Trauma psychotherapy with people involved in BDSM/kink: Five common misconceptions and five essential clinical skills

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Introduction

Multiple studies suggest that psychotherapists have negative misconceptions about people involved or interested in BDSM/kink, are largely unfamiliar with key research findings on BDSM/kink relationships and practices, and lack basic clinical skills needed to provide adequate care for people involved or interested in BDSM/kink (e.g., Bezreh, Weinberg, & Edgar, 2012; Kelsey, Stiles, Spiller, & Diekhoff, 2013; Kolmes, Stock, & Moser, 2006; Wright, 2008a; Wright 2008b). Previous research findings document how psychotherapists' negative misconceptions about people involved or interested in BDSM/kink have often resulted in unethical clinical practices and ineffective or harmful therapeutic outcomes. The following narrative examples describe typical experiences shared by participants across these studies:

I was made to feel like I am not normal and a social deviant. I felt uncomfortable and felt I could not freely be myself or talk openly about issues concerning myself to my psychologist. I spent more than half of one of my sessions trying to defend myself and my position in the BDSM community (as quoted in Wright, 2008a, p. 1).

After finding out about my interest in BDSM, my psychiatrist stated that I "cannot be ruled out as a danger to myself or others due to her interest in BDSM" (as quoted in Wright, 2008a, p. 2).

I've had therapists and shrinks insist on analyzing my avowed masochism as pathology and/or self-hatred and when I told them that I was fine w/it, didn't want to be judged, and had other issues I had come to them for they ignored my comments and insisted on viewing every issue in my life through the lens of BDSM "pathology". Needless to say, I have since changed mental health professionals (as quoted in Wright, 2008a, p. 6).

My BDSM partner was hospitalized at a mental institution. My involvement in the BDSM community and/or practices was questioned and then it was questioned whether or not I should be allowed access to visit my partner. He was not institutionalized for anything to do with BDSM, he was suffering from severe depression and suicidal tendencies (as quoted in Wright, 2008a, p. 3).

For people seeking trauma therapy, stigma and rejection by psychotherapists can have profound negative consequences. In their content analysis of therapy experiences shared by 32 woman/man dyadic relationship partners involved in BDSM/kink in the US and Germany, Hoff and Sprott (2009) identified five categories of therapeutic response: termination of therapy initiated by the therapist due to disclosure of involvement in BDSM/kink; negative comments and evaluations that communicated therapists' discriminatory ideology about people involved in BDSM/kink; "neutral" approaches; knowledgeable and supportive responses; and non-disclosure by participants, some of whom reported this decision was based on concerns about therapists' pathologising responses. Participants who were subjected to negative responses from psychotherapists often felt unable to access therapy in the future and reported feeling unable to seek support again as a result of these experiences.

It is worth noting that therapists' ostensibly "neutral" approaches, which Hoff and Sprott refer to as the "equal treatment of factors" type of response, had multiple negative therapeutic consequences. Despite not being explicitly negative, apparent neutrality failed to provide support to counterbalance stigma due to an often hostile and kink-shaming societal context. People interacting with "neutral" therapists found that these therapists displayed ignorance about BDSM/kink, which resulted in psychotherapy participants having to spend session time engaged in teaching and explaining interactions (e.g., explaining basic BDSM/kink concepts and terminology to the therapist) rather than on actual therapeutic work. Several respondents mentioned that "neutral" therapists would change the session topic back to non-BDSM/kink aspects of their relationships as if they "didn't want to concentrate on it" or would write more extensive notes when BDSM/kink was discussed. In these ostensibly neutral therapeutic contexts, giving psychotherapy participants the autonomy to direct the focus of the interaction, rather than the therapist assuming BDSM/kink was more or less salient to the issue being discussed, helped to prevent damage to the therapeutic relationship. Nichols (2006) discussed how therapists unfamiliar with BDSM/kink commonly experience shock, fear, disgust, revulsion, and anxiety that can result in therapists' "deeply felt conviction that the client's behavior is self-destructive, but have little more than vague abstractions to justify the firmness of the conviction" (p. 286). Similarly, therapists' beliefs that the feelings, actions, and relationships of BDSM/kink practitioners are pathological can be the result of therapists' personal discomfort. Nichols explored how therapists' responses of alarm and concern when hearing descriptions of BDSM/kink interactions may be "based purely on psychological speculation" (p. 286). Given the poor clinical judgements that can result from evaluations based on psychological speculation rather than actual knowledge, "neutral" therapists' ignorance about BDSM/kink can predictably lead to inadequate and unprofessional behaviour by therapists.

In their guide for people involved in BDSM/kink who are seeking psychotherapy, Kolmes and Weitzman (2010) distinguish between a kink-*friendly* therapist and a kink-*aware* therapist. These authors explain that a kink-friendly therapist is merely open to discussing BDSM/kink and can avoid making negative clinical judgements about people involved in BDSM/kink, without necessarily having any specific knowledge about BDSM/kink. In contrast, a kink-aware therapist is one who recognises BDSM/kink as normal, can distinguish BDSM/kink that people describe as being "healthy" for them from non-consensual abuse, is aware of what constitutes safe or risk-aware BDSM/kink practice, understands the diversity and nuance of BDSM/kink, and is aware of BDSM/kink-specific concerns that might be

relevant to therapy. These concerns may include basic concerns common among people involved in BDSM/kink, such as disclosure to self and others, how to communicate about BDSM/kink with non-BDSM/kink partners, how to negotiate about BDSM/kink boundaries and limits, and how to manage stress caused by having to hide one's involvement in BDSM/kink.

Data from the *Survey of Discrimination and Violence against Sexual Minorities* (Wright, 2008b) documented that psychotherapists who might consider themselves non-judgemental and affirming toward people involved or interested in BDSM/kink can be therapeutically ineffective or create unnecessary labour for psychotherapy participants when these psychotherapists lack adequate BDSM/kink-specific clinical knowledge, understanding, and skill. As one participant explained,

Neither my psychiatrist nor my therapist has a clue about BDSM. They don't seem to judge me over it, and the therapist seems genuinely interested in learning, but sometimes it just takes too much effort to teach her (as quoted in Wright, 2008a, p. 7).

For people involved or interested in BDSM/kink, the experience of trauma psychotherapy to address their previous traumatic experiences can itself feel unsafe or traumatic. Many such experiences have been shared with me as an experienced mentor of Dominants, submissives, and *S/switches* (i.e., people whose relational role dynamics involve a combination of being Dominant or submissive. Switch in an S/M context involves a combination of being Top or Bottom. All terms explained below). People whom I have mentored have often shared their negative experiences with trauma psychotherapists who are hostile, uninformed, ineffective, or unintentionally harmful. In my work as a trauma psychotherapist who provides clinical education and supervision for other psychotherapists, I am frequently asked questions that reflect some of the aforementioned misconceptions about people who are involved in or interested in BDSM/kink. For example, some common questions psychotherapists from a wide range of mental health professions have asked me include the following:

- Is BDSM a sign that people are damaged and recreating their trauma?
- Isn't it inappropriate for people to want power dynamics in their relationships?
- How can I tell the difference between abuse and BDSM? Isn't S/M just an excuse to hit people and get away with it?

Five of psychotherapists' common misconceptions about BDSM/kink are: that BDSM/kink relationships constitute a fringe relational style or "alternative lifestyle," that BDSM/kink is inherently abusive and causes trauma, that involvement in BDSM/kink is caused by past trauma, that BDSM/kink relationships are inferior to or less meaningful than non-BDSM/kink relationships, and that BDSM/kink is not clinically relevant or appropriate to discuss in trauma therapy. This article challenges these five common misconceptions, discusses relevant research findings, and explains five of the essential clinical skills for trauma psychotherapists working with people interested or involved in BDSM/kink relationships and practices: understanding D/s and S/M relational roles and headspaces, distinguishing BDSM/kink from abuse, identifying key components of non-abusive BDSM/kink, determining the clinical salience of BDSM/kink, and identifying and managing freefall.

BDSM/kink kinship spheres, social circles, and communities of practice are extremely diverse. It is beyond the scope of this article to document the myriad communities, activities, and relational role identities of people involved or interested in BDSM/kink, nor is it possible to provide comprehensive information about all of the clinical knowledge and skills needed to provide anti-oppressive, effective

clinical care for people involved or interested in BDSM/kink and their kinship spheres. This article aims to provide a basic foundation for trauma psychotherapists to begin the process of addressing clinically relevant gaps in their BDSM/kink-specific knowledge, understanding, and skills.

What is BDSM/kink?

The term "BDSM" is an initialism for consensual forms of bondage and discipline (B/D), Dominance and submission (D/s), and Sadism and Masochism (S/M or SM). The portmanteau "sadomasochism" (sometimes capitalised) is often used instead of Sadism and Masochism to distinguish S/M from non-consensual, abusive forms of "sexual sadism". The term sadomasochism also highlights the central importance of mutuality and co-collaboration in S/M experiences. Turley, King, and Monro (2018) documented the high value people involved in BDSM/kink placed on the co-collaborative process of creating, maintaining, and engaging with BDSM/kink experiences. Within BDSM/kink relationships and communities, Sadists are often called Tops and Masochists are often called Bottoms. (Note that the terms Top and Bottom can have a distinct meaning that refers to non-BDSM/kink sexual activity, particularly when discussing sexual activity between men.)

