

Psychotherapeutic Issues with "Kinky" Clients: Clinical Problems, Yours and Theirs

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SUMMARY. People whose sexual repertoire includes BDSM, fetish, or other "kinky" practices have become increasingly visible, on the Internet, in the real world, and in psychotherapists' offices. Unfortunately, the prevailing psychiatric view of BDSM remains a negative one: These sexual practices are usually considered paraphilias, i.e., de facto evidence of pathology. A different, affirming view of BDSM is taken in this paper. After defining BDSM and reviewing common misconceptions, a variety of issues the practitioner will face are described. These include problems of countertransference, of working with people with newly emerging sexual identities, working with spouses and partners, and discriminating between abuse and sexual "play." [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2006 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Sex therapy, BDSM, sexual minorities, SM, kinky sex, leather sex, queer psychotherapy

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[Haworth co-indexing entry note]: "Psychotherapeutic Issues with 'Kinky' Clients: Clinical Problems, Yours and Theirs." Nichols, Margaret. Co-published simultaneously in *Journal of Homosexuality* (Harrington Park Press, an imprint of The Haworth Press, Inc.) Vol. 50, No. 2/3, 2006, pp. 281-300; and: *Sadomasochism: Powerful Pleasures* (ed. Peggy J. Kleinplatz, and Charles Moser) Harrington Park Press, an imprint of The Haworth Press, Inc., 2006, pp. 281-300. Single or multiple copies of this article are available for a fee from The Haworth Document Delivery Service [1-800-HAWORTH, 9:00 a.m. - 5:00 p.m. (EST)]. E-mail address: docdelivery@haworthpress.com].

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doi:10.1300/J082v50n02_14

While recent decades have seen changes in the way in which gays, lesbians, and to a lesser extent bisexuals and transgendered people are regarded by psychologists and psychotherapists, this comparative enlightenment has not extended to the so-called "paraphilias." Moser (2001) has described in detail the inconsistencies and circular reasoning used in classifying atypical behavior and object preferences as paraphilic "disorders." I write from a perspective shared by a small but growing group of professionals (Kleinplatz, 2001, 2002; Morin, 1995; Moser, 2001, 2002; Weinberg & Levi-Kamel, 1983) who are challenging traditional psychiatric concepts of atypical sexual behaviors.

An underlying assumption of this particular paper is that certain "paraphilic" preferences are statistically abnormal but pathologically "neutral"; i.e., no more inherently healthy or unhealthy than mainstream sexual practices. Psychiatry has a rather shameful history of collusion with institutions of political power to marginalize certain subgroups of the population, particularly women and sexual minorities. Most psychological theories are unconsciously biased towards the preservation of prevalent social mores. Therefore, it is particularly critical, when evaluating behavior that has controversial social meaning, to base judgments of pathology strictly on factual evidence. At this time, the data do not exist to support the idea that BDSM activities are, by themselves, evidence of psychopathology, nor that their practitioners are more likely to be psychologically disturbed than the rest of the population.

Sexual behaviors included in the scope of this writing are variously described by practitioners as SM (sadism/masochism); D/s (dominance and submission); BDSM (bondage/discipline/dominance/submission/sadism/masochism) and fetishism. Collectively these practices and attractions are sometimes referred to as "kink." In general, "kinky" sexual activities include one or more of the following characteristics:

- A hierarchical power structure, i.e., one person dominates and the other obeys/submits
- Intense stimulation usually associated with physical or emotional pain, e.g., hitting, humiliation
- Forms of sexual stimulation involving sensory deprivation, sensory confusion, or restraint, e.g., bondage, use of blindfolds
- Role-playing of fantasy sexual scenarios, e.g., doctor-patient roles, abduction fantasies
- 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 or partialism, e.g., fixation with feet, sexual play with urine

The “kink community”—a loose network of advocacy and support groups, venues, activities and events—has itself promulgated guidelines for what is considered acceptable BDSM practice (Wiseman, 1996): “Kinky” activities may be highly unusual, but they are always “safe, sane, and consensual.” Kinky activities quite specifically do not include, for example, rape or sexual contact with children. Admittedly, these guidelines have blurry boundaries and these boundaries themselves can be a focus of controversy within the BDSM community, but the intent is for participants to be fully informed, fully able to consent and to avoid activities which incur medical or mental danger.

