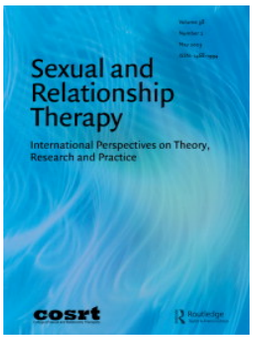

Routledge
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Sexual and Relationship Therapy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/csmt20

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To cite this article: Stefani Goerlich (2023): Cradle and all: outcome differences between kink-affirming and kink uninformed therapies for a complex client with paraphilia, Sexual and Relationship Therapy, DOI: 10.1080/14681994.2023.2215739

To link to this article: https://doi.org/10.1080/14681994.2023.2215739

Published online: 22 May 2023.

SEXUAL AND RELATIONSHIP THERAPY
https://doi.org/10.1080/14681994.2023.2215739

CASE REPORT

Cradle and all: outcome differences between kink-affirming and kink uninformed therapies for a complex client with paraphilia

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ABSTRACT

The *Clinical practice guidelines for working with people with kink interests* offers a powerful framework for therapists to use when conceptualizing their work clients presenting with paraphilic behaviors. Many of the practitioners who would benefit most from their guidance are unaware that this document is available as a free resource at www.kinkguidelines.com. The urgent need to promote this work is highlighted in the case study presented here: a young man presenting to two mental health providers with a constellation of behavioral, social, developmental, and intellectual challenges who self identifies as an Adult Baby/Diaper Lover (ABDL). One clinician, lacking in general kink competency and an awareness of the Kink Guidelines, diagnoses this client with dissociative identity disorder, resulting in a rapid decline in the clients behavioral and psychological functioning. The second, working within the framework of the Kink Guidelines, leveraged a kink-affirming and radically accepting approach to the client that stabilized his mental health, supporting him in setting behavioral goals to integrate his fetish play appropriately into his life and relationships, and helped build an interdisciplinary care team that could support his continued growth towards independence without shame or kink-stigma.

LAY SUMMARY

Mental health providers risk misdiagnosing clients when they lack a full understanding of BDSM, kink, and fetishes. The case study presented here demonstrates how a clinician's kink knowledge can be a powerful influence on the client's therapy experience, their treatment outcomes, and overall quality of life.

ARTICLE HISTORY
Received 26 January 2023
Accepted 15 May 2023

KEYWORDS
Kink-affirming; paraphilia; ABDL; kink guidelines; DID; stigma; bias

Introduction

When doctors are in medical school, they are taught "when you hear hoofbeats, think horses—not zebras." This adage is not one mental health providers encounter often during our training, which is unfortunate, because once or twice in our careers many

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of us will encounter a case that is so knotty and complicated in its presentation that we immediately hear hoofbeats. In the field of sex therapy, one's inclination towards a "zebra" diagnosis is compounded when the treating clinician lacks information about BDSM and kink. A kink aware therapist starts their case conceptualization from an assumption that BDSM, kink, and fetish behaviors are a normal and healthy element of some client's sexuality and relationships. The Kink-Affirming Provider goes one step further and considers their clients' kinks as client strengths and potential clinical tools to leverage during treatment (Goerlich, 2022). When a clinician lacks kink awareness, particularly when they encounter a kink or fetish that can feel uncomfortable for them, they run the risk of pathologizing otherwise healthy behaviors and misdiagnosing their client (Kelsey et al., 2013). The first step in this process is simply recognizing what a paraphilia is when it presents in the treatment room.

Using Kleinplatz and Moser's (2020) operant definition;

> Paraphilias are defined here as a recurrent and intense sexual arousal to unconventional erotic stimuli (sexual interests not seen as acceptable to the dominant culture) as manifested by fantasies, urges or behaviors. Paraphilias are usually contrasted with normophilias – that is, recurrent and intense sexual arousal to conventional erotic stimuli (sexual interests seen as acceptable to the dominant culture).

Paraphilias vary in type and intensity and include, but are not limited to, fetishes—sexual or erotic attraction to non-living objects such as diapers, feces, or the accoutrements of infancy for ABDL fetishists (Lowenstein, 2002). The conceptualization of paraphilias within the field of psychology has been inconsistent at best (Moser, 2018), resulting in conflicting etiological theories (Murphy & Fedoroff, 2019), stigma by providers to clients (Berzeh et al., 2012), the medialization of human sexual diversity (Adis International, 2012) and cruel and misguided interventions (Merricks et al., 2016). These risks are particularly high when the paraphilic behavior is one that is seen as especially socially transgressive.

Among those paraphilias that can cause discomfort in others is ABDL or Adult Baby/Diaper Lover play. "As role-play pertaining to age, age-play is broadly considered a subset of BDSM (encompassing bondage and discipline, dominance and submission, sadism and masochism) … Age players take on heteronormative or genderqueer versions of the roles of Daddy or Mommy (sometimes Headmaster/Headmistress) dominants playing with little girl or little boy submissives in heterosexual and homosexual, sexual and non-sexual constellations alike… In addition to the variety of roles and positions it affords, age-play ranges in its intensities from casual explorations to committed, immersive lifestyles" (Tiidenberg & Paasonen, 2019). Adult Baby/Diaper Lovers represent one end of the age-play spectrum, with submissives taking on the persona of an infant or toddler, while the dominant partner assumes the role of Caregiver. Because it includes not only elements of Caregiver/little kink but may also involve urolagnia (urine fetishism), coprophilia (feces fetishism), and lactophilia (breast milk fetishism), ABDL enthusiasts experience stigma even from within the wider BDSM community, which can result in significant distress from clients who feel isolated, misunderstood, and shamed (Earl & Lucky, 2018). When a clinician encounters a client who enjoys ABDL play, the need for kink-awareness (and if possible, kink-affirmation) is high, because the absence of

understanding of this unique subculture has the potential to cause real and lasting harm to the client—as we will see in our case example. The Kink Clinical Guidelines Project developed a series of guiding principles that they recommend for all clinicians working with kinky clients. These include:

