. “it’s so hard being away from someone who means everything to you and is also your best friend”) and isolation from community (e.g. “back home I was part of close knit community”) were included to ensure that the vignettes were equal in length and equivalent with regard to non-manipulated content. Differences in visible jewelry denoting partnership (i.e. a chain collar for the client depicted in the video for the BDSM condition and a wedding ring for the client depicted in video for the non-BDSM condition) were used as visual manipulations.

Other characteristics of the hypothetical client were selected in order to minimize the possibility of introducing extraneous variance attributable to bias towards other social identities that are associated with increased pathologization by mental health professionals (e.g. racial/ethnic minorities: Garb, 1997; female gender :Becker & Lamb, 1994; Crosby & Sprock, 2004; non-heterosexual sexual orientations: Eubanks-Carter & Goldfried, 2006). A 28-year old White man was chosen to portray the hypothetical client in order to reduce the impact of sexism and racial bias on participants’ appraisal of the hypothetical client. Furthermore, references to the client’s partner in the vignette were written such that the gender of the partner was not identified in order to minimize the amount of variance attributable to heterosexism. In order to avoid introducing variance attributable to differences in actor appearance, the same actor was used to portray the hypothetical therapy client in each video vignette, and the actor was instructed to wear the same clothing when recording each vignette. The client was also coached on how to deliver his characterization in order to minimize differences in emotional intensity. In order to ensure that the scripts and characterization for both clinical vignettes were reasonably equivalent outside of the intended manipulation, the content of each vignette was further refined based on

feedback from clinical faculty at a midwestern university with expertise composing clinical case content after initial development.

To further minimize threats to validity, a focus group was conducted to determine whether the vignettes adequately captured the constructs they were meant to represent, as well as to confirm that the vignette content not related to the experimental manipulation was reasonably equivalent. This focus group was comprised of four subject matter experts, including sex researchers, researchers who study psychotherapy and mental health practitioners. Members of the focus group were chosen to ensure that all members identified as members of the BDSM community and maintained licensure to practice psychotherapy in their state of residence, in line with recommendations from within the field to include members of salient stigmatized groups when formulating research design and instrumentation (Hughes & DuMont, 1993). All four members of the focus group reached the consensus that the content of the two vignettes developed for use in the current study was equivalent, excepting elements related to the study's experimental manipulation. Additional feedback surrounding the content of the vignettes was incorporated in the final version of the scripts used to record the video vignettes (see Appendix C for the final versions of the vignette scripts). The length of the recorded vignette depicting the kinky client was 3 min 44 sec, while the length of the recorded vignette depicting the non-kinky client was 3 min 36 sec.

Measures

Clinical judgment.

Global Assessment of Functioning (GAF). Participants were asked to provide their perception of the hypothetical client's overall level of psychopathology using the Global Assessment of Functioning (GAF), a parsimonious scale used to summarize a clinician's

diagnostic impressions of a client's overall level of functioning (American Psychiatric Association, 2000; Appendix D). The GAF consists of a single item that has the respondent rate a client on a continuous scale from 1-100, with 100 signifying extremely high functioning and 1 signifying severe impairment. The scale provides "anchors" at increments of 10 that describe features characteristic of individuals who fall within each 10 point range.

Salience of clinical issues indices (SCII). In line with previous research on the impact of sexual stereotypes on clinical judgment (Mohr et al., 2001, 2009), a list of clinical issues was presented to participants, who were asked to estimate the degree to which the concerns play a role in the hypothetical client's distress. Participants responded using a 5 point Likert scale that ranged from 1 (not at all) to 5(a great deal). Items contained in the list of clinical issues were divided into four indexes: (1) concerns related to both the client's presenting concerns as portrayed in the vignette and negative BDSM stereotypes; (2) concerns unrelated to the client's presenting concerns but related to negative BDSM stereotypes; (3) concerns related to the client's presenting concerns but not related to negative BDSM stereotypes; and (4) concerns related to neither the client's presenting concern nor anti-BDSM stereotypes. The list of items presented to participants was populated through consultation with a focus group of four mental health professionals that also identify as members of the BDSM community. The focus group was asked to consider a list of clinical issues used by Mohr and colleagues (2001) for research pertaining to the impact of stereotypes surrounding bisexuality on clinical judgment and divide those concerns into the four aforementioned indices. They were then asked to add or remove items, based on their clinical experience and lived experience as members of the BDSM community. The final list of clinical issues presented, and their corresponding indices, is outlined in Appendix E.

Differential diagnosis. Participants were also provided with a list of DSM-5 diagnoses and asked to indicate whether they believed the diagnosis was likely/possible or unlikely based on the case material and their own clinical judgment. As the case material in both vignettes was developed to portray a client that presents with symptoms associated with, but does not meet full criteria for, depressive, anxiety and adjustment disorders, the list of diagnoses included DSM-5 diagnoses from these classes of mental disorders. Given evidence for an association between client sexual minority identity and diagnoses of panic (Cochran & Mays, 2000) and personality disorders (Eubanks-Carter & Goldfried, 2006), DSM-5 diagnoses in these classes of mental disorders were also included. The list of diagnoses was further refined through consultation with the aforementioned focus group of subject matter experts (i.e. licensed psychotherapists who also identify as BDSM practitioners), and were selected based on consideration of the symptomology described in the case material, diagnoses related to negative stereotypes surrounding BDSM, diagnoses associated with marginalized identities and methodological concerns surrounding the possibility of construct guessing and social desirability biases. Participants were also given the option to give no diagnosis, as well as the option to write in any and all diagnoses that they considered possible or likely. See Appendix F for the final list of diagnoses presented to participants during the study.

Attitudinal measures.

Sexual Attitudes Scale (SAS). Due to the observed relationship between sexual attitudes more generally and attitudes towards individuals who engage in BDSM (Rye et al., 2015; Yost, 2010), participants were asked to complete a modified version of the Conservative Sexual Attitude Scale (Hudson, Murphy, & Nurius, 1983) that was adapted by Espinosa-Hernández and Lefkowitz (2009) to address issues of brevity and outdated items. The adapted scale (Appendix

G) contains 12 Likert-type items that respondents answer using a five-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher total scores reflecting more conservative attitudes towards sex. The adaptive scale has been shown to highly correlate with the original scale ($r(202) = .96$) and demonstrates good reliability, with alphas ranging from .85 to .86 when validated within samples drawn from different racial groups (Espinosa-Hernández & Lefkowitz, 2009).

Attitudes about Sadomasochism Scale (ASMS). As attitudes towards BDSM related sexual practices have been found to be related to, but distinct from, the dimension of sexual liberalism and conservatism (Yost, 2010), participants' explicit attitudes about BDSM related practices and identities were assessed using the ASMS (Yost, 2010; Appendix H), a 23-item measure with four subscales that capture the degree to which respondents view engagement in BDSM as (1) socially/morally wrong, (2) violent, (3) tolerable, and (4) representative of one's overall personality or disposition. Respondents responded to each item using a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Sample items include "sadomasochism is a perversion" (socially wrong subscale), "people who engage in SM are more likely to become involved in domestic violence" (violence subscale), "sadomasochists are just like everybody else" (a reverse scored item for lack of tolerance subscale), and "submissives are passive in other aspects of their lives besides sex" (real life subscale). Scores on all items are averaged to yield the overall score, with higher scores indicating more negative attitudes towards BDSM. Assessment of the psychometric properties of the ASMS in other samples have yielded a coefficient alpha of .96, indicating strong internal consistency.

Demographic questionnaire. A short demographic questionnaire was included in the array of measures to collect data on participants' gender, race/ethnicity, years in training and/or

clinical practice, and professional identity. Demographic items were presented with items assessing participants' personal familiarity with BDSM and history of sex-positivity training (For full contents of demographic questionnaire, see Appendix I).

Personal familiarity with BDSM. As personal familiarity with BDSM, either through personal engagement in BDSM practices or through association with individuals who engage in BDSM practices has been shown to predict more positive attitudes about BDSM (Yost, 2010), participants' personal experience with BDSM was assessed using four items. Respondents were asked to identify whether they have personally engaged in BDSM practices and whether they identify as a member of a BDSM community. They were also asked to estimate the number of friends/acquaintances/family members they have who practice BDSM. Furthermore, they were asked to estimate the number of clients they have provided services for who have endorsed engagement in BDSM sex practices.

Sex positivity training. Participants were asked to estimate the number of graduate training and continuing education hours devoted to the topic of sex-positivity that they have accumulated over the course of their clinical training and/or professional practice. Scores on this item served as a continuous variable that represents the degree to which sex-positivity has been a focus of a participant's clinical training and development.

Procedures

Informed consent and deception. Upon opening the survey link, participant were asked to review information about the study, risks and benefits of participation and provide informed consent for participation. As with recruitment materials for this study, informed consent documents were written to obscure the study's true aim, and participants were told that the study was investigating clinical judgment more broadly. The informed consent document was

developed in consultation with the UW-Madison IRB to ensure that no undue harm came to study participants due to the study's use of deception, and the informed consent document was approved by the IRB before use. The full consent document presented to participants is contained within Appendix J.

Group assignment and group characteristics. Upon consenting to participation in the study, each participant was randomly assigned to one of two vignette conditions (A and B) to determine which video vignette they would view before proceeding to the study survey using the randomization function embedded in the Qualtrics survey used to administer all study stimuli and materials. Among the responses that remained in the final sample that was used for analyses, $n = 51$ had been assigned to condition A and $n = 42$ had been assigned to condition B. For more detailed information about the characteristics of each group, please see Tables 1-5.

Study stimuli and measures. After randomized assignment to an experimental group was completed, participants in condition A then viewed the video vignette depicting a hypothetical client that practices BDSM, while those assigned to condition B viewed the video vignette depicting a hypothetical client that does not practice BDSM. After viewing the video vignette according to their assigned vignette condition, participants completed all study measures related to clinical impressions of the hypothetical client portrayed in the video (e.g. the GAF, the clinical salience index items, and DSM-5 Diagnosis). Participants then completed the attitudinal measures (e.g. the SAS and the ASMS) before completing the demographic questionnaire and items assessing familiarity with BDSM and previous sex-positivity training.

All study stimuli and measures were administered in the aforementioned order for all participants, and participants were not given the option to return to previous portions of the survey to change responses after completing each measure. These two elements of the study

design were implemented in an attempt to minimize the impact of social desirability and construct guessing on participant responses. This was achieved by ensuring that measures/items that alluded directly to the study's constructs of interest (e.g. attitudinal measures about sex and BDSM, items about participants familiarity with BDSM), and thus likely to activate social desirability motivations in clients, were completed after participants provided their initial clinical impressions of the hypothetical client depicted in their assigned video vignette.

Debrief and compensation. After participants completed all survey materials, they were debriefed and directed to a separate survey link that they could use to provide an email address for compensation purposes (i.e. for entry into the drawing for one of two $50 Amazon gift cards and delivery of gift card in the event that they were selected through the drawing). To provide a prosocial incentive for participation, participants were also asked to select a charitable organization from a predetermined list, which received a donation of $1 from the study. Participant contact information was not linked to study data, and was stored apart from all survey responses and demographic information to ensure participant anonymity and confidentiality. Debriefing materials can be found in Appendix K.

Analytic Methodology

Data cleaning. Data collected from the final sample of $N = 93$ participants was prepared for analysis by treating invalid responses to items as missing values. This was done when participants provided non-numeric responses to items that required a numeric response (e.g. the response "hundreds" to an item that asked participants to estimate the number of clients they had seen across their professional careers), or provided numeric ranges to items that required a singular numeric response (e.g. the response "20-30" to an item that asked participants to estimate the number of significant others they knew who engaged in BDSM practices). Values

that were presented as tentative (e.g. “400?”) were retained for analyses, as the investigators determined that estimation by participants was appropriate and expected when responding to the items in question.

Responses that contained outlier values for items or scales were examined for other indications that the response was invalid (e.g. data entry error, random response pattern, indiscriminate use of the same numeric response to all scale items, etc.; Aguinis, Gottfredson, & Joo, 2013). No responses with outlier values were removed from consideration due to investigators determining that the values, while statistically extreme, did not constitute invalid responses or meet other requirements for removal from consideration (e.g. evidence of sampling error).

Analyses. An independent samples t-test was used to determine whether participant perceptions of client psychopathology differed systematically with regard to client engagement in BDSM, as measured by scores on the GAF (Hypothesis 1a). Similarly, an independent samples t-test was used to determine if client engagement in BDSM had a significant effect on the number of mental disorder diagnoses given by participants (Hypothesis 1b).

A set of four independent samples t-tests were used to determine whether there was an effect of the independent variable on participants’ perceptions of the client’s presenting concerns, as indicated by scores on each of the clinical salience indices developed for use in this study (Hypothesis 2).

A set of chi-square tests of independence was used to determine whether groups differed with regard to their perception of the relevance of each respective DSM-5 diagnosis presented to participants after the video vignette (Hypothesis 3).