In this article, I have used the widespread BDSM/kink written convention of capitalising the term "Dominance". In BDSM/kink relationships and communities, it is common to capitalise Dominants' names and pronouns (e.g., "Kara is bringing Her sub to the party after She finishes work.") and lowercasing submissives' names and pronouns (even at the beginning of a sentence, e.g., "i am going to the store. i will be home in an hour. my Master will be waiting for me."). The BDSM/kink convention is to combine both uppercase and lowercase letters for S/switches in general (e.g., "S/Samantha told Me that S/she would like to meet Your sub.") and to use either uppercase or lowercase letters for S/switches when discussing them in relation to a particular partner or partners (e.g, "J/jamal asked me to pick up the sandwiches from the deli. his Master asked him to handle the catering, but His sub said he could do it for Him."). Given the high volume of text messages, social media posts, and emails in many people's everyday communications, using BDSM/kink written conventions can be a meaningful way of connecting with partners, nourishing D/s relational role dynamics while physically apart, and expressing BDSM/kink identities. For this reason, people who are involved in BDSM/kink are likely to experience it as disrespectful and exclusionary when therapists ignore or dismiss the importance of using BDSM/kink conventions in written correspondence. Some people of trans and/or non-binary experience who are in BDSM/kink relationships have told me they experience therapists' refusal to match their written BDSM/kink conventions as being as emotionally harmful as intentional misgendering.

Although the term "S&M" has been popularised in mass media, many S/M practitioners avoid this term due to its association with non-consensually voyeuristic and sensationalised depictions of S/M and the consequent devaluing of S/M relationships and kinship ties. Among people who engage in S/M relationships and activities, S/M is often described as *pain play* or *impact play* (e.g., Crane, 2019). In this article, I will instead use the phrase *sensation exchange* for three reasons: to highlight that S/M may constitute a meaningful part of relational role dynamics beyond the scope of what might be considered "play" scenes or sessions (e.g., Faccio, Casini, & Cipolletta, 2014; Lawson & Langdridge, 2019); to emphasise the nature of S/M as an intimate, interactive, and multifaceted sensory experience not limited solely to pain or impact; and, to acknowledge that the physiological phenomena that occur during S/M experiences and headspaces mean that otherwise painful stimuli can produce desirable and arousing physiological, emotional, and relational effects (Ambler et al., 2017; Ioanas, 2013; Klement et al., 2017; Lee et al., 2016; Pitagoras, 2017).

Sensation exchange can include both interludes or time periods during which people engage in S/M activities (often described by the noun "scene" or the verb "scening"), and those D/s and/or S/M relationships in which sensation exchange may form an integral component of regular consensual, mutually desired interactions shared between partners. B/D can include rope bondage, often described as rigging or rope play, as well as other forms of restraint, confinement, or restriction of movement. Experts who are proficient in rope bondage are often described as *riggers*. Discipline can include forms of sensation exchange (e.g., flogging, spanking, caning) as well as relational role scenarios known as *role play* (e.g., a teacher ordering her student to write lines on a blackboard or a doctor "punishing" her wayward patient through restrictions on her clothing and speech).

D/s is often described as *power exchange,* in recognition that Dominant and submissive relational role dynamics can function in complex and collaborative ways, rather than always conforming to the superficial appearance of a Dominant "having power over" a submissive (e.g., Dancer, Kleinplatz, & Moser, 2006; Turley, 2018). Academic theories that seek to delineate D/s from S/M based on the presence of a relational power differential may not be supported by research evidence. For example, Cross and Matheson's (2006) analysis of four empirical studies of S/M Tops and Bottoms found that power exchange rather than pain giving and receiving was a core component of S/M. This less essentialist concept of power exchange can also provide greater inclusion for S/switches.

BDSM/kink relationships and interactions may or may not combine elements of B/D, D/s, S/M, and additional kinks simultaneously. The term "kink" refers to any activity or element that enhances but is not required for a person to experience sensory pleasure, erotic arousal, and/or orgasm (Shahbaz & Chirinos, 2017). The term "BDSM/kink" is increasingly used to provide a more inclusive umbrella term than BDSM alone. Use of this umbrella term reflects an effort to provide greater recognition and acceptance of kinship ties, relational dynamics, and activities that cannot be characterised adequately as fitting within the scope of B/D, D/s, or S/M. One example of a kink that does not fit neatly within the aforementioned BDSM paradigm is *puppy play*, in which humans take on relational roles such as *Owners* and *Their bitches/pups* or, less commonly, *Bitches/Pups* and *Their humans* (e.g., Wignall, 2017; Lawson & Langdridge, 2019).

Another popular kink that may or may not involve any B/D, D/s, or S/M is popularly known by the initialism *DD/lg* or *ddlg*, which stands for *Dominant Daddy/little girl*. Despite the superficial linguistic similarity, it is crucial that psychotherapists avoid the unfounded conflation of ddlg practitioners with people who sexually harm young people. In my psychotherapeutic work, I have consistently encountered ddlg practitioners who, as parents, express genuine horror at the idea of an actual adult engaging in any sexual, erotic, or BDSM/kink activities with an actual child. Although the term ddlg may be more widespread in the public domain, related kinks include MDlg or mdlg, which stands for *Mummy Dominant/little girl*; MDlb or mdlb, which stands for *Mummy Dominant/little boy*; and DD/lb or ddlb, which stands for *Dominant Daddy/little boy*. As many non-binary people have posted online seeking inclusive terminology for this kink, I propose *DClx* or *dclx* as a non-binary-inclusive, non-cisgenderist umbrella term to describe the *Dominant Carer* or *Caregiver/little* kink sphere, with *x* in place of binary terms like girl or boy.

Determinations about which relational dynamics and activities constitute kinks often reveal more about the erotic culture and ideology of the people making the determinations than they do about the people engaging in the kink. For example, some people might consider the wearing of silky lingerie to be a kink, whereas other people might consider wearing silky lingerie to be a normative practice during erotic encounters. In contrast, the term *fetish* refers to a specific sensory stimulus without which a person is

unable to experience sensory pleasure, erotic arousal, and/or orgasm. Although kinks and fetishes are often conflated, all fetishes are kinks, but not all kinks are fetishes. For example, *splosh*—also known as "wet and messy kink" or sensory play with substances applied to the skin, face, or clothing (e.g., giving someone a pie in the face, pouring baked beans on a partner's clothing, or submerging fully clothed into a tub filled with liquid chocolate)—is a popular kink that can be a fetish for some people.

BDSM/kink does not necessarily require orgasm, nudity, genital contact, or even direct physical contact at all (Sagarin, Lee, & Klement, 2015; Simula, 2019b). Some people who identify as being on the asexual (or *ace*) spectrum enjoy various BDSM/kink activities (e.g., Jolene Sloan, 2015). Unfortunately, despite the need for research on BDSM/kink beyond the limited scope of "sexual" activity, researchers often conflate BDSM/kink with "sex". Newmahr (2010) noted how use of the term "kinky sex" can perpetuate this conflation. Researchers' ideological assumptions about BDSM/kink as a purely "sexual" activity have resulted in erasure of people's non-sexual BDSM/kink relationships and experiences. For example, Weinberg, Williams, and Mosher (1984) used exclusion criteria for their sample that required participants involved in BDSM/kink to give these activities sexual meaning in order to be considered "into SM" and thus included in the study. The authors mentioned that people involved in BDSM/kink who gave these experiences non-sexual meanings were excluded.

Five Common Misconceptions and Relevant Research Findings

This section responds to five of psychotherapists' common misconceptions, as documented in previous research, with facts drawn from relevant research.

Misconception 1: BDSM/kink Relationships Constitute a Fringe Relational Style or "Alternative Lifestyle"

Facts: Contrary to negative stereotypes that BDSM/kink desires are alternative, deviant, psychopathological, or rare, research suggests that it is common for people to have fantasised about or engaged in some form of BDSM/kink. For example, Holvoet et al. (2017) found that 68.8% of the general population in Belgium reported being involved in or having had fantasies about some form of BDSM/kink, with 46.8% reporting that they had actually participated in a BDSM/kink-related activity. This study found that BDSM/kink desires and activities were widespread and normative rather than an "alternative lifestyle" or fringe relational style. These findings build on Renaud and Byers' (1999) study of Canadian university students' sexual cognitions. The researchers found that 59% of participants who were classified as women and 72% of participants who were classified as men had fantasised about being tied up by a partner, that 58% in the women group and 65% in the men group had fantasised about tying up a partner, and 31% of the women group and 60% of the men group had positive thoughts about spanking or whipping a partner. Yet one Australian study found that only 1.3% of participants classified as women and 2.2% of participants classified as men had actually participated in BDSM/kink activity in the past year (Richters, Grulich, de Visser, Smith, & Rissel, 2003). Variation in findings on BDSM/kink involvement and interest across geographic regions may reflect differing degrees of societal stigma that can lead to underreporting and under-identification of people's BDSM/kink experiences.

Many BDSM/kink communities around the world are still missing from research literature. Despite these gaps, research shows that BDSM/kink encompasses myriad cross-cultural and international phenomena. For example, researchers have explored BDSM/kink communities in India (e.g., Sharma & Gupta, 2011), Italy (e.g., Zambelli, 2017; Zambelli, 2016), Singapore (e.g., Sheela, 2008), South Africa

(e.g., McCormick, 2018) and Spain (e.g., Rodas, 2017). Rodas (2017) noted that the exclusion of questions about BDSM/kink from national surveys of sexual activity was a key barrier to improving understanding of Spanish BDSM communities.

Misconception 2: Involvement in BDSM/kink is Caused by Psychopathology or Past Trauma

Facts: Despite the myth that people only become interested in BDSM as a result of traumatic past experience, psychopathology, or dysfunction in their family of origin, research documents no credible evidence that a BDSM/kink orientation is due to childhood trauma or past abuse (Coppens, Ten Brink, Huys, Fransen, & Morrens, 2019; Richters et al., 2008). Numerous studies show that BDSM/kink is “a viable and healthy outlook to lifestyle and sexuality” (Shahbaz & Chirinos, 2017, p. 25; see also Cross & Matheson, 2006; Langdridge & Butt, 2004; Lawrence & Love-Crowell, 2007; Rogak & Connor, 2018) and that the role identity development of BDSM/kink practitioners follows a natural trajectory that is not caused by adverse life experiences (Coppens et al., 2019). In fact, one study of 902 BDSM/kink practitioners and 434 non-BDSM/kink control participants found that BDSM/kink practitioners scored more favourably than non-BDSM/kink control participants on a variety of measures designed to evaluate psychological functioning (Wismeijer & van Assen, 2013). This study found that BDSM/kink practitioners were less neurotic, more open to new experiences, more conscientious, less rejection sensitive, and had higher subjective wellbeing than non-BDSM/kink control participants.