- ***Guideline 1:*** *Clinicians understand that kink is used as an umbrella term for a wide range of consensual erotic or intimate behaviors, fantasies, relationships, and identities.*
- ***Guideline 2:*** *Clinicians will be aware of their professional competence and scope of practice when working with clients who are exploring kink or who are kink-identified, and will consult, obtain supervision, and/or refer as appropriate to best serve clients.*
- ***Guideline 3:*** *Clinicians understand that kink fantasies, interests, behaviors, relationships, and/or identities, by themselves, do not indicate the presence of psychopathology, a mental disorder or the inability of individuals to control their behavior.*
- ***Guideline 4:*** *Clinicians understand that kink is not necessarily a response to trauma, including abuse.*
- ***Guideline 5:*** *Clinicians recognize that kink intersects with other identities in ways that may shape how kink is expressed and experienced.*
- ***Guideline 6:*** *Clinicians understand that kink may sometimes facilitate the exploration and expression of a range of gender, relationship, and sexuality interests and identities.*
- ***Guideline 7:*** *Clinicians recognize how stigma, discrimination, and violence directed at people involved in kink can affect their health and well-being.*
- ***Guideline 8:*** *Clinicians understand the centrality of consent and how it is managed in kink interactions and power-exchange relationships.*
- ***Guideline 9:*** *Clinicians understand that kink experiences can lead to healing, personal growth, and empowerment.*
- ***Guideline 10:*** *Clinicians consider how generational differences can influence kink behaviors and identities.*
- ***Guideline 11:*** *Clinicians understand that kink interests may be recognized at any age.*
- ***Guideline 12:*** *Clinicians understand that there is a wide variety of family structures among kink-identified individuals.*
- ***Guideline 13:*** *Clinicians do not assume that kink involvement has a negative effect on parenting.*
- ***Guideline 14:*** *Clinicians do not assume that any concern arising in therapy is caused by kink.*
- ***Guideline 15:*** *Clinicians understand that reparative or conversion therapies are unethical. Similarly, clinicians avoid attempts to eradicate consensual kink behaviors and identities.*
- ***Guideline 16:*** *Clinicians understand that distress about kink may reflect internalized stigma, oppression, and negativity rather than evidence of a disorder.*
- ***Guideline 17:*** *Clinicians should evaluate their own biases, values, attitudes, and feelings about kink and address how those can affect their interactions with clients on an ongoing basis.*

- ***Guideline 18:*** *Clinicians understand that societal stereotypes about kink may affect the client's presentation in treatment and the process of therapy.*
- ***Guideline 19:*** *Clinicians understand that intimate partner violence/domestic violence (IPV/DV) can co-exist with kink activities or relationships. Clinicians should ensure their assessments for IPV/DV are kink-informed.*
- ***Guideline 20:*** *Clinicians strive to remain informed about the current scientific literature about kink and avoid misuse or misrepresentation of findings and methods.*
- ***Guideline 21:*** *Clinicians support the development of professional education and training on kink-related issues.*
- ***Guideline 22:*** *Clinicians make reasonable efforts to familiarize themselves with health, educational, and community resources relevant to clients who are exploring kink or who have a kink identity*

(Kink Clinical Guidelines Project, 2019).

Mental health providers who are not aware of, or who choose not to follow these guidelines can misattribute elements of kink relationships and fetish play in ways that can result in pathologizing behaviors that the client experiences positively. While it is true that not every provider chooses to work within a system that requires a formal diagnosis, an inaccurate case conceptualization predicated on negative or maladaptive assumptions about kink, will likely impact not only the therapist-client relationship but the course and efficacy of therapy itself. The following case study provides one example.

Case context and methodology

Ricky was originally referred to a colleague of mine after another clinician terminated his care following disclosures related to his paraphilia. Prior to this transition, Ricky had been in long-term outpatient therapy with a Licensed Professional Counselor (referred to here as Therapist 1) whose assessment of Ricky and treatment interventions prior had profoundly influenced Ricky's internalized self-concept and behaviors. The referring colleague felt that Ricky's paraphilic behaviors fell outside of their scope of practice and referred him to me (Therapist 2), since I specialize in working with gender, sexuality, and relationship diversities (GSRD). An initial consultation was scheduled with Ricky to review his needs, and after consultation with my Sex Therapy Clinical Supervisor, I agreed to take Ricky on as a client.

Due to the global Coronavirus pandemic, all of Ricky's sessions were held via HIPAA-secure telehealth platform. Additionally, Ricky sent frequent life updates via email, the content of which were discussed in our sessions. Because of the complexity of his case, I sought and received a release from Ricky to speak with his parents, with whom he lives, and with his prior clinical providers, to gather a comprehensive overview of Ricky's diagnostic history and care. I was able to gather a lifespan case history of Ricky from his parents, as well as case notes from the long-term clinician who had been working with him prior to his referral out. Unfortunately, the clinician

to whom Ricky was referred, and who in turn referred Ricky to the colleague who connected him with me, declined to collaborate or share information regarding Ricky's process with them. As a result, there is an approximately five-month gap in Ricky's treatment history. Given the difficulty Ricky had in finding a clinician willing to accept him as a client, it is remarkable that his record of care is as thorough as it is.

Ricky also offered written consent to present his anonymized case both at the Society for Sex Therapy and Research (SSTAR) Fall 2021 Case Conference and in academic publication. To that end, identifying details that do not impact discussion of the case have been changed to protect Ricky's confidentiality.

Case description

A client with a complex web of learning delays, physical and mental health needs, and behavior concerns presents for outpatient, telehealth-based treatment for behaviors related to paraphilic infantilism. An accurate assessment of this client's needs was complicated by multiple transitions between providers, each of whom had varying levels of kink-awareness and sex therapy training. The client's own unreliable narration and desire to please individuals he perceives as trusted authority figures added to the difficulty of case conceptualization.

The client

Ricky Q. is a 25 year old, Hispanic AMAB (assigned male at birth) who, when asked how he would define his gender, responded "I don't even know." Ricky lives at home with both of his biological parents in a suburban, upper-middle-class community. His family reports strong ties to their extended family, although the extent of these relatives' awareness of Ricky's daily life and needs is limited. Ricky's medical history and disability status are discussed at length in the following section.

Although he has struggled to maintain employment due to anxiety associated with not being able to engage in fetish behaviors (his primary coping strategy) while on the job; he is actively involved in his Christian faith community and his church has created a part time job as a maintenance person. A community college student who recently completed a certificate program, Ricky reports few social supports outside of his family of origin and church, denies friendships with peers, and denies an interest in dating. Ricky states that he does not have a strong interest in sexual intercourse but would like to find a long-term partner for a Caregiver-little (CG/l) relationship dynamic.

Ricky identifies as an "adult baby/diaper lover" (ABDL) and at the time of intake stated that his ideal scenario would be a life in which he had a full-time Caregiver who would support him in living life as a full-time baby. Ricky has created a baby ("little") persona named Rebecca that he adopts while role playing as an infant. Within the ABDL community, time spent role playing as one's little persona is referred to as being in "littlespace" and can be compared to the experience of" subspace" that is reported by other BDSM submissives. One self-identified little describes her experience of littlespace as:

> Being little…doesn't mean that I have no responsibility, or that I am incapable of being an adult when I need to be…My 'little' is the part of me that hasn't become bitter over the world, or the things that I've experienced in my life. It's the part of me that looks at life and embraces all that is good…My littlespace is where I can be silly and carefree. When I can let go of all the icky adulty things I have to do everyday and climb up in Daddy's lap for snuggles. (Earl & Lucky, 2018)

Case history

NOTE: It is important to state from the outset that Ricky's in Adult Baby/Diaper Lover play is not in and of itself sufficient to be considered a "presenting problem." Fetishes exist in many forms and fetish play is engaged in by participants of all cultures and backgrounds without incident. The history presented here is only relevant in so much as it lays the foundation for understanding the behavioral concerns that were identified by this clinician as a presenting problem later.

