# Alternative or Nontraditional Sexualities and Therapy: A Case Report

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A traditionally marginalized subset of couples engage in consensual nonmonogamy (CNM: open marriage, polyamory, swinging, etc.) or alternative sexualities, such as kink or bondage/discipline, dominance/submission, and sadism/masochism. Nonmonogamous and sexually diverse individuals often experience discrimination or stigma in various domains of professional services, including mental healthcare. These cases require knowledge, skills, and awareness to provide culturally sensitive care, which is often called "kink aware therapy" or "poly-friendly therapy" within alternative sexuality communities. This article explores one application of a kink-focused and CNM-focused therapeutic framework for working with a couple who is exploring nontraditional sexualities. This case incorporates evidence-based clinical practice and identifies the limitations and significant gaps in the empirical research literature.  J. Clin. Psychol. 00:1–9, 2017.

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Over the past decade, there has been increasing media attention to consensual nonmonogamies (CNM), such as open marriages, swinging, and polyamory (Moors, 2016) and to nontraditional expressions of sexuality generally called kink, bondage/discipline, dominance/submission, and sadism/masochism (BDSM), or fetish (Sprott & Berkey, 2015). For the purposes of this article, these distinct but sometimes overlapping practices and identities will be termed *alternative sexuality*.

Parallel to that trend in popular culture, there has also been increasing academic and clinical interest in alternative sexual identities and practices. Much of this literature has focused on the psychological functioning of people who engage in kink, BDSM, or fetish practices, or who engage in CNM, often with an assumption that alternative sexual behaviors and relationships are an expression of mental disorder or the result from childhood sexual abuse (e.g., Connolly, 2006; Hopkins, Brawner, Meyer, Zawilinski, Carnes, & Green, 2016; Nordling, Sandnabba, & Santtila, 2000). Although some studies have found some significant correlations between historical childhood abuse and engagement in adult alternative sexual practices (Hopkins et al., 2016; Nordling et al., 2000; Yost & Hunter, 2012), a nationally representative survey of Australians' sexual practices found no significant correlation between sexual abuse or coercion and BDSM participation. The assumptions that alternative sexuality engagement indicates pathology appear unwarranted given the preponderance of research that finds little or no difference in psychological functioning and attachment styles when comparing those who engage in alternative sexualities with controls (Cannon, 2006, 2009; Cross & Matheson, 2006; Richters, de Visser, Rissel, Grulich, & Smith, 2008; Rubel & Bogaert, 2014; Wismeijer & van Assen, 2013).

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Although the details of the findings and methodologies of this literature are beyond the scope of the present article, the importance of noting these methodological issues is to highlight that empirical research on alternative sexualities in some cases may reinforce stigma and negatively affect clinic work. Indeed, clinician bias against alternative sexualities has been frequently documented in the literature, along with corresponding poorer treatment outcomes (e.g., Hoff & Sprott, 2009; Kolmes, Stock, & Moser, 2006; Kolmes & Witherspoon, 2012).

Another subset of empirical research on alternative sexuality involves studies that seek to characterize the demographics and prevalence of alternative sexual practices and identities. Although there is a lack of rigorous demographic data regarding kink/BDSM or fetish behaviors in the United States, extrapolating from the aforementioned nationally representative study of Australians, in which 2% of sexually active men and 1.4% of sexually active women had engaged in BDSM within the past year, suggests that perhaps roughly 6 million Americans actively participate in some form of BDSM. Other large sample studies have found that 10%–15% of the population has engaged in some form of BDSM at some point in their life (Janus & Janus, 1993; Richters et al., 2008). Other studies that include BDSM interests and fantasies have found higher participation; these studies suggest that approximately 25%–60% of people have sexual fantasies that involve BDSM, fetish, or kink elements (Arndt, Foehl, & Good, 1985; Joyal, Cossette, & Lapierre, 2014; Kinsey, Pomeroy, Martin, & Gebhard, 1953).

