

discriminate on the basis of religious beliefs. The dangers associated with such laws are obvious, and have far-reaching implications for training and practice. Not only do such laws threaten to dismantle APA's diversity criteria, they legislate professional standards that should not be the province of politicians, but professionals. APA's Education Directorate has developed a working group to issue a report on this issue.

Conversely, the California legislature, as of this writing, is set to vote on a bill prohibiting SOCE with minors in that state, and requiring all who see persons questioning their sexual orientation to provide informed consent about the treatment. Personally, I should be cheering the passage of this legislation, having worked for thirty years with survivors of SOCE, and written extensively about the potential dangers associated with these methods. But I have some very mixed feelings.

First and foremost, I do not believe that we can have it both ways. If we believe that the profession is the rightful source of professional standards, then we cannot oppose "laws of conscience" and support legislation against SOCE. Psychology, not the political arena, is the appropriate source of recommendations for practice

and training. Secondly, the California bill (as of this writing) delineates a broad enough definition of SOCE such that in certain cases, any discussion of ambivalence or question about one's sexual orientation could be interpreted as a violation of the law. This kind of stress placed on the therapeutic relationship is, frankly, the last thing that practitioners working with conflicted clients need.

The policies protecting individuals against discrimination on the basis of both sexual orientation and religious identification touch on strongly felt emotions. I have always found, however individual clients seek to reconcile their own conflicts in this area, that there is no substitute for person-centered treatment, with no unrealistic expectation that one's sexual orientation will change. How someone chooses to manage their religious affiliation in the face of a conflict with their sexual orientation should indeed be their own decision – be it through transitioning to a more affirming religious tradition, or simply learning to tolerate the inherent tension thereof. In any case, the correct venue for developing policies for practice and training in this area is the professional arena – not the legislatures.

Sexual Orientation Microaggressions in Everyday Life: Expanding our Conversations about Sexual Diversity: Part I

—Keely Kolmes and Ryan G. Witherspoon

Recently, the first author of this article attended a consultation group on couples treatment. I was a new member of the group, and I brought another newcomer with me. When I introduced my case, I mentioned that this couple was in a polyamorous relationship. As soon as the word "polyamorous" left my lips, the woman across from me leaned to the woman next to her and whispered. They both giggled. I explained that my couple are in a primary relationship with one another and the wife has occasional dates with another woman, and this time the woman across from me loudly groaned, "Oh noooo. Here we go."

I stopped to ask about her reaction. Her reply: "I hate cases like this." I followed up. "But why? What do you mean by 'cases like this?'" And what do you hate about them?" She rolled her eyes. "Oh they are so complicated. You can't keep track of everyone. I'm too disorganized." I explained that my questions about the case weren't ones of organization and offered to help her stay on-track. Then I continued to the issue for which I was seeking consultation. Although this interaction took perhaps 60 seconds, it had a profound impact on the colleague who attended with me. She later admitted that she decided not to present her own case because her clients were also poly and she did not

feel like this group was a safe space to get her consultation needs met.

What we experienced in this group was a sexual orientation microaggression – an expression of bias and discrimination communicated via seemingly insignificant disguised maneuvers. Microaggressions were initially identified in literature that focused upon racial microaggressions. They may be delivered through looks, gestures, offhand comments, and even tones, all of which may be very subtle and hard to pinpoint (Constantine, 2007; Constantine & Sue, 2007; Sue, Capodilupo, et al., 2007), but all of which were experienced by my colleague and me in that consultation group.

The phenomenon of sexual orientation microaggressions has only recently begun to be addressed in the literature (Nadal et al., 2011, Nadal et al., 2012; Shelton & Delgado, 2011; Wright & Wegner, 2012) but research has focused primarily upon the experiences of lesbian, gay, bisexual, and queer-identified individuals. The experiences of people who identify as polyamorous (those who engage in consensual romantic or sexual relationships with more than one partner) or as kink, leather, or BDSM-identified (those who engage in consensual sensation play along the pain spectrum or who engage in dominance and submission) have yet

to be addressed in the sexual orientation microaggression literature. Yet, it can be argued that poly and kink-identified individuals suffer far greater bias, misunderstanding, and marginalization than LGBT folks, and that they hold reasonable fears of experiencing stigma and harm when seeking mental health care (Kolmes, Stock, & Moser, 2006).