Three pairs of multiple linear regression analyses were used to determine whether participants' attitudes about sex and BDSM (Hypothesis 4), personal experience with BDSM (Hypothesis 5), and experiences with sex-positivity training across their careers (Hypothesis 6) predicted the degree to which participants pathologized a client (as expressed through scores on the GAF), as well as whether these variables predict the degree to which participants deemed clinical issues related to negative BDSM stereotypes as relevant to care (as expressed through participants' total combined score on the two SCII indices containing clinical issues related to BDSM stereotypes). As perceptions of stigmatized sexual minorities have been shown to vary systematically by gender (Barrett & Mcwhirter, 2002; Bowers & Bieschke, 2005), sexual orientation (Grollman, 2017), and age (Kelsey et al., 2013; Yang & Shih, 2017), these participant attributes were also included in each of these regression analyses as control variables. As the current study was aimed at determining the impact of psychotherapist characteristics on psychotherapists' clinical impressions of clients who engage in BDSM, the aforementioned multiple linear regression analyses were run on the subset of the sample assigned to view the vignette portraying the kinky client (Group A).

Addressing violations of test assumptions.

T-tests. While it is common practice among researchers in various fields to consider t-tests robust to the influence of extreme values that fall within three standard deviations of the mean (Pollet & van der Meij, 2017), distributions of continuous variables were examined for extreme values that deviated more than three standard deviations from each group mean in order to identify high leverage outliers that may impact the validity of t-test results. Cases associated with these outlier values were then inspected for random or otherwise invalid response patterns

to other measures in order to identify values for exclusion from analyses (no cases met criteria for exclusion).

When extreme outliers were found in at least one group distribution for a given dependent variable, a pair of t-tests (one using all available data and one with extreme outliers excluded) were used to determine whether the presence of such outliers impacted the statistical significance of the calculated test statistic. If the results of these t-tests converged, the test statistics calculated using distributions that included all data points were reported and interpreted in the interest of accurately characterizing the full range of responses provided by participants. If the results of these t-tests were found to diverge, a Mann-Whitney U statistic was calculated to resolve the discrepancy and determine which t-test result would inform the study's conclusions. Results from t-tests that were not used to inform the study's conclusion have also been reported in footnotes, when necessary, for completeness.

In addition to visual inspection of Q-Q plots, the Shapiro-Wilk Test of Normality was used to assess data for normality before conducting tests of mean differences. In the event that assumptions of normality were not met, statistical significance of mean differences was calculated using 599 bootstrap samples in accordance with conventions surrounding using bootstrap samples to account for non-normal distributions (Wilcox, 2010).

Chi-square. When data for categorical variables were found to violate assumptions of the Pearson chi-square test (i.e. frequencies lower than five in more than 20% of cells and/or expected cell value of less than one for any cell), the chi-square statistic was calculated using the maximum likelihood ratio test.

Linear regression. In preparation for regression analyses, residual outliers—values that represent a standardized residual value more than three standard deviations from the mean of all

observed residuals—were identified. In the event that one or more residual outliers were found with regard to outcome variable scores, linear regression analyses were run both with and without residual outliers included. In the event that the results of these analyses diverged, the cases representing residual outliers were further examined for evidence suggesting an invalid response. If no evidence for an invalid response pattern was found, results of the regression analyses run with extreme values included were used to inform study conclusions. As with the aforementioned t-tests, results of regression analyses that were not selected to inform study conclusions were reported in footnotes, when necessary, for completeness.

Chapter 4: Results

This chapter details the results of study and reports the relevant statistics that will be used to inform the conclusions of the study. Review of preparatory analyses and post hoc analyses are also included.

Assessing Group Comparability for Mean Differences Testing

Preliminary analyses were conducted to determine whether the random assignment of participants to each study condition was reasonably successful in generating groups that were equivalent on the basis of several participant characteristics: age, gender, representation of transgender and nonbinary identities, sexual orientation, non-White race, household income, community of origin, number of years of clinical training and practice and total number of clients seen across the span of training and clinical practice.

The reported age of participants in the group assigned to view the vignette depicting the BDSM-affiliated client (Group A) ranged from 25 to 73 (M = 40.9, SD = 11.46), while the reported age of participants in the group assigned to view the vignette depicting the non-BDSM-affiliated client (Group B) ranged from 25 to 74 (M = 43.3, SD = 13.8.). No significant differences were found between groups with regard to reported participant age, $t(75) = -.84$, $p > .05$.

As the data related to participant gender identity violated the assumptions of the Pearson's chi-square test of independence, maximum likelihood ratio tests were used to determine whether the two participant groups differed with regard to reported gender identity and whether participants reported a gender identity that differs from their gender assigned at birth. The two participant groups were not found to differ with regard to gender identity X^2 (2, N = 84) = 6.00, $p > .05$ The two participant groups were also found to be equivalent with regard to whether participants

endorsed holding a gender identity that differs from their gender assigned at birth X^2 (1, N = 84) = .18, p > .05. A more detailed breakdown of gender identities endorsed by participants in each group can be found in Table 1. A Pearson's chi-square test of independence yielded no evidence for significant differences between groups with regard to whether the participant endorsed a heterosexual/straight sexual identity, X^2 (1, N = 84) = .001, p >.05. For a more comprehensive breakdown of sexual orientation identities endorsed by participants in each group, see Table 2. A Pearson's chi-square test of independence determined that the groups were statistically equivalent with regard to whether participants endorsed a non-White racial identity

X^2 (1, N = 84) = .14, p >.05. A more comprehensive by-group comparison of racial identities endorsed by participants is contained in Table 3. An independent samples t-test determined that groups did not differ significantly with regard to reported household income, t(72) = .37, p > .05. Reported household income in Group A ranged from 0 to 300000 USD (M = 118794.87, SD = 69585.68), while reported household income in Group B ranged from 0 to 250000 USD (M = 113285.71, SD = 56393.87). Moreover, a chi-square test of independence determined that the two groups were equivalent with regard to participants' highest level of education attained, X^2 (1, N = 83) = 2.55, p > .05, and a maximum likelihood ratio test found that the groups did not differ significant with regard to their self-identified social class, X^2 (3, N = 82) = 5.65, p > .05. A breakdown of responses to items related to highest level of education attained and self-identified social class can be found in Table 4.

A maximum likelihood ratio test was used to assess equivalency between groups with regards to community of origin due to the data's violation of the assumptions of the Pearson's chi-square test of independence, and results indicated there were no significant differences

between groups with regard to whether participants lived in urban, suburban or rural settings, X^2 (2, N = 83) = .008, p > .05. See Table 5 for a more detailed breakdown of participants' responses with regard to community of residence.

Clinical experience was also not found to differ by group, with no statistically significant mean differences observed between groups with regard to number of years of training and clinical experience, $t(80) = -1.16$, p > .05.[1] The duration of combined clinical training and practice for participants in Group A ranged from 2 to 48 years (M = 12.80, SD = 9.41), while the clinical experience of participants in Group B ranged from 2 to 47 years (M = 13.52, SD = 9.83). Similarly, participants' estimated total number of clients seen to date did not differ significantly between groups, $t(70) = -1.35$, p > .05.[2] Participants in Group A had seen an average of 1210 clients over the course of their clinical training and practice (SD = 3662), with the total number of clients seen by each participant ranging from 50 to 20000 clients. Participants in Group B had

[1] Due to the presence of outliers more than three standard deviations from the mean in the distributions for this variable in Group B, an additional independent samples t-test was run with outlier values removed. Both analyses converged, with the results of the additional t-test indicating no significant differences between groups with regard to combined years of clinical training and practice, $t(79) = -1.59$, p > .05. As there was no evidence that extreme values were due to invalid response patterns, statistics calculated based on data containing extreme values were reported.

[2] Due to the presence of outliers more than three standard deviations from the mean in the distributions of both groups for this variable, an additional independent samples t-test was run with outlier values removed. Both analyses converged, with the results of the additional t-test indicated no significant differences between groups with regard to number of clients seen, $t(68) = -1.18$, p>.05. As there was no evidence that extreme values were due to invalid response patterns, statistics calculated based on data containing extreme values were reported.

seen an average of 3807 clients (*SD* = 12376), with the total number of clients seen by each participant ranging from 30 to 57000 clients.

Taken together, the aforementioned results suggested that randomization was successful in generating two groups that were equivalent with regard to demographic variables that may impact the validity of the results, allowing analyses for hypothesis testing to be conducted as planned.

Instrument Reliability

Reliability statistics were calculated for the standardized measures utilized in this study to determine whether instrument reliability posed any threats to validity of the results. Both standardized measures used in this study demonstrated strong reliability within the current sample, with the SAS yielding a coefficient alpha of .91 in the current sample, and the ASMS yielding a similar coefficient alpha of .95 for the overall scale. Subscales for the ASMS also demonstrated strong reliability for this sample; the Socially Wrong subscale yielded a coefficient alpha of .94, the Violence subscale yielded a coefficient alpha of .93, the Lack of Tolerance subscale yielded a coefficient alpha of .77 and the Real Life subscale yielded a coefficient alpha of .98.

Hypothesis 1: Impact of Group Assignment on Pathologization

Hypothesis 1a: GAF Scores

An independent-samples t-test was used to determine whether client engagement in BDSM impacted participants' perception of the clients' overall level of functioning, as indicated by scores on the GAF. Specifically, the current study hypothesized that participants in Group A—the group that viewed the vignette depicting the hypothetical client who engages in BDSM

practices—would rate the client lower on the GAF than participants in Group B—the group that viewed the vignette depicting the hypothetical client who does not engage in BDSM practices.

An independent samples t-test was conducted using 599 bootstrapped samples (Wilcox, 2010) to account for a non-normal distribution of dependent variable values in Group A. The independent-samples t-test yielded results suggesting that the two groups did indeed differ systematically with regard to their pathologization of the client, as indicated by scores on the GAF, $t(91) = 2.47$, $p < .05$. However, the mean difference observed ($d = .52$, 95% CI [.11, .94]) was in the opposite of the hypothesized direction, with participants in Group A characterizing the hypothetical client as more highly functioning than Group B. The observed effect size for this observed mean difference fell above the commonly accepted threshold for a medium effect size ($d = .5$; Lachenbruch & Cohen, 1989). As a response on the GAF that deviated more than three standard deviations from the mean was identified in the distribution for Group A, an additional t-test was run with extreme values excluded from the analysis to determine if the observed mean difference between groups on GAF scores was an artifact of this extreme value. The results of both tests were found to converge.[3]

[3] The independent t-test conducted using 599 bootstrapped samples generated from a subset of data that excluded the high leverage outlier found that the groups were found to differ significantly with regard to the ratings they provided on the GAF, $t(90) = 2.26$, $p<.05$ with participants in Group A ($M = 60.74$, $SD = 5.90$) characterizing the hypothetical client as more highly functioning than participants in Group B ($M = 57.76$, $SD = 6.37$). The mean difference of 2.98 ($SE = 1.32$) represents a Cohen's d of .48, which approaches the conventionally established threshold for a medium effect size (Lachenbruch & Cohen, 1989).

Hypothesis 1b: Number of Diagnoses Considered

Another independent-samples t-test was used to determine whether client engagement in BDSM impacted the number of DSM-5 diagnoses considered potentially relevant by participants. A pair of Shapiro-Wilk tests of normality suggested that the distribution of dependent variable values in both groups could not be assumed to be normal, necessitating use of 599 bootstrapped samples for the t-test. The results of the independent-samples t-test suggest that client engagement in BDSM had no effect on the number of DSM-5 diagnoses considered by participants, $t(62)=-.96$, $p > .05$.

See Table 6 for a more comprehensive tabulation of the statistics related to this hypothesis. **Hypothesis 2: Impact of Group Assignment on Perceived Relevance of Clinical Issues**

A series of independent samples t-tests were used to determine whether client engagement in BDSM influenced the perceived relevance of various clinical issues to the client's presentation among participants. Clinical issues presented to participants for consideration were sorted into four indices based on two criteria: whether they were associated with BDSM stereotypes and whether they were salient to the case material explicitly presented in the vignette (see "Salience of clinical issues indexes," Appendix E). It was hypothesized that participants in Group A (assigned to watch the vignette depicting the kinky client) would provide higher ratings of relevance than Group B (assigned to watch the vignette depicting the non-kinky client) on the two indices that contained clinical issues related to BDSM stereotypes. No differences in ratings on the indices containing clinical issues not related to BDSM stereotypes were proposed. As score distributions for each salience of clinical issues index were found to be non-normal for at

least one experimental condition, all t-tests associated with this hypothesis were conducted using 599 bootstrapped samples to ensure that analyses were robust against non-normality.

Clinical Issues Related to Both Case Material and BDSM Stereotypes (SCII-1)

The independent samples t-test assessing the impact of group assignment on the SCII-1 index yielded results suggesting that client engagement in BDSM had no effect on the perceived relevance of clinical issues related to both BDSM stereotypes and the case material ($t(84) = -1.09$, $p > .05$).

