Exploring Fantasies & Kink

Safe Communication, Introducing Sex Toys and Exploring Alternative Intimate Dynamics With a Partner

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Introduction

In my clinical practice in sexual disorders and infertility, patients sometimes discuss subjects that they have never felt comfortable sharing with anyone else. A person may have a sexual fantasy that produces curiosity but also embarrassment. A married couple may want to introduce something new into their intimate relationship but worry that bringing up the subject could offend the other person. Another patient may be interested in a sex toy, role-play, a different relationship dynamic or some form of consensual kink but may not know whether the interest is normal, safe or medically concerning.

These conversations deserve the same professionalism and respect as discussions about erectile dysfunction, infertility, painful intercourse or premature ejaculation.

The first point I explain is very important: **having a sexual fantasy is not itself a disease**. The World Health Organization describes sexuality as including thoughts, fantasies, desires, pleasure, intimacy, beliefs, practices and relationships. WHO's sexual-health framework emphasizes physical, emotional, mental and social well-being together with respectful, pleasurable and safe sexual experiences that are free from coercion and violence.

Similarly, contemporary professional sexuality organizations advise clinicians not to automatically pathologize consensual sexual expression simply because it is unconventional. The American Association of Sexuality Educators, Counselors and Therapists states that consensual atypical sexual expression is not inherently pathological and should be approached without unnecessary stigma.

The clinical questions are therefore not simply, *"Is this conventional?"* or *"Is this unusual?"*

The more useful questions are: **Is it consensual? Is it safe? Is everyone free to say no? Does it respect the values and boundaries of both partners? Is it causing distress, injury, coercion or significant dysfunction?**

Those questions form the foundation of responsible sexual-health care.

Understanding Sexual Fantasies

A sexual fantasy is an imagined scenario, thought, idea or mental image associated with sexual interest or arousal. Fantasies can occur spontaneously or intentionally, and they vary greatly between individuals.

Modern research shows that many fantasies that people assume are exceptionally unusual are actually reported by substantial numbers of adults. A contemporary scientific review concluded that relatively few fantasy themes appear to be statistically rare. Importantly, the review also emphasized that **fantasizing about something does not necessarily mean that a person wants to experience it in real life**.

This distinction is extremely important.

A person can imagine something without wanting it to happen.

A person may find an idea exciting in imagination while deciding that it does not fit their real-life values, relationship, safety preferences or comfort level.

Fantasy is therefore not automatically intention.

It is also not automatically consent.

Fantasy Does Not Create an Obligation to Act

Patients sometimes become unnecessarily worried because they assume:

"If this thought excites me, I must secretly want to do it."

That conclusion is not always correct.

Human imagination can explore possibilities that people would never choose in everyday life. A fantasy may be interesting precisely because it remains imaginary.

A person is therefore free to:

think about a fantasy;

discuss it with a partner;

modify it;

decide never to enact it;

or decide that it conflicts with personal, cultural or religious values.

No healthcare professional should pressure someone into acting on a fantasy simply because they disclosed it.

The goal of sexual healthcare is informed decision-making—not persuading people toward any particular sexual practice.

What Does "Kink" Mean?

"Kink" is a broad umbrella term generally used for consensual sexual interests, fantasies, forms of sensation, role-play or relationship dynamics that fall outside what a particular society or culture considers conventional.

It may include consensual power exchange, role-play, restraint, particular sensory experiences, fetish interests or other alternative forms of intimacy.

The definition is broad because what societies consider "conventional" changes across cultures and generations.

Research reviews have found little support for older assumptions that consensual BDSM or kink automatically indicates psychopathology. A systematic scoping review of 60 studies found BDSM-related fantasies to be relatively common and reported little evidence supporting traditional models that automatically interpreted BDSM interests as mental illness.

More recent biopsychosocial research similarly emphasizes that kink should be understood through biological, psychological, interpersonal and cultural frameworks rather than automatically through pathology.

This does not mean every activity is harmless.

It means that **unconventional is not the same as unhealthy**.

Health and safety depend much more on consent, risk, communication, context and consequences.

When Does an Interest Become Clinically Concerning?

A consensual fantasy or kink preference is not automatically a disorder merely because it is unconventional.

Clinical concern becomes much more important when an urge or behaviour causes substantial distress or impairment, repeatedly leads to injury, becomes impossible to control, seriously damages relationships, or involves people who cannot or do not consent.

If a fantasy involves harming a non-consenting person, minors, illegal activity or another situation in which meaningful consent is impossible, it should **not be acted upon**. A qualified mental-health professional with experience in sexual-health concerns should be consulted if such thoughts are persistent, distressing or create concern that somebody could be harmed.

The same applies when sexual activity is being deliberately used as self-punishment or self-injury rather than mutually desired intimacy. Research recognizes that sexual behaviours can sometimes overlap with self-injurious behaviour, making careful clinical assessment important.

