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ORIGINAL ARTICLE

A Preliminary Investigation into Intersections of Sexual Communication in Bondage, Domination, Sadomasochism and Disability

Jacqueline N. Gunning[1] · Valerie Rubinsky[2] · Ashley Aragón[3] · Monica Roldán[4] · Taylor McMahon[4] · Angela Cooke-Jackson[5]

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Abstract

Extending prior research on the communicative intersections of bondage, domination, and sadomasochism (BDSM) and disability communities, the present article presents preliminary findings on sexual and boundary-setting communication overlaps in relational minority groups and partnerships with disabilities. Both disability and BDSM communities engage in preparatory, open, and boundary-setting sexual communication that prioritizes shifting physical, emotional, and relational needs. Highlighting reflections from partnerships navigating chronic illness, pain, and neurodivergence, our findings extend previous recommendations for boundary-setting to focus on relationships with disability, identifying intersections as including (1) reflecting upon needs and boundaries amidst shifting symptomatology, (2) (re)write sexual and intimate scripts to prioritize (dis)ability, (3) (re)negotiate relational needs and set expectations, and (4) bring awareness to the role of mental health and medication. Findings focus on implications for disability and sexual communication, the disruption of traditional sexual scripts, and therapeutic and clinical application. Limitations and future research are discussed.

Keywords Disability · Sexual communication · Sexual scripts · Boundary-setting

✉ Jacqueline N. Gunning
jacqueline.gunning@uconn.edu

[1] Department of Communication, University of Connecticut, 337 Mansfield Road, Unit 1259, 06269 Storrs, Connecticut, USA

[2] Communication, Social Science Program, University of Maine, Augusta, ME, USA

[3] Department of Communication, University of Maryland, College Park, MD, USA

[4] Intimate Communication Lab, Los Angeles, CA, USA

[5] Department of Communication Studies, California State University, Los Angeles, CA, USA

Introduction

Communicating about sex can be challenging for individuals due to its vulnerable, risky, and face-threatening nature (Manning, 2014), but is key to relational, romantic, and sexual satisfaction (Byers, 2005; Denes, 2015). In partnerships that include disability, conversations about sex are particularly important, for they aid in disrupting traditional sexual scripts (TSS) which have historically excluded individuals with disability. *Disabilities* are physical or mental impairments that substantially limit the activities of daily life (Americans with Disabilities Act [ADA], 2022) and delimits "the amount of control an individual can have" (Charmaz, 1991; p. 7). As a result of these differing physical abilities, TSS have historically stereotyped those with disability as asexual or devoid of sexual needs and desires (Tepper, 2000). This portrayal has potential to impact how individuals with disability are or are not considered as viable sexual partners, resulting in reduced sexual opportunities and education (McCabe et al., 2000) and fostering a belief that they are less desirable than able-bodied individuals (Taleporos & McCabe, 2001). However, through conversations about sex and intimacy, individuals with disability can (re)construct their sexuality and (re)develop individual and relational sexual identities (Dune, 2013).

Sexual intimacy is co-constructed from individual and relational needs and desires, and differs between partnerships that include disability (Kattari, 2015). Currently, a lack of sexual scripts that include disability inhibits direction and space for individuals and couples to discover what sexual intimacy looks and feels like for them (Dune, 2013). For instance, Bernert & Ogletree (2013) found that women with intellectual disabilities engaged in sexual behaviors that differed from what they identified as ideal criteria for sexual encounters, highlighting discrepancies in their sexual education and perceived sexuality. Additionally, these women were unable to identify effective means of preventing negative sexual consequences aside from abstinence and were found to adhere to a traditionally female sexual script (e.g., monogamy, heterosexuality, sex for the purpose of bearing children) (Bernert & Ogletree, 2013). There are negative consequences for a lack of inclusive sexual scripts. For instance, a lack of sexual scripts for individuals with disability places them at risk for sexual and relational abuse (Bargiela et al., 2016; Iudici et al., 2017). When individuals who fall outside of TSS are not socialized with sexual scripts that resonate with them, they become susceptible to engaging in sexual acts that do not align with their needs and wants, such as LGBTQ individuals (Rubinsky & Cooke-Jackson, 2017) and individuals who practice consensual non-monogamy (CNM), and bondage, domination, and sadomasochism (BDSM) (Rubinsky & Roldán, 2021). Negative sexual consequences can be reduced through comprehensive sexual education (Cooke-Jackson et al., 2021; Gunning et al., 2019), resources tailored to individuals with disability (Hayashi et al., 2011; McDaniels & Fleming, 2018) and health care models that integrate sexuality education into primary care (Eisenberg et al., 2015). Additionally, focusing on teaching personal agency in individuals with disabilities positively influences their understandings of sexuality and construction of self as a sexual being (Dune, 2013; Löfgren-Mårtenson, 2004). Further, given the intersection of communication and intimate partner violence for disabled persons (see Iudici et al., 2018), communication and identity construction in this context are especially relevant.

