Therapeutic BDSM: Taboo or Transformative?

By

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Abstract

BDSM (bondage and discipline, dominance and submission, sadism and masochism) is a range of sexual and nonsexual preferences and behaviours involving physical or psychological control, pain, or unequal power dynamics (Goerlich, 2021; Shahbaz & Chirinos, 2017). Many people report that engaging in these activities has been beneficial for their emotional, spiritual, and physical wellbeing. Since being declassified as a disorder in 2013, research regarding potential therapeutic benefits has increased, although it is still lacking. While BDSM aesthetics have been embraced in music, movies and fashion, there continue to be harmful stereotypes about people who engage in the lifestyle. These misconceptions include assumptions that BDSM encourages violence and abuse, promiscuity, and unhealthy relationship dynamics (Chancer, 2000; Stear, 2009). This stigmatization has both moral and legal ramifications, as many BDSM practitioners have shared that their kink practices have been used against them in custody proceedings (National Coalition for Sexual Freedom, 2013, as cited by Cascalheira, 2023). As awareness and research grows, the necessity to provide kink-affirming therapy also increases. Being aware of common BDSM practices and dynamics can decrease stigmatization within the clinical space and further support clients. There are many parallels between traditional trauma therapies and the BDSM practice of trauma play, so knowing how they overlap can create possibilities for meaningful therapeutic work. This paper will discuss the potential therapeutic benefits of BDSM, the overlaps of trauma therapy and trauma play with a focus on exploring the models of therapeutic facilitated trauma play (Bonus, 2024) and surrogate partner therapy (Masters & Johnson, 1970), along with the discussion of legal and ethical considerations in combing the two models to create clinically supported BDSM as a potential modality.

Keywords: BDSM, kink-affirming therapy, trauma, trauma play, mental health

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Chapter One: A Brief Introduction to the World of BDSM

Take a deep breath and strap in for a wild ride to explore the many therapeutic aspects of kink and consensual BDSM, as well as their potential clinical use. From relational challenges such as boundary setting, self-worth, and personal empowerment, to sexual challenges such as abuse or sexual dysfunction, there is a vast range of therapeutic benefit that consensual BDSM can explore.

As humans, sex is at the very core of our experience (American Association of Sexuality Education, Counselors and Therapists [AASECT], 2020), so it makes sense that many people connect their sense of self to their sexuality. It should not be surprising that some people use kink activities to explore and process challenging aspects of life.

Important Distinctions

"BDSM" is an umbrella term that is commonly adopted by practitioners (those who engage in BDSM activities and have knowledge of its core values), which stands for 'bondage and discipline, dominance and submission, sadism and masochism' (Carlström, 2018; Goerlich, 2021; 2023; Shahbaz & Chirinos, 2017;). "Kink" is the overarching community, as well as activities, but there is a common misconception that they are one and the same.

Kink describes any sexual activity, identity, or relationship that is considered "unconventional" by societal norms, and used for elevating intimacy between partners (Goerlich, 2021). This could include, exhibitionism, voyeurism, costumes, etc. BDSM is a form of kink which uses a range of sexual and nonsexual preferences and behaviours involving physical or psychological control, pain, and/or unequal power dynamics in role plays or scenes. Scenes are described as interactions between two or more people (which may or may not involve sexual intercourse) and have a start and stop point (Goerlich, 2021; Shannon, 2021). Common scenes include age play, Dominant [*sic*] and submissive roles, cuckolding, etc. While there are

many overlaps between the kink and BDSM communities, they are not synonymous. BDSM is classified as kink, but kink does not always involve BDSM. For example, everyone has heard of the naughty nurse trope. If the scene involves said nurse shaving a patient to prepare for surgery, it is a kink role play. If in the role play, the patient being shaved is a prisoner handcuffed to the table, there is an inherent power dynamic, so it is considered a BDSM scene.

Another distinction that is important to make is the difference between a Top [*sic*] and a Dominant or Dom [*sic*] (often capitalized), as well as a bottom and a submissive (often written in lower case). A Top is someone who enjoys an active role within play (Bennett, 2024; Goerlich, 2021). This is someone who engages in giving the sensory experience, such as spanking, caning, tying, etc. This does not mean domination. A Dominant (or Dom) takes the role of authority and/or exerts control over another person within play (Goerlich, 2021). This can look like physical domination, such as holding down a partner or orgasm control, or psychological domination, such as verbal commands or humiliation. A bottom is someone who enjoys receiving the sensory experience but does not mean that they are submitting during play or other areas in their lives (Bennett, 2024; Goerlich, 2021). A submissive (or sub) gives control to another person (or people) within play, while a switch is someone who plays both roles depending on the situation or partner (Goerlich, 2021). Think of it this way: in relationships (whether they are casual or long-term), there is usually a Top and a bottom. Someone is giving a sensory experience while someone is receiving, but it doesn't mean that one person is controlling the situation (M. Major, personal communication, April 7, 2025).

The Dominant and submissive dynamic is also common to see as a domestic lifestyle within the BDSM community. This does not mean the Dom is controlling every aspect of the sub's life and forces them to engage in sexual activities at their whim (although they can!), but rather, that the Dom takes responsibility for certain activities and cares for their sub and the sub reciprocates in service to their Dom in areas outside of sexual play. Examples of these could be

overseeing finances, making meals, or providing transportation. It is crucial to reiterate that these dynamics are consensual - discussions have taken place and the sub has willfully (and usually exuberantly) given consent to their Dom, which they can rescind at any point. With that said, there is potential for abuse, which is something that therapists who are trained in kink-affirming practices will assess for (Goerlich, 2021; 2023; Shahbaz & Chirinos, 2017). The lines can get even more blurred within the extreme 24/7 Dom and sub dynamic (formerly referred to as Master and slave [*sic*]) because every aspect of the sub's life is dictated by the Dom. To outsiders, this level of control can look like domestic abuse, and many practitioners feel it is too intense to engage in everyday (M. Major, personal communication, April 7, 2025).

So, in short, Doms are Tops, but not all Tops are Doms, and subs are bottoms, but not all bottoms are subs… Until you get into Power Bottoms and service tops, but we don't have the time to go down that rabbit hole for this paper! To distinguish the two, one must look at the power exchanges within the relationship, rather than the positionality of each partner. There are many nuances to these roles and relationships, and no partners/situations/experiences will be the same. There are many other resources to explore in the Appendix if you want more information about these scenarios.

Papers Focus

For this paper, I will reference the greater kink community but focus primarily on the therapeutic aspects of BDSM. Much of the available research discusses the somatic and visceral overlap between traumatic events and BDSM activities, as well as the transformative aspects experienced from playing with complex power exchanges. This is not to say that other kink activities such as fetish play, cross-dressing, or simple role play do not have therapeutic aspects. Sex itself has plenty of physical and psychological benefits, many of which can be explored with or without concurrent support from a kink-affirming therapist.

I feel it is important to note that I am not an expert in this area. All the knowledge I am sharing has been gained through reading scholarly and anecdotal material, conducting personal interviews, and my own limited experience engaging in BDSM and kink activities. There will be people who read this and think of many exceptions or have varying opinions and thoughts, but this paper is meant to start a journey into learning, rather than be an authority on the subject. I am not claiming to be anyone's Dom here!

Research Question

Research showing the benefits of BDSM engagement has grown in the last decade since it was declassified as a disorder. While it has been increasing in popularity within the public eye and moved from the dark corners of underground clubs to erotic novels and the big screen, there are many people who have adopted it as part of their lifestyle and identity. For those who engage in regular BDSM play and wish to further harness its therapeutic nature, is there a way for BDSM to be used clinically in an ethical and legal way?

Positionality and Connection

Kink-identifying and practicing individuals often share stories of how its use has facilitated emotional or psychological growth and healing. For many, sexuality is linked to important facets of self-concept and identify, so it can be a powerful tool for personal growth and empowerment (Kink Clinical Practice Guidelines Project, 2019). I am one of those people.

I have experienced long standing relationship traumas which led me to believe that I was not worthy of love. I spent my twenties and most of my thirties filling the hole in my heart with meaningless sex, which was all that I thought I deserved. For many years, I had been curious about the kink community, but when I talked to my partners about it, I was either shamed for discussing it, or we tried it, and I was left feeling disappointed and/or objectified. I concluded what most people do: *people who like BDSM do not want a committed relationship and only*

care about painful, weird sex. I now realize how wrong and harmful that assumption is. My current partner and I met through the kink community, and not only are we are approaching our sixth anniversary, but that is five years longer than any romantic relationship I have ever had.

Prior to the Covid-19 pandemic, my partner was very active as a Dom, and we connected because my previous experience with kink was with people who engaged in what they thought BDSM was, rather than what it truly encompasses. Like many people, the partners I had in the past were dipping their toes in kinky waters without diving into education around the core principles of BDSM - consent, communication, safety, and aftercare. I compare it to therapists who use CBT interventions (Cognitive Behavioural Therapy, not to be confused with the BDSM's Cock and Ball Training) with their clients without having the training that goes along with certification in that modality. This distinction of “dabblers” versus “practitioners” is important going forward. It is not to say that one is better than the other, but this paper (and most of the research) is based on those who are deep within the community and embrace this as a part of their identity. With that in mind, everyone must start somewhere, and those who dabble may one day become a frequent and beloved host of their local play parties.

When I began seeing my partner, it was because I wanted to know what it was like with someone who fully embraced the lifestyle and could safely navigate the space with me. Neither of us were looking for a serious relationship; I had too many trust issues, and he was polyamorous, with several other partners at the time. I was sure that would be a recipe for disaster for me, so I only wanted to casually explore impact play. My partner and I have now been living together for five years, and through both our day-to-day routines and the use of kink and BDSM, he has helped me address and work through many of the relationship issues that have followed me for most of my adult life. In conjunction with therapy, many of my challenges have been lessened by the reassurance and safety I have felt in this loving relationship, and I

have been able to gain a greater sense of power, autonomy, and self-worth than I have ever felt before.

Kink-Affirming Therapy

A survey done by the Journal of Sex Research (2016, as cited by Nicols, 2017) reported that nearly half of Canadian adults indicated an interest in at least one of the paraphilic disorders listed in the DSM, approximately one third had participated in a kinky experience at least once, and nearly 64% of adults had kinky fantasies. It is also reported that 20% of the population in Western societies have experienced some sort of kink (Cascalheira et al., 2023), so it is very likely that therapists will encounter BDSM practitioners at some point in their practice. Because of this, it is crucial that clinicians are aware, open, and culturally sensitive to this growing clientele.

The Kink Clinical Practice Guidelines Project (2019) outlined three main levels to strive for as a therapist working with BDSM practitioners. Kink-friendly describes a clinician with minimal knowledge, but who approaches the topic with openness and will not automatically pathologize. Kink-aware is a clinician with specific knowledge of concepts and practices that are important to the subculture and has experience with working with more than a few clients. Kink-knowledgeable is a clinician with an advanced level of knowledge and uses affirmative care (Shahbaz & Chirinos, 2017).

In the 2013, the DSM-5 (American Psychiatric Association) removed BDSM from the list of paraphilias. Before this, adults who willingly chose to participate in activities or behaviours that were considered outside of the norms of society were pathologized (Gerson, 2015).

Goerlich (2021) compares the recent increase in awareness regarding kink-affirming therapy to when homosexuality was removed as a diagnosis in the 1970s. This allowed people in the 2SLGBTQIA+ community to live more authentically, but it also meant that they were now

more open with people about their experiences, and not all therapists were able (or willing) to support them in their newfound liberation and acceptance. In the 1980s, LGBTQ-affirming therapy (or queer-affirming therapy) was expanding, with the premise that mental health problems are not caused by sexual orientation, but instead, people are deeply impacted by discrimination and oppression. Queer-affirming therapy focuses on the unique identity of each individual and keeps a strong sense of self while looking at the negative systems of oppression in client's lives (Tandem Psychology, 2023).

Kink-affirming therapy has many of the same core principles. This modality focuses on being non-judgmental, encouraging consent and boundaries, understanding power dynamics and differentiating from abuse, honest communication, exploring client identities, assessing risk, and embracing empowerment. Kink-affirming therapy is a trauma informed practice that strives to depathologize kink through an intersectional lens which looks at how various systems of oppression are impacting members of the community (Goerlich, 2021; 2023).

It is important to keep in mind that not all challenges that BDSM practitioners experience are related to kink, so being a therapist with a limited knowledge base may not be detrimental, but it is key to have an awareness of the community and how it fits in a client's life. Self-directed studying via individual research, kink-competent supervision and education are important to ensure clients are not further stigmatized, pathologized, or harmed.

Significance to Counsellors

Many people may wonder how BDSM could ever connect to therapy, but there are countless stories of people who experience positive outcomes, whether it is as simple as a sense of stress relief or transformative as being able to fully connect with a partner while recovering from a sexual trauma. It is important for counsellors to have at least a basic awareness and

acceptance of kink practices so that we can support our clients while reducing internalized shame, stigma, and further harm to a misunderstood community.

As mentioned above, abuse is commonly screened for and assessed to make sure it is not hidden within the power dynamics of certain roles and relationships. If a therapist is unaware of practices in the community, they could potentially miss warning signs of a falsely labelled BDSM relationship. For example, one partner being coerced into non-consensual power dynamics versus everyone having the ability to speak freely regardless of their role (Shahbaz & Chirinos, 2017). The Shahbaz-Chirinos Healthy BDSM Behavior Checklist (2017) was created to support counsellors to distinguish whether their clients are participating in "constructive BDSM" (Shahbaz & Chirinos, 2017, p. 105). On the other hand, without awareness, an ill-informed therapist could misread the healthy Dom/sub relationship as something nefarious. This is also the case with distinguishing injuries from impact play. An uninformed therapist may assume that bruises and marks are the result of non-consensual impact play or self-harm behaviours.

Risk assessment is a big component of kink-affirming therapy (and BDSM), which therapists use to collaborate with clients to explore risks of certain activities. For example, if a client was considering erotic asphyxiation with a partner but they had a previous experience that involved their breathing being restricted somehow, this could be re-traumatizing. A kink-affirming therapist would discuss the potential risks and benefits with their client so that they could make an informed decision of whether they wanted to participate in that activity. If they chose to participate, the therapist would be able to collaborate with them to create supportive strategies to use in the moment and then process further in their next session. If this client did not have a therapist who was open and accepting, they may participate in a scene that not only harmed them but could also impact their partner. BDSM has inherent therapeutic aspects that can facilitate healing in many practitioners, but there is also a very real risk of physical or psychological harm if proper support is not offered. Working with a kink-aware/knowledgeable

therapist to process the emotional content that arises from BDSM experiences can further allow clients to move through the healing process in a safe way. This could include information about aftercare, consent building, and providing safest practices. In the continued example from above, the therapist may offer education to the couple about erotic asphyxiation such as applying pressure from the side of the neck versus the front, etc.