Sexual Exploration Should Begin With Communication, Not Activity

One of the biggest mistakes couples make is attempting to introduce something unexpected during intimacy without having discussed it beforehand.

A surprise may sound exciting in theory, but when the subject involves sexual boundaries, restraint, power dynamics, toys or unfamiliar sensations, surprises can create fear rather than intimacy.

I recommend that couples begin outside the bedroom.

A conversation might begin in a neutral way: *“There is something I have been curious about. I don't need you to agree to it, but would you feel comfortable talking about it?”*

That sentence communicates three important things at once.

There is curiosity.

There is no demand.

And the partner has a genuine choice.

Research strongly supports the broader importance of sexual communication. A meta-analysis of 93 studies involving 38,499 people found that better sexual communication was positively associated with both sexual satisfaction and relationship satisfaction, with the **quality** of the communication showing stronger associations than simply talking more frequently.

How to Disclose a Fantasy Without Pressuring Your Partner

Many people hesitate because they fear judgment.

A 2025 study examining fantasy disclosure found that 69.3% of participants reported having disclosed a sexual fantasy at some point in their relationship. Actual responses were often described positively, while people who had not disclosed a fantasy frequently anticipated more negative reactions. This does not mean disclosure will always be welcomed, but it illustrates that imagined rejection and actual partner responses are not always the same.

A healthy disclosure should leave room for several possible responses.

Your partner might say:

"That sounds interesting."

They might say:

"I'm comfortable talking about it, but I don't want to try it."

They might say:

"I need some time to think."

Or they might say:

"That isn't something I'm comfortable with."

All four responses can be legitimate.

Sharing a fantasy gives your partner information.

It does **not** create an obligation for them to participate.

A Fantasy Can Stay a Fantasy

This point deserves special emphasis.

Couples sometimes assume that once a desire has been disclosed, there are only two choices: perform it or disappoint the person who disclosed it.

There is a third possibility.

The couple can acknowledge the fantasy while deciding not to enact it.

For example, one partner can say:

"I understand why that idea interests you. It isn't something I want to do physically, but I'm glad you felt able to tell me."

That conversation itself may increase emotional intimacy.

A relationship does not require identical sexual interests.

It requires the ability to negotiate differences respectfully.

Consent Is the Foundation of Exploration

Consent should be **clear, voluntary, informed and ongoing**.

RAINN's updated 2026 guidance emphasizes that consent cannot be based on pressure, manipulation or fear, that consent to one activity does not imply consent to everything, and that a person can change their mind at any stage. Someone who is asleep, significantly intoxicated or otherwise unable to understand what is happening cannot meaningfully consent.

These principles become especially important when experimenting with unfamiliar activities.

A partner saying *yes* to discussing a fantasy is not consent to perform it.

Saying *yes* to one part of an experience is not consent to everything else.

Agreeing yesterday is not automatic consent today.

Marriage does not remove the need for consent.

And enjoying something once does not mean a person must want it again.

Enthusiasm Matters More Than Reluctant Compliance

A patient sometimes tells me:

"My partner agreed, but I could tell they didn't really want it."

This should not be treated as a successful negotiation.

There is a major difference between:

"Yes, I'd like to try that."

and

"Fine, if that's the only way to make you happy."

A healthy intimate relationship aims for participation that is mutually chosen rather than obtained through guilt.

Repeated persuasion after refusal can become coercive.

Statements such as *"If you loved me, you would do it"* or *"Everyone else does this"* are not respectful ways of obtaining agreement.

Alternative Dynamics and Power Exchange

Some couples are interested in consensual forms of dominance, submission or another negotiated difference in roles.

The word **consensual** is the crucial part.

A role involving power during an agreed intimate scenario does not mean one partner permanently gives up autonomy.

The agreement can have limits.

It can be temporary.

It can be changed.

And it can be withdrawn.

A person participating in a submissive role retains the right to stop.

A person participating in a dominant role has a responsibility to respect the agreed limits and stop signals.

The existence of a "role" never provides permission to ignore actual distress.

Professional clinical guidance on kink therefore emphasizes distinguishing consensual erotic diversity from coercion, abuse and pathology.

Discuss Boundaries Beforehand

Before exploring unfamiliar dynamics, couples should discuss what is acceptable, what is uncertain and what is completely off-limits.

They should also discuss what stopping will look like.

Some couples use an agreed word that immediately means stop.

Others use verbal check-ins or a clear non-verbal signal if speaking may become difficult.

The exact system is less important than one principle:

When someone indicates that they want the activity to stop, it stops.

A stop signal should never become part of the game itself or something to be "tested."

Never Confuse Role-Play With Real Consent

Some fantasies involve imagined resistance or differences in power.