Misconception 3: BDSM/kink is Inherently Abusive and Causes Trauma

Facts: The meanings that BDSM/kink practitioners ascribe to their own BDSM/kink relationships and practices vary widely. Despite attempts by some researchers to impose an ethnocentric, monolithic taxonomy of BDSM/kink experience, no single, universal explanation of BDSM/kink can incorporate available research findings. BDSM/kink has been described by people with lived experience alternately or simultaneously as a sexual orientation (e.g., Coppens et al., 2019; Gemberling, Cramer, & Miller, 2015; Yost & Hunter, 2012), a 24/7 lifestyle or way of life (e.g., Dancer, Kleinplatz, & Moser, 2006; Webster & Klaserner, 2019), a relational role dynamic (e.g., Barker, Iantaffi, & Gupta, 2014; Coppens et al., 2019; Dancer et al., 2006; Galati, 2017), a spiritual path (e.g., Baker, 2018; Kaldera, 2014), an ordeal ritual (e.g., Klement et al., 2017; Lee et al., 2016), an altered state of consciousness (e.g., Ambler et al., 2017), a form of therapy or healing (e.g., Andrieu, Lahuerta, & Luy, 2019; Galati, 2017; Lindemann, 2011), a form of stress relief (e.g., Andrieu et al., 2019), a self-care activity (Galati, 2017), self-medication for mood-related mental health symptoms such as anxiety and depression (e.g., Andrieu et al., 2019; Galati, 2017), an intrinsic part of self (e.g., Yost & Hunter, 2012), a form of deeply personal and lasting transformation or self-discovery (e.g., Baker, 2018; Galati, 2017), a visionary experience (e.g., Baker, 2018), an empowering feminist practice (e.g., Jones, 2019; Zambelli, 2016), a recreational hobby or leisure activity that can be serious or casual (e.g., Coppens et al., 2019; Newmahr, 2010; Prior & Williams, 2015), a calming or meditative activity (e.g., Galati, 2017), a set of kinship ties (e.g., Dancer et al.,r, 2006; Galati, 2017), a social community (e.g., Coppens et al., 2019; Galati, 2017; Graham, Butler, McGraw, Cannes, & Smith, 2016; Webster & Klaserner, 2019), a way to gain new knowledge and practical and interpersonal skills (e.g., Galati, 2017; Graham et al., 2016), a fantasy or escape from mundane life pressures (e.g., Coppens et al., 2019; Turley, King, & Butt, 2011), and a fun sensual game or form of play that results in sensory pleasure (e.g., Turley et al., 2011; Wismeijer & van Assen, 2013). This impressive diversity of meanings and lived experiences among people involved in BDSM/kink highlights the wide scope of benefits people attribute to their involvement in BDSM/kink. Despite the uninformed assumption by many psychotherapists that BDSM/kink is an inherently abusive cause of

trauma, an extensive body of research has repeatedly documented the emotional benefits and potent healing qualities of BDSM/kink. For people involved in BDSM/kink, it appears that trauma psychotherapists' negative stereotypes about BDSM/kink and the discriminatory practices that result from these assumptions are more likely to cause trauma than BDSM/kink itself.

Widespread disregard for the diversity of BDSM/kink relationships and experiences within the field of psychotherapy is a systemic form of abuse that can result in trauma. Attempts to provide a single theoretical framework to explain BDSM/kink both from within and outside of BDSM/kink communities of practice can often intersect with ethnocentrism, racism, and colonialism in complex ways (see Bauer, 2008; Cardoso, 2018; Cruz, 2015; Sheela, 2008; Simula, 2019a). Some BDSM/kink practitioners use the term *vanilla* to describe non-BDSM/kink relationships and activities (Meyer & Chen, 2019), whereas others critique this term as racist and exclusionary. Beres and MacDonald (2015) explored the complexity of determining consent in a context where heteronormative assumptions may undermine women's autonomy, while Jones (2019) explored how submission in BDSM/kink can be an empowering feminist practice (see also Zambelli, 2016). Pitagora (2016) discussed the lack of intersectionality in studies on either polyamorous or BDSM/kink relationships and communities, despite frequent accounts of people involved in both polyamorous and BDSM/kink relationships and communities in the literature. Hopkins (1994) articulated the need for nuanced theorising that distinguishes between *simulation* and *replication* of sexist patriarchal activities. Tellier (2017) discussed how ableist exclusion of people with disability labels and/or impairments from research on sexual satisfaction intersects with conceptualisations of BDSM/kink. More recently, Simula's (2019a) review of literature on BDSM/kink suggested the need for deepening and broadening intersectional analysis of BDSM/kink experiences, exploring specialised roles and identities within BDSM/kink, and analysing variance between people involved in time-limited BDSM/kink experiences and people who experience BDSM/kink as a stable, permanent, and core aspect of their identity. When considered collectively, these analyses suggest some of the perils faced by psychotherapists who may encounter essentialist, reductionist, and universalising discourse even in ostensibly inclusive or affirming research literature in their efforts to acquire clinical knowledge and understanding of BDSM/kink. As trauma psychotherapists, our awareness that BDSM/kink can contribute to healing, interpersonal connectedness, and emotional resilience is vital to ensuring we achieve our therapeutic aim of reducing rather than increasing trauma for people with whom we work.

Misconception 4: BDSM Relationships are Inferior To or Less Meaningful Than Non-BDSM Relationships

Facts: BDSM/kink relationships can be kinship ties as meaningful and committed as marriages, handfastings, and civil unions can be for non-BDSM/kink relationships. Among BDSM/kink communities and social circles, c*ollarings* and *collaring ceremonies* are union ceremonies that recognise the validity and importance of BDSM/kink relationships (e.g., Turley, 2018). Research shows that even the consensual D/s relational role dynamic known as "24/7 slavery" can be long-lasting and satisfying for submissive participants in BDSM/kink relationships (Dancer et al., 2006).

Misconception 5: BDSM/kink is not Clinically Relevant or Appropriate To Discuss in Trauma Therapy

Facts: BDSM/kink is a marginalised topic within mental health professions, where it is often treated as irrelevant or inappropriate to discuss. In a US-based survey of 766 therapists, 66% reported having worked with one or more people involved in BDSM/kink, yet only 48% reported feeling competent in

doing so (Kelsey et al., 2013). There are multiple ways that BDSM/kink may become relevant during trauma psychotherapy. People may find the experience of psychotherapy traumatic due to their therapist's lack of BDSM/kink-specific knowledge or understanding. The trauma that a person seeks to heal may or may not have been created in a BDSM/kink context. People with a history of abusive non-BDSM/kink relationships may seek a therapist to discuss their interest in using BDSM/kink to heal trauma. They may already be in a BDSM/kink relationship that they are using to heal trauma. A person with a trauma history who is new to BDSM/kink may wish to discuss the difference between BDSM/kink and abuse with their therapist to protect themselves from further abusive experiences. Some uninformed therapists believe that all BDSM/kink is abuse. People who have had abusive experiences within a BDSM/kink context often feel unable to seek therapeutic support as a result of the stigma against BDSM/kink relationships and experiences. If a person does experience abuse in a BDSM/kink relationship, they are much less likely to be able to talk about it with a trauma psychotherapist.

Discussing BDSM/kink can also be an essential component of evidence-based trauma therapy. In the field of clinical traumatology, the current evidence-based best practice model of trauma therapy includes four stages (Gentry, Baranowsky, & Rhoton, 2017; cf. Herman, 1992). Stage 1 is *relationship building* and also *safety and stabilisation*. Stage 2, *psychoeducation* and *self-regulation*, provides psychoeducation about the biopsychosocial manifestations of trauma, helps people to develop *interoception* (i.e., an internal awareness of what is going on in one's body), and assists people with developing skills for self-regulation or the ability to maintain optimal biopsychosocial functioning in the presence of a perceived threat. Stage 3, *recovery* and *resolution*, focuses on exposure to past traumatic experiences through narrative, visual, and other methods. Despite the harmful and still widespread use of "flooding" to initiate Stage 3 conversations about past traumatic experiences at the onset of trauma therapy, extensive evidence suggests that this premature initiation of Stage 3 can increase dissociation and retraumatise psychotherapy participants. Current best practice guidelines state that Stage 3 is only indicated in cases where a person is experiencing intrusion or intrusion-related avoidance of necessary or desired domains of life experience following the completion of Stage 2. Stage 3 marks the completion of work to address past trauma. During Stage 4, *post-traumatic resiliency building*, therapists assist people to build meaningful, fulfilling lives following traumatic experiences. The focus is on changing perceptions of self, interpersonal relationships, and philosophy of life. This stage focuses on relating to others, personal strength, spiritual change and maturity, appreciation of life, and new possibilities. Stage 4 work also involves helping people to develop resiliencies that reduce the adverse impact of future life events.

BDSM/kink-related content may be clinically relevant and even essential to discuss during each of these four phases. For example, BDSM/kink practitioners may be unable to build a therapeutic relationship with the trauma psychotherapist or achieve biopsychosocial safety and stabilisation in Stage 1 without appropriate attention to their BDSM/kink-related needs. Becoming aware of one's BDSM/kink needs can be an essential component of achieving interoception during Stage 2. Stage 3 narrative exposure may require discussing abuse that occurred in BDSM/kink contexts or abuse masquerading as BDSM/kink. Achieving a meaningful and fulfilling life in Stage 4 may involve finding ways to provide for BDSM/kink-related needs and develop satisfying BDSM/kink relationships. There are many more possible examples of how BDSM/kink can be clinically relevant and appropriate to discuss in trauma therapy.