Most of us would like to avoid inflicting microaggressions on our clients as well as our colleagues who work with, or identify as, members of these populations. This two-part paper will provide, in Part I, information on BDSM and polyamory and recommendations for psychologists wanting to learn more about these communities. Part II will focus on the harmful effects of microaggressions, examples of them, and recommendations for psychologists who wish to avoid inflicting them on clients.

It is important to note that those who identify and engage in BDSM and polyamorous relationships may be heterosexual, gay, lesbian, and bisexual. LGBT clients, who already have a language around exploring their sexual identity, may have more comfort disclosing these other sexual behaviors and practices with their psychotherapist.

BDSM

BDSM is an acronym that stands for Bondage and Discipline (B&D), Dominance and Submission (D/S), and Sadism and Masochism (SM or S&M). People who engage in these various activities may eroticize bondage, physical or psychological pain, or power dynamics during sexual or non-sexual encounters. In 1990, the Kinsey Institute estimated that 5-10% of the U.S. population engages in BDSM for sexual pleasure (Reinisch & Beasley, 1990). Other research has indicated that up to 14% of American males and 11% of American females have engaged in some form of BDSM sexual behavior (Janus & Janus, 1993). It is worth noting that many others possibly fantasize about BDSM behavior without acting upon these urges due to discomfort and shame about what these desires might mean or how they will be interpreted by a partner.

BDSM practitioners engage in “scenes” when they are “playing” together. Those who are more active in BDSM encounters are called dominants, tops, masters, mistresses, and sadists. Those in more passive roles are submissives, subs, bottoms, masochists, boys or girls, and slaves. Some people switch roles in their life or even within BDSM encounters and these people are called Switches. Within the BDSM community, there is diversity about what these terms actually mean. For example, a masochist may be very clear that she enjoys pain but at the same time she may object to being ordered around by a top because she does not identify as submissive. Similarly, a submissive may enjoy being asked to do acts of service for his mistress but he may not have any interest in pain play.

BDSM holds consent and safety as its principle values. This means that BDSM partners usually have discussed to some degree what activities are comfortable for all partners in a scene and emotional, psychological, and physical safety and care are paramount. Often, “safe words,” – words that any partner can use to slow down or end the scene immediately – are agreed upon in advance. The presence of active and ongoing consent is an important way that BDSM differs from domestic violence and other types of abuse. That said, clients who are just beginning to recognize submissive, masochistic, dominant, or sadistic desires often come to therapy, and they may not be familiar with the consent rituals or boundaries of BDSM. Here is where having a “kink-aware” clinician can be crucial, not only to help them deal with their internalized shame and discomfort, but to help them connect to the broader community and learn about safety practices that will protect them and their partners. In addition, just as in non-BDSM relationships, boundaries and consent can be violated in BDSM relationships and some kink-identified clients will seek therapy in order to sort out such abuses and get support. Having a mental health professional who can help a client make sense of what has occurred without pathologizing or invalidating their sexual identity can be invaluable.

Polyamory

Polyamory describes relationships in which partners have agreements that they will have other sexual or romantic partners. In one study of 3,574 married couples (Blumstein & Schwartz, 1983) 15-28% had “an understanding that allows nonmonogamy under some circumstances.” The agreements made in these relationships can vary widely. The terminology of polyamory includes such language as “primary partner” to indicate a relationship that takes precedence in terms of energy, loyalty, and commitment. A “secondary” relationship would have a lower status in terms of the emotional bond. A “triad” refers to a group of three people who have made a commitment to one another. A “poly family” can also include three or more people in a relationship in which some of them are sexually intimate and they have formed a commitment to one another (Weitzman, 2006).