Communication research can aid in disrupting normative scripts and reconstruct more constructive scripts and understandings of sexuality in populations with disability. In instances of acquired disability and disability that onsets later in life, individuals may find themselves having to renegotiate their sexuality and integrate their new disability into their identity as a sexual being. In Hirschmann's (2013) reflections of the intersecting and fluid experiences of disability and queerness, "the body can change radically and dramatically in an instant… affecting one's encounters with the physical world regardless of people's attitudes" (p. 143). Research has explored this renegotiation in the context of cervical cancer survivors (Liberacka-Dwojak & Izdebski, 2021) and chronic female genital pain (Hintz, 2018, 2019).

Sexual Scripts Theory

Sexuality is interactionally constructed, influenced by societal perceptions and attitudes of what makes an appropriate sexual partner (Simon & Gagnon, 1987b, 2003). Scripts, and specifically *sexual scripts*, are a social guide for behavior– what is deemed appropriate and what is not (Simon & Gagnon, 1987b; Pearson, 2018; Wiederman, 2015). Scripts of sexuality have traditionally prioritized heterosexual, cisgender, able-bodied individuals and monogamous relationships, which can result in marginalizing individuals with differing sexual identities and abilities (Kattari, 2015; Rubinsky, 2021). As a result, these marginalized relational communities may internalize scripts that do not account for or align with their needs and wants (Rubinsky & Hudak, 2022), resulting in sexual interactions that are at best unfulfilling, and at worst, relationally harmful.

Sexual scripts theory (SST; Simon & Gagnon, 1987a; 2003) is an approach to considering the normative scripts that are interpersonally managed during sexual interactions and guide intimate partner communication. Scripts are guidelines for interactional behavior that reflect normative cultural values (Simon & Gagnon, 1987b, 2003). According to SST, individuals and their intimate partners manage three kinds of scripts during sexual interactions: intrapsychic scripts, interpersonal scripts, and cultural scripts (Simon & Gagnon, 1987a). Intrapsychic scripts reflect an individual's personal desire and their experience of their desire, whereas cultural scripts reflect normative expectations for sexual behavior within a given culture (Simon & Gagnon, 1987b). Interpersonal scripts are how scripts are performed or enacted in interaction with a relational partner and involve the management of both intrapsychic and cultural scripts (Simon & Gagnon, 1987b). Because sexual scripts must manage normative cultural guidelines for interaction, many scripts are heteronormative, and highly gendered (see Wiederman, 2005 for a summary).

Conversations and Boundary-Setting in BDSM, CNM, and LGBQ Relationships

For marginalized relational communities, including those who practice BDSM, CNM, and LGBTQ individuals, sexual communication differs from TSS and constructs. Although membership in these groups is not mutually exclusive, we will discuss each identity separately first.

Recently, Rubinsky & Hudak (2022) described how LGBTQ identities may deviate by necessity from normative sexual scripts like the TSS, which assume heterosexuality. TSS are heavily gendered and assume opposite sex, and opposite gender role interactions in which cisgender, heterosexual, and masculine men play the role of initiator, and cisgender, heterosexual, feminine women play the role of gatekeeper, drawing the line of how far a sexual interaction should go to preserve the morally sanctioned version of sexual enactment, such as marriage or within a committed relationship (Wiederman, 2015). Many LGBTQ individuals' sexual and relational experiences deviate from these scripts simply due to their existence, and others have noted that they find the ability to experiment and deviate with alternative roles freeing (Rubinsky & Hudak, 2022).