I am a psychologist and sex therapist who has worked primarily with “queer” clients for more than twenty years—in other words, with people who are gay, lesbian, bisexual, or transgendered, or who participate in “kinky” or polyamorous sexual activities. The agency I founded and direct in New Jersey employs two dozen therapists and has specialized in work with sexual minorities since 1983; the material in this paper derives from our collective experience. Over more than two decades, much of our work has amounted to “damage control”: repairing egos battered by the judgmental attitudes of traditional psychotherapists. The focus of this paper, therefore, is education. First, I will address some of the most prevalent myths about BDSM, and then outline the most common clinical issues encountered in working with this population. Throughout, my goal is to give concrete, practical advice to clinicians who may find themselves working with clients engaged in BDSM activities. All cases used in this paper have been disguised to protect confidentiality.

BACKGROUND: DEFINITIONS AND DESCRIPTIONS OF BDSM

Common Misconceptions About BDSM

Briefly, some of the most common misconceptions about BDSM are as follows:

1. *BDSM is mostly about the “dominant” partner getting his/her way with a passive, exploited “submissive.”* In reality, BDSM

- “scenes” (the name given for the often elaborate playing out of a sexual fantasy) are usually negotiated and scripted ahead of time, and the submissive partner sets the basic “limits.” While the “dominant” is in charge, he or she acts within guidelines set by the “bottom.” In theory, a submissive can be exploited in the same way any trusting sexual partner is vulnerable, and things can go wrong in BDSM sex just as in more traditional sex. The myth ignores the fact that the primary motive for the submissive partner to consent is pleasure—not fear of the dominant person.
2. *BDSM is about physical pain.* First, kinky preferences are highly variable, and even when they do include “pain,” it is not pain as we typically think of it. Think “pain” as in biting your lover in a moment of sexual abandon—not “pain” as in root canal; visualize being pinched or scratched when you are highly aroused, as opposed to being punched in the nose.
 3. *BDSM activities inevitably escalate to extremes and/or become addictive (“it’s so good don’t even try it once”).* Some people who have suppressed their preferences for years may initially be consumed with “making up for lost time”; this is a phenomenon seen frequently when pleasurable desires have been repressed, e.g., married gay men who “come out” in middle age. Eventually, BDSM activity tends to level off, though that level may be different for different people and can range from a desire to occasionally incorporate kinky practices into a predominately “vanilla” script, to the wish to live a “24 by 7” BDSM lifestyle.
 4. *BDSM is self-destructive.* There is no evidence that practitioners of “kink” use it self-destructively any more frequently than “vanilla” sex is used self-destructively. Anything pleasurable is subject to abuse; BDSM is no exception.
 5. *BDSM stems from childhood abuse.* Again, there is no evidence that the incidence of childhood abuse is different within and outside the SM community (Moser, 2002).
 6. *BDSM is an avoidance of intimacy.* In general, sex at times enhances intimacy, at times is an avoidance mechanism, and at times is irrelevant to intimacy. There is no evidence that BDSM is any more or less prone to intimacy amplification or aversion than more standard sexual practices. Many clinicians who practice psychotherapy within this community will tell you about long-term BDSM relationships that are not only intimate, but have “hot” sex years into the relationship, perhaps more frequently than their non-kinky counterparts.

7. *BDSM is separate from “vanilla” sex.* For most practitioners, BDSM activities and “regular” sex—intercourse, oral sex, etc., often called “vanilla” sex within the kink community—are combined some or all of the time, and “vanilla” sex can occur without BDSM.

The “Mysterious” Allure of BDSM: Towards a New Paradigm of Sexuality

Psychological theories, especially psychoanalytic ones, have an abundance of pathology-oriented explanations for the existence of “paraphilic” interests and behaviors. These unproven theories tend to get in the way of effective clinical work with “kinky” clients. It is helpful to remember that sex, by and large, is still a mystery even to those who study it professionally. In recent years attempts have been made to develop new paradigms of sexuality that can encompass the tremendous range of behavior found not only among humans but in all animal species (Bagemihl, 1999; Kaschak & Tiefer, 2001; Kleinplatz, 2001, 2002; Morin, 1995; Nichols, 2000). What these models share is a reluctance to assume pathology without evidence. Here are a few very straightforward, understandable, and healthy reasons why BDSM sexual activities may be appealing to kink aficionados:

1. BDSM can be a lot of fun, and it can make sex very hot. This is probably the most important factor.
2. Some people see BDSM sexuality as spiritual, not unlike Tantric sex.
3. Others feel it enhances intimacy in a committed relationship, and/or accomplishes healing of earlier psychic wounds in the context of a trusting partnership.
4. Some kinky practices explore the “shadow side” of sexuality. Just as risk makes activities like bungee jumping or roller-coaster riding fun for some people, the taboo or apparently risky nature of some BDSM can enhance pleasure. Moreover, as Jack Morin (1995) has pointed out, nearly every emotional state that can inhibit sex—shame, guilt, fear, for example—can also, under different conditions, enhance arousal.
5. Some BDSM practitioners feel that this form of sexuality is a non-chemical way of attaining pleasurable altered states of consciousness.

