Kinky clients, kinky counselling? The challenges and potentials of BDSM

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'Most people find it difficult to grasp that whatever they like to do sexually will be thoroughly repulsive to someone else, and that whatever repels them sexually will be the most treasured delight of someone, somewhere…Most people mistake their sexual preferences for a universal system that will or should work for everyone' (Rubin, 1984,p. 283).

One of the most demonised forms of consensual sexuality is BDSM (bondage and discipline, domination and submission, and sadomasochism). Many counsellors still consider it appropriate to make negative comments about BDSM in a way that is perceived unacceptable in relation to other aspects of sexuality (Hudson-Allez, 2005). Kolmes, Stock and Moser (2006, p.315) found 118 reports of 'biased or inadequate' care from psychotherapists in their survey of 175 BDSM clients. These may be rooted in the threat posed by 'queer' sexualities that trouble the binary constructions of gender and sexuality underlying conventional heterosexuality (Barker, 2003). It may also relate to perceptions of BDSM as inherently sexual, which make claims for citizenship amongst BDSM practitioners problematic (Langdridge & Butt, 2004; 2005).

In this chapter we briefly present the current legal and clinical status of BDSM, revisiting and updating some of the material included in Bridoux's (2000) chapter on this issue. We

consider why BDSM might be perceived as particularly threatening, exploring the extent to which in can be seen as a queer sexuality that challenges heteronormativity. Focusing on an example text we consider how BDSM is currently presented to counsellors and psychotherapists. We also report on the literature covering negative clients' experiences, which illustrates the perpetuation of prevalent demonising and pathologising discourses in therapy (Kolmes, Stock & Moser, 2006). Drawing on the existing, but limited, non-pathologising literature on psychotherapeutic issues with BDSM clients, and social constructionist approaches to psychotherapy, we then suggest good practice for therapists working with clients who practice BDSM.

INTRODUCING BDSM

BDSM is a term used to encompass various activities. These generally involve the exchange of some form of power or pain, often, but not exclusively, in a sexual context. Authors on the topic sometimes use the abbreviation SM or S/M to refer to the same range of practices (Langdridge & Barker, 2005; Kleinplatz & Moser, 2006), but BDSM seems to be a more encompassing term preferred amongst the communities involved (Informed Consent, 2006). It can be difficult for those unfamiliar with such practices to conceptualise what is meant by 'power' and 'pain' in this context and to understand how they might be experienced positively by anyone. However, some degree of power or pain exchange is common in many people's sexual practices. For example, biting or light spanking, role-playing school-girls or doctors, or holding a partner down by the wrists during sex because both parties find this desirable and exciting. BDSM codifies such practices more explicitly and uses terminology such as 'power' or 'pain' exchange in negotiation between partners

and in community-based literature so that there is a shared understanding (see appendix for examples of BDSM scenarios).

Some regard BDSM as an integral part of their sexual identity whilst others view it more as an activity they practice[i]. This mirrors most sexual identities and means that, while it is possible to make some general comments, it is important for therapists to remain aware that, much as one would not assume that the heterosexuality of a monogamous couple in their 70s who had been married for 50 years would necessarily have large areas of commonality with that of a polyamorous triad in their 20s, BDSM is an umbrella term for a type of dynamic and/or identity that is subject to modification by the other groupings within which clients find themselves.

Janus and Janus (1994) report that up to 14% of American men and 11% of American women have engaged in some form of BDSM sexual behaviour and estimates of the extent of BDSM fantasy are much higher. Kleinplatz and Moser (2006) point to the fact that BDSM organisations and events exist throughout the US, UK and in many other Western countries, and there are a huge variety of BDSM-related materials available in adult stores and on the 27 million or so web pages devoted to the topic.

Langdridge and Butt (2004) suggest that stories of BDSM are having 'their time' to be heard at the start of the 21st century (Plummer, 1995), with BDSM themes now commonplace in popular TV programmes and widely released American movies (e.g. *Will and Grace*, 2001; *Buffy the Vampire Slayer*, 2001; *Secretary,* 2002; *Kill Bill*, 2003). BDSM

has been commodified to sell everything from yoghurt to supermarkets (Beckmann, 2001; Sisson, 2005). It could be argued that it not BDSM practices per se but rather the imagery associated with BDSM (e.g. accessories like handcuffs and riding crops) and the way it is signified on the body (e.g. materials like leather and PVC and body piercing), which have become more visible and therefore more acceptable in a mainstream context. High-street sex shops and popular magazines now encourage heterosexual women to incorporate 'kinky' practices to spice up their monogamous sex lives and keep their partners interested (e.g. Scarlet magazine, 2005) whilst policing the boundaries against 'real' BDSM (Storr, 2003). Weiss (2006) reports that mainstream media representations of BDSM are still on the increase, although they, and their viewers, tend to either normalise or pathologise it. Normalisation can be seen in the otherwise traditional heterosexual love-story of *Secretary* (2002) and pathologisation in crime dramas such as *Wire in the Blood* (2002), which links BDSM to mental illness, sexual abuse and murder. Weiss reports that such pathologising representations tend to occur when BDSM falls, in other respects, outside of Rubin's (1984) charmed circle of sexual relationships, that is, for example, by being non-heterosexual or non-monogamous.

