NO SEX PLEASE WE'RE DISSOCIATIVE?

by Clare Staunton

I am a psychosexual and relationship counsellor accredited with COSRT – the College of Sexual and Relationship Therapists. I work specifically with clients where sexual-based issues are present. They may come to see me on their own or with a partner, whether or not they're in a relationship. There's stacks of pressure in society nowadays to have perfect relationships, and a lot of my work is about helping people to figure out what they want, particularly in the area of sex and intimate relationships. I have a few niches of work within that but many of my clients have suffered varying degrees of sexual trauma in the past. For me the key components in a 'healthy' sex life are pleasure and consent, and both are absent in abuse.

HOW PSYCHOSEXUAL THERAPY WORKS

Right from the very first session, I emphasise that sexual problems are more common than people think. It's not something that they are likely to hear from their friends. After all, whoever says, 'I went to see Clare, a sex therapist, and we figured that I have vaginismus and I couldn't have penetrative sex, but it's sorted now'? People understanding that they are not a 'freak', or 'different' is a really important step in the work. Most of the time referrals come to me via the COSRT international register or from other health and wellbeing professionals such as general counsellors, gynaecologists or urologists.

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My role as a psychosexual therapist is to help a client understand what 'language' their body or their behaviours are speaking. Once people understand their triggers and behaviours, they are more likely to allow a change, if that's what they want. For others, it may be an acceptance of their sexuality, in whatever form: from asexuality through to having sexual experiences daily, an interest in kink, or accepting their sexual orientation is more fluid or non-binary.

SEXUAL ABUSE

Sexual abuse impacts people's sexuality in a number of ways. Physically, it can impact desire (sometimes called libido) – either increasing it or decreasing it. There may be difficulties with arousal; a lack of lubrication, a lack of erections or maintaining erections, inability to orgasm, dyspareunia (painful sex), problems with ejaculation. One thing that is very common is vaginismus in women or analismus in either women or men. Although this is experienced physically – the muscles clamp down and stop the other person entering – it is an anxiety-based condition. In many cases it is a protective mechanism in terms of the trauma response of fight/flight/freeze, and specifically the freeze mechanism being activated.

Then there are emotional and psychological impacts: an aversion to sex, avoidance, over-attachment, difficulties with intimacy, spacing out and dissociating, inability to trust. Feelings or emotions often make perfect sense in the light of someone's prior trauma history. There can be a blockage anywhere in the sexual arousal circuit. It stops you from being fully present, or shortens or avoids that sexual experience. Clients may often respond that the language their body is speaking is 'No', 'Get off me', 'I'm scared', 'I don't want to do this', 'I'm not safe'.

Shame and guilt are both really core emotional impacts. People who have experienced sexual trauma can feel enormous shame if there was even the tiniest flicker of physical enjoyment during the abuse. For a female this might have manifested in terms of becoming lubricated; for a man it might involve an erection or ejaculation. I explain to my clients that their arousal was a trauma response too.

We're mostly all familiar with fight/flight/freeze, but there are two other 'F' responses to trauma too, which Carolyn Spring talks about here. They are 'friend' and 'flop'. And becoming lubricated might well have been a 'friend' response. It's the body saying, 'I am under severe threat, so the best way for me to survive here might be to be lubricated. That way it will hurt less, and it will get us through this ordeal more quickly.' I can't tell you the number of times I've seen the shame lifting from someone's body when I explain that to them – it comes as such a

relief. If someone touches your genitals, even if you don't want them to, you can feel and experience arousal. It is an automatic body response, not a matter of choice.

People tend to think that if it wasn't consensual then they shouldn't have been aroused, so it evokes a lot of shame in terms of sex and how people feel about themselves. From my experience survivors have low self-esteem: they use really negative words when referring to themselves and they don't value themselves. That can result in them putting themselves at risk sexually, because they don't believe that they are worth protecting. They see the body not as a temple but more of a vessel, and a contaminated one at that. It's really important to help address those core beliefs because it's do.

GUILT AND THE PANG OF SELF-BLAME

Guilt is also a major factor. The vast majority of abuse survivors knew their perpetrators, so they think, 'What did I do to encourage it?' The reality is 'nothing at all'. For some, the resounding memory is, 'I quite liked the attention – I went along with it.' That can affect the whole way that they view sex as an adult: as a wrong thing, something that makes them feel bad about themselves. It's not surprising therefore that they can find it hard to connect sex with pleasure. The survivor's upbringing and family culture also plays a massive part in how they deal with and view their abuse, and sexual relationships later in life. If they have received very negative messages about sex, or sex has been a taboo, then that makes an enormous difference in whether they felt there was anyone they could tell or talk to about what was happening.