Some primary relationships have rules about what sexual activities can occur, how frequently they can occur, and agreed-upon rituals for how the primary partners will re-unite, including what and how much information is shared after dates with others. For example, a woman may request that her primary partner call and say good night on evenings he has dates with others or she may ask that he schedule time to talk, cuddle, and debrief together soon after a date with another person. Other arrangements may include agreements that allow primary partners to veto other relationship partners, while some people may feel strongly that

this can be a misuse of power and negates the growth opportunities offered by exploring one's reactions, including resistance and jealousy.

There are other relationships that allow for deeper romantic connections to develop simultaneously with other partners and these people may reject the notions of "primary" or "secondary" partners. In these relationships in which people do not adhere to hierarchical arrangements, some of these rules and rituals may not occur although people may still express different preferences about how much information they hear about other dates. What matters most is that the arrangements and "rules" are comfortable for all parties.

Issues that may come up in one's clinical practice with distressed poly individuals may include partners having different desires for level of emotional connection that is allowed with others, or different desires about the amount of detail shared about dates. These pairings may work better when both partners share compatible desires for the amount of information-sharing that occurs. Other issues may arise having to do with coming out or getting family or institutional support during times in which one wants to honor and include multiple partners (e.g., wanting to bring two partners home for the holidays; multiple partners wanting to visit an ailing partner who is hospitalized and meeting with family resistance). Having a psychotherapist who validates one's connection to other partners and who understands the impact of negative stereotypes about these relationships can be incredibly helpful. Polyamorous individuals often struggle against assumptions which include beliefs that they are sexually promiscuous or unsafe, or ideas that they are cheating or are coercing another partner into enduring an affair.

While these examples provide a sampling of some of the clinical issues that can come up for those in altsex relationships, Part II will provide greater depth on microaggressions and how clinicians can avoid enacting them in their work.

Recommended Resources for Learning More About Polyamory and BDSM

Books

Love in Abundance, by Kathy Labriola

The Ethical Slut: A Practical Guide to Polyamory, Open Relationships & Other Adventures, by Dossie Easton and Janet W. Hardy

The New Topping Book by Dossie Easton and Janet Hardy

The New Bottoming Book by Janet Hardy and Dossie Easton

SM 101: A Realistic Introduction by Jay Wiseman

Web links:

Models of Open Relationships: by Kathy Labriola:
<http://www.cat-and-dragon.com/stef/poly/Labriola/open.html>

Link to download Charles Moser's Health Care Without Shame: <http://www2.hu-berlin.de/sexology/BIB/hcws/hcws.html>

National Coalition for Sexual Freedom: <https://www.ncsfreedom.org/>

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Sexual Orientation Microaggressions in Everyday Life: Expanding our Conversations about Sexual Diversity: Part II

—Keely Kolmes and Ryan G. Witherspoon

Harmful Effects of Microaggressions

If microaggressions are so seemingly inconsequential and imperceptible, how harmful can they really be? Microaggressions can accumulate into a significant source of stress which may be difficult for recipients to recognize and manage (Sue, 2010). The invisibility of microaggressions amplifies this effect. Overt acts of discrimination or bigotry, while more stressful on their own, leave little ambiguity in the situation and consequently allow the subject to draw on coping strategies and seek support, whereas microaggressions covertly attack a person's self-esteem, leaving only a nebulous sense of confusion and discomfort in their wake (Shelton & Delgado-Romero, 2011). Given that offending parties are often well-intentioned, the offended parties may be forced to question their own sense of reality (e.g. wondering if the offending party really meant something). Since microaggressions are frequently recognized only in retrospect, those who experience them are often left with few effective options for recourse.

