SEX THERAPY WITH CLIENTS WHO PRACTICE 'KINK'

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Introduction

Pepper Schwartz, the sociologist who has been studying American couples since 1980, and her colleagues completed an internet survey of over 90,000 people worldwide. They reported that 86% of all men and women said they are "intrigued by kinky sex' (Northrup, Schwartz, & Witte, , 2012; p. 77), and her data were collected before the publication of *Fifty Shades of Grey* (James, 2011), the popularity of which likely increased people's fascination with kink. As recently as ten years ago, we would have written this chapter with the intent of convincing the reader that people with sexual interests in bondage and discipline, dominance and submission, sadism and masochism (often referred to collectively as BDSM) are not intrinsically mentally ill, and we would have appealed to the clinician's/reader's sense of justice to have compassion for this under-served and misunderstood population. But now we write, in part, so that sex therapists unfamiliar with kink and the people who practice it can see the strengths inherent in this kind of sexuality. Kinky people are models of sexual communication that we all would do well to emulate; the variety found in their sexual practices can keep sex edgy and hot even in a long term relationship; and BDSM is connected to spirituality and sexual healing, much like Tantric Sex practices.

Kink is a slang term meaning sex that is non-standard and may include role play (e.g., teacher/student, Army sergeant/Army private), performances of power dynamics (e.g., dominant/submissive roles), and unusual forms of stimulation (e.g., flogging or spanking, bondage), as well as the use of specific objects or materials (e.g., leather) or a focus on specific non-genital body parts (e.g., feet) to achieve sexual satisfaction. These behaviors and sexual interests also are often

referred to as BDSM. Many, probably most, people "into" kink incorporate some aspects of BDSM sex into their sex lives privately, with a frequency ranging from occasionally to nearly always. A smaller number feel that being kinky is essential to their identity, and many of these people are members of a BDSM subculture, one that is partially intertwined with the LGBT or queer community but which also includes many heterosexually -oriented people as well. For obvious recruitment reasons, virtually all research on kink is based on the small group of people who belong to BDSM organizations, and thus, most of the research is restricted to those for whom kink is a central part of their identity. We know next to nothing about the many people who just incorporate spanking or bondage or role playing into their private sex lives but who would not identity as kinky or go to a club or an organization. Pepper Schwartz's data and the popularity, not only of *Fifty Shades of Grey*, but also of the BDSM toys and paraphernalia related to the book, indicate that the number of those people may be far greater than we have imagined.

It is fitting that this topic be covered in a book on sex therapy. The field of sexology is considered to have been born with the publication in 1865 of Kraft-Ebbing's *Psychopathologia Sexualis*, a book written to aid police in their pursuit of deviants and perverts, groups that included homosexuals and anyone interested in BDSM (Nichols, 2014). From 1865 to the present day, kinky sexual practices have been viewed within sexology as inherently pathological—"paraphilias"—by some(e.g. Freud and as simply interesting deviations from the norm by others (e.g., Kinsey). From the time of the American Psychiatric Association's (APA) first Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 1952) until the publication of the revised fourth edition in 2000 (DSM-IV-TR; APA, 2000), all of the sexual behaviors entailed in consensual kink have been lumped with each other and with other nonconsensual acts, like pedophilia and sadistic rape, and considered mental illnesses.

The field of psychiatry has a long and ignominious history of aiding in the social oppression of certain groups, such as Black people, women, gays, and anyone with unusual sexual tastes (Lev, 2005). For

most of the twentieth century, laws criminalizing homosexuality were justified on the grounds that gay people were mentally ill predators, and homosexuality was grounds for commitment to a mental institution. Many historians believe the remarkable gains in the social acceptance of gay people in recent decades would not have possible without the removal of homosexuality from the DSM in 1973 (Bayer, 1981).

Social attitudes about kinky sex are evolving as the topic "comes out of the closet" and appear to be following the trajectory established by attitudes and laws about homosexuality. Until recently, the psychiatric label "paraphilic" has been invoked to justify discrimination in housing, employment, even health care, and it has been used to wrest custody and visitation rights away from parents (Klein & Moser, 2006). But the current volume, DSM-5 (APA, 2013), is a radical departure from the past. It distinguishes between people (1) who may be paraphilic but not mentally ill from (2) those for whom the paraphilic behavior has been nonconsensual or has caused significant distress and impairment to personal functioning. The category name has been changed from "paraphilias" to "paraphilic disorders" to highlight that not all paraphilias are considered disordered. These changes were made, in part, because of the educational efforts of civil rights advocates and, in part, because recent research on people who practice BDSM showed them to be overall mentally healthy and high functioning (Richters, de Visser, Risset, Grulich, & Smith, 2008; Sandnabba, Santtila, & Nordling, 2002; Wismeijer, A. & van Assen, J. 2013;). Within months of the release of the DSM-5, the National Coalition for Sexual Freedom, an advocacy group for people in the BDSM and polyamory communities, reported better legal outcomes for kinky people fighting custody or visitation battles (Wright, 2014).