6. The tremendous variety of activities encompassed within kink mitigates against the tendency for sex to become routine and monotonous, especially in monogamous relationships.

It is probably clear by now that the appeal of BDSM sex is quite variable. In fact, it is possible that the only thing that people who engage in these forms of sexuality have in common is that they are sexual adventurers (Moser, 2002) and that sex is a high priority in their lives; they have high libido as a rule and get many needs met by their sexuality. Notice that none of these reasons for interest are necessarily "pathological."

CLINICAL ISSUES

Countertransference

The first and most common issue therapists confront when working with "kinky" clients is dealing with their own judgments, feelings, and reactions to this sexual behavior. The countertransferential feelings most commonly encountered by clinicians with comparatively little experience with BDSM are some combination of the following: shock, fear, anxiety, disgust, and revulsion. When this countertransference is intellectualized, the therapist may experience a deeply felt conviction that the client's behavior is self-destructive but have little more than vague abstractions to justify the firmness of the conviction. When counselors find themselves believing that their clients' pathology is "self-evident" despite no concrete evidence of harm, it is fairly certain that countertransference is present. For example, a client who reports picking up a stranger in a bar, going to an unknown location and allowing herself to be put in incapacitating bondage and experience penile penetration without a condom may alarm her therapist with this report—for very concrete reasons, and reasons having little to do with the "kinky" bondage activities. This client is putting herself in considerable physical danger, and it requires no abstract psychological theorizing to arrive at this conclusion. On the other hand, hearing a client describe sexual play that involves verbal humiliation may trigger feelings of alarm in the counselor as well. The therapist may conclude that this behavior is both evidence of low self-esteem and a reinforcer of poor self-image. The therapist's fears are based purely on psychological speculation—and, in all likelihood, upon countertransferential feelings of revulsion. It may occasionally be true that verbal humiliation play is associated with low

self-esteem, but the therapist new to working with “kinky” clients is more likely to be jumping to this conclusion erroneously, through projection of his or her own reactions.

There are many reasons why this might occur. Often the therapist simply lacks information or experience. For example, the client may tell his or her therapist that he/she participates in “cutting” scenes and the therapist may assume danger when in fact the vast majority of all such activities involve superficial, easily healed wounds that are little more than well-placed scratches. Many sexual activities look strange to the uninitiated: consider children’s usual reactions of disgust or disbelief when sexual intercourse is first described to them. It often helps to explore some of the “technical” information behind a practice. The clinician might want to read BDSM sex manuals such as those by Brame (2000), Miller and Devon (1995) or Wiseman (1996), or watch instructional videos such as *Whipsmart* (Good Vibrations/Sexpositive Productions, 2002). These books and videos often convey not just the technique, but something of the personal experience of BDSM. Besides gaining information, therapists can use these materials to identify their own “kink,” even if it is a minor part of their sexuality. The more adventurous therapist might consider visiting an SM club or organization; this gives both a taste of the lifestyle and an appreciation of the attitude of warmth and community support found in these institutions.

At times, feelings of disgust or aversion may convey information about repressed or disowned parts of the therapist’s own sexuality. In order to work successfully with kinky clients, the therapist should be able to handle unexpected sexual feelings arising in conjunction with his or her work—including feelings the therapist thinks are “wrong” or “dangerous” or “politically incorrect.” In this situation, it is best to cultivate an attitude of slightly detached “observation” of the entire process, including the revulsion, the desire or arousal, and the defensive reaction to the arousal. This process might go something like this:

- a. “I notice I feel disgusted when my client tells me about sexual scenarios in which her partner has humiliated her. What triggers this disgust in me—is it the humiliation, the specific method of humiliation, etc.?”
- b. “Why is my reaction so strong and aversive? Might I secretly want to humiliate or be humiliated?”
- c. “If so, why does that scare me? Why do I think it’s ‘bad’ or ‘wrong’ for me to feel this way? Does it clash with other values? Does it trigger memories of past trauma or other experiences in-

volving humiliation?" In the BDSM community, the term "squicked" refers to having a strong negative emotional reaction to an activity while knowing that you do not actually "judge" the activity as "wrong" or "bad." This is a helpful and neutral way to think of such countertransferential feelings.

This process not only can result in counselors learning invaluable information about their own sexuality; it may also mirror clients' internal experiences of self-hatred or shame. When therapists have analyzed their own negative reactions, they may also have enhanced abilities to be helpful to clients.

While this discussion has focus on countertransferential feelings of fear, disgust, or revulsion, the counselor may also experience being sexually aroused by activities described in session. Again, the therapist has to develop an accepting attitude of his or her own sexual arousal, or the countertransference around this will interfere with therapy.