Mirroring the literature on the harmful effects of racial microaggressions (Sue et al., 2007; Sue, 2010), sexual orientation microaggressions against LGBT individuals have been found to reduce self-esteem, increase negative self-perceptions, and enhance the difficulty of reconciling their sexual minority identity (Wright & Wegner, 2012). Additionally, microaggressions can mentally and emotionally exhaust their recipients, generating feelings of anger, sadness and shame (Nadal et al., 2011; Nadal, Skolnik, & Wong, 2012).

Of particular concern for clinicians, client perceptions of microaggressions perpetrated by their psychotherapists have been demonstrated to predict weaker therapeutic alliances, which in turn correlates with poorer treatment outcomes and higher attrition rates in therapy (Constantine, 2007; Owen et al., 2011; Sharf, Primavera, & Diener, 2010). This finding may be especially pertinent for altsex (poly and kink-identified) clients, as research

has demonstrated that kink-identified clients are often reticent to divulge their alternative sexuality to their psychotherapists (Kolmes, Stock, & Moser, 2006). A well-intentioned clinician who unknowingly commits microaggressions against such clients may inadvertently close a door before it ever opens. This would be especially unfortunate given that the vast majority of kink-oriented clients seek therapy for reasons unrelated to their alternative sexuality (Kolmes, Stock, & Moser, 2006; Weitzman, 2006). Thus it is imperative that clinicians understand microaggressions, how to avoid committing them against their altsex clients, and what to do if microaggressions do occur.

Examples of Alternative Sexuality Microaggressions

What could microaggressions against altsex clients look like? Research has shown that microaggressions are experienced in subjectively different ways by various minority groups (Nadal, Skolnik, & Wong, 2012; Shelton & Delgado-Romero, 2011; Sue, 2010). Building on Sue and colleagues' original taxonomy of racial microaggressions (Sue et al., 2007), Shelton and Delgado-Romero qualitatively derived a list of microaggression themes from LGBTQ participants (Shelton & Delgado-Romero, 2011). The present authors, drawing on our combined research, clinical, anecdotal, and personal experiences, note that while significant overlap exists between LGBTQ microaggression themes and those committed against poly and kink-identified individuals, important differences remain. We propose a modified set of microaggression themes for altsex populations (Table 1 - top of next page).

Many poly and kink-oriented individuals are covert about their lifestyle, as evidenced by the fact that in a survey of 2,995 altsex participants, 43% reported not being "out" about their alternative sexuality (Wright, 2008). Such high levels of discretion, coupled with widespread ignorance and misinformation about alternative sexualities among clinicians, leaves these

Table 1

Sample Alternative Sexuality Microaggressions in Psychotherapy

| Theme | Microaggression | Message |
|---|--|--|
| Assumption that alternative sexuality is the cause of all presenting issues | A psychotherapist tells her BDSM client that she will never be healthy until she ceases BDSM play with her partner. | Alternative sexual lifestyles never "work." |
| | A client presenting with unrelated concerns discloses their alternate lifestyle, and the psychotherapist says, "Oh now I understand what the real problem is." | Your sexuality is the problem. |
| Avoidance or minimization of alternative sexuality | A psychotherapist refuses to use BDSM terminology such as Dom or sub, even though client uses it. | Your alternative sexuality is not "real." |
| | A psychotherapist repeatedly redirects the conversation when a client's other partners are mentioned. | Your sexuality makes people uncomfortable. |
| Attempts to over-identify with kink/poly-oriented clients | A psychotherapist discloses his own polyamorous orientation when it is not appropriate or necessary. | I have something in common with you, therefore I will focus on that. |
| Making stereotypical assumptions about alternative sexualities | A psychotherapist swaps BDSM-related stories with a client. | |
| | A psychotherapist assumes a submissive client has self-esteem issues. | I do not understand kink. |
| Expressions of sexuality-related biases | A psychotherapist assumes a poly couple wants to amass more and more partners. | All you care about is sex. |
| | A psychotherapist recommends a book on recovering from affairs for a polyamorous couple. | You need to conform to a "normal" type of relationship. |
| Failure to do independent research or consultation regarding unfamiliar sexuality of a client | A psychotherapist expects client to be the primary source of education about his or her alternative sexuality/lifestyle. | Your sexuality is not important to me. It is your job to educate me, not mine. |
| | A psychotherapist conflates BDSM with abuse and tells a client that it is not healthy. | You are sick or damaged. |
| Assumption of pathology | A psychotherapist recommends a sex addiction group to a client who comes out as polyamorous or a swinger. | You are out of control. You are deviant. |