One way clients may (consciously or not) opt to turn the negative experience into a positive one is through sexual fantasy, or possible replay in actual sex play. Brett Kahr undertook a survey about people's sexual fantasies in his book *Sex and the Psyche*. All but one of the responses from their findings could be linked back to a traumatic incident. Some of these included replaying a sexually abusive experience. Clients report something similar – that it's a positive way of 'befriending' the memory and making it 'better.' Or indeed of being in control of the experience this time around if role-played in real life – possibly in consensual sexual behaviour such as 'ageplay'.

As a practitioner, I need to be respectful of the client's positive experience, and not pathologise this as 'bad' sexual behaviour, even if it doesn't mirror my own sexual interest. I also need to undertake training in the world of kink, and be aware of risk assessment factors. DK Green gave an excellent presentation on this topic at the 2015 Pink Therapy

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Conference, *Beyond the Rainbow*. In the simplest form, we have to ask, 'Is the client safe, sane and consensual?'

Many survivors find it difficult to remain present during sex. Instead they dissociate, switching off or zoning out a bit. What I'm encouraging clients to do is to have more mindful sexual activity. One thing I might try to address with clients is helping them to be able to 'just notice', to be in the here-and-now and to focus and be mindful in the present. In a recent Kundalini yoga session with Carolyn Cowen I heard her using a great analogy that our 'monkey brain' is bouncing around between the traumas stored in the old limbic brain (the past) and predicting what might be happening in the future. It creates a really busy, frenetic mind.

So what you're trying to learn through the work is a way of sitting on the monkey's tail to simply experience what's going on in the here and now: not responding from the past or from the future in the moment of intimacy, but just focusing on the present: 'What am I feeling, right here, right now? Do I like being touched there? Do I prefer it with a hand, a tongue or something else, such as leather?'

SEX THERAPY

Sex therapy is completely tailored to each client. Length of work, reading suggestions, homework exercises, visualisation, whether or not to use art therapy or more cognitive work: it all varies from person to person and whether they've done previous generic work that has been useful. I base my work largely around what will be familiar to trauma therapists, a three phase approach. Firstly, there is safety and stabilisation; then remembering and grieving – working through the traumatic material whilst staying grounded; and then the final stage of integration. This is explained in the very helpful book *A women's guide to overcoming sexual fear and pain* by Agronin and Goodwin. Their module on working in this field is a great starting resource for client and counsellor alike. I'm adapting from it and integrating from other trainings and experiences when I go through the three stages below.

The focus in phase I is of building a foundation and establishing firm boundaries. I found Carolyn Spring's *Boundaries* article (2014) really helpful in this regard where she uses the metaphor of our life being like a garden, and needing to understand our boundaries of what is inside our garden and outside it. I often use that with clients, along with Carolyn's trauma traffic lights explanation. Clients really love that analogy and I use it to help them identify their triggers, to know in their body when they are being triggered – they can say, 'I'm going into amber now' and implicitly understand that we need to get them

back into the green zone. It just makes it so clear to them, and also gives them the confidence that there are things that they can do to take them back into the 'green'. Breath work and mindfulness are completely in the client's control, as are, for example, naming all the red or square objects in the room, responding to questions about the room they are in, what date or day it is, walking slowly around the room or saying a mantra or doing a yoga move.

If clients can learn these grounding techniques early on, it means that they can feel much more in control, that they understand their triggers and know what to do about them, so that when we go near traumatic material later on they have the necessary tools to manage their trauma response. It's amazing when clients come back and say, 'I noticed myself going into amber, so I did some breathing and some tapping and brought myself back into green.' It's vital because when you're in green you can engage your front/rational/present day brain, you can think and talk, and of course you can engage more mindfully in sexual activity.

PHASE I WORK

In phase I work, I might also set some basic intimacy exercises for them to try with their partner at home. The exercises will be aimed at a manageable level: eye contact, hand holding, gentle body stroking or body contact, hand massages. If clients can undertake these together with a partner it increases the attachment between them – oxytocin is released instead of stress hormones. We test the water a little bit to see what happens, what issues arise for them. It helps people to figure out their boundaries, what they're comfortable with and what they're not, what's stopping them, how they're avoiding things.