BDSM practices are still restricted legally in countries worldwide, and prosecutions are on the increase in the US (Ridinger, 2006). In the UK Spanner case (Regina vs. Brown, 1990), sixteen men were charged. The Judge (Mr. James Rant, QC) declared that consent was not an eligible defence and the defendants had to plead guilty and serve prison sentences either for assault or, in the case of the 'bottoms'[ii], for 'aiding and abetting an assault'. The European Court of Human Rights upheld this decision in 1997 (Chaline, 2005). However,

in Canada in 2004 a judge ruled that BDSM videos seized by police were not obscene and that BDSM is a 'normal and acceptable' part of human sexuality based on consensual play and not violence (Toronto news, 2004). Rubin (1984) points out that BDSM generally results in far less severe injuries than sports such as boxing and football, and BDSMers do not frequent emergency departments more than anyone else (Moser & Kleinplatz, 2003). However boxers are seen as 'sane' and consenting under the law whereas BDSMers are not.

BDSM is also still pathologised in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV-TR)[iii], with sexual sadism and masochism being listed as 'paraphilias' (302.83, 302.84). These are defined as people having 'sexual fantasies, urges or behaviours which involve inflicting (or having inflicted on oneself) psychological or physical suffering to enhance or achieve sexual excitement' (including being beaten, humiliated, bound or tortured). This has to have lasted for at least 6 months and to have caused 'marked distress or interpersonal difficulty'. These definitions are problematic because they equate BDSM with non-consensual 'disorders' (paedophilia, voyeurism) and suggest that BDSMers are more psychologically unhealthy than others, when there is no empirical evidence to support this (Gosselin & Wilson, 1980; Moser & Levitt, 1987). Also, because of the taboos around BDSM in our culture, being involved in BDSM may well involve 'significant distress or impairment in…functioning' for a time, precisely because of the stigma, social unacceptability, discrimination and prejudice surrounding it. Kleinplatz and Moser (2005) present further compelling arguments for the complete de-pathologisation of BDSM, likening its inclusion in the DSM to that of homosexuality until

1973 (Kutchins & Kirk, 1997) and questioning the implication that BDSMers require explaining, treating and curing.

There is also a linguistic slippage which is rarely questioned between sexual sadism as an act whose erotic charge is gained precisely from its *non-consensual* status, and sadism and masochism in BDSM where the explicitly negotiated or agreed status of the act is key to the sexual excitement potentially experienced by the practitioner. There is an illogical conflation of a crime of violence exerted via sexual means and a 'safe, sane and consensual' practice undertaken by two or more consenting adults (Keinplatz & Moser, 2006) A comparable situation would be to equate a subject for whom sexual excitement was a primary motivation to rape and consenting sexual activity between adults. There is little evidence to connect the two behaviours (Baggaley, 2006; Kleinplatz & Moser, 2006). The psychiatrist Chess Denman (2004) makes a persuasive case for the separation of 'transgressive' and 'coercive' practices.

BDSM AS QUEER[iv]

Some authors have explained the continued negative perceptions of BDSM, and its continued criminalisation and pathologisation, in terms of the threat posed by 'queer' sexualities which challenge heteronormativity (Sullivan, 2003).

Freud (1905) saw sadism and masochism as 'sexual aberrations' because they deviated from the 'normal' sexual aim (penile-vaginal penetration). Such theories have shaped dominant understandings of sexuality and Califia (1999, p.141) argues that 'vanilla[v]

heterosexuality is still the psychiatric gold standard' and that mental health professionals generally do not question this received wisdom. Reiersøl & Skeid (2006) agree that current nosologies of sexual disorders are based on notion that heterosexual intercourse is the ideal. BDSM can be seen as queer in the popular sense that it performs a function in this discourse as one of the transgressive behaviours against which the dominant norm can define (Califia, 1980).

As well as challenging Freud's 'normal sexual aim', writers have argued that BDSM also threatens his 'normal sexual object' (the 'opposite sex') since it can enable people to play with gendered notions of dominance and submission and activity and passivity (in combinations involving a man and a woman as well as in same-sex, transgendered and multiple partner combinations). Taylor and Ussher's (2001) female participants spoke of BDSM sex meaning that they could dominate men and be the ones with the 'cock'. It seems clear how BDSM situations involving women 'topping' can challenge traditional gender roles in sex, however, participants also speak of man-dominant-woman-submissive BDSM as 'parodying sexual relations considered as traditionally subjugating, oppressive and exploitative of women' (p.303) and presented it in a rather 'queer' way as ridiculing, undermining, exposing and destroying the traditional man-woman power dynamics inherent in heteronormativity (Ritchie & Barker, 2005). Further, BDSM potentially (although not inevitably) provides an alternative to strong narratives of sex as genitally focussed, as well as severely disrupting narratives of reproduction in otherwise notionally heterosexual sex encounters. (Califia, 1980)