Five Essential Clinical Skills

Five essential clinical skills for trauma psychotherapy with people interested or involved in BDSM/kink are: understanding and identifying BDSM/kink relational roles and headspaces, distinguishing BDSM/kink from abuse, understanding and identifying key components of non-abusive BDSM/kink relationships, determining the clinical salience of BDSM/kink, and identifying and managing freefall.

Clinical Skill 1: Understanding and Identifying BDSM/kink Relational Roles and Headspaces

People involved in BDSM/kink have often described their relational roles in terms unique to D/s, S/M, and kink relationships. The relational role term "Dominant" is used as a noun and often shortened to *Dom* for men and *Domme* for women (pronounced by some people as "dom" and by others as "dom-mé"). Non-binary people who identify with more than one gender may use either of these gendered terms. Some people with more than one gender will alternate between terms depending on their gender expression in the moment. The written form *Dom/me* is used by some non-binary people and by other people who do not identify as either women or men. The term submissive is often shortened to *sub* or the affectionate and diminutive *subbie*. The term "S/switch" (also written as "Switch," both pronounced the same) refers to people who experience some combination of Dominance and submission in a D/s context and are not exclusively Dominant or submissive. The term S/switch can also describe people who experience some combination of Top and Bottom in an S/M context.

In addition to the three overarching categories of Dominant, submissive, and S/switch, each of these three categories contains numerous Dominant types (*D-types)* and submissive types (*s-types)*, terms that describe specific Dominant and submissive archetypes. For example, a *service submissive* is an s-type in which the submissive derives pleasure from providing services to a Dominant, often without any sexual or S/M activity involved. This s-type is often part of a 24/7 or full-time D/s relationship. Some service submissives achieve personal or erotic fulfilment from serving a drink to their Dominant or functioning as human furniture such as a dining table or footstool. A queer woman who identifies as a service submissive explained that,

I get pleasure from serving my dom in almost whatever way she wants me to. This includes things like foot massages, cooking and cleaning for her, repairing her clothing, opening doors for her and generally following orders (as quoted in Bernard, 2018, Service Sub section).

Note that this woman appears not to have used BDSM/kink written conventions and also described her Dominant as "my dom," a term more typically used to describe men and some non-binary people. The wide diversity among people involved in BDSM/kink means that therapist need to pay close attention and adapt to the BDSM/kink conventions a particular person uses to describe their lived experience and relationships.

A *Service Dominant* or *Service Top* is a D-type in which the Dominant or Top derives pleasure from providing pleasure to or doing things to their submissive or bottom. Some Service Dominants can achieve personal or erotic fulfilment from activities such as bathing or dressing their submissive, often without any sexual or S/M activity involved. Some Service Tops can achieve personal or erotic fulfilment from tying up or spanking an enthusiastic Bottom or by stimulating the Bottom to orgasm without the Service Top wanting to orgasm or receive any physical stimulation of their own body.

A few common D-types are *Mistress/Master/Owner*, *Daddy/Mummy/Carer* (each can be used by a person of any gender and do not refer to actual parenthood or any paedophilic content), *Primal/Beast*, *Ma'am* or *Mx* (a non-binary title, pronounced as either "M.X." or "mix") or *Sir*, or *Service Dom/Service*

Top. Any of these terms can also be used by people of any gender.

There are also S/s-types for S/switches, but these are less frequently mentioned in BDSM/kink discourse due to a problem I term *S/switch erasure*. Unfortunately, due to the phenomenon of S/switch erasure itself, the extensive peer-reviewed research on BDSM/kink barely addresses S/switches' needs as distinct from those of Dominants and submissives. Little to no information is provided in the literature about the unique needs and experiences of S/switches, beyond the cursory statement that these needs are somehow distinct (e.g., Martinez, 2018). Even where S/switches' lived experiences are discussed and even when researchers attempt to challenge binarising approaches to BDSM/kink, S/switches are evaluated against the standard of the Dominant/submissive binary rather than in their own right (e.g., Martinez, 2018). The underrepresentation of S/switches (who are common in actual BDSM/kink communities) in participant samples can lead researchers to the erroneous conclusion that S/switches are rare and that most people fit into the Dominant/submissive binary. However, some research suggests that most people involved in BDSM/kink switch at least sometimes (e.g., Moser & Levitt, 1987) and that some people's BDSM/kink orientation varies depending on their partner's gender and other factors that vary by partner (Weinberg, Williams, & Moser, 1984).

Simula's (2019) study of how people perceived their sexual BDSM/kink experiences found that they reported sexual BDSM/kink as both significantly different from and better than "mainstream" or "vanilla" sex. The study found three main differences between sexual BDSM/kink and non-BDSM/kink: Participants reported that sexual BDSM/kink—unlike non-BDSM/kink sex—did not require genital contact. They perceived BDSM/kink as focused more on creating sexual fulfillment than on evaluating sexual experiences according to normative markers such as orgasm. Participants described sexual BDSM/kink as primarily emotional and mental experiences, whereas non-BDSM/kink sex prioritised physical experiences. Participants also felt that sexual BDSM/kink facilitated deeper interpersonal connections than non-BDSM/kink sex. Thus, most participants, using these characteristics as evaluative criteria, reported a strong preference for sexual BDSM/kink over non-BDSM/kink sex. Despite the need for further research with larger samples, this study suggests that people experience and evaluate sexual BDSM/kink in unique ways that cannot be generalised from theoretical frameworks that take non-BDSM/kink practices and norms as their evaluative frame of reference.

Unlike non-BDSM/kink sexuality terms such as "lesbian," "bisexual," "gay," or "heterosexual," people involved in BDSM/kink use terms that make relational role dynamics more salient than partner gender. Where gendered terms are used, D/s interactional aspects remain focal. The term *Femdom* is often used to describe BDSM/kink relationships and communities in which women and feminine-identified non-binary people are Dominant, whereas *Maledom* is often used to describe those where men and masculine-identified non-binary people are Dominant.

Knowing that a prospective partner is a Dominant, submissive, or S/switch is not sufficient information to establish compatibility without more information about the prospective partner's D-type, s-type, or S/s-type (see Cutler, 2003; Dancer et al., 2006). Assisting people involved or interested in BDSM/kink with exploration of their D-type, s-type, or S/s-type can facilitate greater self-awareness of their own needs, improve their ability to communicate limits and boundaries in their BDSM/kink relationships, and help them to establish relationships with compatible BDSM/kink partners.

Visual representations can also be helpful to psychotherapy participants who seek to establish non-abusive BDSM/kink relationships after past abusive experiences within or outside of BDSM/kink contexts. Whereas generic Anglocentric genograms treat gender as the key variable that determines

which symbol is used to represent each person, BDSM/kink genograms treat a person's role as a Dominant, submissive, or S/switch as the key variable. Although no standardised classification exists for genograms representing BDSM/kink relational systems, Table 1 outlines my proposal for an initial system until a more comprehensive system is developed.

Table 1: Some Proposed Genogram Symbols for BDSM/kink Relational Role Dynamics

Dominant/submissive (D/s) power exchange dynamic	Sadomasochistic (S/M) sensation exchange dynamic
Δ = D/s Dominant	← = S/M Top
∇ = D/s submissive	→ = S/M Bottom
= D/s S/switch	↔ = S/M Switch

BDSM/kink practitioners often describe their BDSM/kink experiences in terms of altered states of consciousness, or *headspaces* (for more information, see Pitagora, 2017; cf. Zussman & Pierce, 1998). Widespread terms for these headspaces that typically correspond to BDSM/kink relational roles are *subspace*, *Bottomspace*, *Domspace*, and *Topspace*. In addition, people often have terms for specific s-type, D-type, and S/s-type headspaces (e.g., *littlespace*, *Daddyspace*, *pupspace*, or *ponyspace).* A key therapeutic task in the post-traumatic growth phase of trauma psychotherapy can be to help people to resolve conflicts between parts of themselves that are in BDSM/kink headspace and non-BDSM/kink parts of themselves, recognising that each aspect has wisdom, strength, and vulnerabilities.

The phenomena commonly described as *sub drop*, *Dom drop*, or simply *drop* refer both to the "drop" in energy and mood that many people experience following BDSM/kink headspace or activities and to the psychological after-effects of BDSM/kink experiences that differ from people's everyday public roles (e.g., Johnson, 2008). It is important for therapists to understand that drop is a natural physiological consequence following the rush of endorphins and adrenaline that people often experience during BDSM/kink headspaces and activities (for a general scientific overview of these biochemical processes, see McLaughlin & Zagon, 2013). Few researchers have studied post-BDSM/kink drop empirically, and most literature on drop focuses far more on qualitative narratives rather than on the physiological processes that accompany them. Psychotherapists can help people to normalise these experiences and reduce distress by helping people to recognise when they are in drop and by providing them with language to make sense of these experiences. Sprott and Randall (2016) used the term *x-drop* to refer collectively to four distinct types of drop: sub drop, Top drop, *event drop*, and *scene drop*. These authors further distinguished between the initial x-drop that occurs after or toward the end of a BDSM/kink experience and *later x-drop*, a phenomenon that can occur days or even weeks after a BDSM/kink experience. Later x-drop is less easily explained in terms of physiological responses than initial x-drop. The authors provided a non-pathologising approach to understanding drop, identifying multiple possible explanations for later x-drop that include the initiation of a grief and bereavement process and

as part of the process of identity development. Sprott and Randall's article is worth reading for its demystification of some of the BDSM/kink-specific psychological phenomena that are most likely to be pathologised by trauma psychotherapists.