Although BDSM and kink communities contain relational dynamics in which gender makeup might adhere to TSS, the desired behaviors often deviate dramatically from the script or intentionally play with and exaggerate it (Faccio et al., 2014). BDSM and kink communities engage in play scenes that require individuals to negotiate boundaries, sexual history and needs, triggers, and safety prior to engaging in sexual activities (Faccio et al., 2014; Rubinsky & Cooke-Jackson, 2018). Communication in these sexual encounters emphasize the importance of discussing boundaries before, during, and after intimacy and adapting relational needs accordingly, such as extending aftercare and re-negotiating boundaries (Rubinsky & Cooke-Jackson, 2018). Preparatory sexual communication and boundary-setting is helpful in individuals with sexual and relational trauma (Mark & Vowels, 2020) and individuals with autism (Holmes et al., 2022) and physical disabilities (Kattari, 2015).

In CNM relationships, partners agree to have more than one romantic or sexual partner at the same time, such as an open relationship, polyamory, swinging, and others (Conley et al., 2013). These relational agreements require mutual consent, negotiation of boundaries, ongoing honest communication, and the prioritization of each other's needs and comfort. With multiple partners involved, polyamorous communication establishes boundary (re)negotiation as a relational norm (Rubinsky & Cooke-Jackson, 2018). As a result, CNM relationships have high levels of relational functioning and satisfaction (Hangen et al., 2020). Like BDSM dynamics, CNM relationships may consist of heterosexual or LGBTQ relationships. CNM relationships are not synonymous with group sex, and particularly within the polyamorous community, more dyadic encounters are likely to be emphasized; however, this is a community who must engage in explicit relational negotiation more commonly left out of relational scripts (Conley et al., 2013).

These communities, as well as those with many disabilities, exist in bodies and identities that require some degree of negotiation that varies from normative scripts (Kattari, 2015). As stated by Rubinsky & Roldán (2021), "all relationships, at any point in the lifespan, may benefit from the lessons drawn from those who practice BDSM or CNM, or who are members of the LGBTQ or disability communities. It is our hope that further research will explicitly attend to these conversations as a site of inquiry, but in doing so recall that in many kinds of relationships, they are already taking place" (p. 128).

Boundary-Setting and Script Disruption in Partnerships with Disabilities

Disability and BDSM communities have several intersections (Kattari, 2015; Tellier, 2017; Sheppard, 2019). For instance, Kattari (2015) identified intersections in BDSM and disability populations' sexual communication, finding that individuals who identify as having a marginalized relational, sexual, or gender identity who went through a 'coming out' process were more adept at communicating their sexual needs and boundaries with a partner. Participants cited their coming out processes as preparing them to clearly articulate their needs and boundaries during disclosure of disability (Kattari, 2015). Additionally, boundary setting conversations used in BDSM communication could be directly applied to conversations with their partner(s) about managing daily pain and disability-related issues (Kattari, 2015).

Scholars have explored social scripts, which are socially constructed understandings and appropriate learned behaviors based on identity, and literal scripts, guides for individuals with disability to act-out a social situation (Barnett & Maticka-Tyndale, 2015), to explore sexual communication amidst disability. Similar to BDSM relationships, partnerships involving the autism spectrum engage in planned sensory experiences to ensure sensory regulation and effective and mutually satisfying sexual connection (Barnett & Maticka-Tyndale, 2015). Prior research has identified higher rates of nonheterosexuality (Byers et al., 2012; DeVries et al., 2010), gender nonconfirming (Gilmour et al., 2012), and non-romantic partnerships (Byers et al., 2013) in individuals on the autism spectrum, which perhaps is attributed to the relational intersections of these populations. Heterosexual couples with autism benefitted from disrupting TSS that prioritize heterosexuality by negotiating alternatives to penetrative sexual intercourse, or even genital contact altogether, to accommodate disability needs while fostering mutually beneficial intimacy (Barnett & Maticka-Tyndale, 2015).

In partnerships with chronic pain, Hintz (2019) found that women with chronic genital and pelvic pain negotiate and co-create 'new' sexual norms with their partner(s) that accommodate their disability, including setting clear expectations about sex and disrupting traditional heterosexual sexual scripts that prioritize penetrative sex. In some partnerships, couples navigating chronic pain engaged in CNM, or 'opened the relationship,' to ensure that the partner without disability remained sexually satisfied, however this was often a 'last resort' to prevent relationship dissolution (Hintz, 2019). For others, romantic relationships and intimacy were viewed as 'conditional,' engaged in only when personal criteria were met; otherwise, participants chose to remain alone to prioritize their own physical and emotional well-being (Hintz, 2019). These findings align with Bernert & Ogletree's (2013) who found that women with intellectual disabilities were more apt to remain abstinent as a means to avoid negative sexual outcomes. To clarify, this does not necessarily imply complete potential for complete self-determination in sexual relationships for this population, as some members may have externally imposed social restrictions. This lack of middle ground between monogamous partnership and abstinence in the context of sexual scripts for disability highlights the need for scripts that attend to diverse relational populations with disability. Social perceptions of individuals with disability have historically painted them as devoid of sexual desire or fetishize them