Clinical Issues Unrelated to Case Material, but Related to BDSM Stereotypes (SCII-2)

As extreme values that represented standardized scores more than three standard deviations from the mean were found in at least one group's score distribution for the index containing clinical issues that were relevant to BDSM stereotypes, but unrelated to the case material, separate independent samples t-tests were run with extreme values included and excluded to determine whether the mean differences observed between groups on this index were significant. The independent samples t-test run without outliers removed indicated that the two groups differed significantly with regard to scores on this index $t(84) = -2.11$, $p < .05$, with participants in Group A rating the clinical issues in this index as less relevant to client concerns than participants in Group B. The mean difference ($d = -.47$, 95% CI [-.90, -.035],) represented an effect size that approaches the commonly accepted threshold for a medium effect size (Lachenbruch & Cohen, 1989). The results of independent samples t-test run with outlier values

excluded diverged from this finding[4], and a Mann-Whitney U test was run to resolve this discrepancy. The Mann-Whitney U test determined that the distributions for the two groups were not equivalent ($U = 672.00$, $p < .05$), suggesting that the results of the t-test with extreme values excluded reported above was likely more representative of the differences between each group's score distributions.

Clinical Issues Related to Case Material, but Unrelated to BDSM Stereotypes (SCII-3)

The t-test pertaining to the scores participants provided on the index containing clinical issues related to the case material, but unrelated to BDSM stereotypes, yielded results suggesting that the two groups differed with regard to the ratings they provided on this index, $t(84) = -4.30$, $p < .05$. Participants in group A rated the clinical concerns in this index as less relevant to the case than their counterparts in Group B. The effect size for this observed mean difference ($d = -.89$, 95% CI [-1.34, -.45]), met criteria for a large effect size (Lachenbruch & Cohen, 1989).

Clinical Issues Unrelated to Case Material and Unrelated to BDSM Stereotypes (SCII-4)

No significant differences were found between groups with regard to scores on the index of clinical issues that had no relevance to either BDSM stereotypes or the case material, $t(84) = .98$, $p > .05$.

See Table 7. for all calculated statistics related to this hypothesis.

[4] The independent samples t-test conducted to compare group means with regard to this index that included outlier values representing a standardized score more than three standard deviations from the mean yielded results suggesting no significant differences between group with regard to scores on this index, $t(84) = -.92$, $p>.05$. The results of the independent samples t-test conducted with outlier values excluded converged with the results of the Mann-Whitney U test, and was subsequently selected for use in informing study conclusions.

Hypothesis 3: Impact of Group Assignment on Diagnosis

A series of chi-square tests of independence were used to determine whether there was a statistical association between group assignment and whether participants considered a given DSM-5 diagnosis possible or likely for the hypothetical client depicted in the video vignette (see Table 9). When the data failed to meet the prerequisites for the Pearson chi-square test of independence (e.g., expected frequencies of less than one in one or more cells, expected frequencies less than five in less than 80% of cells), a maximum likelihood ratio test was used to calculate the chi-square statistic. Cramer's V was also calculated to determine the magnitude of observed effect sizes, which were interpreted in accordance with established conventions within the social sciences (Lachenbruch & Cohen, 1989).

The proportion of participants who considered major depressive disorder to be possible or likely for the hypothetical client was found to differ significantly by group assignment, $\chi^2 = (1, N = 93) = 5.41$, $p < .05$, with participants who viewed the vignette depicting the kinky client being less likely to give a diagnosis of major depressive disorder. The observed effect size for this finding ($V = .24$) fell between the commonly accepted thresholds for small and medium effect sizes.

A significant relationship was also observed between group assignment and likelihood to give a persistent depressive disorder diagnosis, $\chi^2 = (1, N = 91) = 6.60$, $p < .05$, with participants assigned to view the vignette depicting the kinky client being less likely to give a diagnosis of persistent depressive disorder. The observed effect size for this finding ($V = .27$) fell between the conventional cutoffs for small and medium effect sizes.

Likelihood of assigning a histrionic personality disorder diagnosis was also found to be related to group assignment $\chi^2 = (1, N = 91) = 4.76$, $p<.05$, with participants who viewed the

vignette depicting the kinky client being less likely to provide a histrionic personality disorder diagnosis. The observed effect size for this finding ($V = .20$) was small by conventional standards in the social sciences.

A significant association between group assignment and likelihood to assign a diagnosis of sexual masochism disorder was found $\chi^2 = (1, N = 92) = 13.215$, $p < .05$, with participants assigned to view the vignette depicting the client that engages in BDSM being more likely to assign a diagnosis of sexual masochism disorder. Analyses yielded a medium effect size for this relationship ($V = .32$).

The association between group assignment and likelihood to assign a fetishistic disorder diagnosis was also found to be significant, $\chi^2 = (1, N = 91) = 5.66$, $p < .05$, with participants in the group that viewed the vignette depicting the kinky client being more likely to provide a fetishistic disorder diagnosis. The effect size for this relationship ($V = .23$) was found to fall between the cutoffs for small and medium effect sizes.

The chi-square tests of independence that assessed the relationship between group assignment and participants' likelihood of assigning a diagnosis of narcissistic personality disorder and antisocial personality disorder did not yield a valid test statistic, as no participants indicated that they would assign either diagnosis, regardless of group assignment. All remaining tests in this set of analyses yielded non-significant test statistics, suggesting no significant association between group assignment and participants' likelihood of assigning the following diagnoses: generalized anxiety disorder, social anxiety disorder, panic disorder, bipolar disorder, adjustment disorder, acute stress disorder, posttraumatic stress disorder, obsessive compulsive disorder, borderline personality disorder, dependent personality disorder, avoidant personality disorder, sexual sadism disorder, and other diagnoses specified by participants. A contingency

table detailing all valid responses to each item associated with this hypothesis is contained in Table 9. **Hypothesis 4: Attitudinal Variables as Predictors of Pathologization and Stereotyping of Kinky Clients**

A pair of multiple linear regression analyses were used to determine whether pathologization of clients (as measured by participant scores on the GAF) and estimated relevance of clinical issues related to BDSM stereotypes to client concerns (as indicated by aggregated scores on the two indices of clinical issues related to BDSM stereotypes developed for the purposes of this study) were predicted by sexual conservatism (as measured by scores on the SAS) and negative attitudes towards BDSM (as measured by scores on the ASMS). Participant age, gender, sexual orientation and trans/nonbinary identity were included as control variables for the models being tested. Responses to the item regarding participant gender was collapsed into a dichotomous variable (i.e., whether the participant identified as female) due to the small number of nonbinary participants and the inclusion of trans/nonbinary identity as a separate control variable. Responses to the item regarding participant sexual orientation was similarly collapsed into a dichotomous variable (i.e., whether the participant identified as straight/heterosexual) for ease of analysis.

These analyses identified participant responses on the outcome variables with standardized residual values more than three standard deviations from the mean. Subsequently, additional linear regression analyses for each outcome variable associated with this hypothesis were run with these responses removed in order to determine whether the presence of residual outlier values impacted the predictive power of individual predictor variables or the overall models. As there was no evidence for invalid response patterns associated with the extreme residual values, and the results of the corresponding analyses for each outcome variable

converged, what follows are the results of the analyses run with responses representing residual outliers included.

Pathologization (GAF scores)

Scores on the GAF were not predicted by sexual conservatism (B = .16, t(36) = .87, p > .05), or negative attitudes towards BDSM (B = -.016, t(36) = -.088, p > .05) in a linear regression model that controlled for age, gender, sexual orientation, and trans/nonbinary identity. The overall model did not explain a significant amount of the variance observed in GAF scores (R^2 = .054, F (6, 36) = .35, p > .05).[5]

Salience of Clinical Issues Related to BDSM Stereotypes

Aggregated scores on the indices of clinical issues related to BDSM stereotypes were also not predicted by either sexual conservatism (B = .013, t(34) = .069, p > .05), or negative attitudes towards BDSM (B = .024, t(34) = .11, p > .05) in a linear regression model that controlled for the same demographic variables. The overall model did not explain a significant

[5] The secondary regression analysis run with outlier values excluded found that scores on the GAF were not predicted by sexual conservatism (B = .24, t(35) = 1.49, p>.05), or negative attitudes towards BDSM (B = .004, t(35) = .023, p>.05) in a linear regression model that controlled for age, gender, sexual orientation, and trans/nonbinary identity. The overall model did not explain a significant amount of the variance observed in GAF scores (R^2 = .14, F (6, 35) = .97, p > .05).

amount of the variance observed in aggregated scores of these indices ($R^2 = .025$, F (6, 34) = .15, $p > .05$).[6]

All statistics related to this hypothesis can be found in Table 10.

Hypothesis 5: Variables Associated with Familiarity with BDSM as Predictors of Pathologization and Stereotyping of Kinky Clients

A pair of multiple linear regression analyses were used to determine whether pathologization of clients (as measured by participant scores on the GAF) and estimated relevance of clinical issues related to BDSM stereotypes to client concerns (as indicated by aggregated scores on the two indices of clinical issues related to BDSM stereotypes developed for the purposes of this study) were predicted by four variables related to participants' personal familiarity with BDSM: (a) whether they engage in BDSM practices, (b) whether they identify as members of the BDSM community, (c) the number of their significant others (acquaintances, friends, partners, etc.) that they know to engage in BDSM practices, and (d) the number of clients they have seen who engage in BDSM practices (see Table 11). As with analyses for Hypothesis 4, participant age, gender, sexual orientation and trans/nonbinary identity were included as control variables, and gender and sexual orientation were collapsed into dichotomous variables.

[6] A secondary linear regression analysis with outliers removed also found that aggregated scores on the indices of clinical issues related to BDSM stereotypes were not predicted by either sexual conservatism (B= .14, t(33) = .75, p >.05), or negative attitudes towards BDSM (B = -.031, t(33) = -.15, p >.05) in a model that controlled for the same demographic variables. The overall model did not explain a significant amount of the variance observed in aggregated scores of these indices ($R^2 = .070$, F (6, 33) = .41, $p > .05$).

To account for participant responses on the outcome variables with standardized residual values more than three standard deviations from the mean, additional linear regression analyses for each outcome variable associated with this hypothesis were run with outlier values removed, and the results of the analyses were compared to determine the potential impact of outlier values on the conclusions drawn from the analyses. As there was no evidence for invalid response patterns associated with the extreme residual values, and the results of the corresponding analyses for each outcome variable converged, the analyses on the full dataset are reported below.

Pathologization (GAF scores)

None of the aforementioned variables related to participant familiarity were found to reliably predict pathologization of the hypothetical client portrayed in the vignette, as measured by scores on the GAF in a model that controlled for age, gender, sexual orientation and transgender/nonbinary identity (see Table 11 for a more detailed outline of all standardized coefficients yielded for the regression model). Furthermore, the overall model was not found to predict a significant portion of the variance observed in GAF scores, ($R^2 = .22$, $F\ (8, 26) = .89$, $p > .05$).[7]

[7] A secondary regression analysis run with outlier values removed found that the overall model did not predict a significant portion of the variance observed in GAF scores, ($R^2 = .41$, $F\ (8, 25) = 2.20$, $p > .05$). The number of kinky clients seen by participants emerged as a significant predictor of GAF scores ($B = .66$, $t(25) = 2.87$, $p < .01$). However, as the model was not found to be significant, and this set of analyses was not chosen to inform study conclusions, this finding should be interpreted with caution. All other predictor variables were non-significant.

Salience of Clinical Issues Related to BDSM Stereotypes

Similarly, a regression model with the aforementioned predictor and control variables was not found to predict a significant portion of the variance observed in aggregated scores of the indices containing clinical issues related to BDSM stereotypes developed for this study, ($R^2 = .25$, F (8, 25) = 1.06, $p > .05$).[8] While the coefficient values for participant age ($B = .18$, $t(25) = .83$, $p < .05$) and number of significant others that participate in BDSM ($B = .75$, $t(25) = .2.67$, $p < .05$) for this model were significant, the poor fit of the overall model poses challenges to meaningful interpretation of these statistics.

Hypothesis 6: Sex-positivity Training as a Predictor of Pathologization and Stereotyping of Kinky Clients

A pair of multiple linear regression analyses were used to determine whether pathologization of clients and estimated relevance of clinical issues related to BDSM stereotypes to client concerns were predicted by the number of training hours that a participant had completed to date on the topic of sex-positivity when participant age, gender, sexual orientation, and trans/nonbinary identity were controlled for (see Table 12). As with Hypotheses 4 and 5, responses to items surrounding gender and sexual orientation were collapsed into dichotomous variables.

[8] A secondary regression analysis run with outlier values removed found that the overall model did not predict a significant portion of the variance observed in aggregated scores of the indices containing clinical issues related to BDSM stereotypes, ($R^2 = .41$, F (8, 25) = 1.06, $p > .05$). The number of significant others that participate in BDSM emerged as a significant predictor of the outcome variable ($B = .75$, $t(25) = .2.67$, $p < .05$). As the model was not found to be significant, and this set of analyses was not chosen to inform study conclusions, this finding should in interpreted with caution. All other predictor variables were-non significant.

As participant responses on the outcome variables with standardized residual values more than three standard deviations from the mean were identified, additional linear regression analyses for each outcome variable associated with this hypothesis were run with outlier values removed, as was done in the cases of Hypotheses 4 and 5. When the results of the analyses were compared, the results of the corresponding analyses for each outcome variable converged. Given that additional inspection of the data found no evidence for invalid response patterns associated with the extreme residual values, the results of the analyses run on the full data set are reported below.