Non-Disclosure of BDSM

Though we have no way of knowing how common this is, it is very clear that many people within the BDSM community go to counseling and never reveal their sexual preferences to their therapists. Sometimes this does not interfere with therapy, especially if the therapy is relatively short-term and problems are unrelated. When the client or clients' problems include sexual or relationship issues, however, therapy can be terribly compromised. Long-term individual work can be damaged as well, because the client is withholding information about a significant portion of his or her life. Clients themselves sometimes do not understand the therapy process well enough to predict that such secrecy may sabotage treatment, and so it may seem simpler to hide than to risk negative judgment. It is hard to blame people in the kink community for doing this, however misguided it may be; given the training most therapists receive about sexuality, many *would* judge a client negatively if the information were revealed.

How can the therapist avoid this and encourage self-disclosure? If the therapist or agency is not known for sexual openness, it can be communicated in indirect ways, with the literature, artwork, and books visible in the office. It is not necessary to have sexually explicit material on view to achieve this. A visitor to our offices sees a rainbow flag in one

of the windows, literature on sexual minorities in the waiting room, and books like *S/M 101* on the bookshelf.

In addition, the questions asked on client questionnaires and in the initial interview with clients can establish a tone of acceptance. For example, clients who come for sex therapy at our clinic are asked to fill out a written survey that includes questions about bondage, fetishes, role playing, D/s, spanking, and so on, right next to the questions about oral, anal, vaginal, and manual stimulation. Other clients are asked less elaborate questions that nevertheless include items about sexual orientation and sexual interests. Over the course of therapy, a counselor might deliberately bring up BDSM in indirect ways. For example, when talking to presumed "vanilla" clients about sex, I regularly mention the excellent communication skills of people who practice BDSM—just in case the client needs permission to reveal a "secret."

Ignoring the Kink, Considering the Kink

It is important to understand that in all probability most clients involved in kink will be coming to therapy for reasons unrelated to their sex lives. For these clients, understanding of BDSM and empathy can be demonstrated by NOT prodding them to talk unnecessarily about their sexuality. In the early 1980s, my agency worked exclusively with gay and lesbian clients. Our clients often said they came to us in order to avoid talking about their gayness. Frequently they reported experiences with uninformed straight therapists who had focused on gay sexuality when the clients wanted to talk about depression, relationship issues, and family problems—in other words, the typical range of problems most people bring to therapy. Even if the desire to focus on a client's kinkiness is motivated by curiosity rather than by negativity, it is inappropriate to steer clients towards talking about issues that they do not consider important problems in their lives.

On the other hand, sometimes BDSM issues affect other apparently unrelated problems. For example, most people hide their BDSM activities from family, colleagues, and even from many friends. The fear of exposure is realistic: Kink practitioners have no protection in areas of employment or housing. Child custody and visitation can be threatened if BDSM activities are exposed, and the threat is as much as from state child welfare agencies as from angry spouses. Some states mandate that physicians report suspicious bruises as suspected domestic violence, and allow police to arrest the "abuser" even if the "victim" partner is not a complainant. These concrete hazards have an inhibiting or limiting

effect on decisions and behaviors in areas like career, child-rearing, divorce, and family relationships. Moreover, hiding can compound fears or lead to a sense of isolation, thus contributing to anxiety or depression. It can be important for clinicians to recognize these connections, validate clients' experiences and help them overcome barriers imposed by unconventional lifestyles.

There can be more subtle interplay between BDSM and nonsexual issues as well. Roger, a man in his mid-thirties, became involved with a twenty-three-year-old woman with some limited exposure to BDSM practices, and through their relationship Roger came to develop and appreciate his dominant, powerful sexual nature for the first time. At the heights of romantic feeling, Roger and Julia decided to extend their master-slave sexual relationship beyond the bedroom; Julia proposed that she hand over her paycheck to Roger. Roger, however, had a history of being attracted to dependent younger women. He would at first be gratified by protecting and caring for each woman, but later he would tire of the responsibility of having an adult 'child' and end the relationship. He did not want to repeat this pattern with Julia, and I encouraged Roger to impose fairly strict boundaries around the BDSM sexual relationship in order to keep that power exchange in the realm of erotic fantasy. I felt, and Roger agreed, that this would help insure that the overall relationship remained egalitarian. It is beyond the scope of this paper to discuss the many subtle ways in which sexuality interacts with, mirrors, and affects other parts of a person's life, but it is clear that BDSM sex like other sexual practices can be rich with nonsexual meaning.