The DSM changes were driven by advocates from within the kink community as well as by scientists and therapists, just as was the removal of homosexuality from the DSM decades before. In the twenty first century, many mental health practitioners and sexologists have moved from arguing about whether BDSM represents a pathology to really exploring the interesting ways in which BDSM people

differ from more "vanilla"[1] individuals, what sexual problems might be specific to kinksters (Ortmann & Sprott, 2013), and what kinky sex can teach us all about sexuality more broadly (Easton & Hardy, 2004; Kleinplatz, 2006; Langdridge & Barker, 2007; Nichols, 2006)

Myths and Misconceptions

Because BDSM practices have long been considered a taboo expression of sexuality and/or identity, the kink community has existed in the shadows, and many myths and misconceptions have developed. Here we discuss some of the most common of them. It is important to be mindful that these myths may have been internalized, not only by treating therapists, but also by the kinky client, as well. Assessing for the client's sense of internalized "BDSM-phobia" must become a part of the therapeutic process in an effort to empower the client to explore and embrace their place along the BDSM spectrum.

Myth #1: BDSM is Abuse

In any community, mainstream or kinky, there will be some individuals who use sex abusively or engage in violence. But BDSM is not abusive per se, and there are many differences between kinky sexual practices and abuse. The motto of the kink community is *"safe, sane, and consensual."* The National Coalition for Sexual Freedom (1998) defined safety as "being knowledgeable about the techniques and safety concerns involved in what you are doing, and acting in accordance with that knowledge"; sane was defined as "knowing the difference between fantasy and reality, and acting in accordance with that knowledge"; and consensual was defined as "respecting the limits imposed by each participant at all times." For any type of BDSM encounter to occur, both parties must be consenting individuals, where limits to the interaction are clearly discussed and agreed upon. Although some aspects of BDSM play might carry an element of risk (e.g., biting and "breathplay," in which

[1] "Vanilla" is a term kinky people use to describe those interested in only "standard" sex—such as fondling, intercourse, and oral sex.

partners temporarily cut off of limit the other person's oxygen supply), both parties must communicate how personal safety will be maximized. This sometimes entails the use of a "safety word" for one partner to indicate to the other that a limit is being reached. Although it might be assumed that this is done solely to protect the partner who is in a more submissive role, it can equally apply to concerns that the dominant partner may have. For example, a dominant might invoke the usage of a safety word if discomfort in exercising control over the submissive is being experienced. Setting limits is a crucial element of BDSM practice; unlike what happens in most vanilla or non-kinky, sex, before having sex, BDSM partners typically communicate explicitly, verbally, and in great detail about what they like, what they are willing to try, and what is a hard "no." This also establishes safety.

In a statement from the Lesbian Sex Mafia (n.d.), seven distinctions are made between sadomasochism (SM) versus abuse: (1) an SM "scene" is a controlled situation whereas abuse is an out-of-control situation; (2) negotiation occurs before an SM scene to determine what will and will not happen in that scene whereas in abuse one person determines what will happen; (3) SM involves knowledgeable consent to participate in the scene expressed by all parties whereas abuse involves the absence of consent; (4) SM employs a safeword that will allow for a discontinuation of the scene at any time for physical or emotional reasons whereas an abused person cannot stop what is happening; (5) everyone in the SM scene is concerned about the needs, desires, and limits of others whereas abuse is the lack of concern for the needs, desires, and limits of the abused person; (6) the people involved in an SM scene are careful to be sure that they are not impaired by alcohol or drug use during the scene whereas alcohol or drugs are often used before an episode of abuse; and (7) after an SM scene, the people involved feel good whereas after an episode of abuse, the person abused feels bad.

Myth #2: People who Like Kink Were Abused as Children.

Many people believe that those who engage in BDSM must have a history of being abused when young, and that this abuse has shaped their "sick" sexual desires. In fact, there is no evidence of greater

incidence of child abuse among the BDSM population in comparison to those who engage in vanilla sexual behaviors (Moser, 2002). Additionally, there is no difference in childhood attachment styles between kink and non-kink individuals (Nordling, Sandabba, Santilla & Alison, 2006). Some therapists assume that "bottoms"—also called "submissives"—must be self-destructive and that those who play the dominant role must be violent or angry, but there is no evidence for these assumptions either (Kolmes, Stock & Moser, 2006).

Myth #3: BDSM is Addictive

Observing the intense stimulation involved in BDSM practices like flogging, some people fear that those who try them will become "addicted." They believe that practitioners habituate to the stimuli and require increasing amounts of, say, pain in order to reach the same "high." From this perspective, even experimenting with kink is viewed as dangerous, as experimentation can become a "slippery slope" that will result in people requiring more extreme or intense experiences. This belief is part of the pathologicalization of BDSM, and there is no evidence for it. Nor is there evidence for the related beliefs that people who like kink ONLY engage in kink or that kinksters gradually spread their interests to nonconsensual paraphilias, like pedophilia or sadistic rape. Unlike addiction, there is no proof that those who engage in BDSM continuously search for a new "high." In fact, most people experience 'levelling off' after initial experiences (Nichols, 2006).