Pathologization (GAF scores)

The number of training hours devoted to sex positivity that participants had completed to date were not found to predict pathologization of a hypothetical client that engages in BDSM, (B = -.11, $t(35)$ = .57, p > .05). The overall model did not explain a significant portion of the variance observed in participants' pathologization of the kinky client portrayed in the vignette, R^2 = .049, F (5, 35) = .36, p > .05.[9]

Salience of Clinical Issues Related to BDSM Stereotypes

Participants' number of completed training hours on the subject of sex positivity were also found to not reliably predict scores on the two indices of clinical issues related to BDSM stereotypes (B = -.23, $t(33)$ = -1.13, p > .05). The overall model also failed to explain a

[9] A secondary linear regression analysis with outliers removed also found that total number of clinical training hours devoted to sex-positivity did not reliably predict GAF scores (B = .076, $t(34)$ = .42, p >.05) in a model that controlled for participant age, gender, sexual orientation and trans/nonbinary identity. The overall model did not explain a significant amount of the variance observed in GAF scores, R^2 = .096, F (5, 34) = .72, p > .05.

significant portion of the variance observed in this outcome variable, $R^2 = .063$, F (5, 33) = .45, $p > .05$.[10] **Post hoc analyses**

As some of the mean differences observed between groups with regard to pathologization of clients and perceived salience of clinical issues were in the opposite of the hypothesized direction, several post hoc analyses were run to determine whether the participant were equivalent with regard to participants' attitudes about sex, attitudes about BDSM and/or personal familiarity with BDSM. These analyses were conducted to guide interpretation of the results by determining whether differences between groups on the dependent variables of interest could be reasonably understood as an artifact of processes other than the experimental manipulation (e.g. randomization error).

Attitudes

An independent samples t-test was used to determine group equivalency with regard to endorsement of conservative attitudes toward sex. As distributions for the dependent variable for both groups failed tests of normality, the test was run on 599 bootstrap samples. The results of the t-test suggest that the groups were equivalent with regard to their endorsement of conservative sexual attitudes, $t(89) = -1.21$, $p > .05$. A corresponding t-test with outlier values excluded from the analyses yielded convergent results.[11]

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[10] Participants' estimated number of training hours devoted to sex-positivity were also not found to predict aggregated scores on SCII indicies related to BDSM stereotypes ($B = -.23$, $t(33) = -1.13$, $p > .05$) in a model that controlled for participant age, gender, sexual orientation and trans/nonbinary identity. The overall model did not explain a significant amount of the variance observed, $R^2 = .063$, F (5, 33) = .45, $p > .05$

[11] An independent samples t-test run with outlier values for the SAS removed yielded results suggesting no differences between groups, $t(88) = -1.76$, $p > .05$.

An independent samples t-test was used to determine group equivalency with regard to endorsement of negative attitudes towards BDSM. As with conservative attitudes toward sex, distributions of the responses for both groups failed tests of normality, necessitating the use of 599 bootstrap samples for the analysis. The groups were found to differ with regard to their endorsement of negative attitudes towards BDSM, $t(82) = -2.62$, $p < .05$, with Group A endorsing significantly less negative attitudes towards BDSM than Group B. The observed mean difference ($d = -.63$, 95% CI [-1.06, -.18],) fell above the threshold for a medium effect size (Lachenbruch & Cohen, 1989). A corresponding t-test with outlier values excluded from the analyses yielded convergent results.[12]

Personal Familiarity with BDSM

A chi-square tests of independence showed that the two groups did not differ with regard to whether participants practiced BDSM themselves, X^2 (1, $N = 79$) = .077, $p > .05$, and a maximum likelihood ratio test yielded results suggesting that the groups did not differ with regard to whether they identified as members of the BDSM community, X^2 (1, $N = 82$) = .011, $p > .05$.

Furthermore, the results of two independent samples t-tests, conducted on 599 bootstrap samples to account for failure of the data to meet assumptions of normality, found that the groups did not differ significantly with regard to participants' reported number of kinky

[12] An independent samples t-test run on 599 bootstrap samples with outlier values for the ASMS removed found that the two study groups differed with regard to their endorsement of negative attitudes towards BDSM, $t(80) = -2.85$, $p>.05$, with Group A ($M = 1.73$, $SD = .48$) endorsing significantly less negative attitudes towards BDSM than Group B ($M = 2.21$, $SD = .90$). The observed mean difference ($MD = .48$, $SE = .17$, 95% CI [.14, .79], $d = .63$) fell above the threshold for a medium effect size (Lachenbruch & Cohen, 1989).

significant others, $t(73) = -1.59$, $p > .05$, or the number of kinky clients that participants have seen in their work as psychotherapists, $t(78) = -1.04$, $p > .05$. The results of the corresponding independent samples t-tests with outlier values (i.e. dependent variable values representing scores more than three standard deviations from the group mean) excluded from the analyses converged with these findings.[13]

[13] Corresponding analyses for these dependent variables run with outlier values excluded yielded results suggesting that no significant differences between groups with regard to participants' reported number of kinky significant others, $t(71) = 1.66$, $p>.05$, or the number of kinky clients that participants have seen throughout their clinical career and practice, $t(77) = 1.55$, $p>.05$. Both of these analyses were run with equal variances not assumed due to a significant result for Levene's Test of Equality of Variances for each analysis.

Chapter 5: Discussion

The purpose of the current study was to determine whether client participation in BDSM impacted psychotherapists' perception of client psychopathology and the relevance of various clinical issues and diagnoses. It also aimed to determine whether specific psychotherapist attributes (i.e., attitudes about sex and BDSM, personal familiarity with BDSM, and clinical training pertaining to sex-positivity) would predict levels of pathologization and the degree to which clinical issues associated with negative BDSM stereotypes were deemed relevant to a clinical case.

At first glance, the majority of the study's findings appear to lend little support to the notion that psychotherapists exhibit an anti-BDSM bias. Contrary to the study's first hypothesis, which predicted that participants would rate clients who engage in BDSM as more pathological, the kinky hypothetical client was consistently rated as more highly functioning by participants and no differences were found with regard to the overall number of diagnoses that participants considered assigning the kinky and non-kinky client. The results also failed to confirm the hypothesis that client engagement in BDSM would prompt participants to rate clinical issues associated with negative BDSM stereotypes as more relevant to a client's case. In fact, clinical issues related to BDSM stereotypes, and not the case material contained within the vignettes, were characterized by participants as *less* relevant to a kinky client's concerns. Clinical issues related to the case material, but not BDSM stereotypes, were similarly rated as *less* relevant to the kinky client's concerns by participants. Moreover, no significant differences were found between groups with regard to perceived salience of clinical issues associated with both BDSM stereotypes and the case material, or clinical issues that had no relevance to BDSM stereotypes or case material.

The kinky client was also less likely to be given several diagnoses by participants: major depressive disorder (MDD), persistent depressive disorder (PDD) and histrionic personality disorder. As the scripts for the video vignettes were created such that the hypothetical clients met partial criteria for adjustment disorder with depressive and anxious features, the differences between groups with regard to the consideration of a MDD or PDD diagnosis converge with the aforementioned finding that participants deemed clinical issues related to the case material (but not to BDSM stereotypes) as less relevant to the kinky client. The differences between groups with regard to participants' consideration of a histrionic personality disorder diagnosis, however, was somewhat surprising and difficult to interpret. Although it is difficult to say definitively why participants would be more likely to diagnose the non-kinky client with histrionic personality disorder, one possible interpretation of this result is that the actor's identities impacted his characterization of the non-kinky client. Since the actor chosen to play the hypothetical client identified as a member of the BDSM community, the actor's affectation when playing the non-kinky client may have been less genuine due to a lower degree of identification with the character, leading participants to perceive the actor's characterization of the non-kinky client as emotionally shallow and thus reflective of characterological traits associated with histrionic personality disorder.

While many of the findings generated by the current study appear to support the notion that anti-kink stigma does not negatively shape psychotherapist appraisal of clients who engage in BDSM, the study also found some evidence for undue pathologization of kinky clients. Twenty participants assigned to the group that watched the video vignette portraying a kinky client considered a diagnosis of sexual masochism disorder "possible" or "likely", and 16.3% of participants in the same group considered a diagnosis of fetishistic disorder "possible" or

"likely." Moreover, participants made these determinations based on case material that contained no mention of non-consensual sexual encounters, harm or distress related to the client's engagement BDSM practices. The willingness of some participants to consider a fetishistic disorder is especially concerning, as the kinky client portrayed in the vignette designed for this study made no mention of any BDSM practices that would satisfy the diagnostic criteria associated with such a diagnosis (i.e. "recurrent and intense sexual arousal from either the use of nonliving objects or a highly specific focus on non-genital body parts;" American Psychiatric Association, 2013, p.700). This pair of findings echoes that of previous research by Kelsey and colleagues (2013) on psychotherapist attitudes surrounding kink, which found that approximately 30% of psychotherapists surveyed did not reject the idea that BDSM can/should be eliminated through psychotherapy. The current study provides more evidence for the possibility that a non-negligible subset of psychotherapists openly pathologize consensual BDSM practices, or, at the very least, are willing to assign a pathologizing diagnosis based on fairly limited information.

As a whole, the majority of these findings appear to contradict research suggesting that psychotherapists may hold implicit negative biases towards BDSM practitioners (Stockwell et al., 2017). Moreover, these findings seem at odds with qualitative research outlining BDSM practitioners' reports of pathologization by mental health professionals (Hoff & Sprott, 2009; Kolmes et al., 2014). However, a key between-group difference revealed by the post hoc analyses poses challenges to the interpretation that the results of the current study indicate psychotherapists as a whole hold non-pathologizing or favorable attitudes towards practitioners of BDSM. Despite random assignment to group conditions, the group assigned to view the vignette portraying the kinky client reported significantly more positive views of BDSM than the group assigned to view the vignette portraying the non-kinky client. Furthermore, the variances

of the two groups' responses to the measure of explicit anti-BDSM attitudes were found to differ significantly, with the group assigned to view the vignette portraying the kinky client exhibiting less variability in its responses. This finding, paired with the seemingly contradictory finding that participants were more likely to assign a paraphilic disorder to a kinky client based on limited case material, necessitates the consideration of several alternative explanations for the results of the current study: (a) failure of randomization to produce equivalent groups; (b) potential effects of study stimuli acting as a form of parasocial contact; (c) elaborative reasoning processes activated in individuals who are motivated to obscure prejudice; and (d) cognitive biases that shaped participants responses based on their prior internal representations of kinky and non-kinky people. What follows is a more in-depth exploration of each of these possibilities.

Randomization Error

While random assignment to study groups was expected to distribute variance related to psychotherapist attitudes between groups, the possibility that randomization happened to generate groups that differed with regard to attitudes about BDSM by chance cannot be entirely discounted. Therefore, it is possible that members of the group assigned to view the vignette portraying the kinky client happened to hold more favorable views of kinky people by chance, and were consequently less likely to pathologize that client or view clinical issues related to BDSM as relevant to the case. However, for this to be a plausible explanation for the differences in clinical impressions between groups, one would expect a negative relationship between explicit negative attitudes towards BDSM and perceptions of functioning to have emerged among individuals who viewed the vignette portraying the kinky client. Similarly, if differences in anti-BDSM attitudes between groups resulting from randomization error were at the root of observed mean differences in perceived relevance of various clinical issues, one might expect a

positive relationship between explicit anti-BDSM bias and perceived relevance of clinical issues related to negative BDSM stereotypes to have emerged. Such findings would have converged with research on the impact of sexual stigma surrounding other sexual minorities (e.g., bisexual individuals), which found that sexual stereotypes predicted overestimation of clinical issue salience for psychotherapists working with bisexual clients (Mohr et al., 2009). Not only did regression analyses fail to detect these relationships, no significant bilateral correlations were found between these variables (see Table 13), suggesting that the differences in pathologization and perceived relevance of clinical issues cannot be exclusively attributed to attitudinal differences between groups caused by faulty randomization. Moreover, this explanation does not explain why participants seemed to rate clinical issues that were related to case material, but not related to BDSM, as less relevant to kinky clients' concerns, necessitating consideration of other explanations for the findings of the current study.

The Current Study as Parasocial Contact

It is also possible that the unexpected mean differences found with regard to pathologization, perceived relevance of various clinical issues and attitudes towards BDSM were unrelated to participants' pre-existing biases, but, in fact, the result of the study acting as a form of parasocial contact with BDSM practitioners for participants that were assigned to view the vignette portraying the kinky client. The role of intergroup contact in reducing intergroup conflict was first proposed in the literature almost half a century ago (Allport, 1954), and contact between groups has become one of the most widely studied and validated mechanisms for reducing negative stereotyping and intergroup bias (Pettigrew & Tropp, 2006). While much of the research on the effects of interpersonal contact have largely focused on face-to-face contact (Dovidio, Love, Schellhaas, & Hewstone, 2017), more recent research has illuminated the

effectiveness of parasocial interactions—interactions with depictions or portrayals of stigmatized group members—in reducing stigmatization of outgroup members (Schiappa et al., 2005). Moreover, parasocial contact has been shown to be effective in reducing prejudice towards sexual minorities in particular (Schiappa, Gregg, & Hewes, 2006) and some research shows that even brief parasocial interactions can produce positive shifts in attitudes (Birchmore & Kettrey, 2021) that may persist well after the interaction has occurred (McDermott et al., 2018). Thus, it is possible that mere exposure to the vignette depicting a client that engages in BDSM led to a positive shift in both participant attitudes towards BDSM and clinical perceptions of kinky clients for the group assigned to the kinky client vignette. However, if the impact of intergroup contact was the primary driver of the mean differences observed in the study, the other forms of contact with BDSM (e.g., training related to sex-positivity, number of significant others who engage in BDSM, number of former clients who engage in BDSM, participation in BDSM and membership in the BDSM community) would have likely emerged as predictors for the outcome variables of this study. Given that this relationship was not found, and that previous research has found anti-BDSM stigma to be resistant to brief intervention (Rye et al., 2015), other explanations must also be considered.