This area requires particularly careful boundaries because pretending within an agreed scenario must never be confused with real coercion.

If partners choose to explore a fictional scenario involving resistance, there still needs to be clear prior agreement about the boundaries and a completely reliable way to end the scene.

When actual consent becomes uncertain, activity should stop.

It is never acceptable to assume that someone is "only pretending" when they show genuine distress.

Alcohol and Drugs Make Negotiation Less Reliable

Introducing a new or complex intimate activity while one or both partners are significantly intoxicated is a poor safety strategy.

Alcohol and other intoxicating substances can impair judgment, communication, coordination and the ability to recognize danger.

They can also impair capacity to give informed consent.

RAINN specifically notes that someone too intoxicated to understand what is happening cannot provide meaningful consent.

When something is unfamiliar, discussing and exploring it while both partners are alert makes communication much safer.

Physical Risk in Kink Should Not Be Minimized

Consensual does not mean risk-free.

A 2023 study involving 513 adults with BDSM experience found that both intentional and unintentional marks and injuries occurred, ranging from relatively minor marks to more

significant injuries. The authors emphasized the importance of clinician awareness, safe-word practices and non-judgmental healthcare.

A 2024 study similarly emphasized that safety is foundational because some BDSM practices can carry risks of injury.

This is why I advise patients not to learn potentially dangerous physical practices solely from pornography or entertainment media.

Entertainment is not clinical safety training.

Breath Restriction and Neck Compression Require a Strong Warning

Some activities deserve stronger medical warnings than others.

Anything that compresses the neck or deliberately restricts breathing can cause serious injury, unconsciousness, brain injury or death. A literature review examining fatal BDSM-related cases found strangulation during erotic asphyxiation to be the most common cause of death among the cases identified. Alcohol or other substances were also involved in many fatal incidents.

There is no technique that can guarantee that intentional strangulation or oxygen restriction will be medically safe.

For this reason, from a clinical safety perspective, I advise avoiding deliberate neck compression and breath restriction.

Knowing When to Stop

Pain is information.

Numbness is information.

Dizziness is information.

Difficulty breathing is information.

Loss of normal movement or sensation is information.

Sexual activity should not continue simply because the couple planned it in advance.

Unexpected severe pain, breathing difficulty, loss of consciousness, major bleeding, suspected fracture, persistent numbness, weakness, severe swelling or confusion requires appropriate medical assessment.

Healthcare professionals should ideally approach these disclosures without ridicule. A 2024 study of BDSM practitioners found that experiences of stigma and discrimination

in healthcare were associated with greater medical mistrust and with some people hiding kink-related injuries from clinicians.

Hiding an injury can delay appropriate treatment.

Introducing Sex Toys Into a Relationship

The subject of sex toys can also be emotionally sensitive.

Some people view a toy as an interesting addition to intimacy.

Others may interpret it as evidence that their body is "not enough."

A partner may think:

"Why do we need this? Am I failing?"

For this reason, the conversation matters as much as the device.

A healthier introduction may sound like:

"I am happy with our relationship. I was curious whether trying something different together might be enjoyable. There is no pressure if you are uncomfortable."

This communicates curiosity rather than replacement.

Sex Toys Are Tools, Not Competitors

A sexual aid does not automatically mean a partner is sexually inadequate.

Medical sexual healthcare already uses devices in certain circumstances, such as vacuum erection devices and pelvic-floor or rehabilitation devices.

Consumer sexual toys have a different purpose, but the general principle is similar: a device can change stimulation without replacing emotional intimacy.

For couples who are interested, a toy may simply be another optional form of shared exploration.

For couples who are not interested, there is no medical requirement to use one.

Choosing a Safer Product

If an intimate device is going to contact sensitive tissue or be inserted into the body, it should be specifically designed for that purpose rather than improvised from household objects.

Planned Parenthood advises choosing products made for sexual use and notes that non-porous materials—such as 100% silicone, hard plastic, stainless steel, aluminum and appropriately designed break-resistant glass—are generally easier to keep clean than porous materials. Products should also be used and maintained according to the manufacturer's instructions.

Any product showing cracks, sharp edges, damaged surfaces, loose components or other deterioration should not be used.

Improvised objects can break, injure tissue or be difficult to remove.

Hygiene and Sex Toys

Sex toys can transfer bodily fluids and microorganisms between people.

CDC states that condoms can reduce the transmission risk of HIV and some other STIs when sex toys are shared. NHS guidance also notes that condoms may be used on sex toys.

Planned Parenthood recommends cleaning toys according to their care instructions and using a new condom when a toy is transferred between partners.

The practical principle is straightforward:

Clean devices appropriately, avoid unnecessary sharing, and prevent bodily fluids from being transferred between people.

Changing Barriers Matters

If a condom is being used on a shared toy, it should be replaced before the toy is used by another person.