After receiving Ricky's informed consent and release, I contacted his prior treating clinicians to seek copies of their treatment records. As previously referenced, one provider who had worked with Ricky refused to provide case notes to this writer, resulting in an approximately six-month gap in records. Ricky states that he was referred out by this provider as soon as the topic of his ABDL interest was introduced. Therefore, much of the case history and conceptualization relies on the records of Therapist 1 who worked with Ricky for approximately two and a half years prior to the incident described above which resulted in termination of care.

Ricky was born premature, at 28 wk and spent approximately 56 days in the NICU. We know that "Prematurity deprives infants of the prenatal sensory stimulation essential to their correct development" and that skin-on-skin contact with parents is a crucial mitigating element (Vitale et al., 2021). Unfortunately, his parents report that they were unable to hold or touch him for much of this time. Because of his status as a preemie, Ricky's parents state that he was enrolled in a "study" that would follow his development and monitor his progress. Ricky was enrolled in full time daycare at six months and would remain in day care until he was eligible to begin kindergarten. Ricky's parents report that Ricky struggled with emotional regulation and social development, which was noted by the research team following him. He was enrolled in an early intervention social skills program, and his parents report Ricky as having "mild" cerebral palsy, primarily presenting as muscle spasticity, pervasive developmental disorder, and nonverbal learning disorder. Later in adolescence, Ricky was diagnosed with a benign arachnoid cyst on his brainstem.

Ricky's reports that his fascination with diaper wearing and use began early in life- approximately at age 2–3. While this may strike some as especially young, many BDSM practitioners report an interest in objects or activities that they later in adulthood identify as kinks or fetishes, before age 10 (Goerlich, 2021). Ricky reports that during this time he made a conscious decision to reject efforts to potty-train him, as he had developed a fascination with watching the younger children in his daycare being diapered and felt jealous of and desirous for the attention they received during this time:

> Preschool is where my interest in diapers really took off…I would try and get glimpses of the babies as they were getting their diaper changes…I felt jealous of the babies and often wished I could switch bodies with them…Also, I would try to poop in my diapers or pull-ups so I could sit in my mess and wait to be changed while observing.

Ricky reports that he created the persona of Rebecca as a kindergartner, in part as a coping strategy to manage the social isolation and bullying he experienced from his peers. Ricky states that he would defecate in his pants partially as a mechanism of self-protection; "my reasoning… was that I could avoid the bullies." These behaviors resulted in social ostracization by other children based on reactions to poor hygiene associated with diaper use, stigma associated with wearing diapers beyond an age typically considered appropriate, and what Ricky describes as the "humiliation" of having his diaper checked on the playground in front of peers.

Ricky states that by elementary school he was struggling to fit in with his peers, understand their social cues, and form friendships. He reports that "I often embarrassed myself, throwing temper tantrums because of my frustrations with their games." These struggles led to a stronger identification with his Rebecca persona, who was allowed as a baby to act in ways that Ricky's peers and supportive adults rejected in a school-aged child.

By his later elementary years, Ricky began to perceive his struggles to relate to peers of his age, and his conscious regression into play and behavior more suitable for an infant/toddler, as problematic. With age came a better understanding of what was considered developmentally normal for his peers and an awareness that he was failing to meet this standard. Ricky's parents describe a lifelong struggle for him to connect with others & form friendships. Parents describe Ricky as suggestible, with a strong desire to please; including participating in playground games that focused on bullying and isolating him. Ricky's parents describe having to explain to him that these were not moments of inclusion, but rather targeting Ricky for abuse he was not recognizing. As he aged and developed more independence, the behaviors associated with his diaper fascination expanded as well:

> Around 10 years old I first thought something was wrong with me. I knew I loved diapers. I would wear all my pairs of underwear and I would take a whole roll of toilet paper and stuff it down into them to simulate the feel of diapers. When I turned 11, I started stealing dirty diapers from trash cans whenever I could get an opportunity.

With the onset of puberty, Ricky began to experience a sexualized response towards diapers and diaper wearing. By age 12, Ricky had begun to steal soiled diapers from public restrooms and use them as masturbatory aids. In an attempt to understand his desire, Ricky conducted an internet search for "kids wearing diapers" and stumbled across the AB/DL community and erotica created by its members online. Ricky reports adopting more of Rebecca's feminine qualities including wearing training bras, buying pink pull-ups and purchasing princess themed sippy cups and pacifiers to use. At age 13, Ricky wrote his parents a letter disclosing his desires and linking them to his relationship with his parents:

Dear Mom and Dad,

> …When I was a kid, I just wanted to remain a baby and now that I am a teen these feelings are even more intense…I love you guys more than anything in this world and if you don't mind, I wouldn't mind going on remaining your little baby boy. Please give this a chance because I am miserable trying to keep this away from you and you always said I could come to you with anything…The only people that have to know are us and ONLY us./

Ricky's parents responded to his letter by encouraging him to focus on building relationships with age-appropriate peers, which included supporting Ricky's interest in his school choir and theatre programs; and enrolling him in outpatient therapy services. Ricky states that he was able to eliminate his daytime usage of diapers entirely during this time, although he continued to steal soiled diapers from area stores and use them for masturbation.

During this time, Ricky began to work his first part time jobs—in an afterschool childcare program and in the daycare room at his church. It was during this time that Ricky shared his ABDL little identity with Therapist 1. Differentiating between "littlespace" and dissociation is heavily predicated on a therapist having a level of kink-awareness that would enable them to ask appropriate open-ended questions to discern fantasy from role play from dissociative episodes (Tiidenberg & Paasonen, 2019). In this case, the absence of a kink-aware framework to contextualize Ricky's identification with Rebecca became a stumbling block in Therapist 1's assessment process. The result was Ricky's littlespace persona being identified as an alter and attributed to Dissociative Identity Disorder (DID).

In reviewing Therapist 1's case notes, this diagnosis seems to be entirely predicated on a lack of kink-aware understanding of Ricky's affinity for adult baby role play combined with his disinterest in achieving the developmental milestones considered appropriate for a young adult of his age. Clinical documentation during this period indicates that Therapist 1 offered psychoeducation about DID to Ricky, particularly emphasizing the point that DID is a diagnosis typically seen in individuals who have experienced traumatic childhood abuse (Kluft, 1999). The focus of treatment was then directed towards identifying the underlying traumas that might have caused Ricky to develop DID as well as any other "alters" that may exist.

At the time of this diagnosis, Ricky had been engaged in some form of clinical observation or mental health care, both within the school system and through outside providers, for approximately 15 years. Throughout this time, no teacher, observer or mental health provider had documented a concern regarding child abuse or neglect, no family trauma or personal injury was treated, and no Child Protective Services investigations were ever conducted. However, after the DID diagnosis was explained to Ricky as something that "*we usually find in people who have experienced childhood trauma*"; he began to report stories of "cult-like family systems, including forced infantilization by his mother, forced wearing of diapers as punishment for masturbation, and forced (sometimes public) diaper changing and usage" (Goerlich, 2021) during his sessions. Over time, under Therapist 1's guidance, Ricky identified three "alters": Rebecca, Mr. Anger, and Buck while also denying (or more properly failing to include in his disclosures) other DID indicators such as lost time and moments of amnesia.