The Potential Influence of Relational Elaboration and Coherence Processes

As Stockwell and his colleagues (2017) noted in their study of implicit anti-BDSM bias among psychotherapists, psychotherapists may endorse more positive attitudes towards kinky individuals when made aware of their own implicit biases in a process known as relational elaboration and coherence (Barnes-Holmes, Barnes-Holmes, Stewart, & Boles, 2010). Proponents of the Relational Elaboration and Coherence Model have theorized that individuals who hold implicit biases towards a given group may act in ways that obscure or contradict those

biases when afforded sufficient time and motivation to engage in more elaborative reasoning and produce a response that is more consistent with that reasoning (Barnes-Holmes et al., 2010). This process may be one of the mechanisms that underlies the well-documented phenomenon of participants underreporting socially undesirable behaviors and overestimating socially desirable behaviors in research studies (Krumpal, 2013), and is a particularly salient consideration for the current study, which investigated the behaviors of a population embedded in a vocational field that increasingly emphasizes the importance of affirming stances towards minoritized identities (Pieterse et al., 2009). Participants in the current study assigned to the kinky client vignette may very well have harbored associations between BDSM and psychopathology that elicited an initial negative response to the client. However, when given an unlimited amount of time to consider their clinical impressions of a kinky client, those participants may have activated other networks of cognition and motivation, such as their awareness of the values of the field of counseling (e.g., non-judgment, multicultural competence, etc.), that prompted them to behave in ways that they perceived to be congruent with the stated values of the field (e.g., adopting a seemingly non-pathologizing stance towards the kinky client).

Other research indicates that this effect may be particularly pronounced when there are considerable social pressures external to the individual (in this case, the therapist) to respond in a non-prejudiced manner, and when individuals more aware of the possibility that that their responses to a stigmatized group will be scrutinized by others (Blanchard, Crandall, Brigham, & Vaughn, 1994; Plant & Devine, 1998). Although the current study utilized deception in an attempt to minimize the impact of construct guessing and social desirability on participant responses, it is possible that the deception employed was unsuccessful in masking the true intent of the study, or that external motivations to react to the client in a non-prejudiced manner were

activated in other ways. Participants assigned to the kinky client condition may have surmised that the study was investigating sexual stigma among psychotherapists simply based on the vague study description contained in recruitment materials coupled with vignette content describing a stigmatized sexual identity. Additionally, it is well established in the extant literature that full awareness of study hypotheses and constructs is not necessary to generate this kind of participant reactivity, and that awareness of observation alone is sufficient to activate social desirability biases among research participants (McCambridge, Witton, & Elbourne, 2014). The description of the study as an assessment of clinical judgment run by a counseling psychology doctoral student in recruitment and informed consent documents may therefore have been sufficient to activate among participants a feeling of being scrutinized by a member of a profession that emphasizes non-judgment and sensitivity towards minoritized groups.

Failure of deception to mask study constructs, participants' awareness of being evaluated by a member of the counseling field and time afforded to participants to engage in elaborative reasoning may have activated networks of cognition related to multicultural competence (e.g. "I am not supposed to view sexual minorities negatively") in participants assigned to the kinky client condition, thereby leading them to respond to study measures in ways that both obscure any anti-BDSM biases that they held, and resulted in more favorable characterization of the kinky client. Thus, the findings of the study may be indicative of reactivity and activation of social desirability motivation through relational elaboration rather than the absence of anti-BDSM bias among mental health practitioners.

The Potential Impact of Shifting Standards

Another alternative explanation for the surprising group differences observed in this study is the possibility that participants may have based their clinical impressions of the

hypothetical clients in each vignette on different sets of expectations for client functioning and pathology. The Shifting Standards Model (Biernat & Manis, 1994) posits that the criteria used to make subjective judgments about others are often anchored to internalized stereotype-based expectations for people who share a social identity or group affiliation with the target individual. Interpretations of similar behaviors in individuals that belong to different social groups may therefore differ if the observer holds biases about the relative likelihood of various groups to exhibit such behaviors. Research assessing this model in the context of mental health providers' clinical decision making has shown that psychotherapists' often initially evaluate members of stigmatized groups as higher functioning (Gushue, 2004), and that this tendency is more pronounced in clinicians that exhibit less multicultural awareness (Gushue, Constantine, & Sciarra, 2008). Thus, the relatively high ratings of functioning and low perceived relevance of certain clinical issues indicated by participants assigned to the kinky client may have been an artifact of participants' initial low expectations for psychological health among BDSM practitioners (i.e., "this client is quite high functioning *for a kinky person*"). Conversely, participants assigned to view the vignette portraying the non-kinky client may have had fewer expectations for pathology associated with the client's perceptible or assumed identities, and consequently perceived the client as relatively more pathological as a result. This effect may have been particularly pronounced in the case of the current study due to investigators' decision to select an actor for the vignettes that was likely to be perceived as holding many non-stigmatized identities (e.g. young, White, male, etc.). The Shifting Standards Model (Biernat & Manis, 1994) would therefore suggest that the higher scores on the GAF and lower scores on some indices of clinical concerns developed for this study assigned to kinky clients by participants indicate the *presence* of anti-kink bias among clinicians, rather than its absence. This

interpretation also reconciles the findings related to these variables with the seemingly contradictory finding that participants were more likely to give kinky clients a highly pathologizing diagnosis with very little support for such a diagnosis within the case material.

Implications

First and foremost, this study highlights some of the challenges involved in studying bias, particularly within a target population that is highly motivated to behave in a non-prejudiced manner. Documents outlining the stated values of various helping professions invariably include respect for diversity of identity (American Counseling Association, 2014; American Psychological Association, 2010), and the motivation to appear in alignment with these values may lead psychotherapists to obscure biased reactions towards clients with stigmatized sexual identities under particular circumstances, including research participation (Krumpal, 2013). While social scientists have tried to develop increasingly sophisticated ways of detecting bias, there is evidence that even implicit measures of bias that are meant to circumvent social desirability motivations may not be entirely robust to the impact of social pressures (Boysen, Vogel, & Madon, 2006). The results of this study, and the numerous divergent explanations for those results, indicate that studying bias among mental health professionals may require methodologies that heavily supplement, or increasingly diverge from, participant self-report and even experimental designs.

The findings of the current study also demonstrate that the prejudice predicted by Herek's model of sexual stigma (2007) may manifest in unexpected ways and interact with other social motivations to produce patterns of behavior that may not be immediately recognizable as prejudice. Anti-BDSM stigma is likely subject to shifts in social norms similar to those that have prompted prejudice against racial/ethnic minorities (Ikuenobe, 2011), women (Swim, Mallett, &

Stangor, 2004), and LGB people (Aberson, Swan, & Emerson, 1999) to take increasingly subtle forms. It is therefore important for researchers to develop increasingly flexible and expansive understandings of how sexual stigma related to BDSM may manifest in populations that are more and less motivated to appear non-prejudiced towards kinky people.

The potential contribution of relational elaboration processes in shaping the results of this study also has complex implications for quality of mental health care for kinky clients. If relational elaboration processes are effective in attenuating the impact of anti-kink biases on psychotherapists' clinical judgment, the helping professions' increasing emphasis on issues of diversity and respect for cultural difference may serve to prevent overpathologization of kinky clients in clinical practice when those professional values are made salient. These processes may be further enhanced by providing ample opportunities for psychotherapists to engage in deliberate contemplation of clinical cases involving BDSM through supervision and consultation. However, it is possible that these same relational elaboration processes may lead psychotherapists to "overcorrect" for their biases in ways are harmful to kinky clients. While the current study found that participants rated a set clinical issues related only to BDSM stereotypes (and not the case material) as less relevant to a kinky client's concerns, they also did the same for a set of clinical issues related *only to the case material* (and *not* BDSM stereotypes). Insofar as relational elaboration can be assumed to have played a role in generating these differences, it is possible that this type of elaborative reasoning may have prevented participants from attending to clinical issues that were actually relevant to the kinky client's constellation of concerns. Relational elaboration processes that activate motivations to appear non-prejudiced may therefore negatively impact care for kinky clients by preventing psychotherapists from accurately determining the nature and/or magnitude of the concerns a kinky client brings into therapy.

Perhaps the most unsettling finding of study was that a considerable number of mental health professionals may consider assigning a paraphilic disorder to kinky clients in the absence of client report of harm, distress or impairment directly related to their engagement in BDSM. Although the number of participants willing to assign a paraphilic disorder diagnosis did not constitute an absolute majority of the sample for this study, the number of clinicians willing to do so based on fairly limited information was certainly not negligible, and would likely give pause to BDSM practitioners seeking mental health care. When contextualized against the backdrop of other pathologizing psychotherapist behaviors reported by BDSM practitioners (Kolmes et al., 2014) and the potential legal implications of paraphilic disorder diagnoses (e.g. loss of child custody; Wright, 2014), this finding highlights the importance of mechanisms by which BDSM practitioners can identify mental health care providers that are kink aware, such as the Kink and Poly Aware Professionals Directory managed by the National Coalition for Sexual Freedom and referral networks maintained by individual kink-aware providers.

Taken together, the findings of the current study also have several important implications for psychotherapist training with regard to issues of sexuality and sexual identity. Given the finding that some psychotherapists may be inclined to assign highly pathologizing paraphilic disorder diagnoses to kinky clients based on little to no case information that would merit such diagnoses, it may be important to integrate more case examples involving kinky clients and discussion of non-traditional sexuality into clinical training curriculum. Doing so may be helpful in exposing clinical trainees to non-traditional sexual behaviors and relationships, uncovering biases that trainees hold at the start of their clinical training, and helping trainees distinguish between BDSM, abusive relationship dynamics and sexual dysfunction. These adjustments to training curriculum may be particularly important to implement in light of research suggesting

that few graduate training programs require psychotherapists-in-training to take coursework pertaining to human sexuality, and that the content of any coursework offered is often limited to discussion of sexuality as a source of identity difference (Burnes et al., 2017). As psychotherapist training materials depicting sexually stigmatized groups that are developed without input from the communities they are meant to portray have historically contributed to overpathologization and harmful stereotyping of sexual minority clients (e.g. LGBT identities; Margolin, 2021), it is imperative that clinical case examples depicting kinky clients for use in training mental health professionals be developed in consultation with members of the BDSM community. This would align with best practices in curriculum development across helping professions, which have shifted towards models of involving marginalized communities in the development of clinical training materials (Goez, Lai, Rodger, Brett-MacLean, & Hillier, 2020; Julian, Mengesha, McLemore, & Steinauer, 2021). Given that pathologization of BDSM has been shown to have serious legal and interpersonal implications for kinky individuals (Wright, 2014, 2018; Wright et al., 2008), trainees should also be made aware of the harm that mental health professionals may inflict on kinky clients through assignment of a paraphilic disorder, and encouraged to make diagnostic decisions with this potential harm in mind. Finally, clinical training programs will need to do more than merely encourage graduate trainees to adopt an accepting stance towards kink, as this approach may enhance motivations to present as non-prejudiced while failing to reduce prejudicial behaviors (Beer et al., 2012; Constantine & Ladany, 2000). Instead, clinical training in this domain will need to provide ample opportunities for trainees to sensitize themselves to the more covert and subtle expressions of their own biases towards individuals who engage in BDSM.

Study Limitations and Future Directions

The small sample size of the study likely limited the capacity for the study to detect smaller differences between groups and weaker relationships between variables. A power analysis run to inform recruitment goals for the study indicated that a sample of approximately 200 participants would be necessary to detect an effect size that fell between thresholds for small and medium effect sizes (d = .4). This target sample size was more than twice the number of cases used for all analyses related to mean differences testing for the current study. While several larger effect sizes were detected, it is possible that other significant mean differences with regard to the various forms of pathologization studied would have been revealed had a larger sample been used.

The study's small sample size likely had a greater impact on the statistical power of the regression analyses run for this study, since regression analyses were only run on half of the overall sample, further compromising the capacity for detecting potential small, but meaningful, relationships between variables of interest (e.g., anti-sex attitudes, negative attitudes towards BDSM, sex-positivity training, pathologization and perceived relevance of clinical issues related to BDSM stereotypes). The non-significant regression results yielded by the current investigation should therefore not be interpreted as strong evidence for an absence of meaningful relationships between these variables, but rather seen as indicative of the need for additional research in this area using larger participant samples.