Similar precautions are appropriate when moving a device between different body areas because bacteria that are harmless in one site can cause infection elsewhere.

Public-health guidance recommends either not sharing sex toys or washing them and using a fresh condom before another person uses them.

This is a health issue—not a matter of embarrassment.

Lubrication and Friction

Friction can cause irritation and small tissue injuries.

Appropriate lubricant may therefore improve comfort and reduce friction.

Compatibility matters.

Water-based lubricants are generally compatible with condoms and most sex toys. Oil-based products can damage latex condoms, while some silicone-based lubricants may damage silicone toys, so users should check the manufacturer's instructions for both the toy and lubricant.

If a product causes burning, itching, swelling or persistent irritation, stop using it and seek medical advice if symptoms continue.

Internal Devices Require Additional Care

Any device intended for internal use should be designed specifically for that purpose.

Products used anally require particular attention because an object can become difficult to retrieve if it lacks an appropriate external stopping feature. Planned Parenthood specifically advises choosing anal toys with a wide base or another design feature that prevents complete insertion.

If an object becomes stuck and cannot be removed easily and safely, medical assistance should be sought rather than repeatedly attempting forceful removal.

Healthcare professionals deal with these situations more frequently than many patients imagine.

Prompt care is safer than embarrassment.

Do Not Use Numbing Agents to Ignore Pain

Pain is one of the body's protective warning systems.

Using strong numbing products specifically to continue an activity that would otherwise be painful can hide developing injury.

If an activity repeatedly produces significant pain, the solution is not simply to stop feeling the pain.

The cause should be understood.

This is particularly important in patients who already have vulvodynia, vaginismus, pelvic-floor dysfunction, vaginal dryness, fissures, hemorrhoids, genital skin disease or another condition that makes sexual activity painful.

STI Risk Still Matters During Alternative Sexual Activities

Sexually transmitted infections are determined by exposure to infected skin, secretions, blood or mucosal tissue—not by whether an activity is considered conventional or unconventional.

Barrier methods can reduce transmission risk for several STIs, though no barrier eliminates every risk. CDC notes that condoms are highly effective against HIV and certain STIs when used correctly but provide less protection against infections spread through exposed skin, including herpes, HPV and syphilis.

People with new or multiple partners may benefit from appropriate STI screening based on their sexual history and risk.

A healthcare professional should be able to discuss this without judgment.

Privacy and Digital Consent

Modern intimacy also involves smartphones, cameras and online communication.

A partner consenting to sexual activity does not automatically consent to photography or recording.

A person agreeing to a photograph does not automatically agree to its distribution.

Couples should therefore discuss digital boundaries separately and explicitly.

Where intimate images exist, privacy should be treated as a serious matter because unauthorized sharing can produce substantial emotional, social and legal consequences.

Kink Is Not the Same as Abuse

This distinction is fundamental.

Consensual power exchange is based on agreement.

Abuse removes meaningful choice.

In a consensual alternative dynamic, both partners know what has been agreed, understand their limits and can stop.

In abuse, one person may use intimidation, fear, punishment, financial control, isolation or actual violence to prevent the other person from freely choosing.

Calling something “kink” does not make abusive behaviour consensual.

Similarly, being interested in kink does not mean a person wants violence outside agreed intimate circumstances.

Clinicians must be able to tell the difference.

A Safe Word Does Not Make Everything Safe

Safe words can improve communication, but they are not magical protection.

A partner may become unable to speak.

Someone may become confused.

An unexpected medical event may occur.

The person in the more physically controlling role therefore remains responsible for observing their partner and stopping when there are signs of actual distress.

Consent requires attention—not merely waiting for a particular word.

Emotional Reactions Can Occur Afterwards

A new intimate experience may produce unexpected emotions.

Someone may enjoy the activity in the moment and later feel vulnerable, embarrassed, emotional or uncertain.

Another person may discover that an experience activated memories of previous trauma.

Couples should therefore be willing to talk afterwards.

A simple conversation about *"How did that feel for you?"*, *"Was there anything you would change?"* and *"Is there anything you definitely do not want again?"* can improve communication.

The purpose is not to evaluate performance.

It is to understand each other.

When Trauma Is Part of the Story

Some people with histories of sexual trauma are interested in fantasies involving control or power.

Others avoid these themes entirely.

Neither response should be generalized.

A clinician should never assume that kink interests prove that someone has been traumatized, nor that trauma automatically produces particular sexual preferences.

Research reviews do not support simplistic theories that BDSM interests can generally be explained by trauma or psychopathology.

However, if a particular experience causes flashbacks, dissociation, panic, nightmares or other trauma symptoms, it may be appropriate to pause the activity and consult a trauma-informed mental-health professional.

Fantasies, Shame and Cultural Values

Many patients come from cultural or religious backgrounds in which discussing sexuality openly may feel uncomfortable.