Linked to this, theorists have argued that the common description of BDSM as 'play' and the assignment of roles involved also render it queer. Foucault stated '[T]he S&M game is very interesting because…it is always fluid. Of course, there are roles, but everybody knows very well that those roles can be reversed' (Macey, 1993, p.368-9). BDSM could be seen as part of a queer critique of humanist, individualist notions of one, coherent self. It could be seen as a subversive form of 'self-fashioning through the use of pleasure' (Sullivan, 2003, p.155), which briefly functions to 'shatter identity, and dissolve the subject', in opposition to the way in which heteronomative sex reproduces selves and reaffirms fixed sexual categorisations (Halperin, 1995, p.95). Terms in common usage in BDSM communities such as 'play' and 'scene' (referring to BDSM acts and the space entered in order to perform such acts) underline an explicitness about the theatricality of BDSM sexuality. The latter, like other 'queernesses', can serve to dissolve both narratives of the 'naturalness' of sexual orientation and action and the normative connections made between sexual acts and the stability of sexual identity/orientation/gender. In this analysis, some forms of BDSM behaviour can be seen as supportive of a notion of gender as performative, that is as highlighting the instability of heteronormative behaviours by staged mimicry (Butler, 1991). Further, such terms support a notion of queer as both a set of practices and as an alternative position 'to the side' of homo and heteronormativity rather than opposed to it (Sedgwick, 2003). Practitioners of BDSM commonly use terms such as 'pervert' to self-identify, as a category, which sits alongside and modifies other sexual labels such as heterosexual, homosexual, bisexual and queer.

Other theorists, however, have critiqued the position that BDSM is automatically a queer and politically powerful activity that challenges the naturalness and normality of heteronormative sex, fixed gendered and self identities. Authors such as Jeffreys (1996, p.86) maintain that BDSM 'eroticises the crude power difference of gender which fuels heterosexual desire, reinforcing rather than ending it'. Many BDSMers are uncomfortable with activities which seem more clearly perpetuating of traditional gender dynamics (e.g. 24/7 slavery, rape and domestic violence scenes), despite their overall emphasis on clear distinctions between fantasy and reality in BDSM play (Ritchie & Barker, 2005). Sullivan (2003) argues that even practices that reverse such dynamics could be seen as perpetuating the dichotomies they may claim to challenge. Jeffreys sees BDSM as a form of internalised abuse (1994) against an inner self, and Sullivan's (2003) analysis of BDSM narratives reproduced in television programmes and books finds several examples of accounts of BDSM as an expression of a core, unified self, suggesting that BDSMers certainly do not all adhere to a queer agenda.

Arguments from BDSM organisations and communities against dominant negative understandings and treatment often involve reversing the claims that are made against them. The BDSM slogan 'Safe, Sane, Consensual' (SSC) explicitly counters popular taken-for-granted assumptions that BDSM activities are dangerous, mentally unhealthy and abusive (Langdridge & Butt, 2005) as do more recent narratives of BDSM as 'healing' or 'therapeutic' (Barker, Iantaffi and Gupta, forthcoming 2007). However, such norms within BDSM communities could be seen as shoring up problematic constructions of 'mental health versus illness' and liberal discourses around informed consent, as well as policing

boundaries against certain forms of potentially transgressive behaviour whilst embracing others (e.g. see Downing, forthcoming 2007). Langdridge and Butt (2004; 2005) found that BDSMers also often present their practice as involving 'power exchange', downplaying the sexual element and links between sex, violence and pain. They suggest that this could be due to attempts to present BDSM in acceptable ways, which could help gain them recognition as sexual citizens. Some have responded to these issues by proposing the slogan 'Risk Aware Consensual Kink' (RACK), as an alternative to 'Safe, Sane, Consensual' (Medlin, 2001). This slogan makes it easier to bracket BDSM with dangerous sports rather than with pyschopathologies, allowing for a complexity of possible harmful behaviours. It also refuses what is seen by some as an unrealistic commitment to safety over risk-taking and instead puts in its place a sense of adult awareness of potential risk accompanied by harm reduction strategies.

BDSMers often defend their practices by drawing on narratives of 'free choice'. They emphasise the agency of the bottom in choosing to be topped, and also the seemingly paradoxical aspect that they are the one in the position of power (Ritchie & Barker, 2003). Sullivan (2003), however, argues that this distancing of bottoms from 'real' submissiveness may serve to reaffirm heteronormativity by reproducing, rather than critiquing, culturally dominant associations between submissiveness, passivity, femininity and inferiority. Some feminists have argued that the notion of consent has often been used to justify women's inequality (Butler, 1982). It could, however, be argued that any group in our society is unlikely to be able to entirely escape gendered power imbalances.

There are also problems with representations of BDSMers as a homogenous group with similar practices and reasons for such practices. BDSMers engage in a diversity of activities with motivations varying between people and within the same person on different occasions[vi]. There are many styles and cultures within the umbrella of BDSM, much as with other sexualities, and differences between, for example, different generations of BDSMers, or lesbian, bisexual, trans, gay, queer and straight-identified scenes may be very significant. Hart (1998) avoids claiming that BDSM itself is queer but emphasises queer potentials in BDSM practices and the construction of BDSM identities. We feel that it is useful to consider the queerness of BDSM in understanding why it might be so threatening to some counsellors and psychotherapists but emphasise that individual clients presenting with BDSM behaviours will most likely span a vast spectrum of degree of identification with queer from complete rejection to acceptance, or regarding queer as one of the labels that they use for themselves and/or others.