Notes recorded by Therapist 1 during this period document that Ricky vacillated between reporting fantastical tales of ritualized abuse and surveillance at the hands of his parents in one session, with denial of the same at the next session. "Ricky continued to bring the personas/alters of Buck and Mr. Anger out during therapy, and to ascribe his explosions at home to these personalities. Therapist introduces the idea of a 'memory vault' to Ricky and his Buck persona agrees that there is a 'problematic memory in the vault' and that he is afraid of the memories and the impact they will cause" (ibid). Ricky's parents report behavioral changes in Ricky, including a significant increase in spontaneous bursts of anger and acts of aggression towards them after the idea of Mr. Anger and Buck were introduced.

During this period of new and increasingly dysregulated behavior, Therapist 1 continued to document her suspicions of an incestuous relationship between Ricky and his mother and others, grounded in various disclosures made by Ricky during their sessions. Therapist 1 did not report these concerns to Adult Protective Services, which could have potentially resulted in an investigation into the veracity of Ricky's claims. This inaction could potentially be attributed to Therapist 1's confusion regarding whether the abusive relationship Ricky described is consensual ("*Client has disclosed a sexual relationship with his mother. Says that he is using her to experiment and to fill in the gap between now and finding a partner. Says he wonders if he has used this relationship as a way of reenacting his childhood trauma from the perspective of someone having some power to choose it.*") versus coercive ("*Over the years client has developed a sexual relationship with his mother that involves being spanked and ejaculating. He is unable to discern if this is a coping method in which he has sexualized his trauma or if he enjoys it.*"). Therapist 1 never seems to consider the idea that these stories could represent Ricky's ABDL fantasies and does not question the veracity of these reports, even as Ricky disavows his tales in the sessions that follow.

Approximately nine months after the DID diagnosis was introduced, Ricky's acting out in the personas of Mr. Anger and Buck led to a serious act of aggression towards his parents. Ricky texted his treating therapist (Therapist 1) to report that Buck was out of control and that he wasn't sure he was able to refrain from hurting someone. Therapist 1 notes that they called the police for a welfare check. While Ricky was taken for a psychiatric evaluation, the family denies that Ricky was involuntarily transported or assessed. The circumstances around this incident are poorly documented and do not seem to align with standards of care for someone experiencing a violent, possibly psychotic, episode. Clinical notes regarding this incident indicate that Ricky texted Therapist 1 expressing frustration with the long wait at triage and informing her that he was leaving. No formal assessment by the ER staff was conducted. Immediately following this incident, Ricky again recanted his allegations of parental abuse and Therapist 1 notified Ricky that they were terminating his care. Ricky describes this as being confusing and poorly communicated and, at the time of intake with Therapist 2, he had not fully grasped that Therapist 1 would no longer be his clinician. Approximately six months later, Ricky was referred to the author (Therapist 2) for care.

When I first received Ricky's referral, my first reaction was to refer him out. While my area of practice specialty is gender, sexuality, and relationship diversity—particularly BDSM/kink and fetishes, I did not have experience working with DID.

Unfortunately, none of the DID specialists that I consulted with felt comfortable taking on a client with ABDL interests, and none of the sex therapists who work with fetishes and paraphilias felt comfortable taking on a client with a DID diagnosis. After consultation with my Sex Therapy Clinical Supervisor, I decided to disclose the limitations of my DID experience to Ricky and allow him to make an informed decision regarding his care (Kink Guideline 2). Ricky felt that having a clinician who was familiar with ABDL lifestyles and comfortable accepting his fetish play was most important to him and chose to pursue outpatient, telehealth-based therapy with Therapist 2 (Kink Guideline 8).

Case conceptualization and treatment approach

Over the course of his lifetime, Ricky has received over a dozen various mental health diagnoses, in addition to learning and cognitive limitations, and medical concerns (CP and cyst) that have been identified by his doctors. At the time of intake, Ricky was carrying five diagnoses offered by Therapist 1: Obsessive-Compulsive Disorder (OCD), Generalized Anxiety Disorder (GAD), Pervasive Developmental Disorder (PDD), Intermittent Explosive Disorder (IED), and Dissociative Identity Disorder (DID). As a Kink-Affirming Sex Therapist, my goal was to understand the physical, mental/emotional, and social variables impacting Ricky's self-concept and behavior without starting from an assumption that his interest in ABDL play was a manifestation of, or a response to, these variables. I began my work with Ricky with the understanding that ABDL play was confusing and off-putting to people outside of the BDSM/kink community, but that ABDL play itself was not disordered or maladaptive. I believed, and continue to believe, that ABDL play can be part of a healthy person's lifestyle and intimate relationships (Kink Guideline 3).

My first clinical priority was to untangle and fully understand the complex web of medical, psychological, and behavioral challenges facing Ricky, and to do so in a way that did not exacerbate the shame and stigma that Ricky had experienced around his ABDL identity both in and out of the treatment room (Kink Guideline 5). I am aware of the controversy surrounding the DID diagnosis (Elzinga et al., 1998; Kluft, 1995), as well as recent social media phenomenon of individuals self-diagnosing DID (Styx, 2022) and wanted to be very clear about whether Ricky's littlespace persona of Rebecca was a manifestation of his ABDL fetish or whether Rebecca was a "true" alter (Kink Guideline 20) before finalizing my treatment plan. I wanted to ensure that this process of inquiry occurred in a way that was affirming of Ricky's right to engage in niche fetish play and to avoid centering his ABDL interest as an area of concern (Kink Guideline 14). The PLISSIT (Permission, Limited Info, Specific Suggestions, Intensive Therapy) model is a conceptual framework for sex therapy developed by Jack Annon (1976) in order to begin the work of standardizing the treatment of sexual dysfunction. Today, the PLISSIT model is used to address sexual problems and behaviors in a wide variety of clients including cancer survivors (Safieh & Ghaffari, 2016), diabetes patients (Hassan Khedr et al., 2018), postpartum women (Karimi et al., 2019), couples (Vaishnav et al., 2020) and individuals with paraphilias (Harsch, 2018) among others. Using the PLISSIT model

within a Humanistic framework of curiosity, unconditional positive regard, and client empowerment, I set out to answer four questions:

1. Is Rebecca a role-play persona Ricky assumes during ABDL play or a DID alter?
2. To what extent do Buck and Mr. Anger manifest in Ricky's life and behavior?
3. To what degree does Ricky's physical health impact his continence and therefore his self-perception?
4. What is Ricky's vision for his future and what steps can he reasonably take to achieve this vision?

Therapist and relational factors

As a Clinical Social Worker, my instinct is to build a strong network of natural and social supports around my clients; however, from our earliest conversations, it became apparent that Ricky was agreeable to the point of suggestibility. Because of this desire to please someone he perceives to be as an authority figure and "expert," I was mindful of the need to center Ricky in his therapy as the expert on his own life and needs. Motivational Interviewing featured prominently in our work together, as well as gentle cognitive challenging of Ricky's need to be cared for by others. While there was a need to link Ricky with necessary services that could support his identified goal of one day living independently from his parents (Kink Guideline 22), the balance between establishing an interdisciplinary care team for Ricky, affirming his identity as an adult baby, and encouraging self-directed independent action was an ongoing challenge. Throughout his treatment, the times when Ricky expressed frustration or anger tended to be moments when his parents or one of his social supports failed to adequately respond to his needs in the time or manner that he felt he required.