Themes to be Explored

When looking through the research, there are countless descriptions of the potential benefits of consensual BDSM. Reading stories of practitioners who have felt a sense of connection, comfort, acceptance, belonging, friendship, sexual expression and satisfaction, physical and emotional intimacy, self-discovery, joy, improved relationships, empowerment, autonomy, and the list continues (Dahl et al, 2023; Easton, 2008; Goerlich, 2012; 2023; Richter, et al., 2008;). In this paper, I will be discussing some of these themes in more detail, but as mentioned above, this just begins to explore what can be experienced in a BDSM scene. Every practitioner is as unique as the kink they enjoy, so this is a general overview to pique one's interest.

Key Definitions

BDSM:

Short for "bondage and discipline, dominance and submission, sadism and masochism." These are a range of sexual and nonsexual preferences and behaviours involving physical or psychological control, pain, and/or unequal power dynamics. (Goerlich, 2021; 2023; Shahbaz & Chirinos, 2017).

Bottom:

Positionality title; bottoms receive a sensory experience (i.e. being spanked), but this does not imply submission or relinquishing control (Bennet, 2024; Goerlich, 2021).

Clinically Supported BDSM:

The proposed therapeutic model created for this capstone, which combines the protocol and session structure of Bonus' (2024) Therapeutic Facilitated Trauma Play and the triadic relational structure of Masters and Johnson's (1970) Surrogate Partner Therapy.

Consent:

The willing agreement or participation of all parties involved to engage in a particular activity or relationship (Kink Clinical Practice Guidelines Project, 2019). In consensual BDSM, consent is freely given, constantly reassessed, and can be revoked at any point in time.

Culture:

Cultural anthropologists' definition of culture as the learned behaviors and symbols of a group, the primary means by which humans adapt to their environments, and the way of life for a particular society (Nanda & Warms, 2011).

Dominant/Dom:

Role title relating to the power dynamic/exchange in some BDSM relationships. A Dominant [*sic*] takes the role of authority and/or exerts control over another person within play (Bennett, 2024; Goerlich, 2021).

Fetish:

Intense sexual desire and gratification that is connected to an object/piece of clothing/specific body part (Goerlich, 2021).

Kink:

Non-normative sex practices/behaviours, sexual identities, relationship orientations/structures, fantasies, or concepts (Shahbaz & Chirinos, 2017).

Kink-affirming therapy:

Trauma informed practice that strives to depathologize kink through an intersectional lens which looks at how various systems of oppression are impacting members of the community (Goerlich, 2021; 2023).

Scene:

Interactions between two or more people with a defined start and stop point, which may or may not involve sexual intercourse (Goerlich, 2021; Shannon, 2021).

Shadow play:

Exploration of suppressed emotions and/or challenging internalized ideas/thoughts/feelings/dynamics with the purpose of regaining control, memories, sense of self, or one's experience (Easton, 2007; Levand et al., 2018; Ortmann & Sprott, (2015).

Submissive/sub:

Role title relating to the power dynamic/exchange in some BDSM relationships. A submissive gives control to another person (or people) within play (Bennett, 2024; Goerlich, 2021).

Surrogate BDSM facilitator:

A term created for this capstone to describe a particular type of surrogate partner. Surrogate BDSM facilitators would engage in a triadic relational structure within the proposed model of clinically supported BDSM.

Switch:

Role title relating to the power dynamic/exchange in some BDSM relationships. A switch is someone who engages in both Dominant and submissive roles (Bennett, 2024).

Top:

Positionality title; Tops give a sensory experience (i.e. spanking), but this does not imply authority or control (Bennet, 2024; Goerlich, 2021).

Trauma:

The lasting emotional response that can result from living through a distressing event that overwhelms one's ability to cope. Experiencing a traumatic event can impact a person's sense of safety, sense of self, ability to regulate emotions, and navigate relationships (CAMH, 2025).

Trauma play:

Using BDSM deliberately to re-enact and rework a traumatic memory for the purpose of processing or coping with the trauma (Thomas, 2019).

Purpose Statement

The purpose of this capstone is to consider the nonsexual therapeutic benefits of consensual BDSM, bring awareness to how counsellors can support their kink-identifying clients in the therapy space, and explore the legality and ethics of using clinically supported BDSM. This may look like encouraging open discussions of a client's connection to the kink community, supporting them and a partner through their own exploration of trauma play, or collaborating with the client and a surrogate BDSM facilitator to create a treatment plan for moving through a trauma if they do not have a trusted and/or consistent partner of their own.

Summary

In chapter one, I provided definitions of key terms and differentiations within consensual BDSM, as well as an overview of the topic and clinical relevance. Kink-affirming therapy was described and connected to this paper. Several themes of nonsexual benefits were touched on, including within my own lived experience.

In chapter two, I will be delving deeper into the nonsexual benefits of consensual BDSM practices, connecting them to historic and current research, as well as discussing limitations. I will also explore how kink-affirming therapists can ethically incorporate trauma play to support their clients in processing and rescripting traumatic events. The chapter will include a detailed overview of Bonus' (2024) Therapeutic Facilitated Trauma Play model as well as Masters and Johnson's (1970) Surrogate Partner Therapy. The purpose of this chapter will be to explore common experiences within the kink community with the hope of de-stigmatization in the therapy room, as well as the public eye.

Chapter three will explore the possibility of further clinical applications. I will invite readers to consider the idea of joining the concepts of therapeutic facilitated trauma play (Bonus, 2024) and surrogate partner therapy (Masters & Johnson, 1970) to create a model of clinically supported BDSM. This includes a hypothetical triadic relational structure like surrogate partner therapy (Masters & Johnson, 1970) and follows the structure and session format laid out by Bonus' (2024) Therapeutic Facilitated Trauma Play. This chapter will include several considerations that must be made to protect clients, therapists, and surrogate BDSM facilitators (ethics, vetting, informed consent, etc.).

Chapter 2: Literature to Arouse Interest

In this chapter, I will discuss the stigmatization and misconceptions faced by the BDSM community, positive nonsexual benefits of BDSM, and the overlap between traditional trauma therapy and the therapeutic facilitated trauma play model (Bonus, 2024). This model was created by Bonus (2024) as a structure for kink-affirming therapists to support clients who were engaging in trauma play to process somatic healing. From there, I will explore surrogate partner therapy (Masters & Johnson, 1970) and how it all can be connected to trauma work.

Stigmatization of the BDSM Community

There is a long history of stigma and oppression within the BDSM community. Freud (1962, as cited in Rogak & Connor, 2018), often described sexuality as the weakness of humanity, stating it was an excuse for people to behave abnormally. He pathologized kink behaviours and condemned many common and consensual sexual acts, such as sadomasochism, fetishism, voyeurism, sexual touching without intercourse and homosexuality. This is likely where the modern discrimination of the BDSM community began. Contrary to what Freud believed (and further misrepresentation from popularization of modern depictions in movies such as “50 Shades of Grey”), there has been no research that shows a connection between BDSM practitioners and history of abuse, mental illness, or predisposition to criminal behaviour or abuse (Rogak & Conner, 2018). This does not mean that there are no predators or people who use BDSM to disguise abusive or ill-informed kink behaviours, but with the use of safety practices such as informed consent and protocols such as negotiation, there are ways to connect to those who truly embrace the core principles of the kink community: consent, communication, safety, and aftercare. This is often encapsulated with the phrases, “Safe, Sane, and Consensual” (SSC; Yates & Neuer-Colburn, 2019; Martinez, 2020) and "Risk Aware Consensual Kink” (RACK; Goerlich, 2021; 2023).

The current Diagnostic and Statistical Manual of Mental Health Disorders (American Psychiatric Association [APA], 2022) lists fetishism, sadomasochism, and voyeurism as psychological disorders only if they cause significant distress or impairment to interpersonal functioning. This should mean that only those who are experiencing extreme levels of distress or dysfunction should be diagnosed, however, the BDSM community continues to be demonized. This stigma is not only experienced in a sexual context but often extends into moral and legal grounds. Between 2006 and 2017, 808 parents contacted the National Coalition for Sexual Freedom (2013, as cited in Cascalheira, 2023) because their kink behaviours were used against them in child custody litigations (Gerson, 2015).

It has been shown that there is a heightened sense of shame in the BDSM community which may come from internalized kink-phobia, partner interest discrepancies, stigma around parenting ability, and violence or aggression from others who reject them (Kink Clinical Practice Guidelines Project, 2019). Like 2SLGBTQIA+ psychology, it is believed that health challenges such as increased anxiety, depression, suicidality, and substance use are responses to individuals and communities under significant minority distress (New et al., 2021). These stigmas may keep clients from disclosing their interests to partners or family, which may then impact their ability to ask for support, including with issues that are not related to kink.

Exploring and expressing desires that have previously been pathologized or criminalized is not only therapeutic but may be considered a form of social justice in the face of oppression. In 1978, Foucault (as cited in Lindermann, 2011) compared stigmas in the kink community to the oppression of homosexuality. Many people in the 2SLGBTQIA+ community feel liberated when they disclose their authentic selves to others, and this is now seen as a therapeutic act to counter the anguish they have felt previously. This could be considered the same for BDSM practitioners.

Misconceptions of BDSM Practitioners

There are many misconceptions about the kink community, including the Feminist debate, in which some believe that BDSM is rooted in violence, subjugation and Western patriarchal norms of sexuality. Others argue that BDSM practices are a form of sexual expression and consensual exploration of masculine dominant power inequalities that empower women both as Doms and subs (Chancer, 2000; Stear, 2009), and this empowerment often transfers to other non-kink related life situations. While the roles and scenarios may mimic patriarchal views, consensual practice would ensure that all the acts within (violent or not) are pre-negotiated by all parties and the level of psychological and physical harm are discussed, agreed upon and consented to. It should also be noted that consent is not just obtained beforehand but continuously reassessed throughout. Practitioners are trained in the routines, customs, and techniques of BDSM, and many find the thrill in the participation of the acts, not necessarily the harm itself.

Deckha (2011) describes feminism from a Western perspective and compares feminists who oppose BDSM to Westerners who object to Muslim head coverings without understanding the cultural contexts. They urge feminists to approach BDSM with the same care and cultural competence that you would with any other practices you did not understand. Before criticizing, it is crucial to learn the context and practices, as well as centre the voices of practitioners themselves.

Those who argue the power dynamics are inherently harmful and patriarchal may not fully understand the relationship. As details are pre-negotiated (which can range from short conversations to in-depth discussions that take months), the submissive has much more control during the interactions than it seems. Practitioners discuss how they would like a scene to unfold; activities are negotiated in terms of what they are willing or unwilling to explore, and that consent is constantly assessed and re-established. While the Dominant is actively taking

charge of the scene and stretching the limits of their submissive, they are constantly checking in regarding consent. Ultimately, the sub has the power to slow or stop the situation, which is not always the case for many in their day-to-day lives. Being at the intentional mercy of someone can be very empowering, and in these situations, participants are choosing how and who to give power to (Lindermann, 2011; Cascalheira et al., 2023).

This exchange of power often goes well beyond the realm of sexual satisfaction and facilitates a sense of partner bonding and increased understanding of expectations, which can create a heightened sense of safety. Predictability within these negotiated experiences (and by extension, relationship roles) has been shown to improve communication, connection, and overall relationship satisfaction (Cutler et al., 2020; Dahl et al., 2023).

Another misinterpretation is the belief that the BDSM community is entirely made up of sex crazed, out of control, dangerous people. While there are many people who engage in the nonsexual aspects of BDSM, kink activities are often wrongly equated to depravity, violence, and abuse. It is crucial for therapists to know that kink and intimate partner violence (IVP) can go hand in hand, but they are not always connected (Kink Clinical Practice Guidelines Project, 2019). It is important to have a contextual picture of kink dynamics and how they fit in with a client, which may not be evident from a simple questionnaire. Being educated about BDSM practices and relationships of one's specific clients, and how they fit within the culture of the community and their life is critical.

Nonsexual benefits of BDSM

Those who condemn kink practices may not be aware of the many nonsexual facets. While there are obvious sexual aspects, many practitioners describe nonsexual therapeutic experiences, such as the exploration of relationship dynamics, sexual and gender identity, self-discovery, autonomy, and self-expression. Some practitioners have said that BDSM teaches

them crucial communication skills such as boundary setting and expressing their needs, which allows them to engage more fully in other relationships. There is also a strong sense of social connection within the kink community. These connections may offer an opportunity to talk about things that they do not feel they can discuss anywhere else, especially when it involves trauma. Not everyone feels safe to talk about abuse or kink related topics with “vanilla” people, so there is a sense of camaraderie without fear of isolation and stigma. Many also believe that vicarious healing takes place; seeing people on their healing journey may support them on their own (Cascalheira et al., 2023).

Self-worth and Value

BDSM can provide the opportunity to address and transform one's internalized sense of sexual shame. Criss (2023) describes the act of confronting and connecting to one’s desires as an initial step to embracing self-awareness and self-acceptance. Ahmed (2004, as cited in Lindermann, 2011) describes shame as being restorative when it can be shown that the failure to meet societal ideals is temporary and not embedded in one’s character. Lindermann (2011) interviewed several professional Dominatrixes, and they discussed the idea of humiliation and degradation being therapeutic if there is a certain level of trust and care involved. They believe that, if done well, it can remind the submissive of their inherent worth and value.

This is why aftercare is so important; to have the space and time to come back to oneself and to have assurance that the roles played within the scenes were only one aspect of them versus being who they are. Aftercare is a time that Doms share their appreciation for the sub's strength, vulnerability, and choice to share the experience with them. It is also a time that Doms can use to leave behind characteristics that were adopted for play (i.e. violence, aggressive language, etc.) and the subs share appreciation for the skills, care and respect shown to them.

Physical and Emotional Intimacy

There are some BDSM practitioners who have limited intimate connections with others, so they use kink to satisfy both physical and emotional needs. Many of the Dominatrixes described their clients as “touch starved” (Lindermann, 2011, p. 164), and shared stories of their clients requesting physical connection activities such as cuddling, back stroking, etc. Many clients also asked to simply talk about things that they did not feel they could share with other people, whether it was regarding stress or fantasies.