DOMINANT DISCOURSES OF BDSM AND NEGATIVE CLIENT EXPERIENCES

Most texts and training courses for counsellors and psychotherapists, even those on sexualities, fail to mention BDSM at all. One of the authors of this chapter (Barker), when starting a sex therapy placement, accessed a very recent basic text aimed at informing counsellors and therapists about such issues. Hudson-Allez' (2005) 'Sex and Sexuality: Questions and Answers for Counsellors and Psychotherapists' acknowledges that counsellors should only focus on 'resolving the behaviour' of BDSM clients if asked to by the client themselves, as they may not have a problem with it (p.120). However, the book also reproduces many dominant discourses[vii] about BDSM, which authors such as Kolmes,

Stock and Moser (2006, p.314) have found contribute markedly to commonplace negative experiences of BDSM clients in therapy. Kolmes, Stock and Moser point out that therapists reproducing these discourses may prevent clients from coming out, or discourage them from returning to counselling if they have used their disclosure of BDSM as a 'screening process'. Kolmes, Stock and Moser (p.318) report that bad experiences lead to some clients avoiding therapy for fear of it being repeated and others trying to suppress their BDSM desires having been treated by therapists who believed that they were 'sick'.

Dominant discourses which are frequently reproduced will now be outlined and exemplifed with quotes from Hudson-Allez' book (*in italics*). They will be briefly countered in relation to other evidence and considered in relation to the negative experiences of clients in Kolmes, Stock and Moser's research. A summary box of all the major assumptions and challenges will be provided at the end of this section.

'Why do some people enjoy the pain aspects, where as for others any sort of pain or discomfort is a complete turn off?' (p.120)

This question reproduces the common discourse that BDSM is all about 'pain'. As mentioned before, several aspects (for example bondage, dominance and submission) may not even be about physical stimulation, and many BDSMers emphasise the role of power or pleasure over pain in their activities (Langdridge & Butt, 2005). Physical stimulation can be regarded as a continuum, which differs for different people and at different times. Nichols (2006) suggests: 'think "pain" as in biting your lover in a moment of sexual abandon – not "pain" as in root canal' (p.284). Some may enjoy extreme levels of pain for various

reasons, but this could be seen as analogous to the pain experienced by long-distance runners or boxers in pursuit of their sport.

'An ideal dynamic might therefore be a sadomasochistic couple, where one partner enjoys giving the pain and humiliation that the other enjoys' (p.119)

This statement privileges BDSM conducted within the context of a coupled relationship. It also suggests a norm of rigid top/bottom roles whereas many BDSMers regard themselves as 'switches' to some degree (enjoying both roles). The terms 'pain and humiliation' here may also obscure the fact that scenes are often, at least to some extent, orchestrated by the bottom with the top reading the bottom's state and doing things they know them to find fulfilling. Participants in Ritchie and Barker's (2005) research emphasised the prior negotiation of BDSM scenes to accommodate the desire of all involved, one concluding that 'everybody knows the bottom really runs the scene' (p.233).

'Such behaviour is thought to be underpinned by severe childhood punishment that has become eroticised' (p.119) 'the lovemap of a person's sexuality […] has been vandalized by actual or vicarious abusive practices' (p.120)

This is a particularly concerning discourse presented, as it is, as factual information. Moser (2002) reports that there is no evidence that the incidence of childhood abuse is any different within and outside BDSM communities. Nordling, Sandabba, Santilla and Alison's extensive (2006) study found no differences in childhood attachment styles between BDSMers and others, refuting the notion that childhood experiences have 'vandalized' the development of a BDSM person's sexuality.

Such a discourse also clearly implies that BDSM is abnormal and unhealthy, as it is only apparent in those with 'damaged' upbringings. Kolmes, Stock and Moser (2006) found that such discourses are commonly reproduced in psychotherapy. Three major examples of biased, inadequate or inappropriate care listed by BDSM clients are: 'considering BDSM to be unhealthy', 'confusing BDSM with abuse', and 'assuming that BDSM interests are indicative of past family/spousal abuse' (p.314) Particularly harmful were times when therapists assume that '"bottoms" are self-destructive' and/or that 'past trauma is the cause of the BDSM interests' (p.316)

'The client may present with 'Monday morning rebound syndrome', which is when feelings of fear, disgust, self-loathing or remorse emerge hours or days after engaging in S and M activities, in which case the client may ask for help in stopping' (p.120)

None of the authors of this chapter have ever come across 'Monday morning rebound syndrome' in our fairly extensive experience of various BDSM communities in both the UK and US. This discourse seems to make an implicit link between BDSM and drug-use (the idea of a 'come-down'), which could serve to further demonise and pathologise BDSM (by linking it to both an illegal activity and to addiction). Nichols (2006) reports that another common discourse around BDSM as addiction is that practices will escalate and become more extreme (the 'slippery slope' argument) and reports that there is no evidence of this, with most people 'levelling off' after their initial experiences in BDSM, although this level may vary between people.