While the nature of some of the recruitment methods utilized for this study were made it impossible to assess for response rate (e.g., social media postings and email listserv postings), the information available to investigators regarding recruitment methods for which a response rate could be calculated (i.e., direct emailing) indicate that the overall rate of response was likely

quite low. Since 200-400 prospective participants were contacted from each of the nine census divisions of the United States through direct emailing, even the most generous response rate for the study would fall around 5%. This falls well below the weighted average of 49.6% yielded by a meta-analysis examining survey response rates in counseling and clinical psychology research (Van Horn, Green, & Martinussen, 2009). Several factors may have depressed the response rate for this study, including: lack of significant monetary compensation for participation, length of expected study participation, and major societal traumas that occurred during study recruitment (e.g. the COVID-19 pandemic and high profile cases of police violence against Black citizens). Study results should thus be carefully interpreted against the backdrop of past and future research in this area to account for the unknown impact of the study's low response rate on the validity and generalizability of the study's findings.

The composition of the sample with regard to several demographic variables also limits the generalizability of the current study. Black, Asian/Pacific Islander, and Native American/American Indian identities were particularly underrepresented in this sample, as were individuals who identified as trans and/or nonbinary. Furthermore, as missing data represented a non-negligible portion of the overall responses on several demographic items (e.g. gender, race, professional identity, etc.), the true composition of the participant groups in the current study, and meaningful differences between groups unrelated to the experimental manipulation, may have been obscured.

It is also important to note that the content of the vignette portraying the kinky client used in this study represented a limited subset of the behaviors and practices that fall under the BDSM umbrella. The umbrella term BDSM encompasses a broad array of relational and sexual activities (Williams, 2006), of which only a few (e.g. bondage, power exchange, impact play)

were represented in the video vignette of the hypothetical kinky client. There is also considerable variability among BDSM practices with regard to visibility within mainstream media and which specific taboos and/or dominant cultural norms that a given practice subverts (Weiss, 2014). As such, this study may be limited in its ability to produce conclusions about how mental health practitioners view BDSM as a whole, or other BDSM practices not depicted in the vignette. Furthermore, some recent research has shown that psychotherapists' perceptions of client engagement in BDSM practices may be influenced by clients' other perceptible social identities, such as gender (Fuss, Briken, & Klein, 2018). Future research on psychotherapists' perceptions of BDSM would benefit from further delineating different kink practices and exploring how anti-BDSM bias intersects with other forms of identity-based bias.

The absence of manipulation check items, social desirability measures and mechanisms for assessing hypothesis guessing also limits the strength of the conclusions that can be drawn from this study. Specifically, the relative contribution of relational elaboration processes and/or participants' preexisting expectations for client pathology to the differences observed between groups could not be quantified, and the degree to which relational elaboration obscured relationships between psychotherapist characteristics of interest and outcome variables could not be determined. Future research employing methodologies that include implicit measures of bias robust to social desirability motivations (i.e. the IRAP; Stockwell et al., 2017, 2010), manipulation and hypothesis guessing checks and more complex deception may be necessary to draw firmer conclusions surrounding the relationships between constructs explored in the current study.

Although investigators consulted a focus group when developing video stimuli for the current study in order to minimize meaningful differences unrelated to the experimental

manipulation between the vignettes presented to each participant group, it is possible that some of the findings could be attributed to differences between the vignettes that went undetected during the vignette development process (e.g. differences in emotional intensity, etc.). Thus, inclusion of a pilot study where participants with demonstrated competence working with kinky clients assess the equivalency of the vignettes used in the focal study may be an important element to include in future iterations of this research.

Finally, the current study only examined clinicians' initial clinical impressions of clients, and, as such, few inferences can be made about how clinicians' clinical judgment and behaviors may shift over time when working with clients who engage in BDSM. As much of the other research on perceptions of BDSM among mental health professionals exhibits this same limitation (e.g. Fuss et al., 2018; Stockwell et al., 2017), exploration of if, when and how anti-kink bias manifests later in the helping relationship in future research is warranted.

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Table 1. Participant Gender

Variable	Total sample		Group A (kinky client)		Group B (non-kinky client)	
	n	%	n	%	n	%
Gender						
Male	24	25.8%	9	16.6%	15	35.7%
Female	59	63.4%	37	72.5%	22	52.4%
Nonbinary	1	1.1%	0	0%	1	2.4%
No response	9	9.7%	5	9.8%	4	9.5%
Trans/nonbinary identity						
Yes	3	3.2%	2	3.9%	1	2.4%
No	81	87.1%	44	86.3%	37	88.1%
No response	9	9.7%	5	9.8%	4	9.5%

Table 2. Participant Sexual Orientation

	Total sample		Group A (kinky client)		Group B (non-kinky client)	
	n	%	n	%	n	%
Gay/lesbian	4	4.3%	2	3.9%	2	4.8%
Bisexual/pansexual/omnisexual	15	16.1%	9	17.6%	6	14.3%
Asexual spectrum	1	1.1%	0	0%	1	2.4%
Straight/heterosexual	62	66.7%	34	66.7%	28	66.7%
Other	2	2.2%	1[†]	2.0%	1[❖]	2.4%
No response	9	9.7%	5	9.8%	4	9.5%

[†]Participant specified sexual orientation as "queer"
[❖]Participant specified sexual orientation as "straight polyamorous"

Table 3. Participant Racial Identity

	Total sample		Group A (kinky client)		Group B (non-kinky client)	
	n	%	n	%	n	%
Asian/Pacific Islander	1	1.1%	0	0%	1	2.4%
Black/African Origin	1	1.1%	1	2.0%	0	0%
Latina/Latino/Latinx	4	4.3%	2	3.9%	2	4.8%
Native American/American Indian	0	0%	0	0%	0	0%
White	77	72.0%	36	70.6%	31	73.8%
Other	3	4.3%	2□	3.9%	1❖	2.4%
More than one category selected	8	8.6%	5†	9.8%	3‡	7.1%
No response	9	9.7%	5	9.8%	4	9.5%

❖ Participant did not specify race when prompted.
□ Participants that selected this category exclusively in this group identified as "Middle Eastern" and "European").

†Participants that selected more than one race category in this group identified as: Black/African Origin, Native American/American Indian and Other (unspecified); White and Jewish; and Asian/Pacific Islander and White (two participants).
‡Participants that selected more than one race category in this group identified as: Asian/Pacific Islander and White; Black/African Origin and White; and White and Other (unspecified).

Table 4. Participant Socioeconomic Status

	Total sample		Group A (kinky client)		Group B (non-kinky client)	
	N	%	n	%	n	%
Highest level of education						
Masters degree	34	36.6%	22	43.1%	12	28.6%
Doctoral degree	49	52.7%	23	45.1%	26	61.9%
No response	10	10.8%	6	11.8%	4	9.5%
Social class						
Working class	4	4.3%	4	7.8%	0	0%
Middle class	40	43.0%	19	37.3%	21	50.0%
Upper middle class	36	38.7%	20	39.2%	16	38.1%
Upper class	2	2.2%	1	2.0%	1	2.4%
No response	11	11.8%	7	13.7%	4	9.5%

Table 5. Participant Community of Residence

	Total sample		Group A (kinky client)		Group B (non-kinky client)	
	n	%	n	%	n	%
Rural	9	9.7%	5	9.8%	4	9.5%
Suburban	48	51.6%	26	51.0%	22	52.4%
Urban	26	28.0%	14	27.5%	12	28.6%
No response	10	10.8%	6	11.8%	4	9.5%

Table 6. T-Tests and Standardized Mean Differences (Hypothesis 1)

Variable	*df*	*t*	*d*	CI Lower	CI Upper	Group A		Group B	
						M	*SD*	*M*	*SD*
GAF❖	91	2.47*	.52	.11	.94	61.27	6.98	57.76	6.37
Number of DSM diagnoses given❖	62	-.96	-.24	-.73	.26	4.14	2.12	4.62	1.82

Note. Positive *d* values indicate $M_A > M_B$, CI = 95% Confidence Interval for the Cohen's d statistic
** = $p < .01$, *** = $p < .001$
❖ Indicates that the Shapiro-Wilk Test of Normality was significant for at least one of the two participant group dependent variable response distributions, and that 599 bootstrap samples were used to calculate the t statistic in order to ensure robustness against non-normality.

Table 7. T-Tests and Standardized Mean Differences (Hypothesis 2)

Variable	*df*	*t*	*d*	CI Lower	CI Upper	Group A		Group B	
						M	*SD*	*M*	*SD*
Clinical issues related to BDSM stereotypes **and** case (SCII-1)❖	84	-1.09	-.22	-1.04	.29	6.85	1.89	7.23	1.49
Clinical issues related to BDSM stereotypes, **not** case (SCII-2)❖□	84	-2.11*	-.47	-.90	-.035	7.87	2.00	8.85	2.19
Clinical issues related to case, **not** BDSM stereotypes (SCII-3)❖	84	-4.30**	-.89	-1.34	-.45	18.83	2.24	20.64	1.74
Clinical issues **unrelated** to BDSM stereotypes **and** case (SCII-4)❖	84	.98	.025	-.40	.45				

Note. Positive *d* values indicate $M_A > M_B$, CI = 95% Confidence Interval for the Cohen's d statistic
** = $p < .01$, *** = $p < .001$
❖ Indicates that the Shapiro-Wilk Test of Normality was significant for at least one of the two participant group dependent variable response distributions, and that 599 bootstrap samples were used to calculate the t statistic in order to ensure robustness against non-normality.
□ Indicates that the t-statistic reported is based on a subset of the data that excludes responses with dependent variable values more than three standard deviations from the mean.

Table 8. Correlations between variables included in mean differences testing

Variable	1.	2.	3.	4.	5.	6.
1. GAF	-	-.022	-.15	-.28**	-.43**	-.22*
2. Number of diagnoses considered	64	-	.24	.37**	-.14	.17
3. SCII-1	93	64	-	.30**	.30**	.25*
4. SCII-2	88	64	88	-	.14	.48**
5. SCII-3	93	64	93	88	-	.098
6. SCII-4	89	64	89	86	89	-
M	59.69	4.36	7.11	8.52	19.73	9.63
SD	6.90	1.99	1.72	2.52	2.26	1.69
n	93	64	93	88	93	89

Note. Sample size used to calculate each correlation is shown below the diagonal.
* = $p<.05$, ** = $p<.01$, *** = $p<.001$ (two-tailed)

Table 9. Chi-square Tests for Differences (Hypothesis 3)

Variable	*n*	*df*	X^2	*V*	Group A(kinky client)		Group B(kinky client)	
					Possible/likely N (% of group)	Unlikely N (% of group)	Possible/likely N (% of group)	Unlikely N (% of group)
Major depressive disorder	93	1	5.41*	.24	40 (78.4%)	11 (21.6%)	40 (95.2%)	2 (4.8%)
Persistent depressive disorder	91	1	6.60*	.27	17 (34.0%)	33 (66.0%)	25 (61.0%)	16 (39.0%)
Generalized anxiety disorder	91	1	2.92	.18	26 (52.0%)	24 (48.0%)	27 (65.9%)	14 (34.1%)
Social anxiety disorder	91	1	2.92	.04	10 (20.4%)	39 (79.6%)	10 (23.8%)	32 (76.2%)
Panic disorder†	92	1	.44	.07	2 (4.0%)	48 (96.0%)	3 (7.1%)	39 (92.9%)
Bipolar disorder (I or II) †	91	1	.72	.09	3 (6.0%)	47 (94.0%)	1 (2.4%)	40 (97.6%)
Adjustment disorder†	93	1	1.21	.10	50 (98.0%)	1 (2.0%)	42 (100%)	0 (0%)
Acute stress disorder	92	1	.63	.08	14 (28.0%)	36 (72.0%)	15 (35.7%)	27 (64.3%)
Posttraumatic stress disorder†	92	1	.44	.07	2 (4.0%)	48 (96.0%)	3 (7.1%)	39 (92.9%)
Obsessive compulsive disorder†	93	1	.02	.01	1 (2.0%)	50 (98.0%)	1 (2.4%)	41 (97.6%)
Borderline personality disorder†	92	1	.19	.05	2 (4.0%)	48 (96.0%)	1 (2.4%)	41 (97.6%)
Histrionic personality disorder†	91	1	4.76*	.20	0 (0%)	49 (100%)	3 (7.1%)	39 (92.9%)
Narcissistic personality disorder❖	-	-	-	-	0 (0%)	50 (100%)	0 (0%)	42 (100%)
Antisocial personality disorder❖	-	-	-	-	0 (0%)	50 (100%)	0 (0%)	42 (100%)
Dependent personality disorder	92	1	.002	.005	20 (40.0%)	30 (60.0%)	17 (40.5%)	25 (59.5%)
Avoidant personality disorder†	92	1	.56	.08	1 (2.0%)	49 (98.0%)	2 (4.8%)	40 (95.2%)
Sexual masochism disorder†	92	1	13.22**	.32	10 (20.0%)	40 (80.0%)	0 (0%)	42 (100%)
Sexual sadism disorder†	92	1	2.48	.14	2 (4.0%)	48 (96.0%)	0 (0%)	42 (100%)
Fetishistic disorder†	91	1	5.66*	.23	8 (16.3%)	41 (83.7%)	1 (2.4%)	41 (97.6%)
Other diagnoses†□	68	1	.71	.03	4 (10.8%)	33 (89.2%)	4 (12.9%)	27 (87.1%)

* = $p < .05$, ** = $p < .01$, *** = $p < .001$

† Indicates that the assumptions of the Pearson chi-square test were not met and a maximum likelihood ratio test was used to calculate the chi-square statistic

❖ Indicates that no participants in either group indicated that they would assign this diagnosis, resulting in an invalid test statistic

□ Diagnoses/clinical codes suggested by participants when asked to specify other diagnoses that they would consider for the client portrayed in the vignetter included: problems related to living alone, unspecified problems related to employment, other specified problems related to psychosocial circumstances, problems in relationship with spouse or partner and adult emotional abuse.

