Couples and Kinky Sexuality
The Need for a New Therapeutic Approach

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Abstract

Recent decades have seen changes in the way gays, lesbians, bisexuals, and transgender people are viewed by mental health professionals, but this comparative enlightenment has not extended to the so-called "paraphilias." The mainstream view in the mental health field is still that non-standard sexual practices are pathologies which should be included in the diagnostic manual. This paper presents an alternative view, first defining BDSM or "kink" and then summarizing the data about practitioners of BDSM. Some clinical issues are delineated, such as countertransference, differentiation of problem behaviors from those that are merely unusual, and provision of resources to isolated clients. A few case vignettes are presented for illustration.

From the very start of psychiatric nomenclature, non-procreative sexual behaviors have tended to be viewed a priori as pathological: guilty until proven innocent. Today we look back on some of the diagnoses and harsh treatments used to 'cure' people of what were considered deviant sexual behaviors and we shake our heads in wonder that our field could once have been so primitive. It is embarrassing to remember that our colleagues once endorsed cliterodectomies and forced sterilization, condemned masturbation and oral sex, and subjected people to electroshock therapy and lobotomies for sexual behaviors we now consider normal.

From a historical perspective, we should be deeply skeptical of psychiatric diagnoses involving sexuality, because the designation of 'sick' and 'healthy' seem to mirror rapidly changing social mores which calls into question the 'scientific' basis for classification Bayer, 1981; Szasz, 1961). Nymphomania, a diagnosis that applied only to women, was included in the

first DSM in 1951 (APA, 1951), during a time when our culture did not expect women to enjoy sex and deemed them defective if they did. As sexual standards for women (and everyone) became more liberal, so did diagnoses: the 1980's saw the DSM discard 'nymphomania' but introduce HSDD (Hypoactive Sexual Desire Disorder) as the culture shifted from condemning women for being too sexual to pathologizing not being sexual enough (APA, 1980). Homosexuality is another prototypical example: before 1973, all manner of invasive and punitive treatment methods were acceptable to 'cure' homosexuality; at this writing, most mental health professional organizations condemn 'reparative' therapy as a cure for what is no longer considered an illness; actually, some even support gay marriage (Bayer, 1981; Drescher & Zucker, 2006).

Recent decades have seen changes in the way gays, lesbians, bisexuals and transgender people are viewed by mental health professionals, but this comparative enlightenment has not extended to the so-called 'paraphilias.' People whose sexual practices are outside the accepted norm have become increasingly visible in our culture and, to a lesser extent, in the offices of psychotherapists. The traditional psychiatric view of sexual minorities, however, has not changed. The mainstream view in the mental health field is still that non-standard sexual practices are pathologies which should be included in the diagnostic manual. This view is being challenged by a vocal minority of sexologists (Kleinplatz & Moser, 2006; Moser, 2001; Nichols, 2006; Weinberg, 2006).

Defining BDSM and Kinky Sex

BDSM is a modern acronym to denote certain sexual activities broadly described as bondage (B), dominance (D), submission (S) and sado-masochism (SM). Many would include

fetishism as properly belonging to this group of sexual activities, and fetishists are considered part of the BDSM community. Collectively, these practices and attractions are sometimes referred to as 'kinky.' In general, kinky sexual activities include one or more of the following characteristics:

- A hierarchical power structure, i.e., ***by mutual agreement***, one person dominates and the other(s) submits. It is important to note that these roles are negotiated for sexual play in much the same way that kids agree on the roles of 'cops and robbers' for the duration of the game;
- Intense stimulation usually associated with physical or emotional discomfort or pain, e.g., slapping, humiliation;
- Forms of sexual stimulation involving mild sensory deprivation or sensory confusion (similar to that experienced on some amusement park rides) and/or the use of restraints, e.g., bondage, use of blindfolds;
- Role-playing of fantasy sexual scenarios, e.g., doctor-patient roles, abduction fantasies. The roles usually incorporate a dominant/subordinate theme, often mirroring roles commonly found in life such as teacher-student and boss-worker;
- Use of certain preferred objects and materials as sexual enhancers, e.g., leather, latex, stiletto heels;
- Other unusual sexual objects or practices often classified as a fetish, e.g., fixation with feet.