The issues around clients being encouraged to stop BDSM must also be considered very carefully. Kolmes, Stock and Moser (2006, p.315) give examples where clients had been told by therapists to stop their BDSM practices. In one case the therapist told the client that she would do see her unless she stopped because BDSM is always abuse. In another case the therapist said she believed that BDSM was 'aberrant and harmful to people who practice it'. Kolmes, Stock and Moser say that the problematic nature of such scenarios can be clearly seen if compared to the hypothetical example of a counsellors telling a client to stop kissing or having sexual relationships with her husband in order to continue treatment. Nichols (2006) suggests a need for caution in dealing with clients who report wanting to stop BDSM themselves. She points out that the most common kinds of BDSM clients are likely to be 'newbies' (those just coming out) and, since they have grown up in a culture dominated by negative discourses around BDSM, they may well express shame and fear. Comparisons with the 'pink therapy' literature on dealing with LGB clients within a homophobic and biphobic society may be useful here (Neal & Davies, 2000).

'Sadists may present with difficulties of hyposexuality, retarded ejaculation or erectile failure. Similarly, masochists may present with premature ejaculation and loss of libido as the behaviour becomes desensitised' (p.120)

The notion of desensitisation is again suggestive of an addiction discourse, which pathologises BDSM. Also there are embedded assumptions here of BDSM as a particularly male practice, and one which is inevitably tied to heterosexual sex (with erection and penetration a necessary part of contact). For some BDSM is a sexual activity, for some it is entirely distinct from sex. Some people always have an orgasm during a BDSM scene,

others do not even become sexually aroused. Some people need all sex to involve an element of BDSM play, others like to also have vanilla sex. Some will differ on the extent to which BDSM is sexual at different times and within different practices.

'The counsellor must be alert to whether the behaviour presented is associated with an antisocial personality disorder […] there is a temporal coupling of erotic stimulation and violence in the childhood histories of all sexually psychopathic serial murders […] Therefore, for personal safety and the safety of others, a forensic referral in these cases might be thought to be essential.' (p.120)

This statement reproduces the 'slippery slope' discourse highlighted above as well as putting consensual BDSM in the same category as rape and murder by suggesting that BDSMers and serial killers have the same linking of eroticism and violence in their developmental histories. Serial killers are a convenient current cultural bogeyman, omnipresent in media depictions and extremely rare in reality (Harrower, 1992) and warnings relating to them represent unnecessary fear-mongering. Clearly BDSM relationships can become abusive, as can non-BDSM relationships, but the emphasis on safety in this quote suggests that this is more of a concern in the former case without providing evidence to support this. Confidentiality is a key area here as Kolmes, Stock and Moser (2006, p.316) report that BDSM clients are particularly concerned about counsellors 'making reports/breaking confidentiality because the therapist assumes others are at risk solely due to BDSM activities'.

Summary box – Assumptions and challenges

Underlying assumption about BDSM	**Challenges to dominant discourses**
BDSM is all about pain.	There may not be any pain involved. There are different kinds of pain.
BDSM always takes place in couple relationships.	Single people and those with multiple partners also engage in BDSM. It may not occur within the context of an ongoing relationship.
BDSMers always assume fixed roles (top or bottom; dom or sub).	Many people switch roles within and/or between scenes.
The top/dom has all the control.	Bottoms/subs are often perceived as having more control and negotiations usually take place in any case.
People who engage in BDSM have been abused or somehow damaged in their lives.	There is no evidence that the incidence of abuse is any greater amongst BDSMers than the general population.
BDSM is addictive and the start of a slippery slope into more extreme activities.	There is no evidence that BDSM is any more addictive than any other behaviour. Many experience an ebb and flow in their levels of BDSM activities and desire.
BDSM is always about sex.	BDSM may or may not take place in a sexual context/relationship.
BDSM is on the same continuum of behaviour as violent sadism and serial murder.	BDSM relationships are no more likely to be abusive than any other. There is generally a strong emphasis on consent and safety in BDSM relationships, communities and literature.

The negative experiences of BDSM clients reported here suggest a strong need for increasing BDSM awareness amongst therapists and counsellors, challenging their own belief systems around sexuality and encouraging exploration of dominant cultural discourses. Barker (2005) presents an example exercise, which aims to challenge counsellors' concerns about BDSM practices and acceptance of analogous culturally acceptable behaviours. Another important issue is therapist's knowledge: Kolmes, Stock and Moser (2006) found that many BDSM clients were frustrated by having to educate their therapists about BDSM, often in order to counter the dominant discourses highlighted above. One said she had to educate her therapist 'that it was not abuse, that it was not

harmful to me, that I was not self sabotaging with it, nor acting out past family/spousal abuse. It actually took quite a few sessions to get the therapist over their hang-ups and misconceptions about BDSM. Time that could (have) been better spent on the actual issues I was there for' (p.315). The issues of how counsellors and therapists can reflect on their own assumptions and enhance their understanding of BDSM are returned to in our consideration of good practice next.