With respect to CNM, one team of researchers (Haupert, Gesselman, Moors, Fisher, & Garcia, 2016) have estimated that approximately 5%, or around 15 million people, currently practice consensual nonmonogamy in the United States and that approximately 20% have reported engaging in CNM at some point during their lifetime. Collectively, these statistics indicate that alternative sexualities appear to encompass relatively widespread variations of sexual and relational practices and identities, despite the stigma and biases that frequently mischaracterize alternative sexualities as fringe, pathological, or exceedingly rare.

Significant gaps in the empirical research literature regarding alternative sexuality exist; areas that merit investigation include the effect of kink/BDSM engagement on relationship quality or psychological functioning. One study (Sagarin, Cutler, Cutler, Lawler-Sagarin, & Matuszewich, 2009) did investigate couple bonding and stress reactivity within an experimental framework, but this research was limited in terms of sample size and scope. Another area that merits investigation involves the distinction between fantasy and behavior, more specifically how kink/BDSM desire and engagement affects relationship functioning.

Finally, a large gap in the research literature concerns identity formation, individual differences, and subgroup characteristics of the CNM, kink/BDSM, or fetish practitioners, differences that might affect clinical practice with this population. Some preliminary research by Sprott (2016) suggests that differences with respect to erotic interest may significantly affect clinical best practice. Thus, despite a recent increase in empirical research on alternative sexualities, there still appears to be frequent bias in a priori assumptions, limited demographic information, little direct clinical advice, and no widely endorsed best practice guidelines in the literature. Overall, this research gap provides an important opportunity because best practice guidelines require a foundational and unbiased understanding of the population of interest.

The demographic numbers suggest that clinicians will likely encounter cases that include nontraditional or alternative expressions of sexuality and relationships. However, there is some indication that clients may not disclose this aspect of their lives. Approximately 25%–30% of clients who practice alternative sexualities may never tell their therapist about these practices (Sprott & Randall, 2015; Weber, 2002). This nondisclosure often is a result of anticipated stigma because clients fear a negative reaction from therapists, which has been supported by research on clinicians' reactions to BDSM identified clients in psychotherapy (Hoff & Sprott, 2009; Kolmes et al., 2006).

More specifically, there is evidence of enacted stigma, discrimination, and prejudice against people practicing consensual nonmonogamy or kink/BDSM behaviors and identities. A 2008 survey conducted by the National Coalition for Sexual Freedom of kink- and poly-identified people found that 37.5% of over 3,000 respondents reported being discriminated against or had experienced some form of harassment or violence, once their alternative sexuality behaviors or identities were made known (Wright, 2008). Within this study, 4.5% of participants reported

discrimination from mental health providers. As one respondent wrote: "The therapist refused to continue to see me until I acknowledge that I was being 'abused'" (Wright, 2008, p. 11).

Consistent with results of Kolmes et al. (2006), Hoff and Sprott's (2009) qualitative study of heterosexual couples involved in BDSM and their therapy experiences found mental health clinician bias in treatment. More specifically, Hoff and Sprott found that therapists sometimes terminated psychotherapy because they held a pathologizing view of BDSM interests and behaviors, and assumed that BDSM is associated with an unhealthy relationship dynamic, as illustrated by the following excerpt from an interview with a woman who had taken a dominant role in her new relationship with a submissive man:

> Sandra: So, I met [Bill] and right after I met him I disclosed [our relationship] to her [my therapist], and she's like "well, you know, you'll be feeding into that activity, if that's what you want to do, you will be feeding off each other's needs, and I don't know if that's healthy." I was not surprised . . . but I didn't think of it that way. . . . I pursued therapy in order to see how I could get out of the [previous] relationship or that I could fix myself in terms of my destructiveness. I didn't think that my sexuality had to do with my destructive behavior; it [the destructive behavior] rather had to do with my relationships with men and not being able to communicate effectively. So, I disclosed my feelings about Bill, to see if it would move towards marriage, and she's like, are you sure you want to get married, you did not want to get married before, you have these issues in your mind. And I am saying, my issues are getting solved by meeting this type of person, and right before we got married she said she was unable to handle my type of situation, that she had no experience with the BDSM lifestyle, she called it SM life style, and that she couldn't recommend anybody who could work with me. I was so in love, and we were on the path towards marriage and in the groove of establishing a life together, I really didn't focus on the fact that she was abandoning me to the wind, leaving me out on a lurch and unsupported emotionally. [Sandra and Bill interview; reported in Hoff & Sprott, 2009]