Some experience shame simply because a thought occurs.

I remind them that a thought and an action are different.

A person can acknowledge a fantasy and still choose behaviour consistent with religious or personal values.

Clinical care should respect both sexual-health science and patient autonomy.

The aim should not be to tell a patient what values to adopt.

The aim is to provide accurate medical information so that choices are made knowingly rather than through unnecessary fear or misinformation.

Your Partner Is Allowed to Have Different Values

A common difficulty arises when one partner thinks:

“Because this is important to me, it should also be important to my spouse.”

That is not necessarily true.

Two people can love each other deeply while having different levels of sexual curiosity.

One may enjoy novelty.

The other may prefer familiar intimacy.

Neither preference is automatically defective.

The goal is negotiation rather than conversion.

“No” Does Not Mean “Try Harder to Convince Me”

If a partner does not want to participate in a fantasy, kink or sex toy, their refusal deserves respect.

You may discuss the subject again later if they are genuinely willing to talk.

But repeatedly raising it until the person gives in can convert communication into pressure.

Consent obtained after exhaustion, guilt or fear is not the kind of free agreement required for healthy intimacy.

RAINN emphasizes that consent should be free of pressure and manipulation and that ongoing communication remains necessary throughout an encounter.

Desire Differences Are Normal

Couples often assume that sexually compatible partners should want exactly the same things.

In reality, differences are common.

One partner may have more fantasies.

Another may have fewer.

One may enjoy discussing them.

Another may prefer privacy.

A 2025 meta-analysis of sexual self-disclosure involving 9,239 people found substantial variability in what people reveal to partners and suggested that individuals balance the benefits of disclosure against the desire to retain sexual privacy. Greater sexual communication satisfaction and assertiveness were among the strongest correlates of disclosure.

Privacy therefore should not automatically be interpreted as dishonesty.

How Couples Can Find a Middle Ground

A useful conversation asks three different questions:

What sounds interesting to both of us?

What is something one of us is uncertain about and wants time to consider?

What is completely off-limits?

The third category deserves particular respect.

Compatibility does not mean one partner repeatedly crossing boundaries.

Sometimes a couple discovers that the underlying need can be met in another way.

For example, an interest described as a desire for “dominance” may actually reflect a wish to feel desired, spontaneous or free from decision-making for a while.

Understanding the underlying emotional meaning can create alternatives that suit both partners.

Sexual Exploration and Erectile Dysfunction

Some couples introduce novelty because they hope it will “cure” erectile dysfunction.

Occasionally reduced excitement or performance anxiety does play a role in erection problems.

However, erectile dysfunction can also result from diabetes, cardiovascular disease, medication effects, hormonal disorders, neurological disease or other medical causes.

A toy or fantasy should therefore not be used as a substitute for proper assessment when erection difficulties persist.

At Saira Health Care, I consider both the physiological and psychological sides of erection problems.

Sexual Exploration and Premature Ejaculation

Novelty may initially increase excitement, which in some men can make ejaculatory control more difficult rather than easier.

Premature ejaculation requires proper assessment of ejaculation pattern, erection quality, anxiety, relationship factors and other possible contributors.

Alternative sexual activities should therefore not be marketed as a guaranteed treatment for premature ejaculation.

Some couples may nevertheless find that reducing a rigid focus on penetration and performance decreases anxiety.

The therapeutic value in such cases comes from reducing pressure and improving communication—not from kink itself.

Low Sexual Desire

Couples sometimes assume that adding increasingly unusual activities will automatically solve low desire.

That is rarely a complete solution.

Low desire can relate to depression, relationship conflict, hormonal changes, menopause, medications, chronic illness, sleep deprivation, stress, pain, trauma or other factors.

Novelty may be enjoyable for some couples, but persistent low desire requires broader evaluation.

Painful Intercourse

Pain is another area where experimentation should be approached carefully.

If a patient already experiences painful penetration, pelvic-floor tension, vaginal dryness or genital pain, introducing devices without understanding the cause may worsen symptoms.

Medical evaluation may be required for conditions such as vulvodynia, vaginismus, infections, hormonal changes, endometriosis, pelvic-floor dysfunction and dermatological disorders.

The principle remains:

Treat pain as a medical symptom—not as an obstacle to push through.

Infertility and Sexual Exploration

Infertility can change the emotional meaning of sex.

Intercourse may become timed around ovulation.

Men may experience pressure to produce semen samples.

Women may undergo repeated examinations and procedures.

Over time, intimacy can feel like a reproductive task rather than a relationship experience.

Some couples become interested in reintroducing non-reproductive forms of affection or novelty as a way of separating intimacy from fertility treatment.

This may be psychologically helpful for some couples, but it is not itself an infertility treatment.