It is often the case that kinks that have little to do with sex at all. Many practitioners share that their desires stem from an unmet emotional or physical need. There is a possibility that when there is a gap in a person’s life, their brain fills it in with fantasy. For example, if someone grew up feeling invisible, they may have desires to be seen in extreme and intense ways, such as exhibitionism or voyeurism. If someone has a high stress and urgent decision-making role in their work life, they may desire to be dominated and have all decision and choice taken away as a way to relax. This could be the nervous system’s way of regulating and finding peace. When it is framed this way, kinks become less about what people want, and more about feeling something they may not have experienced on a regular basis.

Self-discovery Through Altered Consciousness

Another desired outcome from engaging in BDSM activities is subspace or Topspace [*sic*], which is described as an altered state of consciousness where one feels a deep sense of relaxation, peace, extreme focus, groundedness, euphoria, or freedom that can only be achieved through these activities (Cascalheira et al., 2023; Lindermann, 2011; Turley, 2022; Harris, 2024). This is caused by a rush of endorphins that many say can transform emotional and physical pain. These feelings often extend long after the scene is over and can bring a sense of psychological and emotional clarity to other life situations. Turley (2022) explores the idea of “reality slips” (Cohen and Taylor, 1976 & 2002, p.10) as the experience of being overwhelmed with a strong feeling which causes them to re-evaluate their understanding of themselves and

the world. In BDSM practices, the use of intense emotional and psychological states, as well as physical sensations often bring participants to a point of examining consciousness in a different light. Through these reality slips and both subspace and Topspace [*sic*] experiences, many report feelings of increased self-esteem and confidence that last well past the end of the scene.

New et al. (2021) discusses a connection between the impact of exploring and expressing one's kink identity with an increase in well-being. BDSM can provide an opportunity for self-discovery; finding out about one's strengths and limitations, getting to know one's body, exploring desires in an accepting environment (whether sexual or not) and getting to know and understand oneself and one's partner(s) better (Rogak & Conner, 2018; Turley, 2022). Practitioners rewrite narratives for themselves and make meaning of their experiences, and these counter-narratives may be helpful in dismantling societal pressures and expectations regarding power, age, gender, sex, and class (Turley, 2022; Harris, 2024).

Dismantling Societal Norms and Expectations

BDSM may also create new awareness of oneself in the context of both greater society and where they fit in their own personal world. Role play can be a way of examining one's own identity in the context of gender related to class, age, and race (Kink Clinical Practice Guidelines Project, 2019). These experiences can bring a sense of consciousness and insight to one's position of power and oppression in their own life and are not inherently sexual. For example, many people who dress in contrast to their presenting gender (Drag Queens, British Dames, etc.) are not aiming for sexual gratification, they do it to challenge social norms, explore gender roles, or express aspects of themselves that they cannot in their everyday lives (Kink Clinical Practice Guidelines Project, 2019; Sprott, 2020).

While the kink community possesses a fair amount of diversity when it comes to gender and sexual identity, it often does not have the same in terms of race and ethnicity (Erikson et al.,

2021). Martinez (2020) also addressed the "whiteness" (p. 734) of many BDSM spaces and the privilege of those practitioners who live in white bodies. As with greater society, colonialism has had an impact within the kink community, with many people of colour feeling more likely to be discriminated against and/or fetishized (Erikson et al., 2019). In an article describing how to decolonize BDSM, Ntshinga (2021) discusses the danger of adopting Eurocentric views when it comes to natural sexual practices of various cultures. For example, labia stretching is used in many African cultures to increase sexual pleasure and encourage female ejaculation, but Western society has deemed it as mutilation, which creates taboo where there need not be.

While there are many people of colour who do not want to be included in mainstream BDSM because they do not want to be further stigmatized, discriminated against, tokenized, or fetishized, some find empowerment in race play, which is a controversial form of interracial BDSM that revolves around race and commonly includes racist themes, language, and hyper racialization of power dynamics (Cruz, 2015). While violence is often eroticized within the BDSM community, it is said that using it as a vehicle to re-enact racial stereotypes is a way to take charge and reclaim one's power (Easton, 2007; Cruz, 2015; Erikson et al., 2019; Lindermann, 2011). As mentioned earlier, the essence of a consensual BDSM relationship is egalitarian, so the person being "exploited" (most likely the sub) has just as much power, if not more so, than the Dom when it comes to scripting the scene and boundaries regarding comfort levels. Being able to explore these potentially traumatizing dynamics with a trusted partner in a carefully crafted space that is negotiated ahead of time, may allow the opportunity for deeper processing of experiences.

Some practitioners also participate in racial role reversal, where people of colour play the Dominant over white (often male) submissives, which allows them to regain a sense of control and agency (Cruz, 2015). In this type of play, the racial differences of participants are eroticized

and exaggerated, and it is very common to have humiliation as a form of mutual sexual and nonsexual satisfaction.

Relationship Satisfaction

It is often believed that those in the BDSM community are not able to maintain healthy, committed relationships, which is not the case. Rogak and Connor (2018) compiled research regarding relationship satisfaction of BDSM participants and their committed partners and using the Revised Dyadic Adjustment Scale ([RDAS] Spanier, 1976, as cited in Rogak & Conner, 2018), results showed that participants experienced elevated levels of relationship satisfaction. In this study, Rogak and Conner (2018) suggested the idea of looking at BDSM relationship hierarchies and roles from a family systems theoretical lens, although it was not discussed in-depth.

Even the healthiest non-kink relationships can have ambiguity regarding expectations of roles, which may lead to higher confusion and resentment, so it could be that negotiated roles and patterns of interactions within BDSM relationships may ease conflicts in expectations (i.e. the Dominant takes care of their partner by planning and cooking the meals, while the submissive does the shopping and clean up as a service to their partner). It is believed that this results in less ambiguity, more communication, clearer boundaries, and higher relationship satisfaction.

Harris (2024) suggests the principles of Conscious Relationship Design (CRD) can enable people to be intentional in creating a relationship that values equality, autonomy, consent, and authentic communication regarding each person's needs and desires. This is not about setting limits, but instead, empowering each party to express their boundaries and work together to create a trusting and respectful relationship where each voice is heard and valued.

Adaptive Coping Strategies

Coping strategies are the conscious and unconscious thoughts or behaviours used to manage stressful situations and unwanted emotions. They aim to maintain overall well-being by reducing distress and regulating emotions. Coping skills are unique to each person, but common strategies are used by many, and they have been categorized as adaptive and maladaptive. Adaptive coping strategies are considered a healthy way to reduce distress because they improve functioning while decreasing stress, while maladaptive coping reduces stress in the short term, but has no impact on the source itself.

While many BDSM practitioners engage in activities for fun, some use kink to process their trauma (Easton, 2007). Easton (2007) stated that while kink is not therapy, it can be therapeutic. It is suggested that kink-identifying clients who have a history of trauma may benefit from a kink-aware therapist who can encourage the connection and insight between BDSM, abuse, and recovery (Shahbaz & Chirinos, 2017; Cascalheira et al., 2023). In support of this premise, Cascalheira et al. (2023) examined how survivors of childhood and adolescent abuse used kink to transform their trauma. Their hope was to show that kink practices can be a normative and healthy way to process and cope. Haines (2007, as cited in Levand et al., 2018) offers the idea of sexual trauma survivors taking healthy risks to push past their comfort zone without going farther than they can handle, which is a cornerstone of BDSM activities. It is possible that some survivors who engage in BDSM and kink experiences are using adaptive coping strategies like reframing, achieving closure, releasing emotion, seeking social support, engaging in emotional expression, and managing powerlessness, which is the first stage of posttraumatic growth (Tedeschi et al., 2020; Cascalheira et al., 2023). Many kink practices parallel therapeutic elements, such as boundary setting, gradual exposure, developing positive self-concepts through emotional and interpersonal exploration, acceptance, and distress tolerance. It was reported that 40% of people in the kink community use BDSM to cope with

distress (Sprott, 2020; Richters et al., 2008), while using scenes and relationships fundamentals (negotiation, safe-words, and debriefing/aftercare) to maximize benefits and minimize harm.

There are thematic descriptions of how participants experienced self-discovery, gaining self-worth, autonomy, a sense of personal power, enjoying aspects of sex again, and realizing that their abuse does not define them. It was said that using role play allows practitioners to step into their power and choose roles that give them what they need (Cascalheira et al., 2023). Role playing can also provide a safe container to create an alter ego if a degree of detachment is desired (Cohon & Langone, 2022).

Shadow Play for Trauma Work

There is growing evidence that suggests somatic healing is integral to healing psychologically (Hammers, 2014; Kleinplatz, 2006, as cited in Levand et al., 2018). Weille (2002, as cited in Lindermann, 2011) and Easton (2007) compare BDSM scenes to psychodrama, with a potential for relational and psychological growth when favourable conditions are present (such as trust, love, playfulness, etc.), and to explore and reclaim parts that have separated from oneself. It has also been connected to imaginative play (Stear, 2009), where one uses props, predetermined storylines, costumes, and quasi-emotions (the belief in a physiological response to stimulus without motivation to act). Thomas (2019) explains that a key discussion of BDSM research is the exploration of whether shadow play or trauma play can be better described as re-enacting and rescripting trauma.

Bessel van der Kolk (2014) speaks about three approaches to support trauma survivors; psychotherapy, medication, or allowing the body to have a visceral experience that contradicts the feelings of helplessness, rage or collapse that are a direct result of a traumatic event. Some people say that talk therapy does not give the somatic healing that they desire (Levand et al., 2018; Turley, 2022), so this is where the BDSM concepts of shadow play and trauma play might

come in. *Shadow play* can be used to explore challenging emotions and thoughts, or repressed aspects of oneself, but are not directly related to a traumatic event. *Trauma play* is the deliberate, titrated, therapeutic re-enactment of a specific trauma with the purpose of coping and/or healing. For example, one may use the Dom/sub dynamic in shadow play to address reluctance to accept authority figures, whereas in trauma play it would be used to therapeutically re-enact and rescript an experienced trauma.

After engaging in a consensual and therapeutic re-enactment of a potentially traumatic experience, many describe a regained sense of control and wholeness that had been taken away from them (Levand, 2018). A very common form of shadow play is consensual rape play, which some use to heal from sexual abuse (Strokes, 2008; Shadowborne, 1998; Easton, 2007). In an interview with Cascalheira et al. (2023), a practitioner shared this sentiment:

> What helped me work through my childhood molestation the best wasn't going to psychotherapy. It wasn't talking to friends and family about it. It was roleplaying [*sic*] it with a man that I was in love with, and it was the most twisted but romantic roleplay [*sic*] ever. But it really helped me. (p. 18)

Jung speaks about much of the ego as unconscious, therefore calls it a shadow world (1968, as cited by Easton, 2007; Levand et al., 2018). He believed the shadow is an archetype which is guilt-ridden and ego-dystonic, exhibiting behaviours that are forbidden to be expressed, although they always show up one way or another. It is believed that these shadows are created when we experience a traumatic event and split that part off ourselves. Easton (2007) discusses how BDSM (specifically SM) can provide the opportunity for exploring those exiled parts to find acceptance and understanding. It is thought that bringing these traumas and shadows into our consciousness allows us to heal and reconnect with all parts of ourselves.

There are parallels between trauma play and conventional clinically supported techniques for sexual trauma survivors. During the re-experiencing process in trauma therapy, a client is exposed to a controlled reliving experience (Briere & Scott, 2015; Herman, 1992, as cited in Levand et al., 2018). In both trauma play and trauma therapy, there is a predetermined script planned by the therapist and client (or between BDSM participants), aspects of reliving of the event, desensitization, and reprocessing. In both cases, titration is taking place - triggers are assessed and addressed, supported by noticing internal and external experiences, breathing, actively making choices regarding how to deal with them, engaging in choice, and reassessing if needed. Re-enacting a traumatic sexual encounter in a preplanned, consensual manner with trusted people can allow the opportunity to reclaim control, therefore aiding in moving through the trauma. It is believed that through trauma play (along with many other BDSM practices), one can rescript the event and rewrite the outcome. Through these new memories and emotional and/or physical feelings, it is hoped that one may overcome the overwhelming aspects that traumatic re-experiencing brings (Easton, 2007; Levand et al., 2018). This rewriting of trauma may empower and allow people to move forward in their lives.

Trust, communication, and pre-session negotiations are a must for these scenarios to have the desired outcomes. There must be trust that the submissive/bottom has been transparent regarding their limits/needs/desires, and that the Dominant/Top understands those needs and will be mindful of their psychological, emotional, and physical safety. Aftercare is always preferred, however, when engaging in particularly emotional scenes, it is imperative that aftercare is provided so that both parties can return to a place of normalcy and process the encounter. Aftercare addresses physical, emotional, medical, and sensory needs of all participants, and can include being cuddled, wrapped in a blanket, eating a snack, debriefing highs and lows of the session, etc. It is also important for participants to discuss the scene and address any feelings that came up for all parties (during or after the aftercare).

Re-enactment may be a first step towards working through trauma, but it would be beneficial for survivors to have concurrent therapy. Lindermann (2011) shared the experience of one Dominatrix with a client who was working through his abandonment issues and felt the scene was therapeutic. Her client was able to let some of his emotional distress out during the session, but she described her recommendation for him to see a therapist to process what had come up. There is only so much that can be debriefed during aftercare, and it is crucial to have in-depth support when working with profound emotional, physical, and psychological wounds.

Connecting Therapy and Trauma Play

For those practitioners who desire extra support with processing traumatic events through trauma play, it is recommended that they connect with a kink-affirming therapist. Through this therapeutic relationship, they can explore themes, patterns, and insights that emerge from their BDSM activities. In the therapeutic facilitated trauma play model (Bonus, 2024), trauma play is discussed, planned, and completed in collaboration with a kink-affirming therapist. Having a BDSM partner is necessary for this intervention, so sessions include information on how to support clients with choosing someone to enact scenes with. While having a partner who is trustworthy and able to contain all that these scenes can bring up, it does not stipulate that it must be a romantic relationship, so I believe that this model can be utilized with a surrogate BDSM facilitator, which will be explored in chapter three.

It is important to note that the following discussions assume that clients are already BDSM practitioners. This should not be suggested to anyone who is not versed and ideally active within the community and should be explored only if the client has been prepared for trauma play and the therapeutic nature of it. This process must be completely client-led, with the therapist along to provide information, education, and support as needed.

Before exploring the possibilities of clinically supported BDSM, we must first take a deeper look at how conventional trauma treatments and trauma play overlap.