Additionally, Hoff and Sprott's interviews revealed other negative experiences with mental health clinicians that included prejudice and stigma, but did not result in termination. These therapist microaggressions included themes that relied on cultural models of "sickness/addiction/pathology," or "broken/fix," or "wrong/harmful/immoral." (Hoff & Sprott, 2009), which is consistent with Kolmes and Witherspoon's (2012) characterizations of frequent alternative sexuality-oriented microaggressions therapists may unwittingly enact. Bias is not the only obstacle to competent care; there is a lack of knowledge of CNM and BDSM among clinicians. For example, Kelsey et al. (2013) assessed 766 therapists' attitudes toward BDSM, and found that although 76% had treated at least one client who disclosed their BDSM interests or behaviors, only 48% felt that they had enough competence in this area. Additionally, there is limited research on mental treatment that involves individuals and families in which there is CNM engagement or desire. Broadly speaking, the literature provides only limited perspective on significant considerations, including cultural subgroups and intersectionality (Bettinger, 2005), dominant cultural values (Barker, 2005), and negotiation (Bisson & Levine, 2009).

Encouragingly, the last several years have seen a call for, and subsequent increase in, clinically-oriented research targeting CNM populations from a sex positive standpoint (Graham, 2014; Williams & Prior, 2015). For example, Rubel and Bogaert (2014) helpfully reviewed research on findings related to psychological well-being and relationship quality of CNM participants, broadly finding that CNM participants scored similarly on these indices to monogamous participants. Several authors have helped to outline the social challenges of CNM and their implications for therapeutic work (Henrich & Trawinski, 2016; Zimmerman, 2012), and Gigard and Brownlee (2015) provided excellent assessment guidelines for clinicians working with sexually open couples in order to address these implications. In addition, several authors have asserted the utility of certain intervention frameworks, such as existential sex therapy (Berry & Barker, 2014), or the Intersystems approach to sex therapy (Zimmerman, 2012), in working with CNM individuals and couples. Finally, a number of authors are beginning to argue that the cultural practices and norms of certain types of CNM, such as polyamory, may create unique sources of resilience

and strength for their participants (Sheff, 2014), as well as opportunities for healing and growth for monogamous relationships (Conley & Moors, 2014). The importance of these contributions notwithstanding, research on clinical interventions with CNM populations remains in its infancy and a comprehensive CNM family treatment model is sorely needed.

Given the gaps in the available research evidence, clinicians will need to rely on the other two legs of *the three legged stool* of evidence-based clinical practice (Spring, 2007). Clinical expertise and patient values/preferences become the basis of evidence-based practice, at least until there is enough available research evidence. To a certain degree, there is a professional consensus starting to form about competency in care (Nichols, 2006; Shahbaz & Chirinos, 2017). Our goal in this paper is to explore what competent care might involve for clients involved in alternative sexualities and relationships. "Kink Aware Therapy" or "Poly Friendly Therapy" has two different levels: Level 1: Kink or Poly *Knowledgeable* Therapy ("I am familiar with these aspects of relational and sexual diversity, but they are not the central focus of the presenting issue or treatment"); Level 2: Kink or Poly *Focused* Therapy ("the presenting issue and treatment needs to focus on issues that are specific to kink or poly behaviors, identities, dynamics").