Treatment plan and goals

At intake, Ricky stated that his primary goal was to be able to live on his own, independently from his parents, and to eventually have a romantic (and perhaps sexual) relationship with a Caregiver partner who would support Ricky in living full time as an adult baby.

Developing a treatment plan with Ricky to help him reach this goal (Kink Guideline 6) was predicated on first gathering a tremendous amount of information. Ricky had worked with many providers over the years, each of whom had held varying opinions on his level of cognitive function, his behavioral diagnoses, and his ABDL proclivities, which made his actual level of functioning difficult to assess. Ricky and I developed a plan for him to participate in a comprehensive neuropsychiatric evaluation and a vocational assessment, and to meet with both a neurologist and a urologist to better understand the impact (if any) of the arachnoid cyst and his cerebral palsy. My plan was to defer formalizing treatment goals until we better understood both Ricky's strengths and any limitations or physical constraints that could impact goal-setting.

Assessment findings

The consulting neuropsychiatrist found that Ricky had an IQ of 77, which falls within the range of mild impairment. His Beck Depression Inventory-II results were in the normal range, while the Beck Anxiety Inventory showed mild levels of anxiety. Ricky's MMPI-2 validity results were elevated, making interpretation difficult; however, he was found to have severely impaired emotional functioning. Ricky was diagnosed with a mild cognitive impairment. There was no mention of dissociative identity disorder, its presentation or symptomology, in Ricky's neuropsych evaluation.

Ricky was referred to his county vocational rehabilitation program for assessment, in the hopes that they might be able to offer job coaching, vocational training, and other resources to support his goal of independent living. The report provided to Ricky and this writer described Ricky's General Cognitive Functioning as "low average" and his Basic Academic Skills (*via* the WRAT 5) as "average." Additionally, Ricky's score on the Gilliam Autism Rating Scale fell into the "Very Likely" range. Overall, the vocational specialists offered a "guarded to poor" assessment and "recommended (Ricky) focus on his neurological and mental health functioning, prior to obtaining employment." As with the neuropsych evaluation, traits or indicators of dissociative identity disorder were not observed or noted in the report.

One possibility I considered in my case conceptualization was the notion that Ricky's physiological function could be more limited than had been previously realized and that he had eroticized otherwise involuntary behaviors as a way to claim a sense of control over factors that had caused him significant social distress over the course of his life (Kink Guideline 16). Relative to their peers, children with Cerebral Palsy often take significantly longer to toilet train and 70–80% of CP patients have ongoing incontinence due to muscle abnormalities and spasticity. Likewise, Arachnoid Cysts can cause secondary neurogenic bladder in some patients. I was curious to discover what Ricky's physiological capacity was prior to setting behavioral goals around diaper wearing or usage. The consulting neurologist stated that Ricky's cyst was stable and not a concern. However, following a urodynamic flow study, the urologist determined that Ricky's bladder muscle had atrophied—likely due to years of non-toileting—and recommended that Ricky undertake pelvic floor therapy in order to address this concern.

During the period that Ricky was completing the various evaluations described above, Ricky consented to allow this writer to meet with his parents (both retired school teachers) and conduct an in-depth family history. Ricky's parents described him as resistant to learning independent living skills, such as cooking (Ricky's diet is primarily limited to fast foods and breakfast cereals) and resistant to maintaining daily hygiene habits—particularly toothbrushing. This report aligns with the vocational assessment of Adaptive Daily Living Skills (*via* the ABAS-III) and self-care skills as being "borderline to low average." They describe Ricky as loving and affectionate, as long as he is getting his way but reports that he has learned "when he gets really angry, we will back down." Both father and mother deny ever seeing the identified alters of Buck or Mr. Anger—although they stated that Ricky's early intervention program had a book called "Put Your Anger In The Box" which used the personification of anger to teach emotional regulation skills and which Ricky

had used as a coping skill for years. They did report that when Ricky is tired or stressed, he would assume the persona of Rebecca although he never seemed to lose awareness of his "Ricky-ness."

Diagnosis

After reviewing the results of Ricky's medical and psychological testing, as well the case notes provided and information offered during parent/family sessions, my initial diagnosis was:

299.0 Autism Spectrum Disorder with accompanying intellection impairment

318.0 Mild Cognitive Impairment

301.6 Dependent Personality Disorder

r/o 300.14 Dissociative Identity Disorder

Generally, I adhered closely to the findings of the neuropsych evaluation, while also seeking to clarify and refine the myriad of diagnoses Ricky had been handed over the years. Based on the testing evidence, behavioral record, and my observations, it seemed that Ricky's constellation of symptoms was best attributed to his diagnosed Autism combined with a Cognitive Impairment which further limited his executive functioning and self-regulation capacity. While there had been no clear indicators of DID during Ricky's assessments, no identified trauma that may point towards the development of DID symptoms, and his parents stated that they had not witnessed Ricky's non-Rebecca "alters" or other DID symptoms, I felt the most conservative option would be to defer this decision until I had more time to work with Ricky and observe him myself.

Perhaps controversially, I did find that Ricky met the criteria for a diagnosis of Dependent Personality Disorder (DPD), based on his expressed desire to avoid independent "adult" living entirely in favor of a 24/7 adult baby/caregiver lifestyle. While this could be viewed as an expression of an idealized fantasy unlikely to be fulfilled, in Ricky's case his resistance to learning basic ADL's that would allow for independent living (such as cooking beyond preparing a bowl of cereal) and his reliance on his parents to serve as 24/7 caregivers in the absence of either a consensual power exchange relationship OR a justifying disability; it is my opinion that Ricky met the criteria for Dependent Personality Disorder. This diagnosis was validated later in our work together when Ricky shared that his parents had taken a 2 week vacation and that during this time, he had effectively lived as a baby left unattended by its parents: he did not take steps to feed himself beyond what was easily available on hand, he did not maintain hygiene such as bathing or toothbrushing in their absence, and refused to leave the house. When his parents returned, they reported that Ricky had lost weight, was in poorer health than he was prior to their departure and had insisted that they hire a babysitter for him should they ever plan a vacation again in the future.

As a Kink-Affirming Therapist, my practice is to defer use of the DSM paraphilia codes until and unless there is a compelling reason for doing so. Historically, kinky

people have experienced a tremendous amount of stigma and pathologization at the hands of healthcare providers; and it is my practice not to ascribe a mental health diagnosis to what is a normal, healthy, consensual kink practice. There are rare exceptions to my policy and as we read further, Ricky will prove to be one of those exceptions.