BDSM sexual activities share certain characteristics. First, they are statistically non-normative, that is, they seem unusual to those who do not share BDSM proclivities. Second, during a sexual experience, called a 'scene,' the roles appear very polarized (top/bottom,

dominant/submissive). Third, BDSM players experiment with physical stimuli and emotions- like fear, humiliation, or pain- that have a paradoxical relationship to the pleasure of sex. BDSM activities are the 'extreme sports' of sexuality. These sexual activities share much in common with activities like 'Iron Man' competitions, a penchant for sky-diving, and a love of horror movies. The combination of pleasure with negative sensations is the hallmark of BDSM. It is the source of what is often called a 'peak experience', which many believe are an essential quest of humans once basic needs have been met. Peak experiences can be experienced as spiritual, revelatory and healing. A woman with a sexual abuse history who role plays a little girl with a partner who is sensitive and attentive to her history may enact a BDSM scene and may achieve intense sexual satisfaction, a sense of spiritual connection, and a healing of childhood wounds all at the same time. In fact, Kleinplatz (2006) has called BDSM practitioners "extraordinary lovers" who can teach the rest of us a great deal about romance, creativity, sexual bonding and healing, as well as about keeping sex vibrant and authentic in long term relationships.

The 'kink community' is a loose network of advocacy and support groups, spaces and events. The internet has allowed people interested in BDSM to find each other and, over time, to create a network of real-world social organizations, to sponsor events and to organize political and advocacy groups. The social networking site Fetlife.com, similar to Facebook as a social networking site, began in 2008 and as of this writing two years later boasts half a million members. Leaders within the community have promulgated guidelines for what is considered acceptable BDSM practices. The motto of the community is "Safe, Sane, Consensual" (Wiseman, 1996). Kinky activities quite specifically do not include, for example, rape or sexual contact with children. The intent is for all participants to be consenting adults who are fully

informed and to avoid activities that might pose a medical or mental danger. Most community leaders frown upon the use of alcohol or recreational drugs by participants in BDSM activities.

Imposing unwanted danger, trauma or injury is as unrelated to BDSM as rape is to intercourse. Nevertheless, the current Diagnostic and Statistical Manual, the DSM IV APA, 2000), classifies Fetishism, Fetishistic Transvestitism, and Sadomasochism as mental illnesses with such loose criterion for inclusion that people can be, and are, deemed mentally ill because their behavior upsets a spouse. And this has consequences. People who practice BDSM have lost jobs, housing, and custody of their children based on the testimony of 'expert' psychiatrists pathologizing their sexual practices (Klein & Moser, 2006; Wright, 2006). BDSM clients report feeling abused at the hands of mental health professionals (Hoff & Sprott, 2009), and some are arrested for BDSM behaviors despite the clear consensual nature of their decision to participate in BDSM behaviors (White, 2006). Classifying behaviors as psychiatric diseases provides a 'psychological' justification for oppressive discrimination. Thus professional views of BDSM are deeply important not only to our clients but to society as a whole.

Both Moser and Kleinplatz (2005) and the National Coalition for Sexual Freedom (NCSF) White Paper on the DSM Revision (2010) provide comprehensive reviews of the scientific literature on BDSM. This literature clearly refutes most of the DSM-IV statements about paraphilias by exposing the lack of evidence for the APA's assertions. It is beyond the scope of this paper to expand on these arguments; interested readers are urged to read the above sources for a full perspective of the controversy. The proposed DSM-V revisions of the paraphilia section, which can be found at www.dsm5.org, reflect a major shift in the diagnosis, a shift that has been praised, as well as condemned for not going far enough (Moser, 2010). The DSM-5 proposal clearly distinguishes between a 'paraphilic interest' and a 'paraphilic disorder.'