Problems of "Newbies"

If the therapist is not known within the "kink" community, it is possible that the most common kind of BDSM client who will request your services will be the "newbie": the person who is just "coming out" to self and/or others about kinky desires. Ironically, this is precisely the client for whom one must be most knowledgeable and positive about BDSM. People with "kinky" desires have grown up with the same judgmental, uninformed societal attitudes as has everyone else. Therefore, they are likely to have a good deal of internalized shame, fear, and self-hatred about their sexual preferences even if they have finally succeeded in admitting their identity to themselves or telling someone else. For such clients, providing acceptance and modeling positive attitudes is crucial and has intense therapeutic power.

"Newbies" look to therapists for a "seal of approval": The mental health professional can validate that they are "OK." Thus, with these clients one cannot assume a passive, "non-judgmental" stance; one must give feedback. "Newbies" are likely to assume that "no comment" equals negative judgment. Thus the therapist must emphatically reassure them their sexual preferences are not de facto "sick," or pathological. Moreover, the counselor needs to give information about the prevalence of BDSM behavior and the existence of BDSM educational and social organizations. It is comforting for clients in this stage of development to know that they are not alone. The therapist should be able to refer them to books, Internet URLs, and organizations where they can begin to develop support networks of people who can affirm their sexuality and guide them in exploration. The counselor can play an important role here and can be enormously beneficial with relatively simple comments and suggestions.

Some time may need to be spent helping clients understand how their own self-hatred (BDSM negativity) has been inculcated by societal prejudice, and in assisting them in improving self-image. Clients may have social problems related to their isolation; for example, some people avoid intimacy as a way of containing their desires, and therefore may have poor intimacy skills even after "coming out." Other clients may have built all their social relationships on lies, so to speak, and experience stress related to "fronting," fear of being "found out," and/or feelings of being "fakes" or "imposters." And indeed, the fear of being found out is not entirely paranoia. Because at present, few laws protect the rights of the BDSM community, people can and do lose jobs, friends, family, and children because of inappropriate disclosure or inadvertent "outing" (Wright, 2002). Advice about "coming out" to others must include information on realistic dangers. Treatment of "newbies" almost always involves validating them, psychoeducation, bibliotherapy, and guiding them to support groups. It is very gratifying and often not difficult work.

It is almost impossible to work with BDSM "newbies" without receiving requests from clients to eradicate their kinky desires. This can create conflict for the therapist, as clients who want to be "cured" report horrible psychic pain around their sexuality, and it is normal to want to help them attain their goals. In fact, such personal discomfort, coupled with BDSM desires, qualifies the client for a diagnosis of paraphilia, just as, in the 1970s, discomfort with homosexuals qualified an individual for the diagnosis of "ego-dystonic homosexuality" even after homosexuality per se had been removed from the nomenclature.

The category of “ego-dystonic homosexuality” was eventually removed as a diagnosis through the efforts of gay activists, who argued that the average gay person went through at least a stage, if not a lifetime, of introjecting societal values as self-hatred and rejection of the “offending” feelings and behavior. Activists called that phenomenon “internalized homophobia” (now called “homonegativity”), and insisted that appropriate treatment was to help the person eradicate the internalized homophobia—not the homosexuality.

In many ways the BDSM community of the early 21st century resembles the gay community of the 1970s, and individuals who struggle with BDSM desires experience a similar internalized shame about their sexuality (Nichols, 2000). When such clients ask to be “cured” of their kinky feelings, consider that the problem is not the BDSM, but rather clients’ self-hatred and the desire to repress or obliterate their sexuality. In addition, it is important to be mindful that the history of attempts to eradicate particular sexual desires has been pretty dismal. Although clients can choose not to act upon their sexual feelings, they will probably never get rid of them, and not accepting these desires may very well inhibit the rest of their sexuality, as well. In most cases, when we—professionals who are “experts” on sexuality—validate the client’s BDSM desires, the level of their self-hatred is immediately reduced and they quickly abandon their goals of repressing or eradicating their feelings. However, if clients continue to want help eradicating their desires, we refer them to local professional organizations who can connect them to counselors who will agree to work towards this goal. In addition to the fact that we think such “cure” oriented treatment has a poor prognosis, we also feel offering treatment like this would conflict with and compromise our stance of validation of BDSM.

This is not to say that clients always act on their BDSM desires in appropriate and healthy ways. Just as some people use “vanilla” sex in dysfunctional ways—they become “addicted,” use sex to escape other problems, are irresponsible towards themselves and others in their sexual behavior—so can BDSM practitioners abuse their sexuality. Although we do not take a therapeutic “contract” to help someone eliminate “kinky” desires, we certainly help our clients modify all dysfunctional behavior, including sexually dysfunctional behavior. But we start from a position of assuming that BDSM behavior is psychologically “neutral” and is given positive or negative valence by the individual.