POSITIVE EXPERIENCES AND GOOD PRACTICE WITH BDSM CLIENTS

So far, we have highlighted some of the challenges posed by dominant discourses on sexualities for kinky clients seeking therapeutic support. However, Kolmes, Stock and Moser (2006, p.317) also report a number of examples of good practice, which they obtained from their previously mentioned survey of BDSM clients in psychotherapy. Major themes included:

1) Therapist(s) being open to reading/learning more about BDSM,

2) Therapist(s) showing comfort in talking about BDSM issues, and

3) Therapists who understand and promote "safe, sane, consensual" BDSM

Of course, this does not mean that all BDSM clients need to seek therapists specialising in BDSM issues, especially since they might be seeking therapy in relation to other aspects of their life. Nevertheless, being able to engage in a therapeutic relationship with a kink-friendly practitioner would mean that clients can be more relaxed and do not need to censor or edit themselves during sessions. Kink-friendly therapists display a whole list of characteristics, as highlighted by Kolmes, Stock and Moser (2006, p.317), such as 'being

willing to raise questions about BDSM, normalising BDSM interests for clients new to BDSM, open-minded acceptance, being well informed about BDSM and the subculture (or even identifying as one who engages in BDSM practices), and not focusing on kinky behaviour when it's not the client's focus of treatment'. It is clear from this list that such a definition of a kink-friendly therapist could be equally applied to any other context, such as bisexuality or race. Therefore, it seems that we could define a kink-friendly mental health practitioner as someone who is willing to engage with the issue of BDSM not as a pathology but as a different cultural context, which may, or may not, be already familiar to them.

Both Bridoux (2000) and Nichols (2006) also suggest ways in which therapists can engage positively with BDSMers as clients. The former states that 'as therapists our duty is to leave our model of the world on the back burner, so that it doesn't interfere with the client's' (Bridoux, 2000, p.30). In order to do this, he suggests the values of respect, relevance and ecology. That is we should consider how the issue of BDSM relates to the other aspects of the clients' life and their larger systems. Much as these values are useful to bear in mind, we would like to argue that they are not as unproblematic as they might seem at first reading. Bridoux's statement about the necessity for therapists to put aside their own 'model of the world', for example, can be seen as unattainable from a social constructionist viewpoint. If we believe that our therapeutic actions and conversations are joint ones, and that we can only know and act from our embodied positions, both as a client and therapist (Shotter, 1993), then we can never put aside our model of the world since it is not separate from us. However, this does not mean justifying bigotry or moral relativism. On the

contrary, such a position requires us, as therapists, to continuously engage with our own beliefs, stories and experiences as they form part of the negotiated understandings that we often form in therapy and that are themselves moral forms of social action (Gergen, 2003).

From this standpoint, Nichols' (2006, p.286) suggestions for good practice are also valuable, yet not completely relevant to anyone operating from outside a psychodynamic model, which uses concepts such as countertransference. Nevertheless, she highlights the need for therapists working with kinky clients to deal 'with their own judgements, feelings and reactions to this sexual behavior' (ibid.) We would like to argue that a broader concept, which also invites therapists to engage with these issues, is that of reflexivity, as discussed next.

Working from a systemic and constructionist approach to therapy, Cecchin, Lane and Ray (1994, p.8) described the therapeutic process as happening 'in the interplay of the prejudices of therapist and client – a cybernetics of prejudice'. Prejudice, in this framework, can be defined as all that we (clients and therapists) bring with us to the therapy room. In this context, the therapy room 'reflects back only what is voiced within it' (Hare-Mustin, 1997, p.557), with the potential of becoming a 'mirrored room' of society and its dominant discourses. Curiosity (Cecchin, 1987), in this context, is an essential stance for the therapist who then does not become attached to one particular story or interpretation of meaning. This stance is just as essential for therapists to adopt when looking at themselves, as well as clients. Curiosity turn inwards, towards our own beliefs, stories, feelings and thoughts (that is our prejudices as here defined) can be defined as reflexivity.

Being reflexive when engaging BDSMers as clients in therapy can be seen as even more essential since talking about power is something that cannot be avoided when discussing BDSM. This can create an interesting context since power can be seen as a complex issue in therapy. After all, often the therapeutic encounter entails meeting in a safe space, in a ritualised manner, within clear and set boundaries and adopting particular roles (therapist/client), which have their own set of rules, responsibilities and obligations. Encountering BDSM in the therapy room requires therapists to engage seriously with the reflexive process in order to explore their own construct of power, pleasure and pain in relation to sexuality. In our opinion, this does not mean necessarily being comfortable with every BDSM practice that clients might talk about but rather to be conscious of one's levels of comfort around such issues, including practices and ideas that might 'squick'[viii] us. If therapy is seen as a process that is co-created (Shotter & Katz, 1998), then reflexivity is the ability that allows us, as therapists, to remain conscious co-creators throughout this process.

Looking at therapy as a 'cybernetics of prejudice', therefore, challenges traditional notions of neutrality in favour of reflexive practices and curiosity. Such reflexive practices can be seen not just as individual but also as relational. Relational reflexivity (Burnham, 2005), in fact, could be seen as curiosity towards the process, rather than the content of therapy, allowing us to have meta-conversation with our clients: that is to talk about talking. Adopting a stance of relational-, as well as self-, reflexivity in therapy with kinky clients, might lead the therapist to ask questions such as: 'Is this conversation useful for you?' 'Are there books/leaflets/websites, which you would like me to read so that I don't need to ask

you basic questions about your BDSM practices?', 'I notice that you waited five sessions before mentioning BDSM. Was this because it was not relevant until now or was this due to something else?' Engaging in meta-conversations with clients might hopefully avoid some of the negative experiences encountered by BDSMers in therapy, as described earlier, since clients would have an opportunity to address openly something that could easily become a taboo subject.