Although there is not evidence that kinky individuals escalate over time in terms of their need for intensity or in terms of the harmfulness of their behavior, it is the case that most kinky people have a wider repertoire of sexual acts than vanilla people and rarely confine their sexual interests to one activity (Sandnabba et al, 2002). Thus the therapist should expect her/his kinky clients to engage with various aspects of BDSM; the therapist could even encourage the client to explore the variety of BDSM expressions in a safe, sane, and consensual manner, as a way of learning more about their own sexual tastes. **Myth #4: BDSM is All About Pain**

Many people associate BDSM with pain. Although the exchange of pain may be an occasional part of BDSM practices, it is incorrect to assume that activities like flogging or spanking are practiced by all kinky people, or that pain is the only or primary sensation that is experienced during a BDSM interaction. The experience elicited, say, during a spanking, is not pain as most vanilla people think of it. BDSM is an exchange of heightened emotional or physical stimulation, and much of the stimulation takes place during periods of very high levels of sexual arousal when the body is less susceptible to feelings of pain. As Nichols (2006) explained," Think pain as in biting your lover in a moment of sexual abandon—not pain as in root canal" (p.284). Power dynamics are often more significant than the giving or receiving or pain, per se. For example, a person who enjoys being slapped by his partner may be receiving just as much, or even more, stimulation from the act of being submissive to the partner than from the slapping itself.

There are many kink activities that involve a dominant/submissive dynamic but do not incorporate pain, such as bondage or role play. And the sources of pleasure in BDSM are complex. One client recently expressed, "My partner does not allow me to masturbate, sometimes for days or weeks. Of course it's hard for me to control that. But being obedient to him ultimately gives me a rush that no amount of masturbation could ever achieve."

Countertransference

Mental health practitioners across psychological, social work, and counseling professions are obligated to provide therapeutic services to their clients without bias or judgment (APA, 2010; NASW, 2008). This is not always easy. Countertransference is widely understood to be the personal reactions experienced by the therapist in response to the client, and it can often be useful in the treatment itself (e.g., when the therapist's reactions resemble those of people in the client's everyday life and thus provide important information about how the client impacts others). But a distinction must be made between diagnostically useful countertransference and potentially destructive countertransference. If

the therapist is not both educated about kink and self-aware (i.e., conscious of his/her feelings of countertransference), personal reactions may be projected onto the patient (Malcolm, 1988). Because kinky practices and identities are both misunderstood and stigmatized, elements of countertransference may arise within a therapist who is unfamiliar with BDSM. Indeed, "many psychotherapists appear to have limited or inaccurate information concerning persons who engage in BDSM, to be uncomfortable with such persons, to employ unhelpful or unethical practices with their BDSM clients, and to inappropriately pathologize BDSM activities" (Lawrence & Love-Crowell, 2008, p. 68).

Common countertransference feelings described by therapists who have little experience with BDSM include shock, fear, anxiety, disgust, and revulsion (Nichols, 2006). It is imperative for the therapist to be aware if such feelings arise and to work on resolving negative reactions and ingrained biases. Yet, as important as it is to acknowledging one's feelings of countertransference toward kink, this issue has received scant research attention. One qualitative study conducted by Lawrence and Love-Crowell (2008) examined the experiences of psychotherapists who had worked extensively with BDSM clients. The psychotherapists from this study believed, first, that knowledge of BDSM practices and values is a component of culturally-competent practice, and it is the therapist's responsibility to remain educated and knowledgeable about this. Second, the psychotherapists in this study iterated that BDSM is typically a background issue for the client rather than a central issue in therapy. In other words, the unchecked countertransference of the therapist may cause the therapist to exaggerate the role of BDSM practices and values in the patient's treatment-seeking, when in fact, the BDSM might not be the main concern for which the client is pursuing therapy. Third, working with BDSM clients may present challenges to the maintenance of the therapist's boundaries, specifically around the therapist's own unresolved or unexplored issues of sexuality. An unaware clinician may not recognize his or her own fear and anxiety projected onto the kinky client in the form of revulsion or negative judgment. Hoff and Sprout (2009) asked 32 BDSM-identified heterosexual couples in therapy to describe how their BDSM

identities influenced the therapeutic relationship and process. Although some positive experiences were reported, for the most part, respondents indicated that they had not disclosed their sexuality to their therapists or that, when they did disclose, they were greeted with negative judgement and even termination of services.

By addressing her or his countertransference, the sex therapist is able to maintain the non-judgmental attitude so necessary for clients to open up and disclose private sexual issues and to allow an honest therapeutic relationships to develop. Addressing a medical audience, Williams (2012) explained how a nonjudgmental presence can allow the client to discuss erotic activities that may carry certain specific physical or psychological risks. Williams further reminded professionals that lack of knowledge or comfort regarding BDSM may lead to the over-sexualization of kink practices. Understanding that, beyond the role of sex in BDSM, "for some, BDSM offers a safe space to enjoy creative, embodied experiences and to express important aspects of identity that are not often realised or performed" (Williams, 2012, p. 745) can allow for a deeper rapport to be built with the client, which may result in an overall more enriching therapeutic experience.