The Partner and Family

Many “kinky” individuals have been aware of BDSM sexual fantasies from an early age, although a large number will make enormous efforts to suppress behavior and repress desires because of the acute social disapproval of this form of sexuality. Therefore, many “kinky” people have chosen to hide their feelings, behavior and/or identities until mid-thirties and beyond. During their years of secrecy, they may have infrequent clandestine encounters, Internet contacts, or only allow themselves the outlet of masturbating to BDSM fantasies. By the time such individuals feel they can no longer contain their desires, they may have married long ago and perhaps had children in a (presumably) “vanilla” marriage. In addition to the issues experienced by most “newbies,” the person with an unsuspecting partner has a whole host of other problems. In fact, some requests for help may come from the spouse who has just discovered the BDSM partner’s sexuality. In other cases, it is disclosed by the BDSM partner in individual therapy, or both members of the couple may ask for couples counseling. The BDSM may have already been revealed before the person or couple comes for help, or it may be your job to facilitate disclosure.

Sooner or later, individuals in this position usually need to reveal their true interests to their partners. If you are called upon to aid in this process, consider fairness to the spouse as well as the individual desires of your client. While the reaction of the spouse who has been deceived ranges from surprise to horror—occasionally delight—there is almost always some anger about the deception. The therapist has some ethical responsibility to partners, however undefined that may be. Although confidentiality cannot be violated, try to steer the married BDSM client towards a resolution that is fairer to the partner, whether that be separation or disclosure. Aside from ethical concerns, there are practical therapeutic reasons to do this. This kind of deceptive lifestyle usually erodes the self-esteem of the deceiver, rarely works for long periods, tends to hinder growth for both partners, and often makes the situation worse when and if the truth finally becomes self-evident.

On the other hand, timing and readiness are crucial. As mentioned, the partner’s reaction may vary widely. It is important to remember that one’s first reaction is just that—a first reaction. Unless the partner is also unexpectedly kinky, the first reaction is unlikely to be a joyous one. So if your client is the “kinky” one, first prepare and help him or her assess readiness for an unpleasant interlude. When he or she is ready, the client

can plan the disclosure for the most opportune time and setting, and can role-play in therapy to practice the actual situation.

Both the therapist and "kinky" client must be ready for the other partner to experience a grief process before he or she can think rationally about the marriage/relationship. Try to empathize with and validate the reactions of the partner, and provide referrals to support networks/Internet groups. After the partner is able to consider options for the relationship, the therapist will assist the couple to integrate the new desires into their relationship, accommodate the partner's new interests, or separate. In this situation, success is contingent to a large degree upon factors beyond the therapist's control, namely, the partner's feelings, attitudes, and sexuality. In many cases separation or divorce will be the answer. In others, the partner may be willing to allow the kinky person to have some sexual outlets outside the relationship. In yet others, the vanilla partner will develop kinky desires. In fact, this is not at all an impossible goal. Keep in mind that BDSM practitioners usually enjoy vanilla sex as well, so there is already some compatibility in their sex lives. In addition, recognize that enjoyment of "kink" can sometimes be learned in adulthood: Not all kinky people fantasized about BDSM from childhood. Open, curious, flexible vanilla adults can develop quite strong kinky preferences over time; it helps if the vanilla partner has a strong libido.

The case of Gerry and Lisa exemplifies a situation where the vanilla "surprised" wife was able to adjust and accommodation is being negotiated. This suburban professional couple had two young children, an established home in a respectable, high-end community, and a strong and loving relationship. Gerry came for therapy when he was in his mid-thirties, about a year after the resurfacing of long buried, kinky urges. His fetishes included being dominated by a woman and forced to wear diapers or female undergarments. Gerry also enjoyed vanilla sex and many other forms of BDSM, however, and he was somewhat "switchable," meaning he was able to be either dominant or submissive in a sexual situation. Lisa, initially shocked that the man she thought she knew thoroughly could be hiding something of such import from her for so long, adjusted fairly quickly once assured that Gerry was most probably not a transsexual in early stages of transitioning, contrary to what she had been told adamantly by her last therapist. Lisa discovered she could get sexual enjoyment out of dominating Gerry and, in addition, she found she could get the housework done efficiently by ordering him to clean while diapered, and then end this "scene" with intercourse if she desired. This case is interesting in part because Gerry's primary fetishes

are not "turn-ons" for Lisa, but neither do they "squick" her. Rather, what is happening is that the partners are evolving sexual scripts that satisfy his fetishes in a BDSM context while including elements that satisfy Lisa strongly.