Course of treatment

One of the primary challenges for this writer in working with Ricky is the fact that I am a sole practitioner in private practice, lacking many of the support resources that a larger agency could provide. Because of this, it became quickly apparent that my work with Ricky would need to happen within the context of an Interdisciplinary Team setting; and a great deal of effort (during the assessment phase described above) was spent finding providers who could supplement and support my sex therapy work with Ricky. Ultimately, Ricky was connected with our local community mental health provider who could offer ASD services, ADL coaching, and psychiatric medication management while I focused on using the PLISSIT model of sex therapy to support and affirm Ricky's ABDL identity. In this instance, my PLISSIT approach looked like the following:

Permission

Ricky came to therapy with a clearly defined ABDL identity. The challenge here was helping Ricky understand the negative reactions he experienced from others (primarily his parents) around his diaper usage and desire to be a full-time baby. Guilt and shame are not prominent elements of Ricky's experience of his fetish, so helping him conceptualize the need for some limits in his fetish engagement (without introducing guilt or shame) became a central theme in our work. Ricky struggled with any limit being imposed on his diaper fascination and experienced requests from his parents to limit his diaper wearing to his private space and to clean up soiled diapers from shared bathrooms as a form of rejection. Helping Ricky parse out the difference between "you can't do this" and "we don't want to be included in this" was crucial to helping Ricky build the anticipatory empathy that is necessary for the independent living he stated was his goal. I worked to offer ongoing permission for Ricky to identify as an adult baby, while also helping Ricky feel comfortable extending permission to others to opt out of exposure to his adult baby behaviors (Kink Guideline 7).

As Ricky and I built rapport and he came to trust that I would not shame him for his ABDL play or pathologize his Rebecca persona, he made a disclosure that impacted my assessment of his fetish engagement. Approximately nine months into our therapeutic work, Ricky mentioned that he felt comfortable telling me a secret. Ricky shared that he would frequently use the keys provided by his employer to enter the church after-hours. During these visits, Ricky described undressing down to his diaper and playing with the toys in the nursery room. These visits would conclude with Ricky masturbating, using the nursery changing table to clean himself

and change his diaper, then tidying up the space and locking the building once again. Discussing these visits in our session, Ricky was unable to conceptualize the degree of legal risk such behaviors exposed him to. Because he was used to his parents' careful non-engagement with his ABDL behaviors in the home, Ricky's understanding was that if someone else were to enter into his workplace while he was disrobed and/or masturbating, he would simply explain that he was in his Rebecca littlespace and leave. Ricky struggled to imagine someone having a negative reaction to such a discovery and could not identify potential actions (such as calling the police and/or firing him) that they might take if he were discovered. This disclosure influenced the course of my PLISSIT work with him.

Limited information

For Ricky, offering Limited Information took three main forms. First, I focused on safety planning and risk assessment skills. After Ricky's disclosure about work, it became very important to help him understand how his fetish play could negatively impact his life and goals. Helping Ricky understand legal concepts and consequences for behaviors that others would find challenging (at best) without evoking fear and anxiety was difficult (Kink Guideline 17). Ricky struggles to understand why anyone would dislike ABDL play or have a problem living and working alongside someone who chooses to move through the world as a full-time adult baby.

This led to focus area #2: empathy and social cues. Much of this work was accomplished during Ricky's time with his Community Mental Health provider, however it carried over into my sex therapy work with him. Ricky had discovered ABDL pornography online quite early and had relied on this exclusively for both masturbatory and sexual education. As a result, Ricky's understanding of healthy sexual and romantic relationships was one where ABDL play, urolagnia, and coprophilia were not only normalized but celebrated and shared. While this certainly can be true for many ABDL fetishists, Ricky expanded this relational understanding to include the general community. As a result, he frequently made choices that anticipated a positive (or at worst, neutral) response from the community about his fetish engagement behaviors that he was unlikely to actually receive.

Finally, I worked with Ricky to identify and engage with his local ABDL fetish community. This effort had several benefits for Ricky. It allowed him to see that he was not alone in his fetish interest, which decreased his feelings of social isolation and lack of understanding support. It provided role models for socially appropriate (aka "healthy") ABDL fetish engagement by community members who enjoyed the same relationship models and forms of play that Ricky did, but who also were able to separate their littlespace selves from their adult "bigspace" identities. This was crucial to helping Ricky learn for himself that it was possible to be an ABDL practitioner while also navigating independent living skills, separating successfully from ones family of origin, and maintaining "adult" careers and responsibilities. Finally, the meetups and other socialization events organized by his local ABDL community afforded Ricky opportunities to engage in fetish play in safe, legal, consent-based spaces with others who shared his interests (Kink Guideline 1).

Specific suggestions

The specific suggestions that I offered to Ricky focused on two goals; redirecting problematic behavior such as masturbating at his workplace, and leveraging his ABDL fetish as an individual strength and clinical tool. One example of the former is a conversation Ricky and I had not long after his disclosure. The focus was working to identify what specific somatic and sensory needs were being fulfilled for him by his time in the workplace nursery room. Ricky was able to identify specific sensations that he found comforting and erotic, such as the smell and sound of the vinyl changing pad, that drew him back to this setting. I was able to suggest that Ricky purchase a similar changing pad for himself to use at home—giving him the same sensory experience without necessitating an after-hours visit to his place of employment. Relatively simple solutions such as this were typically well-received and acted on by Ricky. In fact, a few weeks after purchasing a changing pad for himself, Ricky asked his mother to hold onto his building keys for him to eliminate the temptation to return to his work and prioritize the safer home option I had identified.

Similarly, when Ricky expressed the insight that he sometimes acted out and became aggressive/angry towards his parents out of the hope that they would assume a Caregiver role and punish him for doing so; I was able to use this desire to suggest that Ricky create a space in his home where he could put *himself* in time-out. Calling it "Ricky's Corner", I suggested that Ricky place a soft blanket and pillow, a sippy cup, and a comforting toy in a designated corner of the family home. When he felt his temper begin to flare, rather than expecting his parents to punish him in the CG/l manner he wished for, he could instead choose to "punish" himself by putting himself in the corner. Ricky's corner thus became both a safe space for Ricky to validate the needs of his littlespace self, a tool of emotional regulation and self-soothing, and a way to redirect Ricky's desire for a strong power exchange-based reaction to his behaviors away from parents who did not wish to engage with their adult child in such a manner (Kink Guideline 9).

Intensive therapy

Intensive Therapy for Ricky prioritized helping him identify his loci of control and make decisions about what he wanted for his life and relationships. Because of the DID diagnosis he had been given by his prior Clinician, Ricky did not initially understand himself as someone capable of self-regulation and controlled emotional and behavioral decision-making. By approaching this question with open-minded curiosity and non-judgement, and simply allowing the medical evidence to speak for itself, Ricky came to see himself as someone with far more agency than he had previously understood. This physiological information was combined with the fact that at no point in his therapeutic work was ABDL play framed as something maladaptive that should be reduced or eliminated (Kink Guideline 3); as a result, Ricky was able to frame his decisions as one of spectrum of acceptable choices which served to reaffirm and validate his self-set goals. For example, after his urodynamic study confirmed that he was physiologically capable of bladder and bowel control, should he wish to exercise the muscles that controlled these functions, Ricky chose

to undergo pelvic floor therapy with the goal of re-toileting himself. This represented a significant clinical milestone for Ricky because his decision was made from a place of choice and autonomy, rather than as a reactive response to feelings of guilt or shame.