as sexual deviants (Tellier, 2017; Turner & Crane, 2016). Without scripts that prioritize boundary-setting and disruption of sexual norms, individuals with disability will continue to struggle with an either-or, black-and-white view of sexuality and intimacy. Prioritizing boundary-setting conversations offers opportunity to find the grey, so individuals with disabilities can co-create healthy, romantic interactions that meet their physical, sexual, and relational needs. Communication is important, but not the only relevant aspect of social experience and sexuality. The intersections of disclosure, boundary-setting, and script disruption in relational minority populations and disability populations spark curiosity as to its possible guide for negotiating and communicating sexuality in disability. Thus, we ask:

RQ: How might BDSM/Kink sexual and boundary-setting communication offer a guide to negotiating sexuality in partners with disabilities?

Methods

The present article highlights a subset of data from a larger study on negotiating intimacy amidst the COVID-19 pandemic (see Rubinsky et al., 2021)[1]. This portion of the data is interested in how disability impacts how individuals communicate about intimacy, sex, and sexual health. Analysis focuses on identifying themes and overlaps in negotiating intimacy across disability and sexuality. The present analysis involves interview, focus group, and friendship pod data collected via Zoom from 29 individual participants. Details of the sample, data collection methods, and analysis are reviewed in this section.

Sample & Recruitment

Following approval by Northeastern University's institutional review board, participants were recruited through social media platforms, including personal accounts and Reddit (see Hintz & Betts, 2022). Of 29 participating individuals, 25 elected to disclose their demographic information. All participants identified as assigned female at birth, with the majority identifying as cisgender ($n=22$, 75.8%) and one participant identifying as genderfluid. Participants ranged in age from 18 to 51 years old ($M=28.21$, $SD=7.10$) and were predominantly white ($n=19$, 65%), in addition to Hispanic or Latina/o/x ($n=4$, 13%), or identified as multiracial ($n=2$, 6.8%). Participants identified diverse sexual orientations, including bisexual or pansexual ($n=9$, 31%), heterosexual ($n=8$, 27.5%), gay or lesbian ($n=4$, 13%), part of the asexual spectrum ($n=3$, 10.3%), and one participant identified as queer. Fifteen participants (51.7%) noted currently being in a relationship and ten (34.4%) noted being single; participants did not share marital status. One participant identified as engaging in solo polyamory and seven (24.1%) participants identified as members of the BDSM

[1] This data analysis has not been previously published. Please see: Rubinsky et al. (2021) for other analyses from the same data set.

and kink communities. Participants self-identified physical, mental, and intellectual disabilities, including depression ($n=7$, 24.1%), anxiety ($n=5$, 17.2%), autism spectrum disorder (ASD, $n=2$, 6.8%), post-traumatic stress disorder (PTSD, $n=2$, 6.8%), interstitial cystitis or bladder disorders ($n=2$, 6.8%), comatose and briefly legally dead ($n=1$, 3.4%), impaired sexual dysfunction ($n=1$, 3.4%), irritable bowel syndrome (IBS, $n=1$, 3.4%), premenstrual dysphoric disorder (PMDD, $n=1$, 3.4%), and breast cancer ($n=1$, 3.4%), with some participants identifying has having two or more conditions.

Procedures and Analysis

Due to the intimate nature of our research question, we engaged in three differing qualitative methodologies for data collection, including individual interviews, focus groups, and *friendship pods*, group interviews where multiple participants who knew one another engaged in conversation about the research topic (see Rubinsky et al., 2021). We use the term *friendship pods* to refer to more intimate of a space than simply a group interview, for the foundation of friendship prompts uniquely open and personal conversations. The premise of friendship pods is inspired by Tillmann-Healy (2003) who writes of the benefits of friendship as a method for data collection as working "toward social justice, relational truths, and passionate inquiry. Through authentic engagement, the lines between the researcher and researched blur, permitting each to explore the complex humanity of both self and other. Instead of 'speaking for' or even 'giving voice,' researchers *get to know* other in meaningful and sustained ways" (p. 733). These qualitative and in-depth methods allowed for intimate conversations between participant(s) and interviewer and bore a small but rich data set. Each data collection method included the same semi-structured interview guide, which asked participants to reflect on communication about sex, reproductive and sexual health, and sexuality. Thus, the questions used in the data collection process were the same across each sample, but data collection involved a different number of participants present and a different relationship between interviewer and participant amongst the three data sets.

