Therapy and BDSM Lifestyles

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Abstract

There is a long, dark history of the psychiatric community's bias against the BDSM community and their practices. Starting with the DSM-II, Sexual Sadism and Sexual Masochism were classified as paraphilias, most likely due to the historical writings of authors such as Freud and Krafft-Ebing. Oddly enough, for a practice that is so based in research and the scientific method, there is no research to date that proves these activities are harmful to the participant's mental state, or that they are indicative of pathology. Therapist's bias can be very harmful to the mental health of their patients; at best a therapist's negative bias can make clients distrust the therapist and the psychiatric community. In some cases, it can damage their self esteem, and can cause other issues as well. There has been a surge of positive and supportive research in the last several years that has demystified and even supported BDSM as a non-pathological sexuality by psychologists, psychiatrists and medical doctors who identify as kink-friendly or kink-aware. This article aims to add to that positive information to assist in education to prevent continuing this harmful trend of negative therapist bias towards people who engage in BDSM activities.

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Imagine, if you will, that your therapist might look at you badly because of the way you choose to have sex; especially the foreplay that leads up to it. Suppose they said you would need to stop participating in that kind of sexual activity as a condition of further therapy. Suppose that no matter what the reason was that you decided to go to therapy, your therapist decides to focus on your sexual activities and treat that aspect of your life simply because they believe that the types of sexual activities you participate in is wrong. How would this make you feel?

It is surprising and disturbing just how much a therapist's bias can interfere with their ability to provide effective service to their clients; in some cases this bias can hurt the client. In just the last few decades, homosexuality has been removed as a paraphilia and more often therapists are providing objective and effective therapy for this group, thanks to the efforts of the Division 44 Committee on Lesbian, Gay, and Bisexual Concerns Joint Task Force, who established the Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients (APA, 2000). Sadly, there is another group of people who practice sexual activities that are also not considered normal by societies standards, and therapists tend to have the same bias towards this group that they used to have for the gay and lesbian communities not too long ago: practitioners of Bondage/Discipline/Dominance/Submission/Sadism/Masochism, also known as BDSM. Through the course of this paper, we shall strive to educate on what BDSM is and the practices of it's participants, the general views on the psychiatric community, the damage that can be done by a therapist's bias and what can be done to help prevent this from being an ongoing problem.

Kinky sexual activity falls under many varied terms and acronyms, including, but not limited to, Sadism and Masochism (SM), Bondage and Discipline (BD), Dominance and Submission (D/s) and Master or Mistress and Slave (M/s). There are many other terms used to

describe the kinky acts that people in this community engage in, however, for the purpose of this paper, we will use the term BDSM as an umbrella term.

In his landmark book SM101, Jay Wiseman defined BDSM as the "knowing use of psychological dominance and submission, and/or physical bondage, and/or pain, and/or related practices in a safe, legal, consensual manner in order for the participants to experience erotic arousal and/or personal growth" (p. 10, 1996). This is an intentionally broad description of what BDSM is to those who participate in kinky sexual or sexually oriented activities. The reason for engaging in these activities varies from person to person, but can include spiritual growth, enhanced sexual arousal and even to bring one closer to one's chosen partner or partners. It is generally agreed upon that most people who engage in BDSM activities do not do so for the pain specifically; rather, they choose to use pain to increase their awareness, their spiritual growth or their sexual arousal, or even just to feel the sensation. These are the same reasons that people considered normal by the standards of society engage in what is generally considered to be normal sexual behavior, or, as BDSM participants call it, vanilla sex.

Some individuals prefer to engage in what they call scenes, where the BDSM activities are limited to the duration of the scene only. These scenes can be very physically and emotionally gratifying to a large number of people, and normally one individual takes on a dominant role and one or more individual take on a submissive role. These scenes are considered Erotic Power Exchange, or EPE, where one individual has more power over the other for the duration of the exchange. There are, however, a number of individuals interested in longterm scenarios called 24/7, meaning 24 hours a day, seven days a week, where they choose to live their entire life in such a relationship dynamic. These individuals so closely identify with the dynamic of power imbalance that they feel more gratification from a relationship structured

entirely around this dynamic. This 24/7 relationship is called Total Power Exchange, or TPE, and one person has more power over the other ongoing, and is not limited to any particular time frame (Dancer, 2006).

Therapist's bias has often caused therapists to treat patients improperly and for problems that the patient truly does not have. Nichols writes, "Unfortunately, the prevailing psychiatric view of BDSM remains a negative one: These sexual practices are usually considered paraphilia, i.e., de facto evidence "of pathology"(Nichols, p. 281, 2006). Further, Nichols writes 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 [SIC] 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" (Nichols, p. 282, 2006)

Sexual Sadism and Sexual Masochism were first listed in the American Psychological Association's Diagnostic and Statistical Manual Revision Two, or DSM-II, as sexually deviant behaviors and were classified as paraphilias in 1968. This listing may have been due to historical psychological literature of authors Freud and Krafft-Ebing. In the DSM-II, these paraphilias were given provisional categories of Sadistic Personality Disorder and Masochistic or

Self-Defeating Personality Disorder. Although the definitions of these have changed throughout the revisions of the DSM, which is currently in Revision Four, this historical negative outlook has seriously biased much of the psychiatric community of past and present (Kolmes, Stock, & Moser, 2006). In the DSM-IV, these have been declassified as paraphilias unless the practice thereof interferes with one's ability to function in normal society. Unfortunately, the damage has been done, and BDSM practitioners have been persecuted in much the same ways that homosexuals used to be, and to some extent still are. Until the majority of the psychiatric community accepts BDSM as a non-paraphilia, this will continue.

As with most issues in our society, there is no easy solution to changing prevailing negative views in the psychiatric community about people who engage in BDSM activities. Education is going to be an important factor in changing these views, and is essential in creating a large network safe psychological environments where BDSM practitioners will not feel embarrassed to discuss their sexuality or lifestyle with their therapist. There has been a surge of positive and supportive research in the last several years that has demystified and even supported BDSM as a non-pathological sexuality by psychologists, psychiatrists and medical doctors who identify as kink-friendly or kink-aware.

Consequently, there is a long road ahead of BDSM practitioners before they will be accepted as a sexual minority rather than as sexual deviants with psychological issues. A therapist's bias against BDSM can damage their client's outlook on their self esteem as well as their willingness to acquire further psychiatric care from that or any other therapist. BDSM is used by participants for mutual gratification and often for spiritual growth using emotionally and sexually charged themes and activities to do so, and there is no research to prove that these activities are harmful to the participant's mental state. Alas, it all boils down to knowledge and

tolerance; therapists need to educate themselves on what occurs in a BDSM setting and relationship and practice tolerance of other peoples sexual tendencies regardless of their own personal beliefs. Fortunately, the number of kink-aware and kink-friendly psychologists and psychiatrists is growing, and they are slowly expanding on education to the psychiatric community at large.

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