Insights from clinicians who specialize in serving the kink and poly communities and data from kink-identified individuals (Kolmes et al., 2006; Nichols, 2006; Shahbaz & Chirinos, 2017; Sprott & Randall, 2016) as well as from those who practice consensual nonmonogamy (Girard & Brownlee, 2015) suggest that competent care might include:

- Knowledge of local and national BDSM and CNM community organizations and resources.
- Knowledge of the core sets of values within BDSM and CNM communities and skills to assess the congruence between clients' behaviors and their personal values and the communities' values.
- Skills to distinguish between BDSM and abuse.
- Skills to examine jealousy and envy without assuming that sexual exclusivity or monogamy will "solve the problem."
- Skills to distinguish between BDSM or CNM as cultural factors versus presenting problems.
- Awareness of the psychological dynamics of coming out and skills to assess the place of BDSM or CNM in a person's identity or self concept.
- Awareness of the effect of minority stress on clients.
- Awareness that BDSM and CNM are not necessarily "an avoidance of intimacy."

While the above-mentioned list comprises some commonly shared suggestions on the part of professionals and clients, it should be noted that there is no professional organization that has published guidelines for working with these populations. The American Association of Sexuality Educators, Counselors and Therapists has adopted statements that explicitly call for professionals to refrain from automatically pathologizing alternative sexualities, due to the lack of scientific evidence for a connection between nontraditional sexual expressions or behaviors and psychopathology.

## Case Illustration: Matt and Tiffany

### *Client Description*

Matt and Tiffany (pseudonyms) are a heterosexual couple who have been married for 20 years. Matt is a 39-year-old White cisgender male with a master's degree and works as an executive at a small company. (In contrast to transgender, "cisgender" is a term to identify people whose gender identity matches the gender they were assigned at birth.) Tiffany is a 38-year-old White cisgender female with an undergraduate degree and works part time. They have two children, aged 15 and 18 years.

Matt's family of origin held rigid social and religious beliefs. He was severely disciplined by his father throughout his childhood and was made to leave the family home at the age of 17 when he started refusing to attend church services with his devout Catholic parents. Matt was taken in by Tiffany's family; Matt and Tiffany had been dating for a year at that point and

were high school sweethearts. Two years later, Matt and Tiffany married. Each of them has never had sexual intercourse with anyone besides each other. Matt is the only person in his family to complete college; he has achieved a level of financial success far beyond his family of origin. Tiffany describes herself as the perpetual "cheerleader," who has always behaved in ways to attract sexual attention through flirtation with men, which continued after her marriage to Matt. For example, Tiffany reported, "I loved getting my male work colleagues all worked up at the bar on business trips and then leaving them wanting me. I went back to my room by myself." Her interest in flirting was not hidden from Matt because she believed that sharing her flirtatious experiences showed her commitment to their marriage. In contrast, Tiffany describes Matt as oblivious to the interests of other women; she believed that he required her protection to prevent other women from "taking advantage of him."

Matt and Tiffany initiated couples counseling because they felt stuck with significantly different sexual desires. Matt had a clear awareness of his interest in bondage and submission since he was 15 years old. When he started a relationship with Tiffany, he disclosed this interest and they had explored this together from time to time until the pregnancy with their first child. Then they stopped exploring and these types of sexual and erotic behaviors were not part of their relationship for 14 years, until 4 years ago, when Matt asked for more adventurous sexual play that included submission to Tiffany. Initially, Tiffany agreed, and for about 3 years, they occasionally engaged in role-playing, bondage, and spanking, usually switching top and bottom roles. They stated that they were self-taught about kinky and BDSM activities based on novels (e.g., "50 Shades of Gray") and movies (e.g., "The Secretary" and "9 1/2 weeks"). Until recently, they were unaware that there were local social groups, local community educational forums, or online kink communities of people who share their interests. Out of shared curiosity, they took a class on "kinky sex play for couples" at a local erotic toy-shop about a year ago. At that event, they heard about Fetlife (a social media site for people into kink and fetish play). They joined Fetlife and together expanded their awareness of different approaches to erotic power exchange, and learned about consensual nonmonogamy.