Conversations and interviews occurred via Zoom during the first summer of the COVID-19. Though this period influenced reflections of relationships and intimacy in other parts of the data set (see Rubinsky et al., 2021), analyses in the present study were not influenced by the pandemic. Much of the reflections were retrospective in nature, prompting recall of experiences prior to COVID-19. Interviews were automatically transcribed with participant consent. The research team practiced self-reflexivity in data collection and analysis, with members across the team identifying as members of marginalized sexual, relational, racial, and disability communities (Scharp & Thomas, 2019). The team who engaged in data collection have described their positionality and relationship between their identity and engagement with participants elsewhere (see Rubinsky et al., 2021 for a full description). In addition, the present analysis includes that same team of researchers, as well as the first author who identifies as a member of the disability community.

The present study highlights responses to one question specific to the role of disability in discussing sex and intimacy (e.g., *have any (dis)abilities affected how you*

talk about sex, intimacy, and sexual health? Have you had relationships with anyone who had to think about (dis)ability?). These three data collection methods were used to triangulate our findings, which involves the use of multiple sources of data (Heale & Forbes, 2013), and comprehensively identify phenomena (Carter et al., 2014; Patton, 1999). Findings from these methods indicated intersections between sexual communication and boundary-setting practices in BDSM and kink relationships and the ways individuals in the disability community and their intimate partners negotiate sexuality.

Transcriptions of interviews resulted in 537 pages of data. Our small sample, from a larger study on intimacy amidst COVID-19, indicated potential intersections and therapeutic applications between communication in BDSM relationships and negotiating sexuality in neurodivergent and chronic illness populations. Guided by Rubinsky & Roldán's (2021) recommendations for applied boundary-setting, the primary goal of the data analysis was to identify overlaps and apply a sexual communication framework in BDSM to relationships with disability. After reading through the data several times, it became clear that participant reflections advance Rubinsky & Roldán's (2021) organizing framework for BDSM boundary-setting communication, more explicitly identifying the application of recommendations to disability populations.

Due to the small sample size, the first and fourth authors utilized reflexive thematic analysis (Braun & Clarke, 2012, 2013, 2019) and Rubinsky & Roldán's (2021) six applied recommendations for boundary-setting to identify themes and overlap in disability and BDSM sexual communication.

Findings & Discussion

Analysis of data revealed four applied BDSM boundary-setting recommendations specific to individuals and partners with disabilities, including (1) reflect upon needs and boundaries amidst shifting symptomatology, (2) (re)write sexual and intimate scripts to prioritize (dis)ability, (3) (re)negotiate relational needs and set expectations, and (4) bring awareness to the role of mental health and medication. These themes are organized to reflect steps in negotiating sexuality and intimacy in a relationship. We discuss these themes and their implications on sexual communication in partnerships with disability in turn. Consistent with thematic analysis, themes were not mutually exclusive, and data may be representative of more than one theme.

Reflect upon Needs and Boundaries Amidst Shifting Symptomatology

Living with disability requires individuals to constantly reassess their needs based on shifting symptomatology. One day they may have a physical ability that they do not have the next. As a result, participants expressed a need to regularly reassess their needs and boundaries, much like the preparatory sexual communication used in BDSM relationships. Notably, although there are differences between chronic illnesses and disabilities, many of our participants described theirs interchangeably.

Evelyn, who navigates IC, IBS, depression, anxiety, and PTSD, reflected upon this (re)negotiation, sharing:

> [There are] the diagnoses but there's also medications that are involved with all those things. So, I have to have those conversations… put in the extra effort to inform a partner or potential partners that if I had a stomachache, [for example], I wasn't going to be feeling up for anything that day. I would probably be in bed with a heating pad and painkillers or something. Or [with] anxiety, in [this] state. It's hard to feel in the mood… It's impacted every type of intimacy for me.