Case vignette: Sam was a 45-year-old man, who was seeking therapy for increasing feelings of depression and anxiety. Heterosexually married for 20 years, Sam had been having an intimate relationship outside of his marriage, with a woman named Kate, for the last six years. During the initial assessment, Sam stated that he had seen countless therapists throughout his life but that most of them were only for a few sessions. He felt he had never "clicked" with a therapist and had never been completely open with any of them. I probed this a bit further, asking Sam if there was a particular issue that he felt uncomfortable discussing in previous therapy. Sam stated that there were certain kinky elements to his relationship with Kate that previous therapists sought to "cure." As a kink-aware therapist, I asked if his relationship with Kate was safe, sane, and consensual. He confirmed that it was, and I began to normalize the range of kinky relationships, using certain terms such as "master/slave"

and "dominant/submissive," terms that are well known to people who engage in kink and that served to reveal my understanding and acceptance of the subculture. Sam's body language and facial expression immediately became more open, and he stated, "I've never had a therapist who spoke my language!" Sam explained that he was the "dom" to Kate's "ub," a relationship that only occasionally involved sexual intercourse. I validated this dynamic by addressing how kink relationships can sometimes be more about a particular mindset than about sexual expression. From there, Sam began speaking of his recent feelings of depression and anxiety, which were largely related to transitions and stress at his place of employment. After exploring the recent changes at his job, the session concluded with Sam thanking me for focusing the therapy on the issues that were problematic for him; all of his previous therapists had focused on his kink interests, making him feel judged for having such interests, and therefore never feeling truly safe in therapy. At the end of the session, Sam stated, "I have told you 90% more in one session than I have ever told a previous therapist. Thanks for not making me feel like a freak."

Common Clinical Issues of Kinky Clients

Lawrence and Love-Crowell (2008) concluded that most people engaged in BDSM practices come to psychotherapy for reasons unrelated to their sexuality. A client entering treatment for, say, depression might well never disclose their interest in kink to a previously unknown therapist. Many practitioners have no idea they are treating clients with a strong sexual interest in BDSM. However, there are two group of kinky clients who might disclose their interests to their therapists—particularly sex therapists—and these groups seek out different types of therapists When kinky clients who are comfortable with their kinky identity have sexual problems or some other issue that involves disclosing their sexuality, they are most likely to seek help from a therapist known within the kink community, who will be affirming of their identity. The average mainstream sex therapist, who does not specialize in kink, therefore, sees a very particular sub-segment of those interested in BDSM, one that may trigger

countertransferential judgments of pathology. For example, a sex therapist who is not a kink specialist often sees people just "coming out" as being into kink, including older people married to vanilla spouses; those who have been "discovered" as engaging in kinky behaviors by their disapproving partners; and those who want to be "cured" of their interest in kink. In other words, a therapist not specializing in work with sexual minorities may see the kinky people who are in the most distress about their sexuality, the most ignorant of the BDSM subcultre, and the most likely to have internalized kink-phobic attitudes.

"Coming Out" as Kinky

Because BDSM has been pathologized and stigmatized, people with kinky sexual interests often go through a period during which they keep their interests secret from others and may even deny or repress them. They come out, much as LGBT people come out," because they are discovered by someone else or because they can no longer deny this important component of their sexuality and even identity. They undergo a process that may be painful and scary, in which they explore their newly-emerging selves and determine where they fit along the BDSM spectrum. Some clients may not know that they are "allowed" to entertain kinky thoughts, and may be seeking "permission" from their therapist—and needing it—to even verbalize these thoughts. Often, a therapist is in a position to create a safe space for the client to first begin to express these desires.

Case Vignette: Chris was a 23-year-old bisexual man, who sought treatment for anger management. Chris was in a two-year-long relationship with his girlfriend Jade, age 25, who sometimes accompanied Chris to sessions. Chris and Jade agreed that Chris's anger often erupted immediately after sex. In individual sessions, Chris expressed his fear that he was impotent, as he found it difficult to maintain an erection during sex with Jade. After exploring this more, Chris finally admitted that he does not find sex to be satisfying with Jade, and this makes him feel like a failure as a boyfriend. Taking a sexual history in session, Chris could only remember one previous sexual partner with whom he was able to feel sexually satisfied on a consistent basis. For some time, Chris maintained that there was nothing

different about this previous sex partner, until he was asked about less typical sexual acts. When asked explicitly if there were any kinks or fetishes that he was able to explore with the previous partner that he was not able to do with Jade, Chris's first response was that he was not into pain or "master and slave stuff." After the therapist normalized kink by giving examples of how it might be expressed (e.g.., "Some people enjoy role play, or foot worship, or being tied, and might think that they are the only ones who have these desires.") Chris then hesitantly admitted that he had enjoyed engaging in watersports (that is, urination play) with this previous partner, and felt that he couldn't tell Jade that he enjoyed this. He said that he was afraid that Jade might think he was "weird" for liking this, and he wasn't sure how to broach this topic with her. As Chris began to accept this fetish as a harmless?? aspect of his sexual behaviour, he developed more confidence in talking about it with Jade. Chris's eventual disclosure to Jade of his interest in watersports led to a dialog in which Jade also expressed some of her desires and fantasies that had never before been expressed. With Chris's disclosure, communication between him and Jade improved overall, allowing a climate of safety to grow.