Table 10. Multiple Linear Regression Results (Hypothesis 4)

	Pathologization (GAF)					**Clinical concerns related to BDSM (SCII-1 + SCII-2)**				
Independent Variable	**R^2**	**ΔR^2**	β	*t*	*p*	**R^2**	**ΔR^2**	β	*t*	*p*
Step 1	.034					.025				
Age			-.22	-1.10	.28			.063	.324	.75
Gender (female)			-.10	-.52	.61			-.11	-.55	.59
Sexual orientation (heterosexual)			.002	.014	.99			-.034	-.20	.84
Trans/nonbinary identity			.034	.21	.84			-.039	-.23	.82
F(4, 38) = .337, *p* = .852						F(4,36) = .23, *p* = .92				
Step 2	.054	.020				.025	.001			
Age			-.26	-1.23	.23			.053	.25	.80
Gender (female)			-.10	-.52	.61			-.11	-.53	.60
Sexual orientation (heterosexual)			-.022	-.12	.90			-.043	-.23	.82
Trans/nonbinary identity			.028	.17	.87			-.041	-.23	.82
Negative attitudes about BDSM (ASMS)			-.016	-.088	.93			.024	.11	.91
Conservative attitudes about sex (SAS)			.16	.87	.39			.013	.069	.95
F(6, 36) = .35, *p* = .91						F(6,34) = .15, *p* = .99				
F Δ (2,36) = .39, *p* = .68)						F Δ (2, 34) = .014, *p* = .99)				

Table 11. Multiple Regression Results (Hypothesis 5)

	Pathologization (GAF)					**Clinical concerns related to BDSM (SCII-1 + SCII-2)**				
Independent Variable	**R^2**	**ΔR^2**	β	*t*	*p*	**R^2**	**ΔR^2**	β	*t*	*p*
Step 1	.12					.034				
Age			-.36	-1.81	.080			.097	.46	.65
Gender (female)			-.051	-.26	.80			-.10	-.49	.63
Sexual orientation (heterosexual)			-.10	-.57	.57			.047	.25	.80
Trans/nonbinary identity			-.005	-.028	.98			-.010	-.051	.96
F(4, 30) = 1.05, *p* = .40						F(4,29) =.26, *p* = .90				
Step 2	.22	.092				.25	.22			
Age			-.41	-1.96	.061			.18	.83	.02*
Gender (female)			-.082	-.41	.69			-.021	-.10	.92
Sexual orientation (heterosexual)			-.060	-.28	.78			.006	.026	.98
Trans/nonbinary identity			.052	.27	.79			-.088	-.45	.65
Engagement in BDSM practices			.26	.94	.36			-.25	-.94	.35
Membership in BDSM community			-.13	-.61	.55			.072	.35	.73
Number of kinky significant others			-.25	-1.25	.22			.75	2.67	.013*
Number of clients who engage in BDSM			.33	1.27	.22			-.45	-1.78	.087
F(8, 26) = .89, *p* = .54 F Δ (4,26) = .77, *p* = .56)						F(8, 25) = 1.06, *p* = .42 F Δ (4, 25) = 1.83, *p* = .16)				

Table 12. Multiple Linear Regression Results (Hypothesis 6)

	Pathologization (GAF)					**Clinical concerns related to BDSM (SCII-1+SCII-2)**				
Independent Variable	**R^2**	**ΔR^2**	β	*t*	*p*	**R^2**	**ΔR^2**	B	*t*	*p*
Step 1	.040					.027				
Age			-.22	-1.13	.26			.066	.34	.74
Gender (female)			-.090	-.45	.65			-.12	-.58	.57
Sexual orientation (heterosexual)			-.023	-.13	.89			-.027	-.15	.88
Trans/nonbinary identity			.034	.20	.85			-.038	-.21	.83
F(4, 36) = .37, *p* = .83						F(4,34) = .24, *p* = .92				
Step 2	.049	.009				.063	.036			
Age			-.27	-1.26	.22			.19	.84	.41
Gender (female)			-.092	-.46	.65			-.12	-.59	.56
Sexual orientation (heterosexual)			-.036	-.21	.84			.009	.051	.96
Trans/nonbinary identity			.033	.19	.85			-.032	-.18	.86
Number of training hours devoted to sex positivity			.11	.57	.57			-.23	-1.13	.27
F(5, 35) = .36, *p* = .87						F(5,33) = .45, *p* = .81				
F Δ (1,35) = .33, *p* = .57)						F Δ (1, 33) = 1.28, *p* = .27)				

Table 13. Correlations between variables included in regression analyses (Group A only)

Variable	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.
1. Age	-	-.574**	.094	-.135	.331*	.373*	-.086	-.105	.041	.152	.430**	-.162	.123
2. Gender (female) ❖	43	-	-.168	.105	-.222	-.281	.106	.072	-.088	-.034	-.193	.043	-.130
3. Sexual orientation (straight/heterosexual) ❖	43	46	-	-.359*	.216	.295*	-.481**	-.249	-.071	.113	.126	-.040	-.034
4. Trans/nonbinary identity❖	43	46	46	-	-.092	-.142	.156	-.033	.191	-.106	-.024	.082	-.024
5. SAS	43	46	46	46	-	.374*	-.234	-.064	-.282	-.059	-.173	.058	.057
6. ASMS	43	46	46	46	46	-	-.361*	-.133	-.326*	-.080	.250	-.033	.086
7. Participant engagement in BDSM❖	39	42	42	42	42	42	-	.054	.001	.029	.935	.681	.975
8. Participant membership in BDSM community❖	41	44	44	44	44	44	42	-	.020	-.081	-.084	-.004	.004
9. Number of kinky significant others	36	39	39	39	39	39	38	39	-	.596**	.134	.032	.302
10. Total number of kinky clients seen	41	44	44	44	44	44	42	43	39	-	.417**	.089	-.087
11. Sex-positivity training hours	41	44	44	44	44	44	42	43	39	44	-	.015	-.072
12. GAF score given to client	43	46	46	46	50	46	42	44	39	44	44	-	-.176
13. Perceived relevance of clinical concerns related to BDSM stereotypes	41	44	44	44	48	44	40	42	38	42	42	49	-
M	40.91	.80	.74	.04	20.34	1.78	.21	.02	1.74	6.16	9.45	61.27	15.16
SD	11.46	.40	.44	.21	7.33	.59	.42	.15	2.16	11.82	17.75	6.98	3.74
n	43	46	46	46	50	46	42	44	39	44	44	51	49

Note. Sample size used to calculate each correlation is shown below the diagonal.
* = $p<.05$, ** = $p<.01$, *** = $p<.001$ (two-tailed)
❖Indicates a dichotomous variable

Table 14. T-Tests and Standardized Mean Differences (post hoc analyses)

Variable	*df*	*t*	*d*	CI Lower	CI Upper	Group A		Group B	
						M	*SD*	*M*	*SD*
Sexual attitudes scale (SAS) ❖	89	-1.21	-.25	-.66	.17	20.34	7.33	22.22	7.84
Attitudes about sadomasochism scale (ASMS) ❖†	82	-2.62*	-.63	-1.06	-.18	1.78	.59	2.29	1.04
Number of kinky significant others ❖ †	73	-1.59	.37	-.088	.83	1.74	2.16	3.08	1.71
Total number of kinky clients seen ❖	78	-1.04	-.24	-.68	.20	6.19	11.96	9.54	16.25

Note. Positive *d* values indicate $M_A > M_B$, CI = 95% Confidence Interval for the Cohen's d statistic

** = $p < .01$, *** = $p < .001$

❖ Indicates that the Shapiro-Wilk Test of Normality was significant for at least one of the two participant group dependent variable response distributions, and that 599 bootstrap samples were used to calculate the t statistic in order to ensure robustness against non-normality.

† Indicates Levine's Test was significant and the t statistic for equal variances not assumed was used.

Appendix A: Recruitment Text (direct emailing)

Hello!

My name is Jaime Lam, a doctoral student at the University of Wisconsin-Madison, and I am working on a research project about the way we make decisions as psychotherapists!

You may qualify if you are a licensed psychotherapist in the US who has seen at least one client in the last year.

Participation involves watching a 4-min video vignette of a hypothetical therapy client and answering questions about your clinical impressions of the person depicted and personal background. The total time required is 15-20 minutes.

If you participate, the study will donate $1 to a mental health related charity that you choose from a predetermined list, and you will be entered into a drawing for one of two $50 Amazon gift cards!

If you are interested in being a part of this study, please click the following link:
https://uwmadison.co1.qualtrics.com/jfe/form/SV_5sEvICxosLmML0F

FOR MORE INFORMATION, PLEASE CONTACT:
Jaime Lam (student researcher): jlam5@wisc.edu
Stephanie Budge Ph.D. (Primary Investigator) 608-263-3753

The content of this correspondence has been approved by a University of Wisconsin-Madison Institutional Review Board (IRB). The UW- Madison Educational and Social/Behavioral Science IRB ID number for this study is 2020-0330.

Appendix B: Recruitment Flyer (social media postings)

Are you a licensed psychotherapist in the United States who has seen at least one client in the past year and has 15-20 minutes to spare? If so, you may be eligible to participate in a quick study that will help us better understand clinical decision making among psychotherapists!

You may qualify if you:

- Are a licensed psychotherapist in the US
- Have seen at least one client in the last year

Participation involves:

- Watching a 4-minute video of a hypothetical client
- Answering questions about your clinical impressions of the person depicted
- Answering questions about your personal beliefs and background

Compensation:

The study will donate $1 to a mental health related charity (that you will choose from a predetermined list). You also will be entered into a drawing for one of two $50 Amazon gift cards!

Potential benefits:

Participants are not expected to benefit directly. Research results will contribute to the field's understanding of how psychotherapists assess clients and make clinical decisions.

If you are interested in being a part of this study, please click the following link:

https://uwmadison.co1.qualtrics.com/jfe/form/SV_5sEvICxosLmML0F

FOR MORE INFORMATION, PLEASE CONTACT:

Stephanie Budge Ph.D. (Primary Investigator) 608-263-3753
Jaime Lam (student researcher): jlam5@wisc.edu

The content of this flyer has been approved by a University of Wisconsin-Madison Institutional Review Board (IRB). IRBs are charged with protecting the rights and welfare of people who take part in research studies. The UW-Madison Educational and Social/Behavioral Science IRB ID number for this study is 2020-0330.

Appendix C: Vignette Scripts

Vignette A (BDSM-identified client)

I really haven't been myself lately, and I've been feeling really down. Sometimes I feel like I know why and sometimes I have no idea what brings it on. Like on some days, I feel like crying for no good reason at all. It isn't all the time, but it's definitely enough to have me worried. The other day, I got home and I just started sobbing. I need to do something about this because these people at work just met me two months ago when I got transferred here, and I want to make a good impression. People at work haven't noticed yet, and I don't need to embarrass myself by crying in front of people I'm just starting to form working relationships with.

Things outside of work have been tough, too. I thought that this year long transfer would be manageable and that I could handle a long distance relationship for that long. I thought, "it's just a year, how hard could it be?" But it's really hard when it's a relationship like ours, where my partner is also my dominant, you know? We try to talk on the phone, and I have this collar to remind me of what we have together [client fiddles with collar], but not being able to actually be in the same room, not being able to have sex the way we want... You can't really get tied up or flogged over Skype. It's just not the same. It's so hard being away from someone who means everything to you and is also someone you feel deeply submissive to. Lately, I just can't stop worrying about what the distance is doing to us. I can't help but think that we are just going to drift apart and the relationship that we've built is just going to slowly die. This relationship has been such a central part of my life, I don't know what I'd do if it were gone. Sometimes I worry so much that I can't really get to bed; I just lay there thinking about what will happen if this project gets extended and I have to stay here for another year, or more. It gets me so riled up that I barely get any sleep and I end up exhausted the next day. I'm scared that if this keeps going, it will affect my ability to get things done at work, so I really need to get a handle on what is going on with me.

It's not just stuff with my relationship. I've been feeling pretty isolated and lonely overall, too. Back home I was part of a pretty active kink community, and there were always people like me to hang out with, but that community doesn't really exist around here, and it's been really hard just sitting alone in my apartment after work.