This articulation of needs aligns with Hintz's (2019) discourse of resistance when disrupting sexual norms, specifically "developing a self-advocating orientation" (p. 120), which encourages vocalization of shifting sexual preferences amidst chronic illness management and treatment. P, a participant with ASD they define as "high functioning," shared the impact of fostering open communication with their partner:

> [Autism is] highly individualistic [and] tends to manifest very differently in women… [so] a lot of my mental health issues (e.g., anxiety, depression) stemmed from an undiagnosed autism neurodivergence[e]. Learning about [autism], learning how to [manage] it and certain things that work and don't work for me… at first really hindered my having a relationship and starting a relationship… but in the end, it has helped me to open up communication lines a lot more and to work through our issues in my relationship over the years.

Sadie, a participant whose wife has ASD and identifies as part of the BDSM community, reflected upon the intersections of kink and disability communication in the context of negotiating sexual intimacy:

> My wife has intense sensory overload as part of her place on the autism spectrum. So, we have to communicate a lot in terms of, 'this is what like,' 'the stimulation is just too intense,' whether it's light or sound or just physical touch or anything like that. [Communicating] 'this is just way too intense, I need to stop, this needs to slow down' … It is highly communicative sex, which I enjoy… Because I am not on the autism spectrum and I do not have sensory issues, [there are] things that I would not normally think about. So, trying to meet those needs, [they have to be] verbally communicated…I would be curious about… the Venn diagram of people [with] varying shades of disability and kink fall because I have noticed that… folks in the kink community have [overlapping] health concerns and needs [to] think about… in really generic sex this would never come up.

These findings affirm and extend Kattari's (2015) suspicion of "significant crossover in the communication expectations and styles that are evident in the kink/BDSM and polyamorous communities, with those of people with disabilities when asking for their needs and wants to be met regarding sexual partners" (p. 895). In both disability

and BDSM/kink communities, individuals and partners are tasked with communicating amidst shifting physical needs and boundaries. Both communities find themselves without relevant sexual scripts to follow and as a result must disrupt sexual 'norms' that are not relevant to them. As a result, they develop an orientation of self-advocacy in sexual interactions (Hintz, 2019). These shifts in interactive sexual norms may constitute revised sexual scripts similar to other marginalized sexual and gender communities (see Wasley, 2013). As expressed by Sadie, there is a Venn diagram of individuals who are a part of both the disability and kink communities. Kattari (2015) highlighted a similar participant finding, writing "one participant shared how she has chosen only to engage with kink/BDSM practicing sexual partners because they are so much more aware of and interested in hearing about her disability related needs in sexual interactions" (p. 895). Future research may benefit from interviewing individuals with disabilities who seek out minority relational partners to more specifically explore this overlap.

(Re)Write Sexual and Intimate Scripts to Prioritize (Dis)Ability

Participants spoke of a need for sexual education that is inclusive of those with disabilities. This included extending understandings of sex beyond traditional heteronormative understandings and prioritizing agency for individuals and partnerships that include disability. For many, this was done through communication, specifically asking what intimacy looks like for each individual and partnership depending on symptomology. Cristine, a participant with a bladder disorder that impacts her ability to engage in penetrative sex, reflected:

> I have a bladder disorder. and I'm kind of lucky because mine isn't bad, but it has changed the way that I think about sex and people's abilities to have sex. I'm on a Facebook group [for this bladder disorder] and a lot of women can't have sex, at least penetration sex. [To] have sex, they have to plan days in advance [and] get certain kind of lubes because if you put the wrong lubes down irritates your bladder… So, it's changed [how I] think about the privileges of being able to have sex whenever you want to, or however you want to do it… a lot of them have lost relationships or gotten divorced because they can't have sex and their partner gets frustrated and then they leave them… I always question… can't you do other things that are similar that aren't penetration, but [could be defined] as sex or use toys and different things? I get confused about why they only have one version of sex… I don't think that's a privilege we often think of, but it can be a privilege in some ways to be able to just physically do what you want to [smiles].

Similarly, Marla, a participant who is learning to renegotiate sexuality following breast cancer and perimenopause shared:

> Adding on a year's worth of cancer treatment, plus breast reconstructive surgery, it messes with your sex life a little bit [laughs], as you can imagine… I don't want to say there are things that are better than sex, but certainly there are

> many other ways in which we are intimate that make me feel close to my partner. And then [there is the] whole body image [shift following] having breast reconstruction surgery… suffice to say, just how much patience we needed to have about that, and [it is] still evolving as we change, as we age… things change, and having a partner who's willing to change with you is something that's really valuable. My husband likes to cuddle so for us, that is something that is significant. [His love language is] physical touch, so I know that is meeting a need for him, even if we are not having sex…Intimacy for me means more mentally being on the same page, being aware of each other's emotional needs… being in sync emotionally.