Nick and Diane, on the other hand, have had a less happy outcome. Nick had gone through a period in his life where he decided he was a sex addict and had decided that kinky sex was inextricably linked to his addiction. During that period he not only repudiated BDSM, but he seemed to deliberately choose a rather asexual and prudish woman for his wife, perhaps in the hopes that she would help him repress his sexual preferences. Years later Nick began to secretly explore BDSM once again. This time, he found he could manage his desires without feeling compulsive, and began to want to manifest his fantasies in kinky sexual behavior with this wife. Diane, however, had not changed since their marriage. She not only refused to participate, she insisted upon Nick's abstinence from kink as a condition of marriage. The couple was sawing back and forth between periods when Nick controlled his urges to make his marriage work, and when he "acted out" sexually and the couple veered towards divorce. Ultimately, the latter seemed inevitable. As this case suggests, many kinky people attempt abstinence in order to keep a marriage and family together. Sometimes this works, depending upon many factors, including strength and quality of the relationship, presence of children, commitment to putting family life above individual needs, and, in all probability, factors like the "kinky" person's level of sex drive and self-control over sexuality.

Issues of Bleed-Through, Good and Bad

"Bleed-through" is a BDSM term used to describe situations when the boundaries between roles in the bedroom and roles in the rest of the relationship blur, or when relationship issues and sexual issues merge. Bleed-through occurs in "vanilla" relationships, too, of course: e.g., the male who feels powerless in his marriage develops erectile problems, or, on a more positive note, the partner who feels nurtured, protected, and connected during a sexual encounter behaves more compassionately to his or her partner in the rest of the relationship. In fact, it is probably unrealistic to think that any couple maintains strict boundaries between the bedroom and "real life." However, bleed-through can sometimes be more complex in BDSM relationships.

Pat and Claudia, a lesbian, self-designated D/s couple, are an example of how sexual and relationship roles blur so that each is a mirror of

problems in the other. These women developed sexual dysfunction relating to their roles as submissive and dominant; Pat was having more and more of a problem being submissive during sexual encounters. Upon exploration, Pat realized she felt she was expected to be subservient to Claudia all the time, in and out of bed. Claudia denied wanting this, and it seemed apparent that both women valued egalitarianism in their day-to-day relationship. It took a few, traditional, couple counseling sessions to unravel the ways in which Claudia unconsciously generated cues that Pat interpreted as demands for subservient behavior. Once this happened Pat's comfort with sexual submissiveness began to increase again. In addition, I began to suspect that the couple's sexual issues were being exacerbated by the fact that the transition between "real life" and their sexual "scenes" tended to be gradual and indistinct. Claudia and Pat were encouraged to develop a special ritual to designate when "real life" was being left behind and "scene life" was being entered; this was all the treatment they needed.

Amy and Joanne, on the other hand, had a more serious kind of bleed-through issue, reflecting the more disturbed nature of at least one of the partners. In their sexual roles, Amy was Daddy to Joanne's little girl. Recently, Joanne had been asking to extend these roles outside of sex to many significant areas of everyday life; for example, Joanne wanted Amy to dress her in the morning for work. Amy felt frightened by her partner's behavior, and suffocated by the demands of the parental role. At the same time, her mild-mannered nature made it hard for her to say no to Joanne's demands. Therapy served to help Amy be assertive with Joanne. Moreover, Joanne was advised to return to her individual therapist to resolve her strongly felt urges to abdicate responsibility for herself and return to an infantile state. In this case, the bleed-through was emblematic of larger relationship issues, and especially of Joanne's psychological problems that were not particularly related to sex. Because sexual problems flagged deeper pathology in the larger relationship, most therapeutic interventions in this case had little to do with sexuality per se.

Diagnosing Domestic Violence or Self-Destructive Behavior

Domestic violence can occur in any type of relationship, including BDSM partnerships. Many BDSM organizations, mindful of the public perception of SM, make special efforts to educate "scene" participants about domestic violence and promulgate guidelines to help assess whether or not their relationships are abusive.

Occasionally domestic violence occurs during an actual sexual interaction, in the guise of SM, as this case illustrates. When Sarah married Dan, she had had submissive sexual fantasies for most of her life but had never participated in kinky activities with anyone. Dan claimed to be an experienced dominant who would teach her about BDSM. Dan, however, was merely an abusive spouse with a slightly different "spin" on abuse. Dan would immobilize Sarah in bondage and then, during sex, put a pillow over her face until she began to asphyxiate—an activity that terrified her. It is standard in BDSM "play" to use a "safe word"—a code word that the submissive partner can use to signify that he or she wants the kinky activity to stop. Dan convinced Sarah that to be a "good wife" she had to give up her safe word, leaving her truly afraid for her life. Sarah's behavior and psychology became that of a battered wife, as by degrees she became more and more passive about her abuse. Fortunately, eventually Sarah managed to assert herself with Dan and ultimately divorce him. Sarah was helped by the fact that her therapist, knowledgeable about BDSM, knew immediately that Dan's behavior was domestic violence, rather than kinky sex.