Finding a Voice After Abuse

In Ortmann and Sprott's (2015) book, they discuss how BDSM has given people a voice to express themselves through more than just their sexuality. Stories of empowerment, courage, and resilience resonate through the pages of this book. Specifically, there is a recounting of a client who requested therapy to support him with a speech impediment that began around the time that his parents divorced as a child. As sessions progressed, this client refused to explore any feelings of depth but eventually shared that he felt he did not have a voice. After this, he brought his wife into session, and together they explained that they had found Ortmann though the National Coalition for Sexual Freedom and contacted him because they wanted a kink-affirming therapist.

The couple reported that during a scene which involved spanking, they had unintentionally triggered a recollection of a traumatic childhood event in which the primary client was disempowered and left without a voice. Years after the original trauma, this client wanted to regain a sense of power and control and incorporate impact play (specifically spanking) into the couple's sexual encounters. After reading Easton's (2007) article about shadowplay [*sic*], they wished to explore this together in a safe and consensual manner with help from Ortmann to plan and process the experience. The couple had negotiated and planned the entire event; they had planned every detail from what tools to use, safe words, what each partner's aftercare would look like, sharing details with a friend as a safety protocol, how long it would be, and how to know that they were finished (Ortmann & Sprott, 2015).

When processing with Ortmann afterwards, the couple shared that this experience was in no way arousing for either party. Infact it was quite the opposite; there were moments that

the client's wife was extremely upset to be representing her partner's abuser, however, she knew that this was something that he felt he needed to move past his trauma. After this event, the client was able to begin processing the deep, forgotten emotionality of this previous experience and address the impact on his current life (Ortmann & Sprott, 2015).

Therapeutic Facilitated Trauma Play

This story is an example of how trauma play can be supported by a kink-affirming therapist. Bonus (2024) takes it further to create a therapeutic model and provides an outline of how therapists can support their clients when engaging in this activity.

Modelling Herman's (2015) triphasic trauma treatment, Bonus (2024) separates Therapeutic Facilitated Trauma Play into similar stages: Pretreatment expectations and relationships (regarding both the client and therapist), stage one is safety, stage two is remembering and mourning (before and after trauma play), and stage three is reconnection.

Pretreatment

Before safely exploring trauma play, there are several criteria that must be addressed for all parties. The client must be a BDSM practitioner with knowledge and experience with the principles of consensual BDSM as well as the use of safe words and aftercare. This prerequisite will allow the therapist to feel confident that the client will be able to safely engage in trauma play (Bonus, 2024).

Therapists must also be educated on the nuances of BDSM, trauma informed practice and safety considerations for both. As mentioned previously, when working with BDSM practitioners, therapists must be able to differentiate abuse from healthy expressions of BDSM dynamics (Bonus, 2024). Remembering that subs freely give and retract consent to engage in these complex power differentials is key in distinguishing from abuse.

Another crucial piece for therapists is awareness of the cross over and distinctions between trauma play and regular BDSM practices. For example, the previously mentioned Top/sub space may be experienced in both situations. These are generally described as being enjoyable and therefore, desired states. Shortly after the scene, the return to baseline functioning, however, can be difficult, especially after engaging in a particularly intense scene (Bonus, 2024). This Top/sub drop is caused by the parasympathetic nervous system (PNS) kicking in, with endorphins and adrenaline levels returning to normal. This drop can include symptoms that mirror depression; loss of interest in activities, mental and physical exhaustion, and decreased ability to concentrate. It is important that therapists are aware of the possibility for this to occur and how to recognize it if it presents itself in sessions. Generally, it is nothing to be alarmed about and will pass quickly. While Top/sub drop is a hormonal occurrence that common happens shortly after a scene, X-Drop (Bonus, 2024; Sprott & Randall, 2016) is a psychological phenomenon that happens in the days following. Sprott and Randall (2016; Bonus, 2024) believe this can be linked to a mental shift in perspective and connects to grief or identity development. Many find that going back to mundane life can be jarring and unsatisfying, which creates a sense of disappointment and desire to re-evaluate aspects of one's life or identity. Major (a Dom and BDSM practitioner for over 20 years) reports this is something that is commonly experienced after weekend long kink events; Sunday night, participants would still be euphoric, Monday they would be frantically pushed back into the work week and by Tuesday or Wednesday, couples would begin fighting because they were not satisfied with how their lives were playing out on a day-to-day level (M. Major, personal communication, April 14, 2025).

X-Drop can also be connected to those who are experiencing a shift in identity. This grief may be describing a sense of loss of who they once were, while trying to discover or acclimate to their new selves (Bonus, 2024; Sprott & Randall, 2016). It is not surprising then, that clients who are involved in trauma play (either on their own or working with a therapist) would

experience X-Drop and an increase in these depressive-like symptoms. Bonus (2024) posits that these feelings of sadness may be evidence that a client is working through the losses that resulted from trauma and carving a new identity for themselves as a survivor. This is like what many clients experience in therapy as their sense of self and perspective shifts when processing trauma.

As with any therapeutic intervention, it is important for a therapist to be aware of their client's history and any diagnoses that may be contraindicative. For example, CBT's thought stopping can be harmful for those who have OCD (McKay et al., 2019). In the case of trauma play, the therapist must be mindful of whether there is a history of suicidality, self-harm, dissociation, etc. These things can be exacerbated by Top/sub drop and could increase the risk for both parties involved in the scene (Bonus, 2024; Sprott & Randall, 2016).

Aside from the expectations and competency of the client and therapist, there must also be a focus on the therapeutic alliance. There must be a strong sense of safety and trust involved while collaborating to use this modality because this is an under-researched area, and there is a serious risk of further harm and re-traumatization. Bonus (2024) recommends using a contract, much like the ones employed at the beginning of DBT. This outlines expectations for both the therapist and client regarding commitment to a certain number of sessions, availability of therapist after a trauma play session, continued mindfulness and coping skill building, and a description of how trauma play works, outlining the potential risks involved.

Stage One: Safety

Safety is one of the highest priorities within the kink community and must also be kept at the forefront of all therapeutic work. As with any trauma therapy, ensuring that clients are emotionally, physically, and psychologically equipped to engage in the process is of utmost importance. As mentioned many times before, being aware of previous history and making sure

that clients are well resourced and supported once this modality is decided upon is imperative (Bonus, 2024).

Exploring their support network and encouraging them to lean into the kink community, create bonds with those around them, continue to educate themselves in BDSM activities and situations can all create a stronger sense of self and how they relate to the broader community. This can all contribute to increased support and a greater sense of connection and growth.

Gaining internal regulation skills is also something that should be continually discussed. Knowing themselves and what helps to ground and comfort them is not only an important life skill but will also support their overall growth as they work through the trauma process (Bonus, 2024). Skills such as progressive muscle relaxation, box breathing, reality orientation, and grounding can help to activate the parasympathetic nervous system and decrease distress.

Stage Two – Remembrance and Mourning

Before trauma play occurs, the traumatic event will begin to be discussed and explored. During this stage, the client will describe their trauma and how it has impacted their life in the past and present. Trauma processing through talk therapy should be utilized along with trauma play to support the processing of cognitive and emotional themes that arise during treatment (Bonus, 2024). Through the process of describing what elements are particularly difficult, the therapist will collaborate with the client and decide what aspects they wish to address with BDSM.

Once these aspects have been identified, trauma play, along with the client's potential partner will be discussed. Bonus (2024) suggests that this person should be acquainted with and have a history of engaging in regular scenes with the client and show a sense of trust and care towards them. It is recommended that both partners attend several therapy sessions together

before participating in the scene so that everyone can be informed of potential risks and impacts so that both parties can give informed consent.

Trauma Play – Joint Session One. During these sessions, expectations and limitations are discussed. Bonus (2024) describes this session as being predominantly psycho-education regarding trauma play, including rationale, goals, limitations, risks, and desired outcomes. There is homework for both partners, which includes limits, coping skills (for themselves and things their partner can do for them in aftercare), themes they want to address, specific activities they want to engage in, etc.

Trauma Play – Joint Session Two. At this point, discussions about the scene start to take place. Bonus (2024) suggests that conversations begin with descriptions of what coping skills will be used, and if needed, they are taught to the partner so they can support the client during moments of distress and/or aftercare. After this, limits from both parties are expressed and needs for aftercare for each partner are described. Caring for the client's partner afterwards is just as important because there is potential for guilt to be felt from playing a role that has caused trauma. The homework for this session is for both partners to discuss details of how the trauma play will unfold.

Trauma Play – Joint Session Three. In this session, specific details are discussed. By the end, there will be a detailed plan in place, and this is the format for how it will occur. There are concrete and deliberate conversations around coping, aftercare, safe words, triggers and limitations, and the scene is described in detail to the therapist (Bonus, 2024). At this point, it is the therapist's responsibility to explore any unmentioned concerns such as what to do if things go wrong, how often to check in with each other, how to know that a scene is over, and what to do if the client experiences a flashback. It is important to note that as with conventional interventions, each BDSM practitioner is unique, and some may want to incorporate a level of triggering stimuli, so this is also important to address in the coping discussion (Bonus, 2024).

This session also must include safety planning for physical and psychological emergencies, such as having first aid kits, scissors for rope play, comforting tactile items, soft lighting, calming music, etc. Once the details of the scene and safety planning have been solidified, a date and time are agreed upon with the therapist. If there is any change in this scheduling, the therapist must be notified so that they can check their availability to be reached once it has been completed. Whether or not the scene went as expected, it is crucial for the therapist to be notified once the trauma play is completed so that they can check in and process if need be (Bonus, 2024).

Remembrance and Mourning – After Trauma Play

As mentioned, it is imperative that the couple call the therapist as soon as the scene ends to ensure that everyone is safe. After this, aftercare should also be done as planned. A few days after the scene has taken place, there should be a session so the therapist and primary client (the partner can attend if desired, but it is not mandatory) can talk about anything that came up. During this session, the client's affect should be monitored to evaluate for any of the "drops," and to begin processing and/or noticing any changes in perspective regarding their trauma (Bonus, 2024). There is also a possibility that the trauma play did not go as planned, so making space for discussing this is also crucial.

As with conventional trauma therapy, it is common for those who engage in trauma play to move through various stages repeatedly. Healing is not linear, and it could be that this exploration brings up challenges that are adjacent to the original traumatic event (i.e. revelations or perspective shifts regarding relational issues, their connection to the outside world, etc.). As always, additional talk therapy interventions should be administered in conjunction with this model, and with time and continued processing, the client should be less activated as they discuss their trauma (Bonus, 2024).

Stage Three - Reconnection

Clients have entered this stage when they are able to have conversations about their trauma without getting overwhelmed. It is not uncommon in this stage for the client's relationship to BDSM to change (Bonus, 2024). It could be that they are not participating as much, or with different activities. It could be that they are not avoiding triggers as frequently, and instead, incorporating them into play, or it could be that their tastes have changed, and they are simply not interested in playing with the triggers (i.e. they used bondage in their trauma play scene because of a previous event and after addressing it they realize they are not afraid, but do not enjoy it). In this stage, reassessment of goals or termination of therapy is common (Bonus, 2024).

After exploring the therapeutic facilitated trauma play model (Bonus, 2024), we must also discuss surrogate partner therapy (Masters & Johnson, 1970). It is through these connections that we will be able to theorize how BDSM may be used in a clinical setting.

Therapeutic Sex

Erotic labor (Chapkis, 1997, as cited by Lindermann, 2011) is nothing new, even in the therapy world. Reclassification of sex work as sex therapy has been proposed by sex workers for many years, with the hopes that the credentialing of sex workers as sex therapists would bring them social status and authority (Lindermann, 2011). In this debate, there must be a distinction between therapy and therapeutic. The goal of therapy is to work on specific issues and promote personal growth, whereas therapeutic activities are things that have a positive impact on our mental and physical wellbeing. By that definition, almost anything can be therapeutic. For example, take the colloquial phrase "retail therapy" - shopping can be therapeutic because it gives an endorphin rush, it can increase our self-esteem and create positive self-image, but it is not therapy.

This therapeutic sex and sex work as therapy proposal for reclassification is not wildly inconceivable. There is a legitimate form of sex therapy that has long been criticized because of its incorrect connection to prostitution.

Surrogate Partner Therapy

Emelianchik & Stickney (2019) describe Surrogate Partner Therapy (SPT) as a type of exposure therapy in which the client is provided access to a safe partner when they may not have alternate ways to practice desensitizing techniques. SPT was originally established in 1970 by Masters and Johnson to treat erectile dysfunction in men without partners and has since carried an elevated level of stigma due to its ethical and legal ambiguity. This grey area combined with general misconceptions and lack of efficacy studies has left the modality underused and unacknowledged in sex therapy (Emelianchik & Stickney, 2019). Surrogates go through training which includes 100 hours of experiential class time in topics of human intimacy, sexuality, and "clinical sexology" (International Professional Surrogacy Association [IPSA], 2023). After completing the course work, an internship with close clinical supervision is required. This supervision is offered by an IPSA Certified Surrogate Partner Mentor and the client's primary therapist. This process has no exact timeline; it continues with regular feedback and processing until everyone is satisfied that the intern can safely and respectfully continue as a certified surrogate partner (SP), or until the intern fails the program. Not everyone who enrolls in the program completes an internship. Only certain candidates are invited to move to the internship phase.

SPT is a triadic format; the client, the certified SP, and the licensed therapist. The therapist and client first try to work through issues in a typical talk therapy session, and if the presenting challenge persists, a referral to SPT is discussed as an option. There is an initial consultation with the triad, followed by a private session with the SP and client to develop a treatment plan. After each session, there is a discussion with the primary therapist so that the

interactions can be processed. This open line of communication between all three parties is hoped to provide links and insight to the presenting issue, especially those clarities which arise outside of the clinical sessions.

The purpose of SPT is to allow a safe space for clients to achieve their goals, many of which are often unrelated to sex. Some referrals are regarding sexual dysfunction or trauma, but other examples include physical or emotional intimacy, improving intimate communication, phobias, reading social cues, promoting relaxation, increasing self-confidence, reducing shame, or addressing identity challenges (Oreg et al., 2024). Therapeutic methods used in SPT are psychoeducation, emotional and physical intimacy, touch, or sexual activities, although Rosenbaum et al. (2014) found that 87% of session time was engaging in nonsexual activities such as holding hands, having emotional conversations, or practicing relaxation techniques. It is important to note that the SP will not see clients who have not first explored the presenting issues with a licensed therapist. SPT is meant to support clients in areas which a typical therapist cannot go to. Working through sexual trauma by addressing negative cognitions is a counsellor's bread and butter, but certain desensitizing techniques which may be helpful to the client can bring the therapist into a world of ethical and legal trouble. This is where SPT can step in and there is potential for clinically supported BDSM with clients who identify as BDSM practitioners and do not have a consistent partner.