People with BDSM interests often go through an identity evolution process similar to that described by Cass (1977) in her stage theory of coming out as gay or lesbian. It is not unusual for feelings of guilt or shame to exist during the time a person is coming out as kinky, even though, in general, BDSM practitioners experience no more guilt or shame than others. Kolmes et al. (2006) warned against therapists perpetuating clients' guilt and shame by urging their clients to stop their sexual practices. Although clients might be urged to go through the process of self-exploration and disclosure slowly, eventually the process leads to self-acceptance and even identity pride. Clients just beginning to explore their kinky sexuality need their therapist to provide an affirming alternative to the negative attitudes of the mainstream culture. Clients in the coming out process also may feel compelled to search for the reasons "why" they identify with some aspect of BDSM. A client asking "why me?" can be encouraged to explore what their beliefs are as to what "caused" their connection to BDSM; this can

allow valuable insight into the client's sexual history and value system, which may be beneficial for the therapeutic process. The therapist can be of critical importance during the initial stage when the client is coming out to themselves, allowing a safe place for the client to express any concerns, beliefs, or opinions related to BDSM.

Coming out as kinky appears to be easier for non-heterosexuals, in part because gay people have already gone through one coming out process and in part because the queer and kink communities have considerable overlap. As a gay clients stated,

> Once you come out as gay, the taboo has already been lifted. I came out to everyone as a gay man years ago, so I already basically declared to my friends and family who it was that I loved, and they now knew who I wanted to have sex with, basically. So I was forced to confront issues of sexuality, masculinity, and identity, and what it meant to me, at a pretty young age. I don't think most straights need to do that. So being into SM, well, it's no problem at all for me to talk about this with people. And I've learned to not be surprised by what people tell me. Someone wants a threesome? OK. A guy wants me to trample him? Sure, why not.

Case vignette: Jon is a 32-year-old, gay, biracial manof African-American and European descent. Since the ending of a long term relationship about a year before, Jon had been casually dating and having sex with a few different men, "nothing serious—just fun." Several months before coming to therapy, Jon had had a sexual encounter with a man who incorporated leather into their sexual play. "I knew that there were guys who were into leather, but never really knew what it meant. But there was something about the scent, the feel of the leather, how it felt on him as we were having sex… it just did something to me, tapped into a different part of myself, and I loved it. It meant something to me—masculine, sexual, and real." After that experience, Jon began frequenting leather bars, met new people, and began to expand his network of friends, acquaintances, and lovers. "It's so freeing. These people I've met at parties, bars, whatever—nothing shocks them. Anything that I previously would have kept to

myself in terms of my sexual desires, or of my need to dominate someone else, they understand. It's like there are other people who speak my language. And the more I meet with these people, the more I realize what I like and what I don't. It reminds me exactly of what I went through when I realized I was gay. As a kid I thought that being gay was this huge sin and that I was the only one, until I began opening up to people and then realizing that I could have actual relationships. With BDSM, it's the same thing." Because Jon had the support of a gay BDSM community, his coming out was relatively easy.

When the client coming out as kinky is heterosexual, the process may be more difficult, especially in more conservative, non-urban areas. BDSM organizations are more invisible outside of queer urban communities, and the person first discovering or expressing their kinky sexuality may feel stigmatized and isolated. These ""need referrals to resources—books, online informational sites, support organizations—because they need to know how to navigate safely within BDSM practices and, if they choose to frequent them, BDSM clubs and parties. One excellent resource for the beginner is Fetlife.com, a kind of Facebook/ Match.com for kinksters. Fetlife has special interest groups for support and information exchange, and the largest special interest group is for novices. Other sites like KinkAcademy.com, include thousands of videos demonstrating BDSM techniques.

BDSM sex, because of its psychological and physical intensity, carries certain risks, and the kink community is acutely attuned to issues of safety and consent. The "safe, sane, and consensual" motto of the kink community is heavily enforced at clubs, organizations, conferences, parties, and other public events. An unaccompanied woman, for example, is likely safer at a BDSM event than at the average vanilla bar. Therapists working with clients just coming out into kink would do well to direct them to the novice group of their local BDSM organization (most major cities have one).

Therapists also should be aware of the laws impacting BDSM (Klein & Moser, 2006). There are no legal protections against housing or employment discrimination for kinky people, so coming out must

be done judiciously. A kinky lifestyle may be grounds to deny child visitation or custody, so disclosure to an unsupportive spouse is fraught with danger. Although the therapist may consider openness and authenticity psychologically healthy, it is not always possible for people who practice BDSM sex to risk such authenticity.