Quarterly family therapy sessions with his parents afforded Ricky opportunities to practice active listening, receiving feedback, and building empathy. These sessions focused on Ricky's ABDL hygiene practices in the home, without judging the existence of the behaviors, and afforded his parents a space to set boundaries and explain their own feelings around Ricky's behaviors (Kink Guideline 12). Because of his limited exposure to adults outside of the home, these conversations represented some of the only times when Ricky had direct conversations about his ABDL habits (such as 24/7 diaper wearing) and the way these are perceived by others. These conversations often resulted in strong emotional reactions from Ricky which often took the form of yelling and tears. These conversations were difficult for him, and certainly represented a willingness on his part to step into a "stretch zone" and build his ability to sit with discomfort. Through this process, Ricky was able to develop a greater understanding of his parent's own feelings of fear, guilt, and love for him and reflect on and integrate this knowledge during his individual therapy. Subsequent one-on-one sessions, where these family sessions were processed, resulted in Ricky expressing greater insight into himself and his relationship with his parents.

Additionally, the intensive therapy process involved monitoring Ricky for indicators of DID such as missing time, family reports of incongruous behaviors that might indicate the emergence of an alter, etc. During our work together, Ricky consistently disavowed his prior disclosures of familial abuse (Kink Guideline 4) and attributed both this and his alters to the encouragement and positive feedback these behaviors evoked in his prior treatment. Throughout the course of our therapeutic work together, neither Ricky nor his parents reported an appearance by either Buck or Mr. Anger. It would seem that, with the suggestion of DID removed, Ricky ceased the performance of these personalities identified by Therapist 1.

Progress monitoring

One potentially controversial element of Ricky's treatment plan that impacted our progress monitoring was the addition of Fetishistic Disorder (302.81) to his diagnosis. There is significant controversy around the inclusion of the paraphilias within the DSM system (Balon, 2013; Moser, 2009; Moser, 2019). Because of this, and my concurrence that nearly all fetish behaviors occur within the context of private, consensual relationships between consenting adults; it has not historically been my practice to diagnose kink play and fetish engagement in my clients. However, in this specific case the behaviors exhibited such as after-hours workplace masturbation (which could legally be construed as breaking and entering), the theft of items from public restrooms, the use of soiled diapers as masturbatory aids, and the disruption his diapering hygiene caused in the family home, represented significant legal, medical, and social risks that merited formal assessment and monitoring. These actions could not be attributed to a differential diagnosis such as Obsessive Compulsive Disorder (OCD), or Problematic Sexual Behavior (PSB) as Ricky did

not meet the other diagnostic criteria. As a result, monitoring of how and when Ricky chose to engage in ABDL/Rebecca littlespace play, without suggesting that he should avoid such play entirely, was a key element of our process.

Ricky's treatment goals emphasized his desire to eventually live independently from his parents, in a setting and with a partner who would facilitate a long-term ABDL lifestyle. This meant that our work focused on setting and monitoring progress towards goals such as identifying vocational support training, exploring career prospects that would not be disrupted by voluntary diaper usage, researching supportive and independent housing options, and establishing a community care team that could offer intervention and support appropriate to Ricky's cognitive and functional skill level to help him build the most independent life possible. In our sessions, Ricky would offer self-report on his making of and follow-through with various appointments such as vocational rehabilitation, exploring the possibility of applying for Social Security Disability Insurance, and other "adult" activities. I also monitored Ricky's growing understanding of the limitations that choosing a 24/7 ABDL lifestyle might have on his ability to achieve independence goals and noted choices Ricky made to modify or wean away from some ABDL behaviors that had served as primary coping strategies and lifestyle choices in the past. These decisions, such as the one to re-toilet himself, were always self-directed and identified by Ricky; not imposed upon Ricky by members of his support team. The message Ricky consistently received was that he was an adult with autonomy and agency who could choose to live as a lifestyle adult baby if he chose to do so (Kink Guideline 15). As our work together progressed, and Ricky began to recognize that his ABDL desire sometimes conflicted with his desire for independence, Ricky would make gestures towards and develop plans for, modifying his ABDL practice.

Termination & treatment outcomes

Ricky and I worked together for approximately two years before insurance changes necessitated a transfer in his care. As we planned for transition, Ricky and I worked together to identify a kink-affirming ASD specialist who would be able to continue his behavioral and independent living goals and manage his psychiatric care needs without stigmatizing his interest in ABDL play. At the time of termination, Ricky had achieved the following goals:

- Elimination of explosive outburst towards his parents that had been previously attributed to the personas of Buck and Mr. Anger.
- Elimination of legally risky behaviors such as entering his workplace after hours, masturbation in public spaces, and theft of used diapers.
- Decreased social isolation through greater connection to the local ABDL community.
- Increased understanding of his own capacity for physiological and psychological self-control around bowel and bladder control, and a sense of empowerment in his decision-making in this area.
- Increased ability to hear feedback from others and to regulate his emotional reactions in order to respond to and respect boundaries they set for themselves.

- Improvement in the quality of his relationship with his parents, with whom he shares a living space and on whom he is financially reliant.
- Improved self-concept and self-esteem, as an adult making the best lifestyle choices for himself and his future.

Discussion

A recent study published in the journal, Sexual Abuse, identified "higher moral disengagement and impulsivity, lower sexual control (i.e. high sexual excitation, low sexual inhibition), and maladaptive understanding of consent" (Vander Molen et al., 2023) as possible factors that may lead an individual to act on their interest in "highly stigmatized" paraphilias, which were defined in the study as "hebephilia, pedophilia, and coprophilia" (ibid). Ricky's coprophilic play both in his home and after hours at his workplace provides an example of how problematic paraphilic behaviors can represent a manifestation of mental health factors outside the paraphilic interest itself. In this case, Ricky's maladaptive understanding of consent may be associated with the difficulty in reading social cues experienced by some clients with autism spectrum disorders. His impulsivity is likely attributable to Ricky's limited executive functioning, while his low sexual inhibition can be correlated to his own enthusiasm for ABDL play.

Therapist 1's approach to addressing Ricky's paraphilic interests (attributing them to childhood trauma and dissociative identity disorder) resulted in a conceptual framework that told Ricky that he was not in control of his experiences, and which reinforced the notion that his impulsivity was beyond his control. Vander Molen et. al. observe that such an approach may mimic elements of strain theory. "In the context of paraphilias, strain theory can be applied to include the stigma and ostracization individuals with paraphilic interests face, particularly if their interests are criminal when acted upon…Further, the loss of positive stimuli (e.g. social supports) or the introduction of negative stimuli (e.g. experiencing victimization) may contribute to delinquent acts." (Vander Molen et al., 2023). In the absence of a kink-aware perspective on ABDL play and fetishes in general, Therapist 1 constructed a narrative which told Ricky that he was a victim of childhood abuse and offered no prosocial outlet for his ABDL desires. It seems then, that maladaptive acting out—towards his parents as ABDL caregivers who rejected him and *via* his diaper theft and workplace masturbation habits were the unfortunate outcome.