We would like to argue that engaging seriously with personal and relational reflexivity could be a 'force for change' (Leppington, 1991) for therapeutic practices with kinky clients and one that is applicable across a wide range of approaches to therapy. However, reflexivity also invites us to view the therapeutic process as circular rather than linear, as something that is co-created by therapist and client and, as such, situated within both the dominant and counter-dominant discourses that are embodied by them. When linear understandings of cause and effect and notions of immutable truths, such as what constitutes consent in a sexual encounter, are put into question as contested, co-created and embodied notions, there can be a sense of crisis or lack of points of references. One of the authors (Iantaffi) has found the concept of irreverence to be a useful foundation from which to know and act as a therapist. Irreverence is defined by Cecchin, Lane and Ray (1992, p.11) as 'to never accept one logical level of a position but, rather, to play with varying levels of abstractions, changing from one level to another. Instead of accepting any fixed descriptions, irreverence posits eroding certainty.' We would argue that the erosion of certainty within therapy could create new spaces in which to talk about queer sexualities, including BDSM, in non-pathologising ways.

CONCLUSIONS

In this chapter, we have addressed BDSM both in the context of queer sexualities and therapeutic practices. We have highlighted how the relationship between kinky clients and therapy is not always an easy one, since BDSM is often still seen as pathological. We have also discussed some of the dominant discourses about BDSM and mental health, as well as negative experiences of therapy for clients who engage in BDSM practices. Some tools for good practice were also introduced, although we are aware that these could be seen as just an initial step and that further dialogue is needed.

Kolmes, Stock and Moser (2006, p.306) state that 'until BDSM practices and lifestyles are included routinely as part of the human sexuality component of training for all practitioners, and until the mental health profession begins to recognise BDSM individuals as a subculture requiring special knowledge, skills, and sensitivity, there remains the risk that therapists may be providing services to BDSM individuals without ever having received appropriate study, training, or supervision.' They also emphasise that it is important that therapists do not present themselves as BDSM-positive when they are not actually knowledgeable as many clients experienced this as problematic in their survey.

In this context, it is also worth reflecting on the foundation of our therapeutic practices, that is the theoretical approach underpinning our actions and conversations. It could indeed be argued that some approaches to therapy would not be as pathologising as others in relation to BDSM. It is then vital to query not just our technique and methods, when reflecting on

our therapeutic practices with kinky clients, but also our theoretical orientation, to see whether coherence is possible across these dimensions. In our experience, BDSM is not yet routinely discussed or included in the syllabus for trainee therapists and both tutors and clinical supervisors have often not yet addressed their own prejudices towards BDSM practices. Nevertheless, the professional landscape is starting to shift and kink-aware professionals are becoming more visible, thanks also to the Internet (e.g. kink aware professionals, 2006), and to the slowly growing body of literature on the subject. Challenging dominant discourses about BDSM is not always easy, as all three of us know from experience, but less traditional approaches to therapy (e.g. constructionism, narrative therapy, existential therapy) are opening new and wider arenas in which these debates can take place.

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BASIC BDSM GLOSSARY (Drawing on Wiseman, 1996)

Aftercare – The period after a BDSM scene when the top looks after the bottom, bringing them up from any submissive headspace and often praising them in general and in relation to the scene they have endured. For some this is almost more important than the scene itself.

Bondage – Restraining/restricting someone, e.g. with ropes, chains, cuffs.

Bottom – Slang term for a submissive/masochists, but generally meaning a person who enjoys being given various physical sensations as opposed to a 'submissive' who enjoys being controlled psychologically.

CBT – Cock and ball torture – strong sensations to the male genitals.

Discipline – Training someone to behave in a certain way through punishment.

Dominant (dom/domme/dominatrix/master/mistress) - Person who takes control over others, e.g. giving orders, binding or 'torturing' them.

Head space – State of mind somebody goes into during BDSM play (e.g. submissive/dominant headspace). Not all BDSMers talk in these terms.

Kinky – General term for BDSM, fetish or non-vanilla sexual behaviour or people engaging in this.

Play – Engaging in BDSM, e.g. 'I played with her', 'want to play?', or a specific activity e.g. nipple play, sensory deprivation play.

Safeword – A word that players can use to end the scene if it stops working for them.

Scene – A BDSM encounter/session, sometimes divided into heavier/lighter scenes depending on physical and/or psychological intensity, although what constitutes this differs between people/occasions.

Sensation Play – A term often used to describe play that involves physical stimulation, which may be pleasurable, painful or both.

Submissive (sub/slave) – Person who gives control over to others, e.g. obeying orders, being bound and/or 'tortured'

Switch – Person who can enjoy both sub/dom or top/bottom roles.

Top – Slang term for dominant/sadist, but generally meaning a person who inflicts various physical sensations as opposed to a 'dominant' who enjoys being in control psychologically.

Torture – Administered erotic pain.

Toys – Devices designed for BDSM or sex (e.g. riding crops, paddles, nipple clamps, dildos) or used for this purpose (e.g. hairbrush, candle, clothes pegs)

Vanilla – A term sometimes used to describe non-BDSM, non-kinky sex.

APPENDIX

A possible scenario from the perspective of a dominant.