Clients Caught by Spouses and Clients Who Ask to be Cured

As we have already mentioned, the average sex therapist is less likely to see clients who are comfortable with their BDSM sexuality and more likely to see people who have BDSM/fetish sexual preferences but who are closeted and isolated, especially if the clients are heterosexual and the area is not urban. Therapists also are likely to see those who have internalized negative social attitudes about kink and are horrified, ashamed, even repulsed by their own sexuality. Some of these people will ask you to cure them of their kinky interests.

There is no evidence that therapy can eliminate kinky sexual desire. Indeed, BDSM calls into question our concept of "sexual orientation." Although the term tends to be used only to describe same- versus other-sex sexual attractions, it has come to connote sexual preferences that seem "hard-wired"; unchangeable, at least through conscious will: and persistent. By this definition, BDSM is a sexual orientation that varies along a continuum just like same- or other-sex attraction, with many people having no interest in BDSM, many having small to moderate amounts of interest, and a few whose kinky tastes dominate their sexuality. At the Institute for Personal Growth, where both authors have a clinical practice, we explain to clients who wish to be cured that they can control their sexual behavior but not their desires. We explain that their sexuality is unusual but not pathological and that there are many others with the same tastes. We validate and affirm them, and we give them resources— online informational sites, groups and organizations, books. Most of all, we encourage self-acceptance. Clients who can achieve some degree of self-acceptance—and therefore lower their distress level—are paradoxically likely to experience a reduction in their obsession with the taboo

sexual preference and may even become more able to enjoy vanilla sex acts. Their kinky sexual preferences are not eliminated, but their intensity abates and their sexuality may expand. Many clients who come in self-hating and asking to be cured eventually act on their preferences without shame or anxiety. Some choose to try not to act on them, with varying degrees of success.

This approach, reframing pathological sex as a less common but normal variation, is most effective with clients who are not in committed relationships with unsuspecting partners (i.e., clients whose lives will not be turned upside down if they acknowledge or express their sexuality). Those whose sexuality is hidden from spouses often are the most distressed, particularly if they believe the spouse will be disapproving and if they want to preserve the marriage. They are reluctant to tell their partners and, once they are convinced that they cannot be cured, likely to either attempt to repress their behavior or to maintain a secret second life.

Case Vignette: Tony was a 33year-old construction worker, who came to therapy in desperation. He had strong BDSM desires, which he had fought for years, acting on them intermittently with women he met online. He was engaged to be married, and his fiancée was pregnant with their first child. Tony had strong, traditional Catholic values. He could not imagine telling his fiancée of his sexual tastes and felt that acting on his BDSM desires would condemn him to a nontraditional life, outside of the mainstream, which he could not tolerate. Over time, he was convinced his desires were not "sick," but he still rejected the idea of telling his fiancée. As he became more self-accepting he was encouraged to at least allow himself to fantasize about kink while making love with his partner. This had the effect of making him enjoy intercourse and oral sex more, which in turn, reduced his anxiety and distress. After months of therapy, he broached the idea of light bondage to his partner, and to his surprise, she showed genuine interest. Once Tony realized that his ability to be faithful to his about-to-be wife would be strengthened by making sex with her more enjoyable to him, he incorporated a little kink into his sex life—without ever disclosing the extent of his BDSM interests. He felt satisfied with this outcome and

left treatment.

Case Vignette: Steven came to sex therapy ostensibly to deal with erectile dysfunction, but it quickly became apparent that his ED was driven by lack of arousal. He had intense interests in bondage and discipline, which he had always suppressed. His had not told his wife of seven years, Karen, about these interests. The sex they had —or attempted to have—was purely vanilla. Steven and Karen, however, were both already non-traditional; they were educated technologically-minded people, who ran a social media business together, knew many gay people, and were liberal and open-minded. Steven eagerly embraced the idea that his sexual desires were normal after only a handful of sessions and worked to reduce his shame and increase his self-acceptance. He wanted to tell Karen, and so eventually, he brought her to sessions so he could come out to her in the safety of the therapist's office. Karen was surprised and distressed, but not because she thought Steven was sick. Steven was a bottom and wanted a partner who would dominate him, and Karen could not imagine herself in that role. She had been physically abused by her father as a child and equated dominance with cruelty. However, Karen and Steve had a solid, loving relationship, and Karen did some individual work to overcome her reticence. To her surprise, she found that being in a dominant sexual role was exhilarating and healing—it felt like a ritualized re-enacting of her childhood abuse in a way she experienced as corrective. This couple has remained in touch with me over the years, and they continue to be happy and contented in their relationship, sexually and in other ways.

Case Vignette: Lou came to treatment asking to be cured of his desires to be in a dominant/submissive relationship. He had been married for over 20 years to a woman who never enjoyed sex and who over the years had gradually ceased to be sexual. During the early years of his marriage, Lou had managed his kinky interests through fantasy during masturbation and during sex with his wife, but as his wife

became less sexual, Lou's drive to act out his kinky fantasies increased. He came to me asking for a cure, but readily accepted the concept that his desires were normal but less common than vanilla sexual interests. Still, Lou refused to tell his wife about his sexual interests or bring her into therapy, instead constructing a secret life for himself while attempting to maintain the image of a perfect suburban husband. After a couple of years, however, his wife discovered his activity and the marriage did, as he had predicted, dissolve. Despite a difficult and costly divorce, Lou feels he is better off now. He is able to pursue BDSM relationships, which he finds rewarding personally and sexually.