Clinical Skill 2: Distinguishing BDSM/kink From Abuse

Non-abusive BDSM/kink bears little resemblance to intimate partner abuse beyond superficial appearance. Despite widespread media coverage of the *50 Shades of Grey* media franchise, these depictions of a D/s relationship and S/M activities received widespread criticism among people with BDSM/kink lived experience for their unrealistic and ignorant portrayal (Freeburg & McNaughton, 2017). Many BDSM/kink practitioners have described the relationship between Christian and Anastasia as dangerous and abusive, with some practitioners suggesting that a Dominant who behaved toward a submissive as Christian does toward Anna would be banned from BDSM/kink organisations and community venues (see Holt, 2016).

Unlike abuse, non-abusive BDSM/kink is always consensual. Whereas abuse is typically unpredictable and does not follow negotiated rules, non-abusive BDSM/kink follows established rules that have been negotiated and mutually agreed for the biopsychosocial safety and wellbeing of all participants. Abuse is used as a tool of control and functions to induce genuine terror and discomfort, whereas BDSM/kink practitioners typically describe their BDSM/kink experiences as being about pleasure, connectedness, personal transformation, and meaningful relationships. Some key elements that distinguish BDSM/kink from abuse include the screening and negotiation process (e.g., Cutler, 2003) and extensive use of safety precautions ranging from safe words and safe signals to candles specifically designed for body wax sensation exchange. For example, a caning conducted by a properly trained and skilled BDSM/kink practitioner bears little resemblance to the unwanted and dangerous form of caning practiced by an abusive partner, teacher, or government to enact coercive control.

BDSM/kink practitioner and educator Evie Lupine (2018) has observed that some common BDSM/kink activities are dangerous when practiced by people without adequate knowledge or skills to manage the attendant safety risks, including choking, breath play, hair-pulling, face slapping, rope bondage or *shibari* (a Japanese word for tying or binding in general, widely used within BDSM/kink contexts to describe erotic rope bondage specifically), waxplay, nipple clamps, and handcuffs. Despite careless depictions in mainstream erotic mass media, non-abusive BDSM/kink relationships can require careful prior negotiation, explicit prior and ongoing consent, and safety measures. For example, non-abusive BDSM/kink waxplay involves using a wax candle specifically designed to have a low melting temperature, a flat top that allows wax to pool, and chemical properties that are safe for dripping on human skin rather than an ordinary household candle. Fire safety tools such as fire extinguishers and fire blankets can be kept in close proximity to the waxplay, such as on the nearest wall or beside a bed. Non-abusive waxplay also involves holding the candle at a safe distance away from the body. Although individual pain tolerances, skin sensitivities, and consensus vary between communities, this is generally considered to be at least 46 centimetres or 18 inches away from the body. These examples provide only a partial list of the essential components of waxplay safety, so readers are advised to obtain adequate knowledge not contained in this article. By familiarising themselves with these kinds of BDSM/kink-specific knowledge, trauma psychotherapists can ensure they have sufficient knowledge to distinguish between non-abusive BDSM/kink and abuse that occurs within both BDSM/kink and non-BDSM/kink contexts.

Clinical Skill 3: Understanding and Identifying Key Components of Non-Abusive BDSM/kink Relationships

It is important for therapists to be able to articulate and discuss therapeutically some key components of non-abusive BDSM/kink. It is beyond the scope of this article to provide a comprehensive checklist of these components, particularly given the diverse norms across different BDSM relational role types, social networks, and communities of practice. However, there are some key components that are likely to be present in non-abusive BDSM/kink relational dynamics and interactions (Jozifkova, 2013). These typically include prior negotiation and screening, limits checklists, BDSM/kink character references, textual BDSM/kink relationship contracts and/or explicit consensual agreements, safety practices (including those previously mentioned in this article), the use of safe words and safe signals, and aftercare.

The presence of a BDSM/kink-specific framework for interpersonal ethics is an important component of non-abusive BDSM/kink. Three main BDSM/kink frameworks for interpersonal ethics in BDSM/kink contexts are *safe, sane, and consensual* (SSC), *risk-aware consensual kink* (RACK), and the newer *caring, communication, consent, and caution* (the 4Cs) (Williams, Thomas, Prior, & Christensen, 2014). Williams et al. (2014) provided a detailed comparative analysis of these three distinct ethical frameworks with which trauma psychotherapists can familiarise themselves. Notably, each of the three provides a unique response to the ethical challenge of balancing "duty of care" with "dignity of risk," a dilemma with which many trauma psychotherapists are likely to be familiar in a professional context.

One widespread practice among people experienced in non-abusive BDSM is asking for character references. Before engaging in D/s or S/M activities, a Dominant, submissive, S/switch, Top, or Bottom can request contact information to communicate with their prospective partner's previous partners. Although some less experienced people may not be able to provide character references, it is a red flag if an experienced Dominant refuses to allow a prospective sub to contact previous submissives to verify the Dominant is a respectful, non-abusive partner who respects consent and has adequate training and skill in the specific activities in which they engage. Even a novice Dominant or Top can often provide a certificate from a rigging/rope bondage class or relevant training. There are multiple checklists available online and in print describing red flags for which submissives can screen prospective Dominants.

The use of safe words and safe signals is a key distinguishing feature of non-abusive BDSM/kink. Consider the following composited, non-identifiable case examples I have written based on a combination of my psychotherapeutic experiences with people in non-abusive BDSM/kink relationships:

A/alexei (pronouns he/him) wants to be able to communicate to his Domme that he wants Her to stop, but he also enjoys the experience of saying "no" and having Her continue. To ensure alexei's consent is respected and to avoid confusion between alexei and his Domme, he and Lady Minerva (She/Her), agree in advance that Alexei will use the safe word "laundry" if he wants Her to stop.

Chandra (She/Her) wants to make sure Her non-binary sub boi corey (they/them) is always able to signal that they want to stop, but this is often difficult due to the fact that boi corey often wants Chandra to use a ball gag on them. Chandra discusses with boi corey in advance that She will give them a piece of soft, fleecy fabric that they can hold in one hand even while restrained. If boi corey drops the handkerchief, Chandra will know that they have used their safe signal and will stop immediately.

Mars (They/Them) is a Dominant whose service submissive lisa (she/her) enjoys giving Mars oral stimulation with her mouth. However, lisa also has asthma, which means that oral play during their scenes could trigger an attack. Mars and lisa use a common safe signal known as the double tap. If lisa taps on Mars's body twice in quick succession, Mars will be aware that lisa might be experiencing respiratory difficulty and provide necessary attention as soon as possible. Mars and lisa report that this works very well for them, as lisa's oral service is a major component of her relationship satisfaction and something she feels is necessary for her relationship satisfaction. By using a safe signal, Mars and lisa are able to engage in a wider range of BDSM/kink activities together in a way that helps them to manage the existing risks to their mutual satisfaction.

Unlike situations of abuse, where people are left in distress by their abuser, non-abusive BDSM/kink almost always involves some form of emotional and physical aftercare or check-in typically initiated by the Dominant or Top. When a psychotherapy participant feels safe enough to discuss their BDSM/kink activities with their trauma therapist, it is vital for the therapist to have an understanding of how to distinguish between non-abusive BDSM/kink and abuse masquerading as BDSM/kink. The following vignettes are de-identified and composited examples I have created based on experiences people have shared during trauma psychotherapy:

After Tito (He/Him) flogged and spanked His brat melissa (she/her), He ended the scene by carefully removing her soft, furry wristcuffs and gently massaging her bottom. He rubbed wound-healing balm into the tissue and slowly kissed each butt cheek before pulling her tenderly into His arms and rocking her gently. He stroked her hair and murmured, "thank you, My beautiful brat". He waited until her heart rate had slowed back to its usual cadence, watching her face closely for signs that she had received sufficient aftercare. That evening and the following morning, He sent check-in texts to remind melissa that she was loved and appreciated, and to see how she was feeling.

Sanjay (He/Him) and His painboy martin (he/him) had spent a long evening together trying out Sanjay's new cane. Sanjay was a very experienced rigger, but He had far less experience using a cane than He had with rope bondage. Sanjay had recently attended a local class on safe use of caning in BDSM scenes. However, He was aware that knowing how to use a cane during class and actually using one in a BDSM scene were likely to be two different things. After careful discussion with martin, Sanjay arranged with martin's wife C/carmen (S/she/H/her) for martin to spend the night with Sanjay after their first caning scene. Although C/carmen and martin were due to go on vacation soon after the scheduled scene, both martin and C/carmen agreed to check in with Sanjay and keep Him informed about how martin was feeling in the week after the scene.

Therapists with adequate understanding of BDSM/kink will recognise key differences between the non-abusive BDSM/kink relationships and activities depicted in these narratives and abuse masquerading as BDSM/kink. An important point for therapists to remember is that the specific activities, visual appearance, and words being used in the scene or relationship are often far less useful ways to screen for an abusive relational dynamic than the way the scene or relationship has been negotiated, the safety elements in place, the presence and extent of aftercare, and whether consent is monitored on an ongoing basis by the Dominant or Top. Dominants can also experience abuse by a submissive or Bottom. This permutation of abuse often goes unrecognised and unacknowledged both within BDSM/kink circles and by therapists. By discussing elements of non-abusive BDSM/kink with people participating in trauma psychotherapy, psychotherapists can better address psychotherapy participants' need to develop, maintain, and assert interpersonal boundaries and assist them in identifying and communicating their needs to prospective BDSM/kink partners.