In contrast, Therapist 2's Kink-Affirming approach offers an example of how the clinician can promote prosocial behavioral change in clients with paraphilic interests without assuming that a pathologizing conversion/elimination framework is necessary for the intervention to be effective. In taking a "broad history" approach to the case intake and making time to consult with cross-disciplinary specialists before finalizing a treatment plan, Therapist 2 was able to support Ricky in gaining a nuanced and deep understanding of his strengths and limitations. Once Ricky was able to conceptualize himself as having agency and control over his body and his behaviors (rather than misattributing these to either medical factors or the presence of "alters") Therapist 2 was able to offer psychotherapy grounded in the Kink Clinical Guidelines.

This process allowed Therapist 2 to address Ricky's maladaptive understandings of consent (Muehlenhard et al., 2016), encourage Ricky to define his own goals and progress benchmarks (Holburn et al., 2000), and support Ricky in identifying social supports who appreciate his unique interests and can support his learning about safe and consensual ABDL play (Dunn, 2021).

The importance of kink-affirming therapy as a modality for treating BDSM-identified clients has been emphasize throughout the literature on this population (Dunkley & Brotto, 2018; Kelsey et al., 2013; Berzeh et al., 2012). We know that clients report better outcomes when they feel safe with their therapists and we know that stigma experienced by kinky clients from their clinicians often results in the termination of care and a resistance towards seeking supportive treatment in the future (Stockwell, 2008). Ricky's treatment experience offers a stark example of how easily a well-intentioned but uninformed clinician can cause harm and how Kink Affirming therapy can positively influence outcomes.

Treatment limitations

There has been some criticism of the PLISSIT model as a useful tool for people with disabilities, due to the tendency of sexual health providers to view their disabled patients as non-sexual and particularly as non-kinky beings (Cambridge, 2013). While Therapist 2 conceptualized the work with Ricky through PLISSIT framework, the actual clinical process included many of the elements of the Recognition Model as well, which is a recommended alternative to PLISSIT for individuals with disabilities, such as cognitive impairments or cerebral palsy conditions. "The recognition model…involves five stages of interaction beginning with a sexual positive or sexual affirmative recognition of the patient, including explorations of the sexual concern or problem, addressing issues if possible, within the team, and referring on to specialists as needed" (Andrews & Lund, 2016). In this case, because Ricky expressed ambivalence about ABDL as a sexual practice versus a desired lifestyle and relationship dynamic, the PLISSIT model was the best framework to use.

Another potential treatment limitation is Ricky's own malleable sense of self. Given his strong desire to please those he views as caregiving adults in his life, it is possible that a future third therapist may receive a slightly different narrative that emphasizes the clinical themes that this next provider seems most responsive to. Recent research has found that 84% (Love & Farber, 2019) to 93% (Blanchard & Farber, 2016) of psychotherapy clients surveyed admit to some form of dishonesty in their therapy—either by telling overt falsehoods or by withholding truthful information. "Some researchers contend that patients may be better off not disclosing shameful details of their lives because doing so both enables them to construct desirable images of themselves while avoiding the risk of losing their therapist's positive appraisal" (Love & Farber, 2019). However, in Ricky's case the dissembling often forms a narrative of helplessness and even victimhood that may resonate with Ricky's identity as a little but which functions as a maladaptive strategy for addressing potentially problematic behavioral and relationship patterns. Creating a therapeutic environment where Ricky feels safe in telling his truth, without worrying

that doing so will let down or fail to please his provider, is the key to a successful clinical relationship in the future.

Finally, a significant limitation in Ricky's treatment was his lack of access to comprehensive interdisciplinary team support. Ricky would have benefited greatly from a service similar to Wraparound programming for at-risk youth, which brings the therapist and client together with the client's family, vocational supports, medical team, LEO/probation officer (where the client is court-involved), as well as natural support such as clergy, friends and extended family. While there is a move towards bringing Wrap-style services to "emerging adults in transition to adulthood with serious mental health conditions (SMHC) or at risk for SMHC" (Laporte et al., 2016) such as the Transition to Independence Process (TIP) or the Rehabilitation for Empowerment, Natural Supports, Education, and Work (RENEW) model, these programs were not available to Ricky at the time of his treatment and as a result, both Therapist 1 and Therapist 2 were left operating in a vacuum, without the insights and ability to reality-test some of their clinical observations with others. Therapist 2, specifically, worked to bring Ricky's family into his treatment team and scheduled regular quarterly family sessions to complement his individual work. However, when Therapist 2 attempted to coordinate care with Ricky's other providers, they declined the opportunity. Because of the complex, multivariable needs and challenges Ricky is working to overcome, collaboration between his care providers is crucial to his long-term success. Unfortunately, the mental health infrastructure and community support programming available in Ricky's home state are severely limited, making building the team he needs (and, as a consumer, deserves) nearly impossible.

Conclusion

Ricky's case is a fantastically complicated scenario that most providers will go their entire careers without encountering again. This is true both for Therapist 1, who walks away from their time with Ricky certain that they have diagnosed a case of Dissociative Identity Disorder and confident that they have helped him identify at least three "alters"; and for Therapist 2, who closes Ricky's file confident that they have taken the steps necessary to address a crucial wrong (misdiagnosis with a severe and stigmatizing label) while building a path towards a healthier, more supportive life for Ricky that makes space for his kink-identities without centering them as the root cause of his behavioral and developmental challenges. The stark differences in the care that Ricky received between these two providers speaks to the importance of kink competency for mental health providers and the ability to structure their treatment plans in a way that align with the Kink Guidelines. In Ricky's case, a lack of kink-awareness and an implicit bias within Therapist 1 could have resulted in a significant breakdown in the young man's key (indeed only) support system at best, and violence towards these support persons and Ricky himself at worst.

It is not uncommon for general mental health providers to view sex therapy as a niche field that they can refer clients to, if and when the need arises. Kink-affirming

therapy is a niche within this niche and its practitioners are often considered as outré as the clients who may need them. However, the case of Ricky shows us just how important comprehensive sexual health education is for non-specialist providers. They may only need to draw on the depths of this knowledge a handful of times across their careers, but the odds are quite good (1 in 3, in fact) that they will have kink-identified clients on their caseloads. A lack of basic kink competency can result in their failure to recognize the unique needs of the person in the chair across from them. This may (like Ricky) cause tremendous harm… or it might result simply in a quiet decision on the part of the kinky client to keep this aspect of their authentic lives and identities to themselves. Both outcomes represent an easily avoidable tragedy.

Acknowledgements

The author would like to acknowledge those researchers and clinicians who created the Kink Guidelines, and whose work has been instrumental in reducing stigma, confronting bias, and laying the foundation for kink-affirming practice.

Disclosure statement

The author has no financial interests to report.

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