Marla's reflections align with prior research exploring the renegotiation of sexuality following breast cancer, balancing both shifting relational and sexual needs (Emilee et al., 2010). By disrupting traditional, heteronormative scripts that constrain definitions of sex to penetration, sexual acts become malleable and accessible to individuals with differing abilities. For diverse relational communities, sex has a myriad of definitions that center pleasure and connection, not solely penetration. Previous research has demonstrated a need for similar, negotiable scripts for individuals with disabilities (Kattari, 2015), especially in the context of heterosexual relationships in which women are tasked with relational maintenance as part of their caring work (Stoppard, 2000). As Christine reflected, members of her online support group experienced relational dissolution and divorce due to their inability to engage in penetrative sex. There is a need for diverse experiences of intimacy for individuals whose chronic illness and pain inhibits them from traditionally heteronormative sexual acts (Hintz, 2019). Such scripts foster understanding of individual and partnership needs and wants alongside ability, (re)negotiating definitions of intimacy to accommodate neurodivergence and disability (Rubinsky & Roldán, 2021).

(Re)Negotiate Relational Needs and Set Expectations

Participants discussed (re)negotiating relational needs and engaging in relational maintenance communication with their partner following onset and subsequent management of their disabilities. Interview data spoke of the evolution of relationships–individuals, partnerships, and health needs are constantly changing; thus, we have the power and agency to re-assess changing needs and wants. Following the onset of illness, sexuality and sexual needs can change and communicating those changes is important to maintaining intimate relationships. Lauren, a participant whose father was briefly legally dead following cardiac arrest, reflected on the intimate, relational shifts they witnessed between their parents:

> "My dad was legally dead for a few minutes [after] coding [multiple times] … After that, their relationship shifted because, well, he is mentally pretty much back to where he was before [but] physically, there are changes in their relationship. He's more dependent upon her for different things, like helping him get his socks on and off, or helping him shower. I look at that and I'm just like, that's a whole different level of love and intimacy that we often don't talk about—the

> caring spouse in that way. Him letting her and feeling comfortable with her doing that, because you get [that relational intimacy] from both [sides]."

Additionally, participants discussed the importance of setting expectations for intimacy. Sometimes this included check-ins before, during, and after sexual acts or applying safe words that indicated pain or discomfort and a desire to pause intimacy. For example, Jamie who has PTSD shared:

> I've been through a bit of trauma, so communication is key. When I was still with my ex, I always asked him how he was feeling. If we were to have sex or anything, we always went through stuff that we will be doing and what we won't be doing… we have talked briefly about why I [do not] like being smacked in the face or getting choked. Because I witnessed some stuff like that before.

Relational agreements shift and change, requiring (re)negotiation of boundaries and continuous communication. Partnerships must continue to define what sex, intimacy, and pleasure looks like to those involved to ensure that it is mutually satisfactory. Similar to polyamorous communication (Rubinsky, 2018), individuals with mental and physical disabilities must continue to (re)negotiate their needs to ensure relational functioning. This may be an example of positive script negotiation stemming from communities of difference (Rubinsky & Hudak, 2022).

Bring Awareness to the Role of Mental Health and Medication

Several participants noted the role of medication and mental health on their relational communication and intimacy. Antidepressants and other chronic illness medications can impact libido. In instances where one partner's sexual drive or needs are different than the other's, participants identified the importance of conveying medication or health condition as the cause or issue, not the relationship. For example, Veronica reflected upon the history of her depression in the context of her relationships, sharing:

> My medication has lowered my libido a lot of times [laughs]…I've had a lot of side effects [that have] impacted my relationships. Not only that, but depression in itself makes me have a lot of self-esteem problems, [which] brings obvious problems to my relationships.

Another participant Candice shared similar experiences:

> It is [hard] to climax with antidepressants, both on my end and on their end – I've had those discussions with a lot of people, and I've been with a few people who have had emotional issues around premature ejaculation [and] mental states [that] affected [them]... I've had to push a couple of partners who were embarrassed… there was definitely a reluctance in terms of talking about it but then I would persevere… when I noticed that they had an issue.