At Saira Health Care, I believe reproductive treatment should protect the couple's relationship rather than allowing fertility schedules to completely define intimacy.

Pregnancy and Medical Conditions Require Additional Consideration

Certain sexual practices or devices may not be appropriate during pregnancy, after surgery, during active infection, after childbirth, or in people with particular cardiovascular, neurological, bleeding or pelvic conditions.

Patients with implanted medical devices, anticoagulant treatment, recurrent genital infections, pelvic surgery or significant pain should ask an appropriate healthcare professional about their individual circumstances.

The safest recommendation depends on what activity is being considered and the person's medical history.

Exploring Something New Should Be Gradual

Couples do not need to move from curiosity to the most intense possible experience.

Gradual exploration makes it easier to learn what feels emotionally and physically comfortable.

This principle is similar to many areas of medicine and rehabilitation: begin conservatively, communicate, observe the response and stop when something is not right.

Intensity is not a measure of sexual sophistication.

Safety and mutual satisfaction matter more.

When Professional Sex Therapy Can Help

A qualified psychosexual therapist or psychologist may be helpful when partners cannot discuss fantasies without intense conflict, when shame prevents communication, when one person feels pressured, when differences in interests are threatening the relationship, or when trauma becomes activated.

A 2024 systematic review and meta-analysis examining PLISSIT and EX-PLISSIT sexual-counselling approaches found improvements in sexual-function outcomes and some aspects of sexual communication, although results varied across outcomes.

Professional counselling is not necessary because someone has a kink.

It becomes useful when distress, dysfunction, conflict or uncertainty is affecting well-being.

Why Healthcare Professionals Need to Be Non-Judgmental

Patients often avoid disclosing alternative sexual practices because they fear that a doctor will immediately consider them mentally ill.

This can create medical risk.

If somebody has a genital injury, infection risk or device-related complication, clinicians need an accurate history.

A 2024 study found substantial reports of discrimination among BDSM practitioners in healthcare and found that medical mistrust was associated with withholding kink-related health concerns.

I believe a good sexual-health consultation should allow patients to speak honestly without having to worry about ridicule.

The clinician can still provide clear medical safety advice.

Respect and safety are not opposites.

The Unani Perspective on Sexual Health

The Unani system of medicine traditionally views health holistically.

The Ministry of AYUSH describes Unani medicine as emphasizing the psychosomatic relationship between mind and body. Its classical framework includes the **Asbab-e-Sitta Zarooriya**, or six essential factors, involving air, food and drink, physical activity and rest, sleep and wakefulness, elimination and mental well-being. AYUSH also describes **Nafsiyati Tadbeer**, or psychological measures, as part of the broader Unani therapeutic tradition.

This perspective is relevant because sexual health does not exist in isolation.

Sexual desire and satisfaction can be influenced by sleep, fatigue, anxiety, relationship stress, general health and chronic illness.

However, responsible medical practice requires an important distinction.

Unani medicine does not need to “treat” a consensual fantasy or kink simply because it is unconventional.

There Is No Unani Medicine for Being "Kinky"

This is important scientifically and ethically.

A consensual sexual preference is not automatically an illness and therefore does not automatically require a herbal medicine.

There is currently no good clinical evidence that a particular Unani formulation should be prescribed simply to eliminate consensual fantasies or kink interests.

At Saira Health Care, the role of Unani medicine is more appropriate when the patient has associated clinical concerns such as fatigue, sleep disturbance, anxiety-related symptoms, digestive problems, general health issues or a separately diagnosed sexual dysfunction.

The fantasy itself should not be medicalized without a genuine clinical reason.

How Unani Principles Can Support Sexual Well-Being

The Unani approach can contribute to overall sexual health through attention to lifestyle and general physical condition.

Adequate sleep supports energy and emotional regulation.

Balanced nutrition supports metabolic and reproductive health.

Appropriate physical activity supports cardiovascular health.

Stress management can help sexual confidence and emotional well-being.

Individualized Unani treatment may therefore form part of a broader plan when genuine health concerns are present.

This is consistent with the Ministry of AYUSH description of Unani medicine as emphasizing individualized health maintenance, lifestyle regulation, diet and the relationship between mental and physical well-being.

Herbal Medicines Should Not Replace Communication

If the actual problem is:

"I am afraid to tell my spouse what I want,"

a herbal medicine cannot substitute for communication.

If the problem is:

“My partner refuses to respect my boundaries,”

medicine does not solve coercion.

If the problem is:

“I feel ashamed of every fantasy I experience,”

the main need may be education or counselling.

And if the problem is erectile dysfunction, premature ejaculation, pain, infertility or another medical disorder, that disorder should be specifically evaluated.

My clinical approach is therefore integrative rather than simplistic.