Both Tiffany and Matt had concerns related to alternative sexual expression in their relationship with respect to roles, perceptions, and exclusivity. In particular, Tiffany became more uncomfortable with Matt's increasing desire to be a submissive because of her fear that it would be required or expected rather than just occasional or something "fun" in the bedroom. Also, in terms of roles, Tiffany consented to taking control of ("topping") Matt, but actually wanted Matt to "take the control" in their sexual encounters. In fact, Matt felt unable to dominate Tiffany because his most potent fantasies involved his submission to a woman. Also, Tiffany worried about possible changes in her own perceptions of Matt, afraid that she might think him "less a man" because of his interests.

Additionally, about 6 months ago, Matt asked Tiffany if they could try consensual nonmonogamy. Matt reported that he never got to explore his sexuality, longed to have sex with others, and stated, "I cannot stand the thought that I might have only one sexual partner in my life." Matt has only had one sexual partner, Tiffany, ever since they started dating, when he was 16 and she was 15. With respect to CNM, Tiffany was ambivalent and feared that she will lose her husband, but also wondered if they can solve their "who's topping who" dilemma by taking the "kinky stuff" out of their relationship and use other partners for erotic power exchange. At the same time, his raising the question of CNM increased the urgency of her concerns that Matt is vulnerable to manipulation by other women.

With respect to CNM, Matt described that he is not interested in being emotionally involved with anyone other than Tiffany, but wanted to have sex and kinky play with others. Tiffany wanted to be a good partner to her husband and wondered if this might be a great way for Matt to have more experience, while relieving her of the pressure to be his Dominant. Tiffany also desired someone to enthusiastically "take control" or dominate her, but she also worried about the risks of sexually transmitted infections and was distressed by thoughts of Matt having sex with other women.

In terms of the effect of these challenging differences in interest and desire, Tiffany reported difficulty sleeping and eating, which she attributed to the ongoing stress and tension in their relationship. Matt was conflicted; he didn't want to hurt Tiffany and wanted to show love and

care for her, but he desired a fuller experience of sexual submission to someone who really wants to dominate him. For the past 8 months before entering therapy, their sexual and kink play became less and less frequent, and their irritability with each other increased. Last month, after a particularly unpleasant argument, during which Tiffany argued that women would lie to him and steal him away from her, Tiffany suggested couples counseling and Matt quickly agreed. They searched for a kink-aware professional in their community but had difficulty finding one, until a kinky play instructor at a workshop recommended one of the authors (AR).

In the therapy sessions, Matt and Tiffany were friendly, warm, and generally kind to each other, but they reached a stalemate in negotiating their erotic differences and relationship boundaries. Matt insisted on an open marriage including experiences as a submissive to other women. Tiffany demanded that Matt change his mind and commit to monogamy in their marriage. Tiffany vividly described herself as having obsessive thoughts and fears that, without monogamy, these changes in sexual expression and relationship structure will lead to unfettered excess and the inevitable end of their marriage.

### *Initial Assessment*

Consensual nonmonogamy and kink are significant to the presenting problem, rather than just cultural background variables, and thus require specialized experience and knowledge. This is a case that requires a kink-focused and poly-focused therapeutic approach.

Both Tiffany and Matt are experiencing "interest discrepancy" when it comes to their desires, fantasies, and interests in kink. This is a common topic in therapy with kink-oriented clients, when nontraditional sexual practices are the focus of the presenting problem. This interest discrepancy also extends to their desires and fears around a sexually open marriage. The couple is confronting more than one "two-choice dilemma" (Schnarch & Maddock, 2002). Matt loves Tiffany deeply and does not want to destroy his marriage but fears that it will be destroyed anyway if he spends the rest of his life regretting that he never had sex with more women. Tiffany fiercely wants the uniqueness and safety of being each other's only sexual partner but feels she will lose him if she denies Matt his freedom to explore his interests and desires.