It stipulates that BDSM activities are not pathological unless they cause distress or harm to self or others. Critics of this revision, like Moser and Kleinplatz (2005), point out the similarity between the 'distress' criteria and the old category of 'ego-dystonic homosexuality' that was removed from the DSM. Both ignore the likelihood that the 'distress' of the paraphilia is socially caused, like the 'distress' of homosexuality. According to these authors, the diagnoses still reflect socially negative attitudes toward an oppressed minority, and reinforce that oppression.

What the Data Tell Us

The image of a person with a pharaphilic disorder as portrayed by the DSM and most psychiatry texts is that of a socially isolated person at a low functioning job, with an impaired ability to sustain intimate relationships and a high likelihood of depression, anxiety and personality disorder. This person is usually assumed to be male. His sexuality is supposedly narrowly focused on a particular fetish or behavior; he is compelled to engage in this behavior, and he is driven to escalate his sexual activity to more intense levels. He ultimately progresses from consensual to nonconsensual acts (APA, 2000). Paradoxically, although his sexual focus is narrow, he is also more likely to engage in multiple paraphilic behaviors including pedophilia. His impulse control is impaired and he is likely to engage in "frequent, unprotected sex…. [that includes] infection with, or transmission of, a sexually transmitted disease ... [and that incurs] injuries ranging in extent from minor to life threatening" (APA, 2000, p. 567).

Shockingly, there is no scientific evidence beyond 'clinical observation' to support this portrait (Moser, 2001; Weinberg, 2006). To the contrary, the few studies that actually include adults who engage in BDSM practices show results in direct contradiction to this stereotype. First, BDSM practices are not as rare as previously thought and are found among women at rates close to those for males. Janus & Janus (1993), in a national study of 2800 respondents to a

lengthy questionnaire asking about sexual practices, found that about 12% of male and female respondents had engaged in some BDSM behavior. Moser & Kleinplatz (2006), reviewing multiple studies that attempted surveys of BDSM, estimate that about 10% of adult have participated in these practices. Richters et al. (2008) in the only population-based prevalence study to date found that about 2% of respondents, male and female, had engaged in BDSM activities in the twelve months prior to the survey, greater than the percent who declared their identity to be gay. Both Cross and Matheson (2006) and Weinberg (2006) conclude that SM practitioners have the same rates of mental illness and the same degree of psychological adjustment as non-practitioners. And Richters et al (2008), who included mental health measures in their survey, found identical rates of pathology in the BDSM compared to non-BDSM sample, but a more diverse range of sexual activities in the BDSM practitioners. They concluded, "Our findings support the idea that BDSM is simply a sexual interest attractive to a minority, not a pathological symptom of past abuse or difficulty with 'normal' sex." (p. 1660)

Countertransference: If it is Not Sick, Why Does it Seem so Weird?

For many clinicians, negative countertransference is the greatest impediment to working with kinky clients. Despite the research findings, a few of us find it difficult to see BDSM as 'normal' because some of the sexual behaviors seem strange, frightening, and inexplicable to an outsider. Because of the difficulty in imagining how a particular activity can be genuinely pleasurable, the tendency is to judge its appeal as 'sick.' It is therefore helpful for therapists to try to gain a personal understanding of the appeal of BDSM. Many people can find something in their own personal experience that helps them understand BDSM practices. Those who have ever had sex someplace where it isn't 'supposed' to take place – the in-laws' bathroom or the kitchen

table – or fantasized having sex with someone 'off limits' will understand the appeal of transgressive sex. People who have liked 'dirty talk' during sex may understand how erotic a little bit of humiliation can be. Those who have experienced a hickey as erotic, enjoyed a love bite or love scratch, or liked having their hair pulled have a glimpse of dominance and submission, sensory distortion, and sado-masochism. Discovering that corsets, silk undergarments, or thongs are a turn-on is similar to the erotic pull of a fetish. Even if none of these experiences appeal to you, consider other activities where positive affect seems, at first blush, counterintuitive: horror movies, amusement park rides, extreme sports, car racing, zip gliding, boxing. These common experiences illustrate the fact that pleasure can come from many seemingly contradictory sources.