Dr. Nizamuddin Qasmi's Clinical Approach at Saira Health Care

When a patient brings up fantasies, kink, sex toys or alternative intimate dynamics, I believe the physician's first responsibility is to listen without immediate judgment.

I want to understand whether the person is simply seeking reliable information or whether another health concern is present.

The consultation may explore whether the activity is consensual, whether the partner feels pressured, whether injury or pain has occurred, whether there is an STI risk, whether sexual dysfunction is present, whether fertility is a concern, and whether trauma or severe shame is influencing the experience.

Physical health is also considered where relevant.

If a man has erection problems, we should not automatically blame the fantasy.

If a woman has pain, we should not assume the problem is psychological.

If a couple is experiencing infertility, appropriate reproductive investigations remain necessary.

A Biopsychosocial Approach

Sexual healthcare is most useful when it considers three broad dimensions.

The **biological dimension** includes hormones, circulation, nerves, genital health, medications, fertility and chronic illness.

The **psychological dimension** includes anxiety, trauma, shame, body image, beliefs, fantasies and mental health.

The **social and relationship dimension** includes communication, trust, culture, religion, consent, compatibility and relationship dynamics.

Focusing exclusively on one dimension can miss the real problem.

This is why my work in sexual disorders and infertility at Saira Health Care aims to look beyond a single symptom.

Values-Sensitive Sexual Medicine

A patient should not have to choose between medical care and personal values.

If a couple's religious or cultural beliefs lead them to decide that a particular fantasy or practice is not appropriate for them, that choice deserves respect.

If another adult couple chooses a consensual practice within their values and without coercion, a healthcare professional should not automatically pathologize them.

Medicine should provide health information.

Patients make their own values-based decisions.

When I Recommend Psychological or Psychosexual Referral

I may recommend a psychologist, psychiatrist or qualified psychosexual therapist when a patient experiences severe shame, compulsive sexual behaviour, trauma symptoms, persistent relationship conflict or sexual interests associated with significant distress.

Referral is also appropriate when a patient fears losing control of urges that could harm another person.

For trauma, anxiety, depression and other mental-health disorders, evidence-based treatment should not be replaced by herbal therapy alone.

Similarly, couples with persistent conflict over sexual differences may benefit from structured couple or sex therapy.

Special Attention to Trauma-Informed Care

If a patient has survived sexual assault or abuse, exploration of new activities should proceed particularly carefully.

The person's right to stop must be respected.

There should be no assumption that they need to “overcome” a boundary.

The aim is not maximum sexual adventurousness.

The aim is safety, autonomy, confidence and the ability to make choices without fear.

Warning Signs That Require Medical or Professional Attention

The following situations deserve particular attention:

- **Repeated injuries, severe pain, bleeding, loss of consciousness, breathing difficulty, persistent numbness or inability to remove an inserted device require medical assessment.**
- **Any activity involving coercion, threats or a person unable to consent should stop; safety takes priority over relationship experimentation.**
- **Persistent trauma symptoms, severe anxiety, depression or compulsive sexual behaviour should be evaluated by an appropriate mental-health professional.**
- **Fantasies involving non-consenting people or other situations where legal and meaningful consent is impossible should not be acted upon and warrant professional advice when they are persistent or distressing.**
- **Persistent erection problems, premature ejaculation, painful intercourse, loss of desire or infertility should receive an appropriate sexual or reproductive-health assessment rather than being attributed automatically to kink or fantasy.**
- **STI concerns, genital sores, unusual discharge, persistent irritation or suspected infection warrant appropriate testing and medical evaluation.**

Frequently Asked Questions

Is having an unusual sexual fantasy a disease?

Usually not. Fantasies are part of human sexuality, and research shows that many themes people assume are unusual are reported by substantial numbers of adults. Clinical concern depends more on distress, harm, impairment and consent than on whether a fantasy is conventional.

Does having a fantasy mean I secretly want to do it?

No. Research specifically distinguishes fantasy content from real-world intention or behaviour. Someone may enjoy imagining something while having no desire to experience it in reality.

Is kink a mental illness?

Consensual kink is not automatically a mental illness. Reviews have found little evidence supporting older assumptions that BDSM interests by themselves represent psychopathology, and professional sexuality organizations recommend against pathologizing consensual atypical expression.

Do I have to tell my partner every fantasy?

No. People retain a legitimate degree of sexual privacy. Disclosure can strengthen intimacy for some couples, but it should be a personal decision. Research suggests people balance the potential benefits of sexual disclosure against privacy concerns.

What if my partner says no?

Respect the answer. You can ask whether they are comfortable discussing the subject, but participation should never result from guilt, repeated pressure or fear.

Can my partner change their mind after agreeing?

Yes. Consent is ongoing and can be withdrawn at any time.

Are sex toys medically safe?

Many can be used safely when designed for sexual use, maintained according to manufacturer instructions and used with appropriate hygiene. Sharing can transmit infections, so cleaning and barrier precautions are important.