Matt and Tiffany have been exploring their interests in sex without being aware of the wealth of knowledge available from a variety of sources, including local peer education groups, online blogs, and a growing body of professional and peer written books, articles, and research. They are also not aware of the cultural norms, educational opportunities, and safety precautions that are considered best practices in kink and consensual nonmonogamy. Kink aware therapy suggests that there is a lesser chance of adverse events when individuals become more involved in larger kink communities. Involvement in their local, national or large online communities such as Fetlife.com (which has over 5 million members), could make for less isolation, a richer understanding of their interests and motivations, and a decrease in their anticipated stigma.

Specifically, they will have opportunities to discuss cultural norms and community values. They will be able to learn about the community emphasis on negotiation of consent, the negotiation of relationship boundaries that reflect individual needs and desires while respecting the needs and desires of all others involved, and the value of open-minded respect for sexual kinks or fetishes that are not shared (a common phrase in kink communities: "Don't yuck my yum.").

Jealousy and fear of abandonment often arise when a couple is negotiating CNM. Tiffany may be experiencing Matt's desire for nonmonogamy as an attachment breach. In CNM-focused therapy, the therapist would treat Tiffany's jealousy as an expression of "larger values within the relationship including freedom versus togetherness, and privacy versus sharing, and independence versus dependence" (Girard & Brownlee, 2015, p. 4). In addition, a therapist would explore Matt's contentions that it will be easy to separate sex and emotional attachment and intimacy and that negotiating relationship boundaries will be easy from a perspective that recognizes the complexities of intimacy, attachment, and the complicated meanings of sexuality for individuals.

### *Course of Treatment*

Treatment planning would include individual therapy for each member of the couple to help them manage distress and explore their own feelings and desires. Tiffany was referred to dialectical behavior therapy (DBT) to increase her coping skills, and within weeks she was able to tolerate in couples therapy conversations about further exploration of kink interests and an open marriage.

After 7 months of weekly sessions, Tiffany's fear of losing Matt decreased, as their level of intimacy deepened. Each reported that they have never felt closer and are more committed to staying together than ever. Tiffany began initiating sexual activity more, enjoyed it more, and described that she is more present with Matt during sex. Matt reported that he feels wanted and that she is more open to topping him. Matt reported that last week he initiated sex and was comfortable being more dominant in the way Tiffany wanted. When describing this in the most recent session, Tiffany smiled, laughed, and threw her arms around him.

Matt began sharing more of his work stresses with Tiffany and she asked Matt to keep her apprised, which made her feel more connected and secure. Matt continues in individual therapy and has joined a men's support group. Tiffany is back in the DBT skills group and is working weekly with a therapist.

Matt and Tiffany have gone to two different local poly get-togethers. They were surprised by the differences in the groups and Tiffany was delighted at the second group's openness and appreciation of her questions and skepticism. They met one couple with a similar story about nonmonogamy, and in a recent couples' session, Tiffany openly admitted to fantasizing about sex with the husband of this couple.

Matt and Tiffany have agreed to explore an open relationship. They continue to negotiate their agreements about consensual nonmonogamy and both have become more flexible when confronted by challenges. Tiffany had long held the opinion: "I just don't want to know who they are and when he's seeing them." When the reality hit Tiffany that Matt's online conversations were transitioning to coffee dates, Tiffany's previous groundswell of fear was tempered by her discovery that knowing was more empowering than not knowing.

Matt has not yet had sex with anyone. They continue to use the couples' sessions as a place to discuss boundaries and agreements. Matt is finding that there is much more to CNM than "just finding someone to have sex with." Tiffany is performing the exercises in a handbook on jealousy management while Matt continues to read books on consensual nonmonogamy.