In working with people in the kink community, it is helpful to try to extend one's own experiences to find common ground. But sometimes this is difficult; there are times when a certain activity seems bizarre or repugnant, and it might be hard to not pathologize those who participate. People in the BDSM community have a word for this: it is called being "squicked." 'Squicked' is an invented word meant to connote an uncontrollable physical revulsion that includes no moral judgment. If you are strongly turned off to an activity and therefore decide that those who participate are 'sick,' you are exhibiting judgment. But if you are 'squicked,' you may feel repulsed but remain non-judgmental. When members of the BDSM community face this visceral reaction they assume it might come from ignorance, or be a reaction formation to their own arousal, or simply express an idiosyncratic distaste. When a clinician is 'squicked,' it is neither cause for alarm nor a reason to judge the client, but rather an opportunity to examine our own countertransferential feelings, perhaps with a colleague or supervisor sensitive to BDSM issues. Clinicians who are troubled by their own reactions may also benefit from more

information, such as one of the excellent books explaining and describing BDSM practices (Califia, 2001; Morpheus, 2008; Thompson, 1992; Wiseman, 1996).

Sometimes, understanding how a practice produces pleasurable sensations helps quell the 'squicked' feeling. Steel nipple clamps can look frightening. But they make more sense when one understands that, once the clamps are removed, the nipple is left exquisitely sensitive. Spanking and flogging make sense as well in the context of the physiological phenomena induced by extremes of sensation. The flow of blood to the surface of the skin, the rush of endorphins and other chemicals create an experience known to BDSM practitioners as 'sub space' (i.e., a psychological submissive space) – an experience often described as an out of body altered state like flying or floating weightless. This experience – which some people interpret as spiritual (Thompson, 1992) – can be deeply fulfilling on levels beyond sexual.

Another common barrier to understanding BDSM is the perceived need to explain the origin of the behavior. "*Why* would someone want to (fill in the blank: be a bottom, flog their partner, get tied up, etc)?" The question itself is a subtle way of pathologizing behavior. Just as people want to know the origins of homosexuality but do not question how heterosexuality develops, we often assume a psychodynamic reason for nonstandard sexual practices. Therapists want to know why someone likes spankings but not why they like oral sex, therapists question why a man would want to urinate on a partner's body but not why he wants to ejaculate on her. Before pursuing psychodynamic explanations for unusual sexual behavior, a therapist might ask herself whether she would do the same for more mundane sexuality.

How to Tell When a Behavior Really *is* Problematic

Therapists sometimes encounter cases where sexual behaviors really are problematic and/or pathological. Some of these situations are easy to discern, like rape or child sexual abuse. Other behaviors, however, require contextual assessment: when does someone have a 'sex addiction' and when are they merely very sexual beings? Sexual issues, like other socially charged concerns – How much drinking is too much? When is child corporal punishment of a form of abuse? - evades simple agreement, even among experts. This problem may arise more often for clinicians relatively less experienced in working with BDSM practitioners. The clinician may not automatically know if a behavior is safe or sane, two of the three criteria for appropriate BDSM activity. Many of us harbor unconscious biases regarding sexual risks as compared to other more common risks. We often tend to accept common risks more than uncommon ones, for example, the risk of allowing a child to play football.