Lauren, another participant, who struggles with PMDD reflected how "intimacy can be dependent on the healthiness of a relationship… [and on] mental health and issues around that, and other types of health issues." Two participants noted the importance of communicating mental illness symptoms to participants, with M, a participant with depression and anxiety, sharing:

> Mental health, depression, and anxiety were really big for me, especially when I was in grad school. It was something that I had dealt with before, but I finally had the language to say, 'I have anxiety. I'm anxious. I'm having a panic attack.' That was something that I learned and I had to communicate with my partner… asking myself [what I need] and then communicating with him has been a practice… he just has a way of asking certain questions [that help] me come to certain realizations that maybe would have taken longer to do on my own. So, I'm grateful for that support.

Sadie, a participant with severe anxiety who is also a part of the kink community reflected upon the importance of communicating mental health needs with sexual partners, sharing:

> I have to be really upfront about certain trigger things [because] if you [grab] or [touch] me [in a certain way], it's going to set up a really bad trigger. and it sucks when you don't know the triggers ahead of time. I wish I was a little more forward thinking about it because like, once, you know, I was like, in a scene with somebody where they like, grabbed my neck and choked me and I had a full-blown panic attack… In retrospect, if I had just talked with this person more about my anxiety ahead of time, then this could have been avoided because the person that was having sex with felt… like it's their fault. [I said] 'no, I didn't tell you that was my trigger.' I also didn't fully understand it was a trigger, [so] now I'm much more upfront about it… there are going to be certain physical things that will upset my anxiety because I'm a highly medicated but still very severely anxious person. So, if I am in a kink situation in particular, I'm going to be much more upfront about it because of that experience.

These examples demonstrate individuals needing to renegotiate, often explicitly, their interpersonal scripts in light of the intersections between BDSM identity and their disability experience. This process of renegotiation may offer opportunities for positive deviation or the development of more personally satisfying interpersonal scripts (Rubinsky & Hudak, 2022; Wasley, 2013).

Limitations & Future Research

The present preliminary study offers a limited sample of individuals, with responses emerging from a question of disability as part of a larger study on intimacy amidst COVID-19. Studies that specifically seek out members of both relational minority and disability communities may provide results with more specificity and depth in understanding the connections between these groups. Additionally, participants self-

disclosed health conditions, which spanned neurodivergence, mental health, and chronic physical health conditions. Future research would benefit from studies that focus on overlap with specific communities, notably individuals with ASD who are a part of the kink community (e.g., Kattari, 2015), as each disability experience may be uniquely different. Future research may also benefit from analyzing the specific sexual scripts of people with disabilities and their networks. Finally, this study includes a selection bias, as friendship pods consisted of individuals who know one another and recruit within their social circles. Future studies may benefit from survey methodology dispersed on online platforms to recruit a more diverse population.

Conclusion

Research on sexual communication and the disruption of sexual scripts in disability is limited, however, the need is apparent. Members of both BDSM and disability communities find themselves in unique situations that require continued negotiation and communication of physical needs, boundaries, and desires. As a result, members of these communities may avoid romantic relationships altogether to limit discomfort and anxiety, as illustrated by participant reflections and prior research (Bernert & Ogletree, 2013). This is often due to a lack of sexual scripts that illustrate aligning sexual needs, wants, and physical abilities (Hintz, 2019; Kattari, 2015). Regardless of (dis)ability, sexuality, or relationship, individuals and couples deserve access to scripts that align with their needs and desires. Communication research can aid in this pursuit by highlighting narratives that fall outside of the TSS and offering guiding frameworks (like Rubinsky & Roldán, 2021 and Hintz, 2018) for individuals and couples to follow, if desired. As this introductory study has highlighted, boundary-setting processes seen in the BDSM and kink communities offer guidance for individuals and couples to explore and articulate their sexual and relational needs and desires. Regardless of relationship or (dis)ability, individuals and couples would benefit from deviating from the TSS and heteronormative and ableist ways of perceiving sexuality. Disrupting antiquated sexual scripts affirm that individuals deserve intimacy without physical and relational compromise. Alternative sexual scripts also prioritize reflection and communication of needs, desires, and boundaries, which all sexual relationships will benefit from. Regardless of attention by research, these relational conversations and definitions of sex are already taking place in the communities highlighted. It is our hope through these introductory findings that boundary-setting and sexual communication seen in the BDSM, kink, and disability communities will extend beyond these communities and disrupt the TSS, so our society's sexual scripts become encompassing of all definitions of sex; not only for inclusivity, but so all bodies may experience more rich, diverse, and pleasure and consent-centered sexual acts.

Declarations

Conflict of Interest The authors do not have any conflicts of interest to report.

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