Note: Table adapted from Shelton & Delgado-Romero, 2011.

individuals at high risk for *microinvalidations*, often considered the most harmful type of microaggression due to their nullification of the recipient's subjective reality (Sue, 2010). For example if a polyamorous client experiences a breakup with one of her partners, and her therapist insinuates that she should not grieve the loss of the relationship since she still has another partner, the client may feel that a crucial aspect of her identity has been casually dismissed.

On the other hand, altsex individuals may also find themselves receiving *microassaults*, which are conscious and deliberately discriminatory practices and behaviors. While clinicians would hopefully take care to avoid enacting such conscious hostilities upon their clients, *microinsults*, that is subtle snubs, gestures or verbal slights which communicate insensitivity, could be unconsciously expressed by clinicians as a product of personal biases or countertransference (Sue, 2010). A seemingly innocuous chuckle, sigh, or comment can be construed as rude or insensitive to a marginalized group such as poly or kink-identified clients.

Like LGBT clients in decades past, many kink-identified individuals find themselves unfairly pathologized by clinicians (Kolmes, Stock, & Moser, 2006). This can take obvious forms, such as a clinician assuming that a client's involvement in BDSM automatically indicates sexual abuse or psychopathology, despite empirical evidence negating these theories (Connolly, 2006; Richters et al., 2008). However sexual biases can be expressed by the clinician much more surreptitiously, such as assuming that a polyamorous client's feelings of jeal-

ousy toward his partner's partner signify that the client cannot tolerate such a lifestyle.

Even open-minded and well-meaning clinicians can fall prey to microaggressions. Perhaps due to pathologization, exoticization, or simple curiosity, many clinicians unduly focus on a client's sexual identity when the presenting complaints are unrelated, often drawing clients into multiple sessions of unnecessary exposition. On the other end of the spectrum, clinicians who are altsex-oriented themselves are not immune, as they run the risk of allowing boundaries to inadvertently slip, perhaps mistakenly believing that clients will welcome such disclosures, or thinking that it is appropriate to "bond" in this way. Despite a clinician's best efforts, the possibility exists that microaggressions may happen. The more educated clinicians are about microaggressions, the less likely they will find themselves having to do damage control.

Recommendations

We offer the following recommendations to help clinicians avoid enacting microaggressions on their altsex clients (adapted from Kleinplatz & Moser, 2004):

- Do not assume that a client's presenting issue is caused by or is related to their kink or poly lifestyle.
- Do not make assumptions about clients' treatment goals – particularly that these goals include changing their sexual desires.
- Do not try to "cure" clients of BDSM or poly desires. This may be as ineffective as reparative therapy for LGBT clients.

- Be aware that distress over kink or poly identity may be a normal part of internalized cultural bias against the sexual orientation rather than evidence of a disorder. The clinician can take the role of validating the distress and helping a client to locate and get support from community resources.
- Take note of whether and how kink or poly identities affect work, social, and family relationships.
- Do not assume abuse when someone is in a BDSM relationship. Do not assume a client is cheating or is tolerating cheating if they bring up other partners.
- Do not assume that BDSM interests mean that a client is not also interested in conventional sexual behaviors.
- Be aware of your own countertransference issues and how they may enter the therapy. Consult with colleagues who are knowledgeable about altsex behavior.
- Educate yourself, seek consultation, or refer out when you are practicing outside of your boundaries of competence.

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