It should be clear from these examples that the affirming approach we advocate here has some potentially momentous consequences. Some clients, when affirmed, decide to act upon their impulses and leave their committed relationships, a potential outcome that should be explained to the client at the outset of treatment. If clients decide to act on their desires in a secret way, the therapist faces the ethical dilemma of being in some ways complicit in adultery. Working with this population who is seeking a cure, almost entirely heterosexual men who are married, is very similar to working with married gay men who are struggling with a secret sexual attraction to men, and raises some of the same ethical and countertransferential issues.

If the therapist is able to see the couple together, it is critical to validate the wife's point of view. Regardless of the final outcome, initially she usually feels betrayed and blindsided, frightened, confused, and angry. If she was really ignorant of her husband's sexual interests, her faith in her own judgment is shattered. How could she have lived with this man and not known? These feelings are likely exaggerated if there was adultery involved. The kinky partner, the husband most likely, may have unreasonable expectations of understanding from his wife, driven by his own needs and desires, and he may be hurt or angry when he does not receive the compassion that he expected. The wife must be allowed time to process her grief, loss, and mistrust before therapy can deal with the issue of whether there is any way for the two to "match'" their sexual scripts and often the marriage will

dissolve as a result of disclosure. Clients who consider disclosing must be made aware of this risk.

Learning from Kinky Clients

If one adopts the view that BDSM desires and practices are not inherently pathological, but are instead normal, if less common, sexual variations, one can learn things from the BDSM subculture that might be helpful to those who practice vanilla sex (Kleinplatz, 2006). Those familiar with the BDSM community are impressed by the level of sexual satisfaction attained by kinksters and the way in which sex has stayed hot for decades in many long-term kinky relationships. How has this been attained?

Communication and Negotiation

For a BDSM encounter to be successful, the dominant person, the person in charge, must know a great deal about his or her submissive, and both partners must reach a mutual understanding about the general parameters of what will take place between them. Questionnaires listing the kind of information a dom often obtains from the sub can be found online as well as in SM manuals. This one at http://www.cepemo.com/checklist.html is a good example. Two hundred sexual activities are listed, and the submissive rates each with an 8-pointsystem ranging from "Essential" to "Curious" to "Not now, maybe in the future" to 'Never." The average vanilla person likely could not list two hundred sex acts, much less readily identify his or her level of interest in each. BDSM forces people to know their own sexuality intimately and in great detail; to acknowledge their deepest sexual fears, desires, and fantasies; and to communicate those things to a partner. At the same time, participants in an SM scene agree upon rules and procedures, including safe words, and ways to communicate discomfort and lack of consent clearly during the sex act itself.

BDSM scenes also require sexual negotiation. Participants often must push their boundaries, restrain their desires, or compromise a bit on what they want in order to create a joint pleasurable experience. Sexual giving and generosity is emphasized, and participants are forced to clarify their boundaries, within themselves and with their partner in order to determine where they are and are not willing to

compromise (Sophia, 2013).

Objectivity and Non-Judgmentalism about Sex

After working with people in the kink community, who go out of their way to be nonjudgmental of any consensual adult sexual practices, one is struck by the sexual judgmentalism of the mainstream culture and of many mainstream couples. Kinky people approach sex with what Buddhist's call, "Beginner's Mind," a mind free of pre-conceived expectations and opinions. This attitude engenders mutual trust and openness, whereas mainstream value-laden sexual attitudes encourage shame, guilt, and fear of sharing one's deepest sexual fantasies even with one's partner. In the vanilla world, sexual inhibitions often are related to fear of judgment, and sadly that fear is sometimes realistic. BDSM practitioners may not share one another's desires but they do not condemn each other for these desires. There is even a word—getting "squicked"—that kinksters invented to say, "It's a turn off for me but, hey, whatever…."

Sexual Variety

Surveys of people who identify as kinky invariably find that BDSM practitioners are not only NOT focused just on one type of kink, they incorporate a far greater variety of sex acts than their vanilla counterparts (Richters et al., 2008). Sandnabba et al. (2002) found 40 different sex acts and six role plays that had been experienced by their participants, and the most common, oral sex, is not even "kinky." Kinksters are sexual adventurers whose tastes range far and wide, rather than being narrowly focused. They actually achieve what Esther Perel (2007) and others recommend: No matter how mundane their everyday relationship may be, no matter how familiar they become with their partner, they can always explore new and slightly risky, edgy sexual fantasies together. Over time, the variety results, not just in a breadth of activities, but in psychological and emotional depth in the form of trust and intimacy (Kleinplatz, 2006).

Planning vs. Spontaneity

How many times as sex therapists do we struggle to get couples to accept that they must plan for sex? The myth of spontaneity is firmly ingrained as a sexual value—except in the kink community. By necessity, BDSM sex must be planned—equipment prepared, scenes negotiated, costumes assembled. Not only does this not detract from the enjoyment of the sexual encounter, it facilitates "simmering," or anticipation of pleasure, which heightens and extends the entire experience.