## Clinical Practices

### *Clinical Work With Alt-Sex Cultural Factors*

In general, when working with marginalized sexualities, a consideration of whether the marginalized sexual identity is a cultural background factor to the presenting problem or an integral focus of the presenting problem is warranted. In this case, Kink/BDSM interests and interest in CNM are significant to the presenting problem, rather than contextual or cultural background variables, and thus require specialized experience and knowledge. In contrast, a client with an established nonmonogamous or kink identity may seek short-term therapy for a nonsexual reason, such as an unrelated anxiety condition, which requires cultural sensitivity on the part of the clinician but not necessarily the specialized knowledge and skills that this case merits. Weitzman (2006) provides some general guidance regarding cultural considerations in working with polyamorous clients. Kolmes and Weitzman (2010) offer a psychoeducational guide to choosing a kink-friendly therapist. Ortmann and Sprott (2012) offer an introductory overview of kink/BDSM cultural factors that intersect with psychotherapy. For cases that merit referral to a specialized provider, preparing clients and referring without rejection is an important consideration.

The cultural factors here include having an understanding of community values, practices, and resources and assessing clients' level of socialization to those community values and practices. Supporting the exploration of community resources becomes an important strategy in supporting the health and personal growth of clients.

### *Clinician's Stance: Advocacy Versus Empowerment*

In cases involving BDSM and CNM, it is important to normalize and empower clients rather than advocating for culturally normative values and beliefs. In cases in which clients' sexual interests differ from the therapist's, examination of the clinician's own biases is critical. It is important not to assume, for instance, that attraction to CNM or kink/BDSM is an avoidance of intimacy or to recommend monogamy to resolve problems of jealousy or insecurity. Kolmes and Witherspoon (2012) provide useful guidance in avoiding potential microaggressions towards BDSM and CNM identified clients.

Additionally, just as a less knowledgeable clinician could pathologize BDSM or CNM interest or behavior, a CNM- or kink-positive clinician could unwittingly advocate for participation in BDSM or CNM inappropriately. Examining possible countertransference and supporting the client's right to self-determination are key to providing effective care with marginalized sexualities.. To generate better self-awareness with respect to alternative sexualities, clinicians might reflect on their own beliefs and assumptions regarding sexual exclusivity and relationship longevity, what types of power dynamics and physical behaviors are unacceptable, and their assumptions about healthy relationships.

### *Importance of Consultation*

Because of the current gaps in research literature on alternative sexualities, clinical expertise and clients' values and preferences become more critical to ensure an evidence-based practice approach. Given the wide diversity of behaviors, interests, and identity dynamics around alternative sexualities, individual clinicians won't necessarily have much opportunity to develop clinical expertise unless they serve only a kink/BDSM or CNM population. Hence, consultation with colleagues and current researchers becomes a critical element of providing competent care. In addition, accessing resources, both professional and community resources, will be important. Using guidelines for practice with LGB clients or transgender clients canprovide some insight, as some of the areas covered might aid in providing care to a sexual minority population. Community-based professional resources like the National Coalition for Sexual Freedom, The Alternative Sexualities Health Research Alliance, the Southwest Sexual Health Alliance, Bay Area Open Minds, or the Community-Academic Consortium for Research on Alternative Sexualities can also be resources for consultation.

## Conclusion

Given the likely prevalence of nontraditional sexualities and relationships, and given the minority stress and stigma that are associated with these sexualities and relationships, it is likely that clinicians will encounter clients who have these interests, behaviors, or identities. However, there is insufficient research on CNM and BDSM demographics, relationship dynamics, and best practices as well as a lack of foundational training and resources for clinicians. More empirical research is needed to answer the following questions: What is the effect of kink/BDSM or CNM behaviors on relationship quality and psychological functioning? What interventions ortreatments are effective for working with this population when presenting problems are kink or poly focused? How do people form identities around alternative sexualities and why some people but not others–and how is this identity process related to healthy and unhealthy behaviors? How should clinicians address CNM and BDSM engagement and identities within individual and family therapy? Answering these questions will improve competent care for this population. In the meantime, clinicians will need to rely on support through consultation with more experienced clinicians, learn about kink/BDSM and CNM subcultures, and examine their own attitudes toward nontraditional sexualities and relationships.

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