I sit on the edge of the bed. You kneel at my feet. Slowly, carefully, you unlace my boots. You slide my foot tenderly out of its shoe, then do the same for the other one. You peel the socks from my hot skin, tracing your fingers softly down my ankle, along my sole. You hold one foot in your lap, massaging it, pinching each toe gently, rubbing the tiredness of the day away. I watch you as you work. You gaze into my eyes as you raise my other foot to kiss your way along the bridge and across the toes. Your eyes are heavy with desire to please. There'll be no need to beat you into submission tonight. You're already there pet. Your look says it all. You belong to me. You'd do absolutely anything to please me. I lean my head back and sigh contentedly.

A possible scenario from the perspective of a submissive.

We'd agreed that she would send some texts during the day before our date, but I hadn't expected this much. It started relatively easily, she ordered me to furtively masturbate and pinch myself, but as the day wore on she started getting me to do mildly embarrassing things in public, although nobody would be aware of it but me. There's always a feeling of power associated with being topped, but this day it was amplified enormously. I think the most challenging thing she did was to tell me I was only going to be allowed to come if I replied to a text message within 20 seconds. I managed it in 14. Later she said that being at work, knowing that I was anxiously waiting for my phone to beep was highly distracting. She was glad she didn't have much work to do that day. I certainly never thought I'd get so turned on by text messages. I still have them in my phone.

A possible scenario involving sensation play.

Three men arrive at a club already filled with anticipation of the evening to come. First they sit on the sofas for a while chatting with friends. After some time they separate off to check in with each other that they are both still happy with what they planned the evening before. Then they move through to the play room. The tops tie the bottom to a bar on the wall so his hands are fastened above his head and his feet to the floor, legs spread. First one top runs a pinwheel over the bottom's back and thighs which gives a prickling sensation to his skin. Then the other taps a light wooden cane across his buttocks, gradually increasing the pressure until the feeling becomes mildly painful but pleasurable. Several times they check in with the bottom to find out where he is on a scale of one to ten (with ten being the most intense, almost unbearable, level of pain). The bottom experiences an endorphin rush from the experience and is aware of feeling the most relaxed that he has been all week. After the scene they retire to the sofas and all hug for a while. Later on in the evening they reverse roles and move once again to the play room for a different scene.

ABOUT THE AUTHORS

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Alessandra Iantaffi is an active researcher and lecturer in the fields of diversity, inclusion, identities and research theories and methodologies. Since moving to the UK, she successfully completed her PhD, undertaken at the University of Reading, which focused on the experiences of disabled women students in higher education and her thesis was awarded the BERA (British Educational Research Association) Award as best dissertation in educational research for 1999. She has taught on several aspects of disability studies, equity in education, women's studies, inclusion, sexuality and young people and research methodology, as well as being involved in various research projects. Alessandra has used both quantitative and qualitative methodologies during the course of her research and is particularly committed to the use of Personal Construct Psychology (PCP) and Social Constructionism as theoretical and methodological frameworks. She is about to qualify as a systemic family psychotherapist and is currently pursuing a portfolio of activities on a part-time basis whilst raising her daughter.

Camelia Gupta is a mental health worker, independent researcher and journalist. She worked for several years in a voluntary capacity for Threshold Women's Mental Health Initiative, providing support and listening to a broad range of clients. A member of several working groups concerning LGBT mental health, she has written on sexuality, BDSM, safe space and mental health for a number of publications. She also writes about visual culture,

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[i] There are also a number of other terms for practice and identity that are used, often for contextual reasons of difference in region, era, cultural formation, and/or sexual community. Such labels include 'kink' and 'leather' or 'leathersex'. For simplicity, we have used the term 'BDSMer' here to refer to those involved in BDSM communities or practices in whatever way.

[ii] Various words are used for the different participants or positions in BDSM. Here we use 'top' for a person in the position of power or giving out the stimulation and 'bottom' for a person who opts to give over power or control of the scene. A 'switch' is someone who takes both kinds of roles (see Easton & Hardy 2001; 2003).

[iii] They are also classified as disorders in the F65 section of the international World Health Organisation International Classification of Diseases (ICD) (Reiersøl & Skeid, 2006).

[iv] It is notable that Queer Theory, emerging as it does from deconstructionist practice, provides one of the most useful frameworks for non-pathologising discussion of BDSM. This is indicative of a cultural shift away from the Modernist validation of bodies, narratives and identities as singular monolithic concepts. In 21st century western culture there is a wider acceptance of, and need for, descriptors that allow for contradiction and disparity, refusing notions of inherent value. There is much to be said on this topic, but it is beyond the scope of the current chapter to examine this turn in detail.

[v] 'Vanilla' is a term used, mostly in BDSM communities, to refer to non-BDSM sex.

[vi] For example, being the submissive party in an SM scene may allow someone to safely relinquish the responsibilities of day to day adult life, to gain control in one specified area as they negotiate the scene, to increase their sense of intimacy with the others involved, to break taboos, to prove their ability to endure what is happening to them, to enjoy a pleasurable physical sensation, and/or to induce a meditative state.

[vii] By 'dominant discourse' we mean the prevailing cultural understandings which are reproduced and legitimated in everyday talk, mass media representations, and so on (Van Dijk, 1993).

[viii] Nichols (2006, p.288) presents an interesting exploration of the BDSM term 'squick' as a useful concept. It can be defined as a strong negative emotional reaction to an activity which acknowledges that 'you do not actually judge the activity as wrong or bad'.