Emelianchik & Stickney (2019) break down SPT into four stages: 1) emotional bonding through verbal communication, 2) becoming comfortable with touch (called sensate focus), 3) sexual intimacy deemed appropriate by the client's comfort and treatment plan with the clinician, and 4) closure and termination. Once everyone agrees that the goals have been achieved, the SP and client end their relationship, and the client continues to work with the therapist to integrate what they learned into their daily life.

While recognition for SPT has been slowly growing over the past decade, the research remains limited. Many of the articles regarding SPT have simply reassessed previous studies from early on, so there is minimal data (especially longitudinal) to show efficacy of the practice (Rosenbaum et al., 2014). When Masters and Johnson (1970) originally studied the outcomes of SPT, they considered 28 men with primary or secondary erectile dysfunction (ED). When working with a SP, they found a success rate of 63% in the men with primary ED and 78% in men with secondary ED (Rosenbaum et al., 2014). Later, Sommers (as cited by Rosenbaum et al., 2014) studied 12 men who engaged in 10 SPT sessions. Of these 12 men, eight men showed an obvious improvement, three men showed some form of improvement, and one man showed improvement which may or may not be linked to SPT.

Retroactive studies have had mixed reviews as well. Cole (1982, as cited by Rosenbaum et al., 2014) found that in the six months following SPT, 73% of participants said that they had maintained their improvements and successfully applied them to new relationships. In another study, Dauw (1988, as cited by Rosenbaum et al., 2014) reported that 89% were satisfied and felt they had resolved their issues, with an additional 5% being partially satisfied, while 6% of respondents terminated sessions. In yet another study, only 69% said they had complete success, 21% had partial success, 7% of participants saw no change, and 1% reported their situation had gotten worse (Apfelbaum, 1984, as cited by Rosenbaum et al., 2014). This range of success makes efficacy unclear. Limitations and considerations for future studies must be considered to determine whether SPT is a viable option to assist sex therapy.

When SPT was initially created, SPs were required to be void of emotion and disconnected from their own needs or demands. Apfelbaum (as cited by Emelianchik & Stickney, 2019) proposed that a more realistic view of the relationship would honour the experience of both the surrogate and the client. In its modern practice, the therapist considers both the client and the SP, especially when terminating treatment. Each party engages in

separate sessions with the therapist to address closure of their relationship. This relationship dynamic has been misunderstood since SPT was conceived, and there have been several attempts made by various magazines and movies over the years to clarify it.

Many therapists have shared their opinions on its potential benefits but are weary of recommending it because of its legal ambiguity. In an attempt to explain the relational nature and triadic structure of SPT and connect it to the model of clinically supported BDSM introduced in chapter three, it may be useful to discuss a film that is based on real experiences of SPT.

"The Sessions" (Lewin, 2012) aims to shed light on the mystery of SPT and is based on a disabled Californian Poet named Mark O'Brien. As a young child, Mark contracted Polio, which caused severe physical impairments. This diagnosis, paired with his religious upbringing, other experiences in his life, and societal ideals, had convinced him that he was not worthy of physical or emotional love. Fearing that he was close to the end of his life, O'Brien and his sex therapist discussed the option of working with a surrogate. He was then introduced to Cheryl Cohen-Greene and the film focuses on this relationship and their time together.

While the film beautifully explores the intersectionality of disability and sexuality, it leaves many gaps when truly explaining SPT and takes some liberties when discussing the relationship between O'Brien and Cohen-Greene. Obviously, Hollywood's goal is to tell exciting stories, and this story was very romanticized. Some dialogue was taken right from the article O'Brien published in The Sun (1990), and other aspects were inserted to create a fictional love story between the main characters. Many of the therapeutic aspects were glossed over, most likely to save time and sensationalize the story. Sessions did not take place in a clinic or office; they were held at the home of someone O'Brien had previously interviewed. In the original article, it was explained that Cohen-Greene's office was not accessible because of several flights of stairs, so they arranged to use a close friend's cottage. In the film, the interview process only

took about 5 minutes before the prospect of undressing was discussed, instead of time being spent to build a sense of trust and rapport. While Cohen-Greene did complete clinical documentation describing their sessions, it was not made clear that she was not the primary therapist, and there was no mention of the therapeutic triad. This is a cornerstone of SPT, which was left out in the film. Cohen-Greene made decisions about the direction of sessions, and it did not appear that O'Brien was included in the goal setting, which is critical to the process. As the film unfolded, he did have input in requesting one goal, which was making Cohen-Greene orgasm from intercourse. Once that was achieved, the termination was abrupt and decided mid-session, immediately after they had sex. Termination was chosen because of apparent feelings of love which were starting to arise. It was unclear if the feelings (and quite frankly, the decision to terminate) were mutual, as it appeared to be in the heat of the moment. Either way, this scenario did not address the sensitive topic of closure or transference/countertransference.

While there were definite holes in the explanation of what SPT is, there were also moments which illuminated its potential. Cohen-Greene briefly touched on the difference between SPT and prostitution; one being about repeat business and one wanting the client to blossom after sessions. There was also obvious care and emotion involved in the relationship between them. Cohen-Greene treated O'Brien with dignity, respect, and unconditional positive regard. She appeared to care deeply about his progress and wanted to help him overcome his emotional, physical, and sexual challenges, which highlights the relational aspect of SPT.

For a more detailed information about surrogate partner therapy, it is recommended that one looks further at the International Professional Surrogacy Association and the Dr. Ronit Aloni Clinic in Tel Aviv, which provides SPT and is the home base for most of the research studies available.

Legal Considerations

The only country that is clear about the ethical and legal standing of SPT is Israel, where it is an accepted modality, and several studies have been conducted at Aloni's sex therapy clinic. The clinic, located in Tel Aviv, employs doctors, surrogates, physiotherapists, sex therapists and social workers. Aloni has been advocating for surrogacy work since she learned about the modality in the U.S. in the 1980s. Sexual rehabilitation has become a focus in Israel, especially since rehabilitation of disabled veterans is a state supported service. Because of this, she has successfully testified in many personal injury cases to pay for SPT, and the Defense Ministry not only refers severely injured soldiers to her clinic, but also pays for their treatment (Tobin, 2017). The clinic follows IPSA code of ethics and requires the SP to work closely in the therapeutic triad, while acting within their scope of practice and limitations (Emelianchik & Stickney, 2019). They must use contraception, get tested for STIs every six months and be vaccinated for hepatitis B. SPs must also sign contracts agreeing to use safer sex practices in their personal lives. If ethical issues arise, therapists and surrogates have joint meetings to process and resolve them. Clinically supported BDSM would be used in a similar process with specific protocols that would be put into place to ensure the collaborative and holistic nature is preserved while also protecting all parties.

Limitations of Previous Research

While there are vast amounts of research within the BDSM community, it has mostly been conducted with white, middle to upper class participants with a high level of education, therefore it is difficult to generalize findings. As mentioned previously, there are many people of colour who report not wanting to be involved in the kink community, and those who are involved may not be included in the research for various reasons. Cruz (2015) suggests that there may be fear of further discrimination or stigmatization to be associated with a fringe community. She also states that some studies omit race and ethnicity to protect the identities of

participants (Cruz, 2015). Whatever the reason may be, this research lacks consideration for intersections of racial diversity. However, there have been many studies addressing gender, sexual identity, and orientation within the community.

Considerations for Therapists

People engage in consensual BDSM for a myriad of reasons other than the obvious goal of sexual satisfaction. Themes of self-discovery, self-esteem, numerous gains of relationship skills, and reclamation of sexual and personal power fill the pages of the articles examined for this paper.

While scenes and rituals in aftercare may be curative for some, concurrent therapy with a kink-affirming therapist is recommended for those who need additional support to unpack what surfaces from their kink activities and relationships. If practitioners are partnered and actively practicing BDSM, there is no way to ensure that they are using healthy expressions of BDSM concepts and safe practices, so in this case, couples therapy would be encouraged so that the therapist can support them through exploration. This means that there is a necessity for counsellors to create space to further process kink in the therapy room, which may lead to a reduction of stigma, and improve clinical outcomes (Goerlich, 2021; 2023; Cascalheira, 2023). The lack of research regarding the clinical use of BDSM and its therapeutic nature may stem from the fact that many therapists are underprepared and/or unwilling to explore concepts of sexuality other than those deemed acceptable by Western society. This causes more harm, leading to the continued stigmatization of the BDSM community, premature termination of therapy, and creates further barriers to access care (Goerlich, 2023; New et al., 2021).

New et al. (2021) reported that many graduate training programs do not include sexuality from a psychological lens, which leads therapists to feel underqualified to support clients with sexual challenges that are beyond textbook dysfunction (erectile issues, avoidance

due to trauma, etc.). Taking a sex positive approach to desires, exploration, and expression of sexuality and how it connects to identity is the next step in accepting and empowering our clients. If therapists are unaware of kink-affirming practices, they run the risk of further harm by relying on clients to overly explain and justify their sexuality or misdiagnose common BDSM practices (i.e. superficial injuries from high impact play as self-injuring behaviours). These are all things that trained kink-affirming therapists are aware of and assessing with all clients.

It is crucial for therapists to explore how sexuality and kink fits into the context of their clients lives and not assume that their distress is linked to their BDSM practices. It is possible that the presenting problem is related to their kink identity (whether they realize it or not), but it is just as possible that there is no connection, and an assumption has been made because of the therapist's biases. It is imperative to explore the causes of distress to find the true source. It could be that kink is something that helps them to relieve stress and process certain challenges in their lives, in which case, criticizing them for an adaptive coping skill can further isolate, lower self-esteem, and create internalized shame and kink-phobia.

Summary

This chapter explored themes of personal growth and empowerment, linking common themes within therapy to BDSM practices. There is no question as to the therapeutic value of consensual BDSM. Many people who are engaging in kink activities are experiencing therapeutic benefits that address some sort of personal challenge, be it sexual, relational, or spiritual.

After examining the points explored in this paper, it is not to say that clinicians should recommend BDSM to their clients, but if they are already actively participating in the community, it would be beneficial for therapists to be aware and know how they can further support their kink-identifying clients in the therapy room.

Chapter Three: Tying it All Together with a Decorative Shabari Knot

Now that the positive effects of BDSM have been discussed, it is hard to deny that there is the potential for therapeutic value when engaging in these activities. Whether it is utilizing the somatic experience of impact play (spanking, flogging, caning, etc.) to distract from chronic pain and improve circulation, or re-enacting and rescripting a specific traumatic event to regain a sense of control, many practitioners share stories of how BDSM has been transformative for them. Most of these transformations have been experienced without support from a mental health clinician, so imagine what could take place with further emotional and cognitive processing with a kink-affirming therapist.

In this third chapter, I will investigate whether BDSM can be used within the clinical space. The model would combine the structure and protocol of Bonus' (2024) Therapeutic Facilitated Trauma Play and include a triadic relational structure like Masters and Johnson's (1970) Surrogate Partner Therapy (SPT). This idea of clinically supported BDSM would include a client (practitioner), therapist, and surrogate BDSM facilitator (SBF) working together to address therapeutic goals.

Clinically Supported BDSM

Could the triadic format of SPT be transferred to working with the kink community? If the therapist has training to work in a trauma setting and has no sexual contact with clients, and the client is already an active practitioner, is there an ethical and legal way to utilize BDSM in a clinical setting? If adopting the same template as SPT, the therapist would first meet with the client to try to address the presenting problems. In this hypothetical situation, if talk therapy was not enough, a surrogate BDSM facilitator (who was a vetted and trusted member of the BDSM community and an associate of the therapist) would then be introduced to the client. If consent was obtained to continue, there would be collaboration between all parties to formulate

a treatment plan. After this, private sessions would take place between the SBF and the client. Between "active" sessions with the SBF, the therapist and client would debrief and process events and discuss challenges and progress. It would also be expected that the SBF would routinely connect with the therapist to share insights, concerns, discuss the course of treatment and challenges that were arising for the client as well as themselves (limitations, countertransference, etc.).

As with traditional sex therapy and SPT, there are many challenges that could be addressed with clinically supported BDSM. While most would assume there would be some sort of sexual theme (dysfunction, assault, trauma, etc.), there are many nonsexual and non-trauma related issues that could also be explored in a way that talk therapy cannot. For example, healing attachment and relationship wounds can be examined by using rituals, intentional role plays and emotional bonds between participants. BDSM allows practitioners to re-write the experiences of neglect/abuse or betrayal in safe, consensual, and pre-negotiated environment.

After reading about Bonus' (2024) Therapeutic Facilitated Trauma Play, I believe that this model could be combined with surrogate partner therapy (Masters & Johnson) for those clients who want to explore healing trauma though BDSM but do not have access to a partner. This could be because they are new to the local kink community (but have previous experience) and have not met someone they connect with yet, they may not have one consistent partner, or someone they trust with information about their trauma. Using the principles and ethics of both models, I believe that there is a way to safely use BDSM in the clinical space.

Inclusion and Exclusion Criteria

As mentioned previously, this form of trauma therapy is not meant for anyone. There is very specific criteria for choosing to use this type of intervention with a client, which has been discussed in chapter two. When considering this path, it is crucial to know their history

regarding suicidal ideation, self-harm, dissociative tendencies, depression, etc. (Bonus, 2024) Although BDSM is not inherently dangerous, there can be an increased risk of harm physically and psychologically in any of its activities, which is why clear and honest communication is one of the core foundations for safe, sane, and consensual engagement.

This method must be completely client led and only considered if the client was already an active member of the BDSM community. They must have previously discussed the idea of trauma play or their own connection to the therapeutic value of kink or BDSM. It is important for them to be aware of their own internal and external resources, such as coping skills, connection to community and support system (other kinksters, family, friends, etc.), and have previous experience, competence, and deep knowledge of the principles of BDSM.

Surrogate BDSM Facilitators

Many kink-affirming therapists will support their clients with information regarding how to choose a play partner, looking at personal and BDSM characteristics. In this model, the therapist would use the same criteria to select surrogate BDSM facilitators. The therapist would keep a list of multiple facilitators to offer choice to the client, transparency about how facilitators are "vetted," informed consent about their training, credentials, etc., and plan for ongoing consultation.