Can sex toys cause infection?

They can contribute to infection transmission if bodily fluids or microorganisms are transferred between people or body sites. Cleaning, correct storage and appropriate barrier use reduce this risk.

Can sex toys treat erectile dysfunction or premature ejaculation?

Consumer sex toys are not established universal treatments for either condition. Persistent erectile dysfunction or premature ejaculation requires appropriate assessment of physical, psychological and relationship factors.

Can Unani medicine help people with sexual fantasies?

A consensual fantasy does not require medication. Unani medicine can instead contribute to general sexual well-being by addressing appropriate health issues, lifestyle, sleep, diet, mental well-being and separately diagnosed sexual disorders.

Can kink improve a relationship?

Some couples experience novelty, trust or greater communication through consensual exploration, while others have no interest in it. Kink is neither required for a healthy

relationship nor guaranteed to improve one. What matters is whether both partners genuinely want the experience.

What if kink causes relationship conflict?

A qualified psychosexual therapist or couples therapist can help partners understand differences without treating either person's preference as automatically wrong. Professional guidance increasingly emphasizes helping couples discuss erotic differences with safety, clarity and compassion.

Saira Health Care's Contribution to Sexual Health and Infertility

At **Saira Health Care**, one of our important objectives is to create a clinical environment where patients can discuss sensitive sexual-health concerns without unnecessary embarrassment.

Sexual medicine is not limited to prescribing medicines.

Patients may need education.

They may need evaluation of erectile function.

They may need infertility assessment.

They may need help understanding sexual pain.

They may need reassurance about normal sexuality.

They may need counselling about communication and consent.

And occasionally they may simply need a qualified professional to answer a question they have been too embarrassed to ask elsewhere.

When patients receive scientifically grounded information, they are less likely to depend on myths, unsafe internet advice or unregulated products.

About Dr. Nizamuddin Qasmi

My work at **Saira Health Care** has a focused clinical emphasis on sexual disorders, reproductive health and infertility.

My professional profile includes:

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility
BUMS, Hamdard University, Delhi

MD
CGO
Certificate in Infertility, MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility by MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health (ISRH, UNFPA)

My approach is to understand sexual symptoms through medical, reproductive, psychological and relationship perspectives rather than treating every patient with the same formula.

A Message From Dr. Nizamuddin Qasmi

When someone tells me:

"Doctor, I have a fantasy that I am embarrassed to talk about,"

my first response is not to judge the fantasy.

I want to understand what it means to the patient.

Does it cause distress?

Does the patient actually want to act on it?

Does the partner know?

Would everyone involved freely consent?

Is there a health risk?

Does it conflict with deeply held values?

Is there trauma behind the distress?

Or has the patient simply been frightened because they assumed that having an unusual thought meant something was medically wrong?

These questions matter more than whether the fantasy sounds conventional.

I also remind couples that sexual exploration should never become a competition to become more adventurous.

There is no prize for doing more.

A healthy sexual relationship may be simple and conventional.

It may contain consensual novelty.

Both can be healthy.

The important elements are **respect, communication, autonomy, safety and mutual comfort**.

Final Perspective

Human sexuality includes thoughts, fantasies, desires, intimacy and a wide variety of forms of expression. Modern sexual-health science recognizes this diversity while maintaining very clear boundaries around consent, safety and freedom from coercion.

A fantasy does not have to become reality.

A kink does not automatically indicate mental illness.

A sex toy is not a replacement for a partner.

A partner's curiosity does not create an obligation.

And saying “no” does not make someone sexually inadequate.

Healthy exploration begins with communication.

It proceeds only with mutual agreement.

It pays attention to physical risk.

It stops when someone is uncomfortable.

And it remains compatible with the couple's personal values.

The Unani system can contribute a valuable supportive perspective by considering sleep, lifestyle, diet, mental well-being and general physical health as interconnected parts of sexual well-being. However, consensual fantasies and kink should not be medicalized merely because they are unconventional, and herbal medicine should never replace communication, consent, safety measures or appropriate psychological care when those are needed.

At **Saira Health Care**, my aim is to provide confidential, medically responsible and respectful care in which patients can discuss sexual disorders, infertility and difficult sexual-health questions without humiliation.

Because sexual health is not simply about what the body can do.

It is also about whether a person feels **safe, informed, respected and free to make choices about their own body and relationships.**

Medical Disclaimer

This article is intended for adult patient education and general sexual-health information. It does not replace individualized medical, psychological or relationship assessment. Some alternative sexual practices carry risks of injury, infection or psychological distress. Anyone experiencing significant pain, injury, loss of consciousness, breathing difficulty, coercion, trauma symptoms, persistent sexual dysfunction or another health concern should seek appropriate professional care.