Clinical Skill 4: Determining the Clinical Salience of BDSM/kink

People involved in BDSM/kink often come to therapy for reasons unrelated to BDSM/kink, as is often the case for psychotherapy participants seeking trauma psychotherapy. Unfortunately, therapists who are unfamiliar with BDSM/kink are likely to impose their own frame of reference when determining the clinical salience of BDSM/kink in the therapy space. For some therapists, BDSM/kink seems "alternative" or different from their norm. It is important to remember that BDSM/kink is a normal (not "alternative") and common part of everyday life for many people. Even therapists who market themselves as "BDSM-friendly" or "kink-aware" often use marginalising and discriminatory language on their websites or in therapeutic discussions. For example, some therapists describe themselves to psychotherapy participants and on their websites as "affirming to BDSM and other alternative lifestyles". This attempt communicates that the therapists *think* of themselves as inclusive and informed, but such marginalising language contains unexamined and unprofessional assumptions from the therapist's personal reference point regarding what constitutes a "regular" versus "alternative" lifestyle or relationship.

Some therapists experience personal discomfort when thinking about or discussing BDSM/kink. This discomfort can manifest in the form of clinical judgements biased toward attributing trauma-related symptoms and adverse emotional health consequences to BDSM/kink without investigating other possible factors. Therapists' personal discomfort can also interfere with the therapeutic process by creating an emotional conflict of interest with determinations of whether BDSM/kink is relevant to discuss in therapy.

Therapists who find BDSM/kink relationships and practices unpalatable or distasteful due to personal sensibilities can often conflate these personal preferences with clinical judgements. For example, I screened for and identified a submissive's complex trauma history during the first session with two D/s partners coming to me for relationship therapy. When I attempted to discuss the importance of addressing the submissive's childhood and family of origin trauma with the submissive's therapist, the therapist insisted that all of the submissive's trauma stemmed from the D/s relationship and that it was the source of the submissive's emotional problems. I explained the lengthy and substantial trauma history the submissive was bringing to our sessions and how it was affecting the relationship. This therapist also refused to discuss BDSM/kink with the submissive, despite the submissive's repeated attempts to explain why it was relevant to the therapeutic goals they had identified. When I also tried to explain the clinical relevance of the submissive's D/s-related emotional needs to their emotional regulation and moods, the therapist became hostile and said that the D/s relationship was, "not relevant, we won't discuss *that* stuff. That's *your* job".

Clinical Skill 5: Identifying and Managing Freefall

For many people of Dominant, submissive, and S/switch lived experience, these relational roles and their associated headspaces are linked to core emotional, sensory, and psychospiritual needs that, when met, provide people with optimal health, wellbeing, and life satisfaction (Baker, 2018; Lindemann, 2011; Turley et al., 2011). *Freefall* is a clinical term I propose to describe the state of "freefall" or dysregulation—a key target of attention in trauma psychotherapy—that often occurs when a person's core BDSM/kink needs are unmet or inadequately met. The clinical presentation of freefall is distinct from both the drop and later x-drop described by Sprott and Randall (2016). *Freefall subbing* and *freefall bottoming, or submissive freefall* and *Bottom freefall*, describe the particular clinical presentation of this freefall or dysregulation when a person's core needs as a submissive or Bottom are

not satisfied. *Freefall Domming* and *Freefall Topping*, or *Dominant freefall* and *Top freefall*, describe the corresponding state of dysregulation that often occurs when a person's core needs as a Dominant or Top are not fulfilled. Addressing trauma and trauma risk in BDSM/kink relationships means helping people to identify and manage freefall.

Freefall headspaces can have subtle and complex clinical presentations. Before psychotherapists attempt to identify the signs of what I will collectively term *freefall* headspaces during trauma therapy, it is first essential to establish a clinical baseline for each person's BDSM/kink lived experiences. This will reduce the danger of therapists jumping to inaccurate conclusions about the meaning of, for example, a submissive psychotherapy participant's offer to pour a glass of water for the therapist when pouring one for themselves, or of a Dominant informing the therapist She/They/He would like the therapist to switch off a harsh overhead light.

Some common potential signs of submissive freefall may include being more solicitous of a therapist's needs and comfort than usual, more frequent apologies peppered throughout conversation, increased anxiety or low mood, "childish" behaviour where that is atypical for the submissive's clinical presentation, unusually provocative or confrontational behaviour or "brattiness," more hesitant or halting speech or slower cognitive processing than usual, reduced eye contact in comparison to the submissive's clinical baseline, heightened concerns about appearance or declined body image, and increased comments about being "worthless," "stupid," "disgusting," or "pathetic". Some common potential signs of Dominant freefall may include increased feelings of guilt or fear of wrongdoing both within and outside of the psychotherapeutic relationship, increased irritability, and levels of micromanaging and critical behaviour toward self and others that are atypical for their clinical baseline. Both freefall Domming and freefall subbing can have similar clinical presentations, with signs of increased frequency and magnitude of interpersonal conflicts, moods and mood fluctuations that are atypical for the psychotherapy participant, and increased difficulty focusing or concentrating. Some Bottoms may become more "clumsy" or accident-prone than usual or seek out non-BDSM/kink forms of extreme sports and thrill-seeking activities to compensate for the need to experience the endorphin rush often associated with S/M activities. Signs that can accurately identify freefall headspaces will vary depending on a combination of factors, including but not limited to a particular person's specific BDSM/kink relational role(s), their D/s or S/M-type, how experienced they are with BDSM/kink, the extent to which they understand and can communicate about their BDSM/kink headspaces, their interoceptive skills (i.e., their ability to understand and feel what is going on in their body), their emotional distress tolerance, and their skills in self-regulation. In addition to unique permutations of *S/switch freefall*, S/switches may experience both Dominant and submissive freefall simultaneous, thus leading to a complex clinical presentation that may be misunderstood or invisible to therapists. This example highlights how information about people's D/s or S/M types can be essential to accurate clinical assessment.

The following representative, de-identified composite case examples are fictional vignettes drawn from a range of typical experiences in my clinical trauma psychotherapy work. Non-BDSM/kink formatting has been used for me, due to my role as therapist.

malik (he/him) was a self-identified service submissive who came into one of our sessions and immediately asked me if I would like him to pour me a glass of water. he watched me attentively and repeatedly apologised as he discussed his week, something that he did not ordinarily do. Several times during the session, he asked whether I was comfortable and if I minded that he was sitting with his feet resting on the recliner. I observed that he seemed more alert than usual to my comfort, instead of

focusing on his own. During the course of the session, malik shared that he had recently been released by his Dom and that he had been feeling very emotional and lonely. he shared that he had let his supervisor at work pile him with extra tasks and had given in to an inappropriate request by a co-worker to get coffee for colleagues at a business meeting.

During our session, I helped malik to identify that he was freefall subbing and we discussed ways he could keep himself safe if he found himself drawn to provide service outside of mutually consensual and negotiated environments. We discussed the dynamic that had occurred during our session and developed strategies that could help malik to meet his core needs as a submissive and thereby come out of a freefall subbing headspace. malik was able to negotiate with a close Dominant friend an agreement for his Domme friend to provide opportunities for safe service in Her home until he found a new Dominant.

sonali (she/her) was a primary school teacher in her mid-30s who was close to her parents and extended biological family overseas. she dreamed of finding a relationship and settling down, but the relationship she wanted seemed elusive to her. Although she hadn't felt able to tell her family and had only told one friend, sonali had realised during her late 20s that she was a submissive. her earliest attempts to meet a Dominant for a relationship had been unsuccessful. The first Dom she met, Ahmed, had seemed respectful and had a lovely temperament, but He was highly specialised in decorative rope bondage and seeking a submissive partner with whom to share this kink. she felt His D-type was not particularly compatible with her s-type. After several evenings of bondage with Ahmed that she described as "comfortable but boring," sonali went searching for the kinks that would most move her. she felt drawn to Dominants whom she felt could provide her with heavy impact play scenes involving verbal humiliation. During her search, she found herself drawn to several Dominants who turned out to be abusive and later discovered they had been put on several BDSM/kink community lists of Dominants banned for mistreatment of past submissives.

During our trauma psychotherapy work together, sonali gained greater insight into her core needs as a submissive. She identified freefall subbing as a key contributor to her attraction to abusive Dominants. During the first year of our trauma psychotherapy work, sonali gained skills for screening and setting boundaries with prospective Dominants, and developed strategies for preventing, communicating about, and managing freefall subbing These achievements facilitated her continued healing and post-traumatic growth. sonali used these developing skills to initiate a mutually fulfilling relationship with a Dominant who had the BDSM/kink expertise to meet her core emotional needs as a submissive and thus to reduce the frequency and magnitude of her freefall subbing responses.

Demain (They/Them) had been in a seven-year relationship with Their submissive, levi (he/him). They were both used to daily contact by phone, video chat, and text message. They had fallen into a regular pattern or two regular overnights and one long weekend BDSM/kink session each week. When levi moved overseas to conduct postgraduate field work in an area with limited internet or phone access, Demain found Themselves getting irritable with staff at Their workplace and noticed that They were involving themselves more closely in the intricate details of colleagues' emotional lives. They found Themselves taking on a relational role within Their workplace that alternated between helicopter parent swooping in to save the day and stern disciplinarian meting out judgements.

Despite being familiar with Dom drop and having developed an effective self-care plan to address it, Demain did not have language to describe freefall Domming and thus did not realise until our psychotherapy session that They were freefall Domming. By providing Demain with psychoeducation to

describe and understand Their experience of freefall Domming, Demain was then able to communicate about this experience in a letter to levi, to explain Their needs to friends in a way that meant they could receive emotional support, and to develop an effective, distinct self-care plan for handling freefall Domming.

These examples illustrate how identifying and addressing freefall in therapy can assist people in understanding their core emotional needs, communicating these needs to their partners, and protecting themselves from abusive or unsatisfying relationship situations. By helping people to identify and manage freefall, trauma psychotherapists can support people with BDSM/kink needs to better address their BDSM/kink and trauma-related needs, to develop and sustain satisfying relationships and kinship ties, and to achieve a sense of connectedness and belonging following trauma.