When looking at personal characteristics, surrogates must show respect and humanity in interactions with others. Showing that they are empathetic and trustworthy and have experience with trauma play in a must. While most Tops/Doms have participated in shadow scenes that play within the realm of consensual non-consent (abduction, rape, blackmail, etc.), it does not mean that they have participated in deliberate re-enacting and rescripting of a trauma. They must use a trauma informed approach and be able to emotionally attune to others to create a physical and emotional space that is as safe as possible. Being able to show that they have

awareness of their own triggers and limitations as well as concrete examples or their own regulation skills is also important.

On the BDSM side, having immense knowledge of the foundational principles of consent, communication, safety, and aftercare is not negotiable. This is something that a SBF must live and breathe. It is also crucial that they have vast experience in the community and have participated in many types of kink and BDSM activities. It is not uncommon for practitioners to be vetted before being able to attend private events or parties. Because of this, it is widely accepted for people to ask for references and talk to people in the community before deciding to participate with someone. This is something that the therapist would also need to do. Finding out relationship history (how many partners they currently have and have had, how these relationships have ended, are they still on good terms, etc.) along with sexual history is also important. While many BDSM activities do not involve intercourse, there can be a sexual undertone, so it is important to be aware of this as well. The consent process must also involve discussions regarding potential for fluid exchange, bruising, and uncertain emotional outcomes. Current and frequently updated STI and criminal record check results should be kept on file to add another layer of safety for everyone involved.

Being aware of previous diagnoses and mental health history of the SBF is also important. Even if they are an experienced BDSM practitioner, there is always a possibility of vicarious trauma and harm when engaging in these intense activities. Knowing their limitations and whether the SBF is involved in their own therapy is something to discuss when considering potential candidates.

Ideally, these SBF would be trained surrogates who belong to the International Professional Surrogacy Association (2023) so that they already have a professional association and code of ethics to adhere to. More realistically, they would be average practitioners with immense empathy and passion for helping others. Having a background in psychology and

relevant relational and emotional skills would be a huge asset when supporting people in these situations, as there is potential for increased harm when engaging in this type of activity, especially regarding trauma. Obviously, many people address traumatic events through BDSM without support from a therapist but finding someone who can predict potential responses or reactions and outcomes, understand and address window of tolerance, and the ability to co-regulate would be ideal.

Therapeutic Contracts and Consent Forms

Bonus (2024) suggested using contracts like DBT with slight modifications. For clinically supported BDSM, I would also suggest something similar, including expectations for all parties involved regarding commitment to a certain number of sessions, the availability of therapist during all sessions (in addition to the trauma play session), continued mindfulness and coping skill building, descriptions, and definitions of BDSM and trauma, as well as a clear explanation of the potential risks involved.

In addition to this, there should be an explicit instruction of expectation around the safety precautions regarding routine STI testing and safer sex practices in everyone's relationships. There should also be a strict no outside contact policy between the client and SBF. It must be understood that all communication should be done through the therapist, with nothing being shared directly between the client and SBF, and the therapist should be available to contact during all sessions. This is to protect all parties and make sure that there are no blurred lines into social contact. It would also be expected that there would be limited contact after the termination of services. Since the client and SBF (and perhaps the therapist themselves) will be practitioners, it may be likely that SBF and client see each other at local kink events, and it is expected that they will not interact socially unless it is unavoidable.

The consent form should also include a detailed explanation of the collaborative process of creating a treatment plan, and the importance of consultations taking place between all parties to increase transparency and to reduce the risk of triangulation.

All these contracts are also applicable to the SBF. Confidentiality, consenting to potential risks and safety practices are needed from them as well. These contracts not only remind them of the importance of their role but ensures that they are protected as well.

Clinically Supported BDSM and Trauma Play

If after discussing the idea of using trauma play to address a previous event, a client shares that they have a partner who is willing to participate, Bonus' (2024) model of Therapeutic Facilitated Trauma Play can be utilized. If, however, the client wishes to explore trauma play but does not have access to a suitable partner, perhaps clinically supported BDSM with a surrogate BDSM facilitator may be an option. This would follow the same format as Bonus' (2024) model, but instead of the client's partner, it would be the SBF, who would be working closely with the therapist to discuss concerns, progress, and challenges that were arising.

In therapeutic facilitated trauma play, the "Remembrance and Mourning" stage (Bonus, 2024) is when the client is beginning to discuss who they will choose as a partner for the trauma play. In the proposed clinically supported BDSM model, traditional talk therapy would be employed to support the client, and they would be introduced to the SBF through a joint meeting during this stage. As trust and safety is imperative to any BDSM activity, especially trauma play, the client would be required to meet with the SBF several times before the scene was discussed and completed. Spending a few sessions for the client and SBF to get to know each other on a human level would be needed before engaging in any BDSM activities. If there is mutual agreement from both parties to continue, STI tests should be completed, and done every

few months while they are in contact with each other. They should both also commit to safer sex practices in all relationships they are involved in (Oreg et al., 2024).

Once there was a level of trust and comfort established between the two, "regular" BDSM (not that there really is such a thing as a regular BDSM, but this is meaning non-trauma related) would be explored so that they can continue to build trust and rapport. During this process, the client and therapist would be continuing with talk therapy to discuss and debrief experiences and concerns, and the SBF would be doing the same. Full transparency would be enforced to make sure that there was no triangulation occurring. Once the client and SBF had experience engaging together and were ready to explore the trauma in more depth, they would attend several joint sessions with the therapist, as mentioned in Bonus' (2024) original model.

The joint sessions and stages before the trauma play occurs would follow a similar process as Bonus' (2024) original model. The client, SBF and therapist would discuss the treatment plan, triggers, limitations, coping, aftercare, safety plans, etc. Once the details are solidified, they must be enacted as planned. There is always the possibility of things not going as outlined, but the details must be kept as close as possible. This is why it is important for the SBF to be closely connected with the therapist and have previous experience with trauma play. If something were to happen during the re-enactment, the SBF would act as the "first responder" to co-regulate and address any distress in the moment. If they are following the plan and the SBF is routinely checking in using the stop light model, the scene should be able to progress without harm.

As with many trauma therapies, there is an element of going slightly past the client's comfort zone to try to broaden their window of tolerance with exposure. In the BDSM world, the yellow zone is generally where people want to exist for most of the scene. Yellow lets the Top know that there is some level of activation to be aware of, but it is still within the bottom's comfort zone (or window of tolerance). From here, the experience can be titrated and pendulate

between moments of comfort and discomfort. Tops do not want to let their bottoms enter the red zone because it means there is extreme distress or discomfort, and things need to end immediately. This is not to say that there has never been a bottom who has not said “red” out of panic or discomfort when it was not that extreme, or that the Top missed a subtle cue, but this method must be always respected to ensure safety and trust. This is another reason why previous BDSM experience is needed; getting to know your own levels of distress (as well as your partners) and how to regulate is mandatory when it comes to trauma play. Through role play and exploration prior to the trauma play, the SBF (and often the client themselves) gets to know and understand the client’s comfort level, triggers, limitations, and strengths, and builds rapport and safety.

As expressed by Bonus (2024), the therapist must be aware of when the trauma play is taking place so that they can be on call if something were to happen during the event and be available after it takes place so they can debrief. Even if it goes as planned, they should let the therapist know so that everyone is on the same page and that the safety of the client can be assured. The therapist should be letting the client know the signs of Top/sub drop and X-Drop and advise them of the possibility that symptoms be more intense when working with traumatic material (Bonus, 2024). Reminding them of the aftercare plan with the SBF as well as how they can support themselves over the following days is something that should also be done by the therapist. As with Bonus’ (2024) model, connecting with both the client and the SBF to debrief further should be done within a few days of the event so that emotions, thoughts, and physical aspects can be processed as needed. Having a joint session and separate is recommended. From here, talk therapy would be used, with various modalities to address things like intimacy, negative cognitions, acceptance, trauma processing, etc. As with conventional trauma therapy, it could be that more than one session would take place with the SBF to address the same trauma or other aspects that arose within the debrief. It may also be that the trauma play was broken up into several sessions after creating an exposure hierarchy ladder where the client is gradually

exposed to their trigger. For example, if someone wanted to explore impact play but they were overwhelmed even being around the toys, perhaps they would spend the first session sitting in a dungeon with paddles and floggers in the opposite corner. The second session they may sit in the middle of the room (or closer), the third may involve holding one of the toys, before the final session which involved being paddled.

Once all parties feel that the trauma has been addressed, and the client reports less distress when discussing their trauma and able to cope consistently when triggered, sessions with the SBF would be terminated. During the "Reconnection" stage (Bonus, 2024), the client and therapist reassess the goals and discuss whether sessions will continue. It could be that the client could be transferred to a sex therapist or terminate therapy all together.

As with SPT, clinically supported BSDM would be considered a brief therapy, with sessions likely happening on a weekly basis, hopefully only lasting a few months. The sessions between the therapist and client would take place between sessions involving the SBF. The sessions with the therapist would explore theoretical aspects which would then be put into place with the SBF (Oreg et al., 2024). To continue the hypothetical scenario above, the client may explore regulation strategies with the therapist and then practice them when feeling distressed while the SBF instructs them to hold the paddle.

Ethical and Legal Considerations

When considering whether clinically supported BDSM with a surrogate BDSM facilitator is a viable option for referral, there are many ethical and legal questions to explore. During this discussion, it is important to also consider SPT, since this is one of the templates used.

In one study, several therapists were asked their opinions of the modality of SPT, and while 70% stated they thought it was important for treating certain problems, only a small

number of them had used it because of ethical concerns, a lack of SPs and the excessive cost (Malamuth et al., 1976, as cited in Ben-Zion et al., 2007).

Intake and Consent Process. As mentioned previously, there must be an in-depth intake completed, including a history of depression, suicidal ideation, self-harm and dissociative episodes. If any of these are present, it is not recommended to use trauma play, even with the support of a therapist (Bonus, 2024). There is greater potential for harm due to sub/Top drop and X-Drop, which can exacerbate depression and dissociative symptoms leading to increased risk of self-harm behaviours and suicide attempts (Bonus, 2024; Sprott & Randall, 2016).

Relationally speaking, one must consider the client's attachment history. Are they likely to form a strong attachment to the SBF, which may result in emotional harm when the relationship terminates? Is the client already in a committed relationship? If so, can traditional sex or trauma therapy with a kink-affirming therapist support them? If conventional methods are not an option for the couple, it is imperative that their primary partner be part of the discussion and perhaps Bonus' (2024) original model of Therapeutic Facilitated Trauma Play is something that would be explored.

Along with the intake, there should be an explicit consent form that is explained in detail with the client so they are informed of the risks and benefits of trauma therapy, an explanation of both BDSM and trauma play, how they can be used in a therapeutic way, and what the risks are when in engaging in this sort of therapy. With the client's full understanding and informed consent, treatment can begin.

Surrogate BDSM Facilitator Referral Process. The referral process must also be considered when thinking about SPT and by extension, clinically supported BDSM. Where do the referrals come from? Can any mental health provider refer to a SBF? If the SBF is a solo practitioner, do they take "walk ins" (foot traffic from their private websites), or do they only

take clients from therapist referrals? For clinically supported BDSM to be ethical, the SBF cannot be the primary therapist/mental health provider, so the client must be connected to another clinician and be actively exploring the issues they wish to address with the SBF. To protect everyone involved, there must be a professional connection to the therapist so that they can vouch for the SBF. Another consideration is how does one know if they are a good fit? As described earlier, there should always be an initial meeting to make sure everyone is comfortable and ascertain a good fit between the client and SBF. It would be likely that therapists have several SBFs on the "roster" so that there are options for the client to make sure they feel comfortable and able to build rapport. In addition to this reasoning, there should also be multiple options so that an authentic experience can be offered if re-enactments of specific situations are desired.

Another question is how would one switch if they found they did not connect with the SBF or if they had a complaint? How would the therapist handle this as well as keep the anonymity and safety of their client during the process? While the client's safety is the priority, the comfort and safety of the SBF must also be considered. There may be things that the client wants to explore that the SBF is not able or comfortable participating in. For example, if a male client was raped by a man, but the SBF does not feel comfortable participating in anal sex.

Location of Sessions. Preferably, sessions between the client and SBF would take place in a neutral location. This could look like meeting at a coffee shop or other public location for the initial sessions after being introduced by the therapist. In an idea situation, the clinically supported BDSM sessions would take place in a specialized room at the clinic, as with the SPT sessions at the Dr. Ronit Aloni Clinic (Tobin, 2017; Oreg et al., 2024).

In this clinic, SPT sessions are held in a special room which is set up like an apartment (Oreg et al., 2024). All the equipment needed for sessions is kept in this room, which is routinely stocked and cleaned. In the case of clinically supported BDSM, having a similar set up at a

therapist's office or clinic would be ideal. This room would be a functional dungeon, which would include various stations and typical “tools” on display for easy access of use, explanation, and would allow clients to become comfortable. Having a room in the clinic would allow for easy access to an optimal space, assures the quality of the equipment, intentional set up, as well as the cleanliness, and would ensure that the therapist was aware of who and what was coming and going in the space. This would add another layer of safety for all parties. It should be planned that anytime a session is taking place in the room, the therapist is on location and available to intervene if needed.

To my knowledge, there is no clinic like this in existence at the moment, so it would be likely that sessions would take place at the SBF’s studio. If using a studio space, the therapist should, at the very least, be available by phone during sessions. It would be better to be waiting nearby; many studios have waiting areas, which would be an option, or at a nearby coffee shop. Waiting in the therapist’s own office would not be helpful in an emergency if they are several kilometers away. This process is similar to what Bonus (2024) outlined in Therapeutic Facilitated Trauma Play and raises the question of whether the therapist’s fees would apply during this “standby period.” There was no discussion regarding that aspect, and it may be a topic for future discussion if clinically supported BDSM was to be researched further.

Closure Protocol. There is also a need for clear protocols regarding closure and feelings which may arise during sessions. The holistic view of modern practice within SPT encourages authentic experiences and reactions from the client and the SP. As BDSM is a relational experience, it would be expected to translate into clinically supported BDSM with the SBF. This results in emotionally intimate moments and the potential for attachment from both sides. There must be resources to support these situations and clear boundaries regarding future relationships between former clients. Professional accountability and guidance around these other considerations could be offered if there was a governing or regulating body, as there are

with other health professionals (Freckelton, 2013). This is why it would be beneficial if the SBF was part of a healing, wellness, or health profession, or had relevant skills to apply.