Sometimes BDSM activities, like other behaviors, are turned to a psychologically self-destructive use. Suzy was a young woman with borderline personality disorder who was a sexual masochist. At times her BDSM activities, which mostly revolved around getting heavily flogged, were pleasurable and she felt connected to herself and to her partners. But at other times she, by her own acknowledgement, got herself flogged because she was full of self-hatred. Although these floggings seemed to temporarily alleviate tension, both Suzy and I came to believe over time that they ultimately reinforced her self-loathing. Suzy eventually learned to distinguish when she wanted to be flogged for pleasure and when she was driven by the desire to punish herself. Once this happened, Suzy was able to stop the behavior that was motivated by self-hate without giving up her BDSM sexuality.

It is often difficult to detect when BDSM is being used in an abusive fashion, particularly if the activities involved are ones that "squick" the therapist. The client may accuse the therapist of bias or ignorance in a defensive attempt to cling to pathologically ingrained behavior; a victim of domestic violence may deny his or her partner's abuse. Consulting a colleague with a specialty in sexual minorities might be particularly helpful in these cases where real danger exists.

These cases illustrate situations in which BDSM is being used in an unhealthy way. Like all forms of sexual behavior, kinky sex can be enlisted in the service of neurotic or self-destructive forces, and it is not al-

ways easy to distinguish between positive and negative expressions of sex. When negative sexual behavior is suspected, it is of course important for the therapist to examine his or her countertransferential feelings, as described earlier in this paper. If, after doing so, concern about the client's behavior still remains, one can apply the same guidelines one would use in evaluating "vanilla" sexual behavior. Here are some questions the psychotherapist might consider:

1. How does the client feel about his or her behavior? If the client is worried, can this concern be accounted for by internalized sex-negative attitudes, or is there substance to the client's fears?
2. Is the behavior interfering with activities of daily life, such as work, family relationships, or friendships and social life? Caution is needed here; for example, isolation from friends may simply mean the kinky person needs to build a new support group that is accepting of his or her lifestyle.
3. Is the behavior compulsive? Does the client experience a loss of control over sexual impulses?
4. Is the client participating in genuinely risky behaviors, e.g., picking up strangers in unsavory places, engaging in unprotected sex, allowing alcohol and drug use to impair judgment?
5. Does the sexual behavior seem to be making the client feel worse—more depressed, anxious, guilty, self-hating—rather than better?

Recognizing situations in which BDSM is being used in an unhealthy way can take time because both client and therapist may have to counteract ingrained sex-negative feelings. However, a genuinely unbiased clinician neither automatically condemns nor automatically confers approval upon any behavior, but rather considers all evidence over time in the context of each client's particular life situation.

CONCLUSIONS

When "kinky" individuals and couples seek therapy, most of the time they are seeking help for the same reasons as other clients: depression or anxiety, family or relationship issues, and so on. However, there are some issues that are special to this population. Chief among them are problems related to "coming out," i.e., the recognition of "kinky" preferences after years of suppression of these desires. These problems in-

clude internalized shame and self-hatred, isolation from others with similar sexuality, and possible conflicts with existing marital or couple relationships.

Before therapists can help kinky clients with these problems, they must first examine their own beliefs about BDSM. The counselor must discard most pathology-oriented paradigms of sexuality; adopt new models that allow for neutrality and, at times, celebratory attitudes towards diverse sexuality. Therapists must also learn to analyze counter-transferential feelings that are based not only upon ignorance but sometimes on fears about their own "darker" sexual desires. In addition, therapists wishing to help "kinky" clients must undertake to educate themselves, not only about BDSM, but about all sexual minorities, because there is considerable overlap between the BDSM community and gay/lesbian/bisexual populations as well as with the polyamory movement.

Although considerable courage, effort, and honesty are required to attain a stance that will be helpful to clients in the BDSM community, the therapist is amply rewarded for his or her labor. First, this is a population that is truly under-served: The typical attitudes evinced by professionals towards BDSM are judgmentalism and condemnation. It is gratifying to know that one makes a difference, and supportive and validating therapy for "kinky" clients genuinely helps, perhaps even saving lives. But there are other benefits to the therapist as well. Working with sexual minorities keeps us constantly rethinking, questioning, and reformulating our own concepts of sexuality, and thus keeps our work in this area from becoming stagnant. And finally, working with people living "on the edge" helps bring us to our own edges, and this keeps us alive, growing and vibrant human beings.

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