Lately, I've been starting to feel really hopeless about this whole situation, and I've been asking myself "what's the point of all this?" I've never really felt that way before, so it's shaken me up a little bit. That's why I came to therapy—to get help before things get really out of hand.

Vignette B (non BDSM-identified client)

I really haven't been myself lately, and I've been feeling really down. Sometimes I feel like I know why and sometimes I have no idea what brings it on. Like on some days, I feel like crying for no good reason at all. It isn't all the time, but it's definitely enough to have me worried. The other day, I got home and I just started sobbing. I need to do something about this because these people at work just met me two months ago when I got transferred here, and I want to make a good impression. People at work haven't noticed yet, and I don't need to embarrass myself by crying in front of people I'm just starting to form working relationships with.

Things outside of work have been tough, too. I thought that this year long transfer would be manageable and that I could handle a long distance relationship for that long. I thought, "it's just a year, how hard could it be?" But it's really hard not having someone to come home to every night after you've been together for so long, you know? We try to talk on the phone, and I have this ring to remind me of what we have together [client fiddles with ring], but not being able to actually be in the same room, not being able to have sex... It's just not the same It's so hard being away from someone who means everything to you and is also your best friend… Lately, I just can't stop worrying about what the distance is doing to us. I can't help but think that we are just going to drift apart and the relationship that we've built is just going to slowly die. This relationship has been such a central part of my life, I don't know what I'd do if it were gone. Sometimes I worry so much that I can't really get to bed; I just lay there thinking about what will happen if this project gets extended and I have to stay here for another year, or more. It gets me so riled up that I barely get any sleep and I end up exhausted the next day. I'm scared that if this keeps going, it will affect my ability to get things done at work, so I really need to get a handle on what is going on with me.

It's not just stuff with my relationship. I've been feeling pretty isolated and lonely overall, too. Back home I was part of close knit community, and there were always people to hang out with, but I haven't really had any luck finding people with similar interests around here, and it's been really hard just sitting alone in my apartment after work.

Lately, I've been starting to feel really hopeless about this whole situation, and I've been asking myself "what's the point of all this?" I've never really felt that way before, so it's shaken me up a little bit. That's why I came to therapy—to get help before things get really out of hand.

Appendix D: Global Assessment of Functioning (GAF)

Based on the clinical case information provided, please rate the client's overall level of functional impairment using the following scale (1-100). Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100- 91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of their many positive qualities. No symptoms.

90- 81 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities. socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g. an occasional argument with family members).

80- 71 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g., temporarily failing behind in schoolwork).

70- 61 Some mild symptoms (e.g. depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

60- 51 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g.. few friends, conflicts with peers or co-workers).

50- 41 Serious symptoms (e.g.. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40- 31 Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30- 21 Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

20-11 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

10-1 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0 Inadequate information

Appendix E: Salience of Clinical Issues Indices
(adapted from Mohr et al., 2001, 2009)

Listed below are a number of clinical issues that are seen in adult populations. Using your clinical judgment, estimate the degree to which each of these issues may play a role in the client's difficulties using the following rating scale. Please rate each item using a whole number between 1-5, and record your response in the space next to that item.

1————2————3————4————5
Not at all Some A great deal

_____ 1. Depression

_____ 2. Anxiety

_____ 3. Mania/bipolar disorder

_____ 4. Life adjustment

_____ 5. Social isolation

_____ 6. Relationship distress with spouse or intimate partner

_____ 7. Sexual distress

_____ 8. Low self-esteem

_____ 9. Hopelessness

_____ 10. Trauma

_____ 11. Personal history of spousal/partner violence

_____ 12. Personal history of childhood abuse (sexual, physical, emotional)

_____ 13. Alcohol or other drug abuse

_____ 14. Sleeping disturbances

_____ 15. Eating disturbances

_____ 16. Housing or economic problem

_____ 17. Personality disorder

_____ 18. Dissociation

_____ 19. Psychosis

Content of Salience of Clinical Issues Indicies (SCII)

	Related to case material	Unrelated to case material
Related to BDSM stereotypes	SCII-1 -Relationship distress with spouse or intimate partner -Sexual distress	SCII-2 -Low self-esteem -Trauma -Personal history of spousal/partner violence -Personal history of childhood abuse -Alcohol or other drug abuse -Personality disorder
Unrelated to BDSM stereotypes	SCII-3 -Depression -Anxiety -Life adjustment -Social isolation -Hopelessness	SCII-4 -Mania/bipolar disorder -Sleeping disturbances -Eating disturbances -Housing or economic problem -Dissociation -Psychosis

*This matrix was not shown to participants and is included in this appendix for reference purposes only.

Appendix F: DSM-5 Diagnosis

Listed below are a number of diagnoses from the DSM-5. Using your clinical judgment, please indicate which, if any, of the following mental disorder diagnoses are possible or likely given the case material presented.

1. Major Depressive Disorder
2. Persistent Depressive Disorder
3. Generalized Anxiety Disorder
4. Social Anxiety Disorder
5. Panic Disorder
6. Bipolar Disorder
7. Adjustment Disorder
8. Acute Stress Disorder
9. Post Traumatic Stress Disorder
10. Borderline Personality Disorder
11. Histrionic Personality Disorder
12. Dependent Personality Disorder
13. Avoidant Personality Disorder
14. Narcissistic Personality Disorder
15. Antisocial Personality Disorder
16. Other diagnosis or Z-code (please specify)
17. None

Appendix G: SAS
(Espinosa-Hernández & Lefkowitz, 2009)

Please rate your agreement with the following statements by circling the appropriate number.

	Strongly disagree	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
1. I think there is too much sexual freedom given to adults these days.	1	2	3	4	5
2. I think that young people have been given too much information about sex.	1	2	3	4	5
3. I think there is too much sexual freedom given to teenagers these days.	1	2	3	4	5
4. I think there is not enough sexual restraint among young people.	1	2	3	4	5
5. I think people indulge in sex too much.	1	2	3	4	5
6. I think sex should be reserved for marriage.	1	2	3	4	5
7. People should not masturbate.	1	2	3	4	5
8. Heavy sexual petting should be discouraged.	1	2	3	4	5
9. There should be no laws prohibiting sexual acts between consenting adults.	1	2	3	4	5
10. What two consenting adults do together sexually is their own business.	1	2	3	4	5
11. There is too much sex on television.	1	2	3	4	5
12. Pornography should be totally banned from bookstores.	1	2	3	4	5

Scoring:
Total of all items

Appendix H: ASMS (Yost, 2010)

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

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

Use the following definitions when considering your responses:

Sadomasochism (SM): sexual practices that involve dominance and submission (the appearance that one person has control over the other), sometimes involving 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 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
can be computed by averaging responses to all 23 items.

Scoring:
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 can be computed by averaging responses to all 23 items.

Appendix I: Demographic Questionnaire

Age
Please indicate your age:

Please select the option that best describes your gender:
Female
Male
Nonbinary

Please select the option that best describes your sexual orientation:
Gay/lesbian
Bisexual/pansexual/omnisexual
Asexual spectrum
Straight/heterosexual
Other:_____

Please select the option(s) that best describe(s) your race (select all that apply):
Asian/Pacific Islander
Black/African origin
Latina/Latino/Latinx
Native American/American Indian
White
Other:_____

Please indicate the number of years of clinical experience you have (include practicum and clinical training experiences during graduate training):_____

Estimate the number of psychotherapy clients you have seen over the course of your clinical training and/or career: _____

Please select the option that best describes your theoretical orientation/approach to psychotherapy:
Psychodynamic
Humanistic
Cognitive/CBT
Interpersonal process
Solution-focused
Narrative
Eclectic/Integrative
Other:_____

Please select the option that best describes your current or future professional identity:
Clinical psychologist
Counseling psychologist

Marriage and family therapist
Professional counselor
Social worker
Other:_____

What is your annual household income?

Please choose the best descriptor of your social class from the choices below:
Working class
Middle class
Upper middle class
Upper class

Please indicate your highest level of education:
Masters degree (MA, MS, EdM, etc.)
Doctorate (Ph.D., Psy.D.)

Please estimate the number of acquaintances, friends and family members who you are aware of who practice BDSM:

Do you identify as a member of the BDSM community?

Have you ever engaged in BDSM sex practices?

Please estimate the number of psychotherapy clients you have seen over the course of your clinical training and/or career that have engaged in BDSM sex practices: _____

Please estimate the number of hours of clinical training and/or continuing education devoted to topics related to sex positivity: _____

Appendix J: Informed Consent Document

UNIVERSITY OF WISCONSIN-MADISON
Research Participant Information and Consent Form

Title of the Study: Assessing three domains of psychotherapist clinical judgment

Principal Investigator: Stephanie Budge, Ph.D.

Student researcher: Jaime Lam (email: jlam5@wisc.edu)

DESCRIPTION OF THE RESEARCH

You are invited to participate in a research study about how psychotherapists make clinical decisions about clients.

You have been asked to participate because you are a currently practicing licensed psychotherapist who has seen at least one (1) client in the last 12 months.

The purpose of the research is to expand knowledge surrounding how psychotherapists make decisions about clients' presenting concerns and form their overall impression of clients.

This study will be conducted at the University of Wisconsin- Madison. All study-related activities will take place online and all data will be collected via Qualtrics.

WHAT WILL MY PARTICIPATION INVOLVE?

If you decide to participate in this research you will be asked to view a video vignette of a hypothetical psychotherapy client, provide your clinical impressions of the client, and respond to surveys about your beliefs, training, and personal background.

You will be asked to complete 6 smaller surveys as part of your overall participation, which, will last approximately 15 minutes per session and will require 1 session.

De-identified data from this study will also be retained to answer future research questions.

ARE THERE ANY RISKS TO ME?

Participants may experience some discomfort when responding to items related to personal beliefs and personal background.

There is a small risk that demographic information being collected (e.g. gender, sexual orientation, etc.) could be used to identify participants in the event of a data breach. To mitigate this risk and protect participant confidentiality, data will be stored on a secure password-

protected server, only group characteristics will be published, and participants will be allowed to skip any questions that they are not comfortable answering.

ARE THERE ANY BENEFITS TO ME?

We don't expect any direct benefits to you from participation in this study.

WILL I BE COMPENSATED FOR MY PARTICIPATION?

The study will donate $1 to one charitable organization that each participant will choose from a list of organizations after participation is complete. Additionally, participants can also choose to provide the study with contact information to be entered into a raffle drawing for one of two $50 Amazon gift cards. Participant contact information collected for the purposes of the raffle will be stored in a database separate from study data to ensure participant confidentiality.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?

While there will probably be publications as a result of this study, your name will not be used. Only group characteristics will be published. Participant contact information collected for compensation purposes (i.e. gift card raffle) will be stored in a database separate from study data to ensure participant confidentiality.

WHOM SHOULD I CONTACT IF I HAVE QUESTIONS?

You may ask any questions about the research at any time. If you have questions about the research after you leave today you should contact the Principal Investigator Stephanie Budge at (608) 263-3753.

If you are not satisfied with response of research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education and Social/Behavioral Science IRB Office at 608-263-2320.

Your participation is completely voluntary. If you begin participation and change your mind you may end your participation at any time without penalty.

By continuing on to the video vignette and survey, you indicate that you have read this consent form and voluntarily consent to participate in this study. Please print or save a copy of this consent form for your records before proceeding.

Appendix K: Post-Study Debrief

Thank you for participating in this study! The primary objective of this research was to investigate how psychotherapists may differ in their conceptualization of clients and their presenting concerns based on verbal and non-verbal cues related to the client's participation in BDSM (bondage, discipline, sadism, masochism)—an umbrella term for non-mainstream sexual practices that eroticize differences in power.

We invited licensed mental health practitioners who have provided individual or group psychotherapy services in the past one year to participate in this study. In this study, you were asked to assess a hypothetical client's overall functioning, determine the degree to which a list of clinical issues were relevant to the client's presenting concerns and identify possible appropriate diagnoses. The hypothetical client portrayed in the vignette that you viewed was depicted as either engaging or not engaging in BDSM sex practices, based on the participant group that you were randomly assigned to. Your responses will be aggregated with others and analyzed to determine how clinical judgment may differ based on client participation in BDSM sex practices, and what psychotherapist characteristics are associated these differences. The results from this study will contribute to the scientific literature on how perceived client sexual identity and sexual behavior may shape therapists' conceptualizations of their clients.

If you have further questions about the study, or wish to withdraw the data that you have submitted to the study, please contact the Principal Investigator: Stephanie Budge, Ph.D. at (608) 263-3753 or budge@wisc.edu. In addition, if you have any concerns about any aspect of this study, you may contact University of Wisconsin-Madison Education Research and Social & Behavioral Science IRB Office at 608-263-2320.

Please proceed to the next survey at the link below to designate a charitable organization for the study to donate to, and to provide contact information for entry into the raffle for one of two $50 Amazon gift cards.

https://uwmadison.co1.qualtrics.com/jfe/form/SV_3lLDyIj448uy1NP

PLEASE CLICK THE BLUE ARROW BELOW BEFORE CLOSING THIS WINDOW TO ENSURE THAT YOUR RESPONSE IS RECORDED.

Thank you very much for your participation!