Cultural Considerations. Another aspect is sexuality in a cultural context. Discussing sex can be empowering according to Western values, but that is not the case for everyone. In many cultures and religions, discussing sex, especially in such explicit detail, is forbidden. Women are often thought to be virginal and pure, so even having a simple conversation regarding physiology can have negative impacts that the clinician is not aware of (Lavee, 1991). Being aware of gender and societal norms and practices around certain issues is also important. For example, in some cultures it is only acceptable for men to talk to other men about their problems. In some cultures, if there is not a prescription to "fix" the problem, they do not believe the diagnosis. Keeping these things in mind can be useful when navigating sensitive topics such as sex.

Legal Considerations. On the business side, it is recommended that the referring therapist check with their liability insurance, ethics board, and criminal lawyer in their district to make sure that they are legally and ethically covered, and receiving extensive supervision (peer and otherwise) would be critical.

Many of the ethical and legal concerns regarding SPT stem from idea that it (and by extension, clinically supported BDSM) is considered sex work and thought to be related to prostitution. Prostitution is driven by desires of the client with the hopeful outcome being repeat business, which results in financial gain for the sex worker. Certified surrogate partners complete a specialized training program and are invested in the therapeutic process. The primary goal of SPT is to help clients build self-awareness, consciousness, and skills in the realm of physical and emotional intimacy (Freckelton, 2013). Though SPT is classified as sex work, to further distinguish it from prostitution, SPs are required to have alternate income sources to provide stability (Rosenbaum et al., 2014). The clinics or primary therapists are paid directly,

with the SP paid as a contractor (IPSA, 2023; Rosenbaum et al., 2014). It is possible that clinically supported BDSM may follow this same idea of requiring external income, but SBF (and SPs) should be compensated for their skills, sensitivity, and labour, so why should they not be able to make a living from this? It could be argued that continually forcing the distinction from prostitution is further stigmatizing not only the BDSM community, but also sex workers in general.

While SPT has been embraced in some European countries, North American society continues to have confused ideals. On one hand, people are pressured to live authentically and empower themselves sexually but are also shamed by society for those same reasons. This creates a delicate dance that therapists must perform when it comes to supporting their clients while upholding an ethical and professional (a concept which is often archaic) practice. As time consuming and frightening as it may seem for therapists to make a referral, it is argued that the potential benefits make the ethical and legal considerations of SPT worth looking into further. Dr. Marty Klein, (as cited in AASECT, 2013) has provided training for SPs and the therapist who partner with them, and he explains that:

> Surrogate Partner Therapy is a valuable clinical modality. Unfortunately, any licensed professional who refers a patient to a surrogate is putting his/her license at risk. We all accept various risks as part of doing therapy in a sex-phobic society and sex-phobic psychotherapeutic profession, but anyone who uses [SPT] without considering the legal risks is simply not paying attention to the world in which we live. (pg. 4)

In 2010, the California Association of Marriage and Family Therapists (as cited in AASECT, 2013), said that when practiced by a qualified SP along with licensed therapist, SPT is indeed ethical. It is thought that this would be the same as a SBF working with a licensed therapist.

It is unclear if there is any reference to SPT in U.S. or Canadian law. As of the latest time for most of these articles (in 2013) there was no mention of them. In 1997, Kamala Harris, then a District Attorney in California, was quoted in the San Jose Mercury News as saying, “If it’s between consenting adults and referred by licensed therapists and not involving minors, then it’s not illegal.” (Surrogate Partner Collective, n.d.). There is no law that says SPT is not legal, but there is also no law that says it is legal, which makes for muddy waters. IPSA (as cited in AASECT, 2013) states that there has never been a SP charged while practicing SPT, but since they are engaging in sexual practices, they may be considered under laws regarding sex work. This is another grey area because laws are not all enforced at the same government level.

According to a CBC report (Luksic, 2015), Canadian Law states that people cannot consent to physical harm, which lands BDSM in the middle of the grey zone. Exceptions are made for activities that have broader social or cultural value, such as certain sports and body modification. In private, practitioners can willfully and enthusiastically consent to activities that may result in bodily harm, but it appears that legally, consent may not stand, which could have negative consequences for therapist (Luksic, 2015). While the courts do not make a habit of getting involved in the average person’s bedroom activities, this could have very serious legal consequences for therapists who are considering incorporating BDSM in their practice, whether in or out of the clinical space. Having very explicit and comprehensive consent forms and contracts when using BDSM is imperative, and it is strongly recommended for therapists to consult their liability insurance providers and a lawyer to make sure that they are legally and ethically protected.

It seems that there is nothing that clearly states whether SPT or clinically upported BDSM is unequivocally ethical or legal, but this does not mean that it is not. All of these articles share the requirements of being between consenting adults and having referrals from licensed therapists to be considered legal. As mentioned, it would be recommended that therapists who

are considering this should consult with the ethics committee of their local and national associations, a lawyer, and a representative of their liability insurance carrier.

Conclusion

Since being declassified as a disorder in the mid 2010's, BDSM culture has continued to permeate into the pop culture. Whether it is through music (Rhianna's "S&M" was certified as sextuple platinum, which is a fitting category considering the nature of the lyric content), movies (most practitioners loathe "50 Shades," because of misrepresentation of the community and the exploitative nature of the character's relationship, so it is recommended to try something like "The Secretary" or "9 ½ Weeks"), or fashion, most people have had crossed paths with BDSM or kink in some form.

The growing influence on wider society has also meant there are more people who are opening up about their connection to the BDSM community and its practices. As this comfort grows, the need for kink-affirming therapists increases. After reviewing the research, it is obvious that people are using kink and BDSM to cope, express, and explore their sexual and nonsexual desires. Through this paper, themes of self-discovery and awareness, physical and emotional intimacy, adaptive coping, and trauma processing were explored, and the importance of destigmatization was discussed. These discoveries lead to the question of whether there is a way to further harness BDSM's therapeutic nature ethically and legally in a clinical setting.

The anecdotal and peer-reviewed research shows that people are engaging in both shadow play and trauma play without support from a mental health clinician, which leaves out important trauma processing and can cause further harm to both participants. Through the explanation of Bonus' (2024) Therapeutic Facilitated Trauma Play and reviewing literature by Ortmann and Sprott (2015), there is a way for therapists to facilitate healing and utilize trauma processing for BDSM couples who want to re-enact and rescript a traumatic event.

Masters and Johnson's (1970) Surrogate Partner Therapy is a form of sex therapy that addresses intimate needs of clients who do not have a partner. These needs may touch on esteem, self-worth, social cues, relationship building skills, or be related to sexual challenges. There is a strong triadic relationship involved in this model, which requires the client, therapist, and SP to connect, process and debrief regularly to create transparency and trust.

After reviewing the therapeutic facilitated trauma play (Bonus, 2024) and surrogate partner therapy (Masters & Johnson, 1970) models, it is feasible that they could be combined to create the model of clinically supported BDSM. Following the stages and protocols laid out by Bonus (2024) and implementing the triadic relationship of surrogate partner therapy (Masters & Johnson, 1970) along with explicit and comprehensive consent forms and contracts, this is something that kink-affirming therapists could use to support clients who want to use trauma play to process a traumatic event, but do not have a partner to re-enact with.

Whether or not counsellors decide to support the use of kink and BDSM with their clients, it is imperative to be educated about the cultural practices and norms within the community. The number of practitioners is steadily increasing, and this means therapists are more likely than ever to have a client who embraces the lifestyle. To ensure that counsellors are reducing stigma and increasing acceptance, continued exploration through self-directed research, education and kink-competent supervision is needed.

BDSM is a healthy and beautiful expression of sexuality and has many positive impacts on other aspects of life such as mental health and wellness, social justice (activism, dismantling harmful social norms and stereotypes, etc.), and overall life satisfaction. While there is still a high rate of stigmatization and discrimination towards the community, working with a kink-affirming therapist (whether they facilitate BDSM or not) can drastically improve the well-being and empowerment of a client's experience.

References

Afana, E. D. (2021). *Perception Correction: Addressing Social Stigmatization Around BDSM and Mental Health (thesis)*. Alliant International University

Aloni, R., Keren, O., & Katz, S. (2007). Sex Therapy Surrogate Partners for Individuals with Very Limited Functional Ability Following Traumatic Brain Injury. *Sexuality and Disability*. 25. 125-134.

Andrieu, B., Lahuerta, C., & Luy, A. (2019). Consenting to constraint: BDSM therapy after the DSM-5. *L'Évolution Psychiatrique*, *84*(2), 17-30. https://doi.org/10.1016/j.evopsy.2019.02.005

Ashford, M., Timberman, S., Beverly, C., Lippman, A., & Verno, J. (2013-2016). *Masters of Sex* [TV series]. Round Two Productions; Timberman/Beverly Productions; Sony Pictures Television; Showtime Networks.

American Association for Sexality Educators, Counselors and Therapists. (2013). Sexual Surrogacy Revisited. *Contemporary Sexuality, 47*(1). https://www.aasect.org/sites/default/files/Contemporary%20Sexuality%20-FEB2013-Final.pdf

American Association of Sexuality Education, Counselors and Therapists. [AASECT]. (2020, August 11). *Sexuality Professionals Talk AASECT* [Video]. YouTube. https://www.youtube.com/watch?v=oKhwrl8jGO0

American Association for Sexality Educators, Counselors and Therapists. (n.d.). *Certification Overview*. https://www.aasect.org/aasect-certification#professional-guidelines

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.117/appi.books.9780890425787

Bechthold, J. A. (2020). *Surrogate Partners' Experiences Working with Sex Therapy Clients: A Multiple-Case Study* (Order No. 27955507). Available from ProQuest One Academic. (2403132696). https://www.proquest.com/dissertations-theses/surrogate-partners - experiences-working-with-sex/docview/2403132696/se-2

Bennett, T. (2024). "switch it up": A qualitative analysis of BDSM switches. *Sexualities*, *0*(0), 1–22. https://doi.org/10.1177/13634607241305967

Ben-Zion, I., Rothschild, S., Chudakov, B., & Aloni, R. (2007). Surrogate versus couple therapy in vaginismus. *The journal of sexual medicine, 4*(3), 728–733. https://doi.org/10.1111/j.1743-6109.2007.00452.x

Bonus, A. (2024). *Kinky or Risky? An Exploration of Therapeutic Facilitated Trauma Play*. (Publication No. 31300341). [Doctoral Dissertation, Widener University]. ProQuest Dissertations & Theses. https://www.proquest.com/openview/8a7d47e9117e81acb91eb 2d3a0c7f6d6/1?cb l=18750&diss=y&pq-origsite=gscholar

Borges, A. (2019, June 25). *5 ridiculously common worries sex therapists hear all the time*. SELF. https://www.self.com/story/sex-fears-from-sex-therapists

Brabaw, K. (2021, May 1). *5 things people learned when they finally started talking about sex with their therapists*. SELF. https://www.self.com/story/discuss-sex-with-therapist

Briere, J., & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. SAGE.

Centre for Addiction and Mental Health. (2025). *Mental Illness & Addiction Index-Trauma*. CAMH. https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/trauma

Carlström, C. (2018). BDSM, becoming and the flows of desire. *Culture, Health & Sexuality, 21*(4), 404–415. https://doi.org/10.1080/13691058.2018.1485969

Cascalheira, C. J., Ijebor, E. E., Salkowitz, Y., Hitter, T. L., & Boyce, A. (2023). Curative kink: Survivors of early abuse transform trauma through BDSM. *Sexual and Relationship Therapy, 38*(3), 353–383.https://doi.org/10.1080/14681994.2021.1937599

Chancer, L. S. (2000). From pornography to sadomasochism: Reconciling feminist differences. *The ANNALS of the American Academy of Political and Social Science, 571*(1), 77–88. https://doi.org/10.1177/0002716200571001006

Cohon, B., & Langone, A. (2022, August 23). *A rationale for offering kink-affirming therapy*. Couple And Family Counseling. https://coupleandfamilycounseling.wordpress.com /2022/04/20/a- rationale- for-offering-kink-affirming-therapy

Criss, C. (2023, February 3). *Transforming sexual shame with BDSM*. Sex Coach U. https://sexcoachu.com/bdsm-and-sexual-shame/

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., Lee, E., Cutler, N., & Sagarin, B. (2020). Partner selection, Power Dynamics, and mutual care giving in long-term self-defined BDSM couples. *Journal of Positive Sexuality, 6*(2), 86–114. https://doi.org/10.51681/1.624

Dahl, A. A., Cramer, R. J., Gemberling, T., Wright, S., Wilsey, C. N., Bowling, J., & Golom, F. D. (2023). Exploring the prevalence and characteristics of self-labelled identity, coping, and mental health among BDSM-practicing adults in the United States. *Psychology & Sexuality, 15*(1), 54–72. https://doi.org/10.1080/19419899.2023.2203134

Damm, C., Dentato, M. P., & Busch, N. (2017). Unravelling intersecting identities: understanding the lives of people who practice BDSM. *Psychology & Sexuality, 9*(1), 21–37. https://doi.org/10.1080/19419899.2017.1410854

Deckha, M. (2011). Pain as culture: A postcolonial feminist approach to S/M and women's agency. *Sexualities, 14*(2), 129–150. https://doi.org/10.1177/1363460711399032

Denton, A. M. (2018). *Graduate student attitudes regarding the therapeutic use of surrogate partner therapy: An exploratory study* (Order No. 10840432). Available from ProQuest One Academic. (2085321659). https://www.proquest.com/ dissertations-theses/graduate-student-attitudes-regarding-therapeutic/docview/2085321659/se-2

Dunkley, C. R., & Brotto, L. A. (2018). Clinical considerations in treating BDSM practitioners: A Review. *Journal of Sex & Marital Therapy, 44*(7), 701–712. https://doi.org/10.1080/0092623x.2018.1451792

Dunkley, C. R., & Brotto, L. A. (2019). The role of consent in the context of BDSM. *Sexual Abuse, 32*(6), 657–678. https://doi.org/10.1177/1079063219842847

Easton, D., & Hardy, J. W. (2001). *The New Bottoming*. Greenery Press.

Easton, D. (2007). Shadowplay: S/M journeys to our selves. In D. Langdridge & M. Barker (Eds.), *Safe, sane and consensual: Contemporary perspectives on sadomasochism* (pp. 223–234). Palgrave Macmillan.