Conclusion and Future Directions

As explained in this article, BDSM/kink relationships are a natural part of human sensory, erotic, and emotional diversity rather than a fringe or "alternative lifestyle". BDSM/kink is not inherently abusive. BDSM/kink can help people to heal from trauma rather than being the cause of trauma. People's BDSM/kink relationships can be as meaningful as, or even more meaningful than, their non-BDSM/kink relationships. BDSM/kink is a clinically relevant and appropriate topic to discuss in trauma therapy. Adequate attention to BDSM/kink-related content may be essential to achieving key therapeutic tasks in trauma psychotherapy. Further research from a BDSM/kink-inclusive approach is needed to provide more comprehensive clinical guidance for trauma psychotherapists working with people who are involved or interested in BDSM/kink.

References

Ambler, J. K., Lee, E. M., Klement, K. R., Loewald, T., Comber, E. M., Hanson, S. A., … & Sagarin, B. J. (2017). Consensual BDSM facilitates role-specific altered states of consciousness: A preliminary study. *Psychology of Consciousness: Theory, Research, and Practice*, *4*(1), 75-91. https://doi.org/10.1037/cns0000097

Andrieu, B., Lahuerta, C., & Luy, A. (2019). Consenting to constraint: BDSM therapy after the DSM-5. *L'Évolution Psychiatrique*, *84*(2), e1-e14. https://doi.org/10.1016/j.evopsy.2019.02.005

Baker, A. C. (2018). Sacred kink: Finding psychological meaning at the intersection of BDSM and spiritual experience. *Sexual and Relationship Therapy*, *33*(4), 440-453. https://doi.org/10.1080/14681994.2016.1205185

Barker, M., Iantaffi, A., & Gupta, C. (2014). Kinky clients, kinky counselling?: The challenges and potentials of BDSM. In L. Moon (Ed.), *Feeling queer or queer feelings?* (pp. 106-124). London: Routledge.

Bauer, R. (2008). Transgressive and transformative gendered sexual practices and white privileges: The case of the dyke/trans BDSM communities. *Women's Studies Quarterly*, *36*(3/4), 233-253.

Beres, M. A., & MacDonald, J. E. (2015). Talking about sexual consent: Heterosexual women and BDSM. *Australian Feminist Studies*, *30*(86), 418-432. https://doi.org/10.1080/08164649.2016.1158692

Bernard, R. (2018). *Service tops, bratty bottoms and pillow princesses: Other words you use to describe how you have sex*. Retrieved from the Autostraddle website: https://www.autostraddle.com/service-tops-bratty-bottoms-and-pillow-princesses-other-words-you-use-to-describe-how-you-have-sex-426800/

Bezreh, T., Weinberg, T. S., & Edgar, T. (2012). BDSM disclosure and stigma management: Identifying opportunities for sex education. *American Journal of Sexuality Education*, *7*(1), 37-61. https://doi.org/10.1080/15546128.2012.650984

Cardoso, D. (2018). Bodies and BDSM: Redefining sex through kinky erotics. *The Journal of Sexual Medicine*, *15*(7), 931-932. https://doi.org/10.1016/j.jsxm.2018.02.014

Coppens, V., Ten Brink, S., Huys, W., Fransen, E., & Morrens, M. (2019). A Survey on BDSM-related activities: BDSM experience correlates with age of first exposure, interest profile, and role identity. *The Journal of Sex Research*, 1-8. https://doi.org/10.1080/00224499.2018.1558437

Crane, P. (2019). Bondage, impact, power… and word play?: Language use in online BDSM communities [Powerpoint slides]. Retrieved from https://ttu-ir.tdl.org/bitstream/handle/2346/84246/Crane_B12LGBTQIA-Presentation.pdf?sequence=1

Cross, P. A. & Matheson, K. (2006). Understanding sadomasochism: An empirical examination of four perspectives. *Journal of Homosexuality, 50*(2/3), 133–166. https://doi.org /10.1300 /J082v50n02_07

Cruz, A. (2015). Beyond black and blue: BDSM, internet pornography, and black female sexuality. *Feminist Studies*, *41*(2), 409-436. https://doi.org/10.15767/feministstudies.41.2.409

Cutler, B. (2003*). Partner selection, power dynamics, and sexual bargaining in self-defined BDSM couples* (Unpublished doctoral dissertation*).* The Institute for Advanced Study of Human Sexuality, San Francisco, CA.

Dancer, P. L., Kleinplatz, P. J., & Moser, C. (2006). 24/7 SM slavery. *Journal of Homosexuality*, *50*(2-3), 81-101. http://dx.doi.org/10.1300/J082v50n02_05

Faccio, E., Casini, C., & Cipolletta, S. (2014). Forbidden games: The construction of sexuality and sexual pleasure by BDSM "players". *Culture, Health & Sexuality*, *16*(7), 752-764. https://doi.org/10.1080/13691058.2014.909531

Freeburg, M. N., & McNaughton, M. J. (2017). Fifty shades of grey: Implications for counseling BDSM clients. *VISTAS 2017.* Retrieved from http://www.counseling.org/knowledge-center/vistas

Galati, M. (2017). *The therapeutic impact of rope bondage: A case study in the UK* (Doctoral dissertation). University College London, London.

Gemberling, T. M., Cramer, R. J., & Miller, R. S. (2015). BDSM as sexual orientation: A comparison to lesbian, gay, and bisexual sexuality. *Journal of Positive Sexuality*, *1*, 37-43.

Gentry, J. E., Baranowsky, A. B., & Rhoton, R. (2017). Trauma competency: An active ingredients approach to treating posttraumatic stress disorder. *Journal of Counseling & Development, 95*(3), 279-287. https://doi.org/10.1002/jcad.12142

Graham, B. C., Butler, S. E., McGraw, R., Cannes, S. M., & Smith, J. (2016). Member perspectives on the role of BDSM communities. *The Journal of Sex Research*, *53*(8), 895-909. https://doi.org/10.1080/00224499.2015.1067758

Herman, J. (1992). *Trauma and Recovery*. London: Pandora.

Hoff, G., & Sprott, R. A. (2009). Therapy experiences of clients with BDSM sexualities: Listening to a stigmatized sexuality. *Electronic Journal of Human Sexuality*, *12*(9). Retrieved from http://www.ejhs.org/Volume12/ bdsm.htm.

Holt, K. (2018). An exploration of the experience of harm in the bondage/discipline/sadomasochism community. *Violence and Victims*, *33*(4), 663-685. https://doi.org/10.1891/0886-6708.VV-D-16-00194

Holt, K. M. (2016). Blacklisted: Boundaries, violations, and retaliatory behavior in the BDSM community. *Deviant Behavior*, *37*(8), 917-930. https://doi.org/10.1080/01639625.2016.1156982

Holvoet, L., Huys, W., Coppens, V., Seeuws, J., Goethals, K., & Morrens, M. (2017). Fifty shades of Belgian gray: The prevalence of BDSM-related fantasies and activities in the general population. *The Journal of Sexual Medicine*, *14*(9), 1152-1159. https://doi.org/10.1016/j.jsxm.2017.07.003

Hopkins, P. D. (1994). Rethinking sadomasochism: Feminism, interpretation, and simulation. *Hypatia*, *9*(1), 116-141. https://doi.org/10.1111/j.1527-2001.1994.tb00112.x

Ioanas, H. (2013). *A brief overview of pain processing and research-relevant conditions.* Retrieved from http://chymera.eu/docs/OPR.bopprrc.pdf

Johnson, Z. (2008). Cuffs. *Ethos*, *2008*(1), 6-9. Retrieved from Iowa State University Digital Repository: http://lib.dr.iastate.edu/ethos/vol2008/iss1/3

Jolene Sloan, L. (2015). Ace of (BDSM) clubs: Building asexual relationships through BDSM practice. *Sexualities*, *18*(5-6), 548-563. https://doi.org/10.1177/1363460714550907

Jones, K. (2019). *Sub-fems: An exploration of the intersectionality of empowerment through submissive identity, grounded in feminist theory* (Doctoral dissertation). The Chicago School of Professional Psychology, Chicago, IL.

Jozifkova, E. (2013). Consensual sadomasochistic sex (BDSM): The roots, the risks, and the distinctions between BDSM and violence. *Current Psychiatry Reports*, *15*(9), 392. https://doi.org/10.1007/s11920-013-0392-1.

Kaldera, R. (2014). *Power circuits: Polyamory in a power dynamic*. Hubbardston, MA: Alfred Press, Inc.