Technical Skill

Too often sex therapists down play the importance of sexual technique. BDSM practitioners pride themselves on being highly practiced and technically competent in, say, the use of particular floggers or a type of bondage. Among kinky people, there is an expectation that sexual skill is learned through practice, and that responsible players learn and perfect their skills before trying them out on a partner. Non-kinky people, however, often maintain the myth that sex should come "naturally" and that skills are irrelevant. For many people, it is insulting—or shame inducing—simply to suggest that their sexual technique needs improvement because the assumption is that they are naturally unskilled. In reality, though sexual skills like all skills are learned.

Sex as a Form of Healing

Barker, Guta, and Iantaffi (2013) wrote: "One key narrative, which has emerged recently in accounts of BDSM experience, is that of BDSM play as a safe space to explore issues that might traditionally have been brought to contexts such as counseling and psychotherapy" (p. 203). Kleinplatz (2006) movingly describes therapy with a lesbian couple who used BDSM to explore, reenact, and resolve trauma induced by one partner's childhood abuse. Although people with BDSM desires are no more likely than others to have endured such childhood trauma, for those who have, kink can be a pathway to sexual healing. Easton (2013) called this "shadowplay," after the Jungian concept of the shadow side of one's personality, the part that holds darkness and negative emotions but also tremendous capacity for creativity. Shadowplay is not always about childhood issues or psychological problems. Easton

described a woman who constructed a BDSM scene in which she was “abused” by four gay male friends and, while she was restrained in bondage, she could safely vent some of the rage she felt about living in a sexist society and dealing with patriarchal abuse every day. Easton and Hardy (2004) described scenes in which one of the participants used the scenes to come to terms with a feared part of herself, a part she named the “hostile horny nasty teenage boy.”

Therapists working with kinky people need to acknowledge there are many ways to resolve trauma and negative feelings and that incorporating this resolution into sexuality is not necessarily pathological. If one believes that intimate relationships can heal old wounds, BDSM is the ideal crucible in which to re-enact and/or resolve trauma and fears partners exemplify closeness. ’ Sagarin, Cutler, Cuter, Lawler-Sagarin, and Matuszewich (2009) researched the neuronal and chemical changes experienced during extended BDSM play and confirmed hormonal changes that enhance intimacy. Shadowplay is not recommended for beginners, but it can accomplish healing when done thoughtfully between experienced, trusted partners. It could be thought of as a form of erotic bodywork.

Sex as Spirituality

BDSM play takes much longer than more standard sexual encounters, requires more planning, and often is much more emotionally and physically intense. In fact, people in the kink subculture have BDSM sex much less frequently than the average couple has heterosexual intercourse, often once a month or less (Sandnabba et al., 2002). The BDSM scene itself involves an extended amount of time in what Masters and Johnson would label the plateau stage, the very heightened arousal state that precedes orgasm. Probably because of this, BDSM participants often experience altered states of consciousness referred to within the kink subculture as “sub space” or “dom space.” Researchers have recorded changes in cortisol levels and blood flow during and after extended kink encounters of the sort that are capable of altering consciousness (Ambler et al,2013). One part of the brain that seems to be affected during BDSM is responsible for one’s sense of identity, leading researchers to speculate

that the experience produces a sense of dissolution of self and union with the universe (Ambler et al., 2013). But BDSM practitioners have long known this (Beckman, 2013), and many are open about considering these sexual practices sacred, a path to spirituality. Just as those who practice Tantric sex experience, not only more intense sexual experiences, but also a sense of spiritual connection, so do some kinksters. Easton and Hardy (2004) described this:

> When I am dancing in the storm of a flogging, to the song of the whip; when I am writhing in the throes of orgasm; when Kundalini the great snake is awake all through my body and beyond and I am thrashing and bellowing on my meditation mat, I know that the divine is real. (p. 57)

Summary and Conclusions

Like same- or other-sex sexual attraction, the attraction to BDSM sexual practices varies along a continuum. At one end of the continuum are those who, not only prefer kinky sex, but who identify as kinky and spend a good deal of their time with others who practice BDSM, within BDSM organizations, in a BDSM lifestyle. Somewhere in the middle of the continuum are "kink curious"people who want to incorporate some BDSM practices into their vanilla sex life. At the far end are those who have no interest in or willingness to try kink.

In the twenty first century, BDSM has entered the culture at large. There is tremendous interest in kink as a sexual spice, and this may be slowly leading to increased acceptance of those whose sexual interests are mainly or exclusively kinky. The mental health field is also de-pathologizing BDSM; In contrast to all editions of the DSM that proceeded it, DSM-5 does not consider these practices to be mental illness unless they cause distress or functional impairment.

Sex therapists can help clients with kinky sexuality by affirming and validating them and helping with resources and psychoeducation. Moreover, sex therapists can learn lessons from their kinky clients, lessons about how to communicate, how to be neutral about sex, how to negotiate sex, and how to use

sex for psychological healing and spirituality. These lessons are important for all clients, kinky and vanilla alike.

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