Most clinicians, at least those who have training in domestic violence, will have more ability to assess the third component, consensuality. One of its key aspects is mutual enjoyment: the difference between a violent sexual sadist and a sadist in the BDSM community is that the former has no interest in the needs or well-being of their partner, while sadists in the BDSM world usually pride themselves on how well they take care of their 'bottoms.' Mutually arousing and agreed upon sexual activities are consensual. Non-consensual BDSM relationships are a particular form of partner/spousal abuse, and this abuse is marked by the lack of pleasure and the presence of real fear on the part of the submissive partner, a fear that is not confined to the sexual encounter but pervades the relationship. When consensuality is not obvious, the therapist can assess the couple for domestic violence, and it is also important to recognize that domestic abuse can also occur towards the more dominant partner, from the one who is more submissive. The therapist should interview the partners separately to assess safety and look for non-sexual

violence, and evidence of rage and/or contempt for his or her partner. The therapist can assess for signs of fear and intimidation, incidence of non-sexual abuse, and a sense of being trapped in the relationship.

Resources and Suggestions for Working with BDSM Clients

As therapists begin to work with clients practicing BDSM, they may be comfortable having an affirmative stance, but not yet ready for complex cases. There are numerous resources available for therapists wanting to develop a more kink-friendly practice. Communities often have local resources that may not be well-known, including colleagues with experience working with the BDSM community who are available for supervision. A national listing of providers is available through KAP (Kink Aware Professionals), a referral directory listed on the NCSFreedom.org website. Additionally, clinicians who desire more training in how to better serve BDSM clients can contact CARAS (Community-Academic Consortium for Research on Alternative Sexualities) and can view their DVD on clinical 'do's and 'don'ts' (CARAS, 2008) as a way to begin. CARAS also provides special programs given through sex therapy organizations like the American Association of Sex Educators, Counselors, and Therapists (AASECT: www.aasect.org).

The belief that BDSM behavior automatically needs to be assessed for clinical significance is itself a biased belief. Ironically, a therapist might best display sensitivity by not bringing BDSM into the therapy when it is not warranted. In general, it is unwarranted unless the client brings it up as a problem. Hoff and Sprott (2009), in a study of the therapy experiences of members of the BDSM community, found that many people were critical of therapist who they perceived to be 'voyeurs,' because they kept inquiring about sex when it was not part of the

presenting problem. Positive BDSM experiences can however be highlighted for couples where they exemplify connection and collaborative communication.

Occasionally BDSM practitioners come into therapy needing assistance with advocacy. BDSM activities are still pathologized and misunderstood, and in some parts of the country BDSM sexual play is viewed as spousal abuse. The partner of a spouse with visible minimal bruises may be automatically arrested and charged with assault, even if both partners maintain that the sexual activity that produced these bruises was consensual. There are occasions when child welfare organizations remove children from the home of the parents because of BDSM activities, or when such activities are used in divorce suits to challenge custody or visitation. A therapist can play an important role in these situations by being willing to give affidavits or court testimony in support of the couple and in defense of their sexual preferences.

Individual therapists may also encounter clients who have internalized societal stigmatization of BDSM, who express self-hatred and may even ask to be cured. Hearing a therapist officially state that their sexual behavior is not an illness can be an incredibly powerful experience. Encouraging such clients to view their self-hatred as socially induced may liberate them to accept their own sexual behaviors. Finally, some therapists refuse to help clients rid themselves of their paraphilia, believing that, like homosexuality, it is nearly impossible to extinguish strong, specific sexual desires.

By far the most common problem a couple and family therapist will encounter when working with BDSM clients is marital discord following the revelation that one partner is kinky. Just as, for example, some gay men still repudiate their own sexuality and mask their orientation behind a heterosexual family, many people with a kinky ‘orientation’ do the same. These clients hide their sexual preferences from their spouse and may or may not practice them in secret.

Sometimes they are ‘found out,’ and sometimes they themselves come to abhor the deception inherent in their double lives and desire a fuller and more honest expression of their sexuality. The traditional treatment for these couples has been to label the BDSM partner’s behavior as pathological, both as a paraphilia and as infidelity. Attempts are made to cure the transgressing partner of his or her desires, or at least to convince him or her to suppress them. Sometimes the BDSM partner enthusiastically endorses this approach, internalizing the view that the behavior is ‘sick.’