Klement, K. R., Lee, E. M., Ambler, J. K., Hanson, S. A., Comber, E., Wietting, D., ... & Reid, E. (2017). Extreme rituals in a BDSM context: The physiological and psychological effects of the “Dance of Souls”. *Culture, Health & Sexuality*, *19*(4), 453-469. https://doi.org/10.1080/13691058.2016.1234648

Kelsey, K., Stiles, B. L., Spiller, L., & Diekhoff, G. M. (2013). Assessment of therapists’ attitudes towards BDSM. *Psychology & Sexuality*, *4*(3), 255-267. https://doi.org/10.1080/19419899.2012.655255

Kolmes, K., & Weitzman, G. (2010). *A guide to choosing a kink-aware therapist*. Retrieved from https://ncsfreedom.org/images/stories/pdfs/KAP/kap_white_paper%20final.pdf

Kolmes, K., Stock, W., & Moser, C. (2006). Investigating bias in psychotherapy with BDSM clients. *Journal of Homosexuality, 50*(2-3), 301-324. https://doi.org/10.1300/J082v50n02_15

Langdridge, D., & Butt, T. (2004). A hermeneutic phenomenological investigation of the construction of sadomasochistic identities. *Sexualities, 7*(1), 31-53. https://doi.org/10.1177/1363460704040137

Lawrence, A. A., & Love-Crowell, J. (2007). Psychotherapists' experience with clients who engage in consensual sadomasochism: A qualitative study. *Journal of Sex & Marital Therapy*, *34*(1), 67-85. https://doi.org/10.1080/00926230701620936

Lawson, J., & Langdridge, D. (2019). History, culture and practice of puppy play. *Sexualities*, https://doi.org/10.1177/1363460719839914

Lee, E. M., Klement, K. R., Ambler, J. K., Loewald, T., Comber, E. M., Hanson, S. A., ... & Sagarin, B. J. (2016). Altered states of consciousness during an extreme ritual. *PloS one*, *11*(5). https://doi.org/10.1371/journal.pone.0153126

Lindemann, D. (2011). BDSM as therapy?. *Sexualities*, *14*(2), 151-172. https://doi.org/10.1177/1363460711399038

Lupine, E. (2018, September 3). *5 types of BDSM play people don't realise are dangerous.* [Video file]. Retrieved from https://www.youtube.com/watch?v=QkubpzH4t04&t=185s

Martinez, K. (2018). BDSM role fluidity: A mixed-methods approach to investigating switches within dominant/submissive binaries. *Journal of Homosexuality*, *65*(10), 1299-1324. https://doi.org/10.1080/00918369.2017.1374062

McCormick, T. L. (2018). Yes Master! Multimodal representations of BDSM bodies on a South African website. *Southern African Linguistics and Applied Language Studies*, *36*(2), 147-160.

McLaughin, P. J., & Zagon, I. S. (2013). Chapter 217 – POMC opioid peptides. In A. J. Kastin *(Ed.). Handbook of biologically active peptides (2nd ed.)* (pp. 1592-1595). San Diego, CA: Elsevier. https://doi.org/10.1016/B978-0-12-385095-9.00217-7

Meyer, C. G., & Chen, H. M. (2019). Vanilla and kink: Power and communication in marriages with a BDSM-identifying partner. *Sexuality & Culture*, *23*(3), 774-792. https://doi.org/10.1007/s12119-019-09590-x

Moser, C., & Levitt, E.E. (1987). An exploratory-descriptive study of a sadomasochistically oriented sample. *Journal of Sex Research, 23*(3), 322–337. http://dx.doi.org/10.1080/00224498709551370

Newmahr, S. (2010). Rethinking kink: Sadomasochism as serious leisure. *Qualitative Sociology*, *33*(3), 313-331. https://doi.org/10.1007/s11133-010-9158-9

Nichols, M. (2006). Psychotherapeutic issues with "kinky" clients: Clinical problems, yours and theirs. *Journal of Homosexuality*, *50*(2-3), 281-300. https://doi.org/10.1300/J082v50n02_14

Pitagora, D. (2017). No pain, no gain? Therapeutic and relational benefits of subspace in BDSM contexts. *Journal of Positive Sexuality*, *3*(3), 44-54.

Pitagora, D. (2016). The kink-poly confluence: Relationship intersectionality in marginalized communities. *Sexual and Relationship Therapy*, *31*(3), 391-405. https://doi.org/10.1080/14681994.2016.1156081

Prior, E. E., & Williams, D. J. (2015). Does BDSM power exchange among women reflect casual leisure? An exploratory qualitative study. *Journal of Positive Sexuality*, *1*(1), 12-15.

Renaud, C. A., & Byers, E. S. (1999). Exploring the frequency, diversity, and content of university students' positive and negative sexual cognitions. *The Canadian Journal of Human Sexuality, 8*(1), 17.

Richters, J., De Visser, R. O., Rissel, C. E., Grulich, A. E., & Smith, A. M. (2008). Demographic and psychosocial features of participants in bondage and discipline, "sadomasochism" or dominance and submission (BDSM): Data from a national survey. *The Journal of Sexual Medicine, 5*(7), 1660-1668. https://doi.org/10.1111/j.1743-6109.2008.00795.x

Richters, J., Grulich, A. E., de Visser, R. O., Smith, A. M., & Rissel, C. E. (2003). Sex in Australia: Autoerotic, esoteric and other sexual practices engaged in by a representative sample of adults. *Australian and New Zealand Journal of Public Health, 27*(2), 180-190. https://doi.org/10.1111/j.1467-842X.2003.tb00806.x

Rodas, I. P. (2017). A quantitative study of the Spanish BDSM community, preliminary results. *The Journal of Sexual Medicine*, *14*(5), e325. https://doi.org/10.1016/j.jsxm.2017.04.546

Rogak, H. M., & Connor, J. J. (2018). Practice of consensual BDSM and relationship satisfaction. *Sexual and Relationship Therapy*, *33*(4), 454-469. https://doi.org/10.1080/14681994.2017.1419560

Sagarin, B. J., Lee, E. M., & Klement, K. R. (2015). Sadomasochism without sex? Exploring the parallels between BDSM and extreme rituals. *Journal of Positive Sexuality*, *1*(3), 32-36.

Shahbaz, C., & Chirinos, P. (2017). *Becoming a kink aware therapist*. New York, NY and Oxon, UK: Routledge.

Sharma, J., & K. Gupta. (2011). Eroticism, pain and consent: Some reflections from the BDSM community in India. *Culture, Health, & Sexuality, 13*, S146 –S147.

Sheela, C. S. (2008). *The state of discipline: Chinese masculinity and BDSM in Singapore* [Doctoral dissertation]. Retrieved from National University of Singapore Repository: https://scholarbank.nus.edu.sg/handle/10635/12946

Simula, B. L. (2019a). Pleasure, power, and pain: A review of the literature on the experiences of BDSM participants. *Sociology Compass*, *13*(3), 1-24. https://doi.org/10.1111/soc4.12668

Simula, B. L. (2019b). A "different economy of bodies and pleasures"?: Differentiating and evaluating sex and sexual BDSM experiences. *Journal of Homosexuality*, *66*(2), 209-237. https://doi.org/10.1080/00918369.2017.1398017

Sprott, R., & Randall, A. (2016). Black and blues: Sub drop, top drop, event drop and scene drop. *Journal of Positive Sexuality*, *2*(3), 53-61.

Tellier, S. (2017). Advancing the discourse: Disability and BDSM. *Sexuality and Disability*, *35*(4), 485-493. https://doi.org/10.1007/s11195-017-9504-x

Turley, E. (2018). Leading and following? Understanding the power dynamics in consensual BDSM. In Beggan, J. T., & Allison, S. T. (*Eds.*). *Leadership and sexuality: Power, principles, and processes* (pp. 183-196). Cheltenham, UK: Edward Elgar Publishing.

Turley, E. L., King, N., & Monro, S. (2018). "You want to be swept up in it all": Illuminating the erotic in BDSM. *Psychology & Sexuality*, *9*(2), 148-160. https://doi.org/10.1080/19419899.2018.1448297

Turley, E. L., King, N., & Butt, T. (2011). "It started when I barked once when I was licking his boots!": A descriptive phenomenological study of the everyday experience of BDSM. *Psychology & Sexuality*, *2*(2), 123-136. http://dx.doi.org/10.1080/19419899.2010.528018

Webster, C., & Klaserner, M. (2019). Fifty shades of socializing: Slosh and munch events in the BDSM community. *Event Management*, *23*(1), 135-147. https://doi.org/10.3727/152599518X15378845225401

Weinberg, M.S., Williams, C.J., & Moser, C.A. (1984). The social constituents of sadomasochism. *Social Problems, 31*(4), 379–389. http://dx.doi.org/10.2307/800385

Wignall, L. (2017). The sexual use of a social networking site: The case of pup twitter. *Sociological Research Online*, *22*(3), 21-37. https://doi.org/10.1177/1360780417724066

Williams, D. J., Thomas, J. N., Prior, E. E., & Christensen, M. C. (2014). From "SSC" and "RACK" to the "4Cs": Introducing a new framework for negotiating BDSM participation. *Electronic Journal of Human Sexuality*, *17*(5), 1-10.

Wismeijer, A. A., & Van Assen, M. A. (2013). Psychological characteristics of BDSM practitioners. *The Journal of Sexual Medicine*, *10*(8), 1943-1952. https://doi.org/10.1111/jsm.1219

Wright, S. (2018). De-pathologization of consensual BDSM. *The Journal of Sexual Medicine*, *15*(5), 622-624. https://doi.org/10.1016/j.jsxm.2018.02.018

Wright, S. (2008a). *In their own words.* Retrieved from the National Coalition for Sexual Freedom website: https://ncsfreedom.org/images/stories/pdfs/BDSM_Survey/in_their_own_words.pdf

Wright, S. (2008b). *Second national survey of violence & discrimination against sexual minorities*. Retrieved from the National Coalition for Sexual Freedom website: https://www.ncsfreedom.org/images/stories/pdfs/BDSM_Survey/2008_bdsm_survey_analysis_final.pdf

Yost, M. R., & Hunter, L. E. (2012). BDSM practitioners' understandings of their initial attraction to BDSM sexuality: Essentialist and constructionist narratives. *Psychology & Sexuality*, *3*(3), 244-259. https://doi.org/10.1080/19419899.2012.700028

Zambelli, L. (2017). Subcultures, narratives and identification: An empirical study of BDSM (bondage, domination and submission, discipline, sadism and masochism) practices in Italy. *Sexuality & Culture*, *21*(2), 471-492. https://doi.org/10.1007/s12119-016-9400-z

Zambelli, L. (2016). Feminism and BDSM: empirical findings and theoretical debates in the US, UK and Italy. Journal of the International Network for Sexual Ethics and Politics, 4(2), 37-58. https://doi.org/10.3224/insep.v4i2.05

Zussman, M., & Pierce, A. (1998). Shifts of consciousness in consensual S/M, bondage, and fetish play. *Anthropology of Consciousness*, *9*(4), 15-38.

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