Easton, D. (2024). Shadowplay: Journeys to our abandoned selves. *Journal of Humanistic Psychology, 64*(6), 1084–1099. https://doi.org/10.1177/00221678241288658

Emelianchik-Key, K., & Stickney, K. (2019). Using surrogate partner therapy in counseling: Treatment considerations. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education, 1*(2). https://doi.org/10.34296/01021020

Erickson, J. M., Slayton, A. M., Petersen, J. G., Hyams, H. M., Howard, L. J., Sharp, S., & Sagarin, B. J. (2021). Challenge at the intersection of race and kink: Racial discrimination, fetishization, and inclusivity within the BDSM (bondage-discipline, dominance-submission, and sadism-masochism) community. *Archives of Sexual Behavior, 51*(2), 1063–1074. https://doi.org/10.1007/s10508-021-02102-9

Frantzman, S. J. (2017, May 7). *Terra incognita: Israel is not a western country, and never has been*. The Jerusalem Post. https://www.jpost.com/opinion/terra-incognita-israel-is-not-a-western- country-and-never-has-been-490048

Freckelton, I. (2013). Sexual surrogate partner therapy: Legal and ethical issues. *Psychiatry, Psychology & Law, 20*(5), 643–659. https://doi-org.proxyqueensu.ca/10.1080/13218719.2013.831725

Gerson, M. N. (2015, January 14). *BDSM versus the DSM*. The Atlantic. https://www.theatlantic.com/health/archive/2015/01/bdsm-versus-the-dsm/384138

Goerlich, S. (2021). *The leather couch: Clinical practice with kinky clients*. Routledge.

Goerlich, S. (2023). *Kink-affirming practice: Culturally competent therapy from the leather chair*. Routledge.

Haines, S., & Standing, S. (2016). *Trauma is really strange*. Singing dragon, an imprint of Jessica Kingsley Publishers.

Harris, J. (2024, May 1). *Designing bonds: The therapeutic power of BDSM and conscious relationship design*. Medium. https://medium.com/conscious- relationship-design/designing-bonds-the-therapeutic-power-of-bdsm-and-conscious-relationship-design-e474c1a38c3a

Heartman, A. (2023). *Uses and benefits of Surrogate Partner therapy*. Surrogate Partner Therapy. https://www.surrogatepartner.us/benefits.htm

Holzum, D. M. (2015). *Exploring attitudes on the issues of sex positive therapy and surrogate partner therapy referral and execution by licensed clinical mental health professionals* (Order No. 1573060). Available from ProQuest One Academic. (1651621987). https://www.proquest.com/dissertations-theses/exploring-attitudes-on-issues-sex-positive/docview/1651621987/se-2

International Professional Surrogates Association (2020). *SurrogateTherapy.org*. https://www.surrogatetherapy.org/what-is-surrogate-partner-therapy

Jardine, N. (2024, August 12). *BDSM and attachment theory: Exploring emotional bonds in Kink*. The Aftercare Lounge. https://www.theaftercarelounge.com/post/bdsm-and-attachment-theory

Jarvis, H. (2024). *The Ethics and Efficacy of Kink-Affirming Therapeutic Practice* [Unpublished capstone project]. City University in Canada.

Jung, C.G. (1968). *Analytical psychology: Its theory and practice*. Pantheon Books.

Kassel, G. (2020, February 27). *A Beginner's Guide to Surrogate Partner therapy*. Healthline. https://www.healthline.com/health/healthy-sex/sex-surrogate

Kink Clinical Practice Guidelines Project. (2019). Clinical Practice Guidelines for Working with People with Kink Interests. Retrieved from https://www.kinkguidelines.com

Kleinplatz, P.J. (2006). Learning from extraordinary lovers: Lessons from the edge. *Journal of Homosexuality*, 50, 325–348.

Langdridge, D., & Barker, M. (2013). *Safe, sane and consensual: Contemporary Perspectives on Sadomasochism*. Palgrave Macmillan.

Lantto, R., & Lundberg, T. (2021). (Un)desirable approaches in therapy with Swedish individuals practicing BDSM: client's perspectives and recommendations for affirmative clinical practices. *Psychology & Sexuality*, *13*(3), 742–755. https://doi.org/10.1080/19419899.2021.1918230

Levand, M. A., Chando, S. C., Wolfe, M., Pillai-Friedman, S., & Love, E. (2018). The light in the shadows: Therapeutic explorations of fantasy and fear. *Sexual and Relationship Therapy, 34*(4), 473–495. https://doi.org/10.1080/14681994.201 8.1486 029

Lavee, Y. (1991). Western and non-Western human sexuality: Implications for clinical practice. *Journal of Sex & Marital Therapy, 17*(3), 2013-213, DOI:10.1080/00926239108404344

Lewin, B. (Director). 2012. *The Sessions* [Film]. Such Much Films; Rhino Films.

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

Luksic, N. (2015, February 26). *BDSM in Canada is 50 shades of legal grey*. CBC News. https://www.cbc.ca/news/canada/bdsm-in-canada-is-50-shades-of- legal-grey-1.2969194

Madison, A. (2024, December 20). *What is BDSM CNC kink? consensual non-consent explained*. Dom Sub Living. https://domsubliving.com/5-things-about-consensual-non-consent

Martinez, K. (2020). Overwhelming whiteness of BDSM: A critical discourse analysis of racialization in BDSM. *Sexualities, 24*(5–6), 733–748. https://doi.org/10.1177/1363460720932389

Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy*. Little Brown: Boston.

McKay, D., Abramowitz, J., & Storch, E. (2019). *Ineffective and potentially harmful psychological interventions for obsessive-compulsive disorder*. International OCD Foundation. https://iocdf.org/expert-opinions/ineffective-and-potentially-harmful-psychological-interventions-for-obsessive-compulsive-disorder/

Melby, T. (2011, Oct). Trying to dance, but missing rhythm. *Contemporary Sexuality,* 45, 1-7. https://www.proquest.com/magazines/trying-dance-missing-rhythm/docview/897931954/se-2

Merida, N. G. (2022, May 10). What is consensual non-consent? The kink shrouded in fear and misconception. VICE. https://www.vice.com/en/article/m7vyk4/consensual-non-consent-meaning

Murray, C., Pope, A., & Willis, B. (2017). *Sexuality and mental health*. SAGE Publications, Inc., https://dx.doi.org/10.4135/9781071801116

Muzacz, A. K., McCleskey, K., & Dorn-Medeiros, C. M. (2023). Queer, Kinky Social Justice Counseling and advocacy. *Journal of LGBTQ Issues in Counseling, 17*(2), 146–163. https://doi.org/10.1080/26924951.2023.2155751

National Coalition for Sexual Freedom Inc. (2024). *Kink is Not a Diagnosis*. https://ncsfreedom.org/wp-content/uploads/2024/06/Kinky-Is-Not- A-Diagnosis-2024-Update.pdf

Nevard, I. (2019). Counselling and the Kink Community: A thematic analysis. *British Journal of Guidance & Counselling*, *49*(4), 617–628. https://doi.org/10.1080/0 3069885.2019.1703899

New, C. M., Batchelor, L. C., Schimmel-Bristow, A., Schaeffer-Smith, M., Magsam, E., Bridges, S. K., Brown, E. L., & McKenzie, T. (2021). In their own words: Getting it right for Kink clients. *Sexual and Relationship Therapy*, *39*(1), 94–114. https://doi.org/10.1080/14681994.2021.1965112

Nicols, M. (2017). Foreword. In *Becoming a kink aware therapist* (pp. xiii–xvii). Essay, Routledge.

Ntshinga, T. (2021, August 31). *What does it mean to decolonise BDSM?* African Arguments. https://africanarguments.org/2021/05/what-does-it-look-like-to-decolonise-bdsm/

O'Brien, M. (1990, May). *On seeing a sex surrogate.* The Sun Magazine. https://www.thesunmagazine.org/issues/174/on-seeing-a-sex-surrogate

Oreg, A., Avlagon, E., & Gitlitz, T. (2024). Being a surrogate partner: The challenges of fragile boundaries. *Archives of Sexual Behavior, 53*(4), 1403–1414. https://doi.org/10.1007/s10508-024-02821-9

Ortmann, D. M., & Sprott, R. A. (2015). *Sexual outsiders: Understanding BDSM sexualities and Communities*. Rowman & Littlefield Publishers Inc.

Patz, A., & Roberts, N. (2003, May). *In bed with a sex surrogate.* Psychology Today, 36, 48-56. https://www.proquest.com/magazines/bed-with-sex-surrogate/docview/214497952/se-2

Poelzl, L. (2011). Reflective paper: Bisexual issues in sex therapy: A bisexual surrogate partner relates her experiences from the field. *Journal of Bisexuality, 11*(4). https://doi.org/10.108/15299716.2011.620454

Pukall, C. (2022, January 11). *Surrogate partner therapy: Why aren't we doing it?* Sexual Health Research Lab. https://www.sexlab.ca/blog/2021/1/12/surrogate-partner-therapy-why-arent-we-doing-it

Richters, J., De Visser, R. O., Rissel, C. E., Grulich, A. E., & Smith, A. M. A. (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

Roaring, R., Gibney, B., Ananda, N., & Heartman, A. (n.d.). *Ethics & Legality: Surrogate partner collective*. SPC. https://www.surrogatepartnercollective.org/ethics-and-legality

Rakić Vojin. (2020). Prostitutes, Sex Surrogates and Sugar Babies. *Sexuality & Culture, 24*(5), 1207-1217. https://doi.org/10.1007/s12119-020-09702-y

Rogak, H. M. E., & 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

Rosenbaum, T., Aloni, R., & Heruti, R. (2014). Surrogate partner therapy: ethical considerations in sexual medicine. *The journal of sexual medicine, 11*(2), 321–329. https://doi.org/10.1111/jsm.12402

Savage, D. (2018, August 22). *Savage Love: The truth about surrogate partner therapy*. The Georgia Straight. https://www.straight.com/life/1119901/savage-love-truth-about-surrogate-partner-therapy

Schrader, J. (2016, October 13). *BDSM as harm reduction.* Psychology Today. https://www.psychologytoday.com/ca/blog/standard-deviations/201610/bdsm-harm-reduction

Schuerwegen, A., De Zeeuw, I., Huys, W., Henckens, J., Goethals, K., & Morrens, M. (2021). The Psychology of Kink: A Cross-Sectional Survey Study Investigating the Roles of Sensation Seeking and Coping Style in BDSM-Related Interests. *Archives of Sex Behaviour* 50, 197–1206. https://doi.org/10.1007/S10508-020-01807-7, 50, 1197–1206.

Shadowborne, R. (1998) http://www.leathernroses.com/generalbdsm/ravenrapefantasies.htm

Shahbaz, C., & Chirinos, P. (2017). *Becoming a kink aware therapist.* Routledge, Taylor & Francis Group.

Shannon, H (2021, August, 20). *What is a "scene" in the BDSM community?* [Video]. YouTube. https://www.youtube.com/watch?v=jkGvCnvUHaI

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. https://doi.org/10.51681/1.233

Sprott, R. A. (2020). Reimagining "kink": Transformation, growth, and healing through BDSM. *Journal of Humanistic Psychology, 64*(6), 987–992. https://doi.org/10.1177/0022167819900036

Anonymous, (2013) Sexual Surrogacy Revisited. *Contemporary Sexuality*, 47, 1-6. https://www.proquest.com/magazines/sexual-surrogacy-revisited/docview/1345907582/se-2

Stear, N.-H. (2009). Sadomasochism as make-believe. *Hypatia, 24*(2), 21–38. https://doi.org/10.1111/j.1527-2001.2009.01030.x

Surrogate Partner Collective. (n.d.). *Ethics & Legality: Surrogate partner collective.* https://www.surrogatepartnercollective.org/ethics-and-legality

Tandem Psychology. (2023, November 6). *What is queer-affirming therapy?*. Tandem Psychology.

Taormino, T. (2012). *The Ultimate Guide to Kink: BDSM, role play and the erotic edge*. Cleis Press.

Tarsha, A. A., Xantus, A., & Arana, R. (2016) Can Sex Partner Therapy Treat Sexual Distress and Dysfunction in Transgender Patients After Gender Confirmation Surgery?, *Journal of Sex & Marital Therapy, 42*(7), 573-575, DOI: 10.1080/0092623X.2016.1158758

Tedeschi, R. G., Moore, B. A., Falke, K., & Goldberg, J. (2020). *Transformed by trauma: Stories of posttraumatic growth.* Boulder Crest.

Thomas, J. N. (2019). BDSM as trauma play: An autoethnographic investigation. *Sexualities*, *23*(5-6), 917-933. https://doi.org/10.1177/1363460719861800

Tobin, A. (2017, September 26). *This Tel Aviv therapist is selling the healing power of sex with a stranger*. Jewish Telegraphic Agency. https://www.jta.org/2017/05/15/lifestyle/inside-the-tel-aviv-clinic-where-israelis-learn-to-have-sex

Turley, E. L. (2022). 'I feel so much better in myself': Exploring meaningful non-erotic outcomes of BDSM participation. *Sexualities*, *27*(1-2), 154-170. https://doi.org/10.1177/13634607211056879

van der Kolk, B.A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Penguin Books.

Vane, E. (2017). *The Little Guide to getting tied up. Tips for rope bondage bottoms*. Wanton Press.

Vane,, E. (2017). *Better bondage for every body: With rope bondage experts from around the world*. Wanton Press.

Wiseman, J. (2000). *Jay Wiseman's Erotic Bondage Handbook*. Greenery Press; Turnaround.

Yates, S. M., & Neuer-Colburn, A. A. (2019). Counseling the Kink Community: What Clinicians Need to Know. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education, 1* (1). https://doi.org/10.34296/01011007

Appendix

Resources

Books:

- “The leather couch: Clinical practice with kinky clients” by Stephanie Goerlich
- “Kink-affirming practice: Culturally competent therapy from the leather chair” by Stephanie Goerlich
- “Clinical Practice Guidelines for Working with People with Kink Interests” by Kink Clinical Practice Guidelines Project
- “Becoming a Kink Aware Therapist” by Caroline Shahbaz and Patricia Chirinos
- "The Ethical Slut" by Dossie Easton and Janet Hardy

Organizations:

- The Kink Aware Professionals Directory
    - www.kapprofessionals.org
- International Professional Surrogates Association.
    - www.surrogatetherapy.org/what-is-surrogate-partner-therapy
- National Coalition for Sexual Freedom (NCSF)
    - https://ncsfreedom.org
- Kink Aware Professionals (KAP) Canadian directory
    - https://www.kapprofessionals.org/kap_directory/wpbdm-region/canada/page/4/
- The American Association of Sexuality Educators, Counsellors, and Therapists
- (AASECT)
    - www.aasect.org
- Sex Information & Education Council of Canada (SIECCAN)

    - www.sieccan.org
- The Canadian Alliance for Sex Work Law Reform
    - www.sexworklawreform.com
- Dr. Aloni's Sex clinic Tel Aviv
    - www.dr-aloni.co.il/the-clinic-english