A different approach is, first, to separate out the issue of fidelity and of sexual preference, and, second, to normalize the sexual behavior of the BDSM partner and frame the situation as a (possible) mismatch of sexual scripts. Of course, if the BDSM partner has engaged in secret activities, many of the issues of betrayal and mistrust are the same as those encountered when one partner has had an affair. But there is an important difference. The BDSM partner is more like a gay man who has spent a lifetime avoiding his sexual orientation than he is like a cheating spouse. Even if the partner forgives the infidelity, it will not be very effective to simply dismiss the BDSM sexual preferences. The partner who feels betrayed has far more to deal with than the partner of someone who has had an affair. He or she must not only cope with the pain and shock of infidelity, but also confront the reality that, as partners, they have sexual differences that may not be resolvable. The partner of the BDSM-oriented individual has been deceived on a much deeper level; one partner has concealed fundamental parts of his or her identity, not just sexual behavior, even if the deception has been wholly a by-product of the lack of readiness to cope with ego-dystonic sexual desires. The couple faces a number of threats to their integrity, and the therapist must shepherd the relationship through what will certainly be a profound transformation. However, it is not usually necessary to deconstruct the relationship to understand

what ‘caused’ the sexual straying. Many couples in this situation have admirably intact relationships in other respects, and the revelation of the BDSM partner’s secret life probably has more to do with chance rather than with relationship dynamics. Working with these couples can be deeply rewarding, as couples can become more creative in finding common sexual interests. If the romantic or sexual component cannot be salvaged, these marriages can successfully transform into close and affectionate friendships.

Clinical Vignette:

> Michael, a man in his mid-thirties who had been married for ten years to a woman he adored, consulted me in great distress about what he initially presented as a problem with erectile dysfunction. Within the first session it became clear that his erectile difficulties were related to his suppression of his intense desires to be placed in bondage. While he enjoyed more common forms of sex (which he called ‘vanilla sex,’ as many members of the BDSM community do), his secret unfulfilled wish to be a ‘bondage bottom’ gradually dominated his thoughts, disrupting his ability to function sexually with his wife. Michael had never revealed his interests to Judy because he was sure they would repel her.
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> When Judy was brought into the sessions, she did initially react with confusion, shock, and a sense of being betrayed. The psycho-education I provided helped her accept the idea that Michael was not ‘sick.’ While metaphorically comparing Michael’s situation to one of a closeted gay men helped her feel less personally betrayed, she still felt some repugnance for the sexual behaviors he desired. However, the two partners had an extremely strong bond, a great deal of quality intimacy, and both were strongly motivated to work through this problem. Through some individual sessions that included the use of EMDR to help Judy resolve her own childhood abuse issues, Judy lost the sense of distaste she had about Michael’s sexual interests. She became curious and open to experimentation, and together the partners enacted some of Michael’s fantasies. To her surprise, Judy found that she was not only able to tolerate being a ‘bondage top’ – putting Michael in restraints and controlling his behavior in a sexual situation – she discovered that this role produced a powerful sexual ‘high’ for her as well. Several years later, they still periodically update me. The two continue to enjoy this sexual behavior and have connected with others in the kink community by participating in BDSM events.

Not all such situations have such happy resolutions. Some couples with discordant sexual preferences do not find a satisfying agreement and choose to part. But even when the outcome of

therapy is divorce or separation, much can be accomplished. The therapist can help the BDSM partner rid him or her self of shame and can keep the non-kinky partner from personalizing and blaming him or herself for the partner's sexuality. Child custody and visitation issues can be prevented from becoming enmeshed with the partner's sexual behavior. In some future world, we may all understand and accept our diverse sexualities at an earlier age, before we enter serious, committed relationships. But in this world, a couple and family therapist can help prevent an unfortunate situation created by stigmatization of non-normative sexuality from becoming a tragedy that destroys both partners in a relationship.

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