A fairly normal response is for people to return and admit that they didn't do the exercises at all. That's ok in phase I – the aim is not to 'race through' exercises. When people are ready, they'll move forward. Consent is most important in this stage. And that includes saying 'no' to the sort of sex they used to have. Very explicitly this may have been having sex because you believed you 'should' or that your partner would leave you if you didn't. During this stage I often support a client in having a 'sex ban'. It gives time and space to process, settle, ground, with no expectations so that we can stop reinforcing ingrained neural networks and retrain the brain into new ways of being. If the person is in a relationship this might mean having a tough conversation with a partner about masturbation.

Along with intimacy exercises, we might start to explore some of the psychodynamics of their situation. For example, Harville Hendrix, in his book

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Getting the love you want, talks about how often we're attracted to people with the same characteristics as our key caregivers, both positive and negative. If they were avoidant or abusive, we tend to find ourselves attracted to the same kind of person. Those negative traits in our relationships can then be really triggering for us, and we tend to adopt the same coping mechanisms we used when we were younger. I might look at this kind of issue in phase I work, looking for patterns in the types of partners the client has been choosing over the years, and exploring whether they want to make different choices in the future.

I work with people both on an individual basis and as couples – where possible both partners together, because the relationship is a unit and the way I see it is that there's a difficulty in the relationship. A difficulty in one partner might actually mask another sexual difficulty in the other, so it's not helpful to point the finger and blame one partner as being the one with the 'problem'. When I'm working with a couple I'll warn them of a common reaction that can happen during this work. When the person who previously has been less 'present' starts to become more 'available' emotionally and sexually, the other person might start to experience avoidance of their own – vaginismus or erection or desire difficulties, or suddenly being unavailable for exercises. We explore the shift in dynamic and reasons for it.

PHASE II WORK

Phase II work – tackling the trauma – is much more challenging, especially for people with mental health difficulties such as bipolar disorder or a dissociative disorder. My biggest learning around this work is just to go slow, and not to push. Psychosexual therapy can sometimes have a bit of a reputation that we're going to go in, do some exercises, and hey presto! you're fixed. But if the therapist hasn't had any trauma training, that approach can be far too fast. With a trauma-informed approach, we tread much more gently, working more relationally and looking specifically at emotional blocks as opposed to just giving exercises.

All the really important trauma skills training that you've learnt in phase I comes into its own here – safe place visualisations, how to avoid flooding, applying the brakes, keeping in the green zone. That connection with the client is imperative. Carolyn Spring talks in her training about the therapist only having to be 'good enough' – for me that also includes having some thoughts or suggestions about what other tools or things outside of my therapy might be useful. This might include EMDR, yoga, mindfulness, psychosomatic work, reading the stories of other people who have been in the same position, or even changes in medication. If not already integrated in phase I, these may be useful in phase II.

Talking in phase II in detail about sex can of course be extremely triggering, and it's a fine line that we're always trying to tread. Clients have come to see me because they want to regain their sexuality and be more at peace with it, but by the nature of the work we're doing, we're talking about things that are triggering to them because of their previous victimisation, so there has to be a solid grounding of the relationship and the skills of phase I in order to hold that place safely.

Phase II is such difficult work, often resulting in resistance: the client pushing boundaries – not liking the therapist so much, possibly not attending sessions, not doing the homework tasks or just 'getting a bit stuck'. It is so painful and scary for them. I've learnt that the important thing is just to stick with the client and give them time. The emotions that were often never experienced previously may all start to come out. This phase really cannot be rushed. It may be that if I'm working with a couple and sexual trauma comes to light once couple therapy has already commenced, then this stage of the work may be undertaken one-to-one with another therapist where all of the attention can be given to one person.

PHASE III WORK

In phase III work, when we've been able to reduce the automatic trauma response during our work in phase II, clients can really focus on reclaiming their sexuality. In phase II touch exercises may have increased in intensity, reducing items of clothing, increasing in duration – whatever is the risk progression for the clients. For people who are not in a relationship, this may include reading, or writing sexual fantasies, attending a support group – like the amazing Café V (hosted at Sh! Women's Store), giving yourself more self-touch and care, masturbating, using sex toys, dilators or a 'vagiwave', or getting into the dating scene.

Clients report that Cabby Laffy's book *LoveSex: an integrative model for sexual education* is a great resource and inclusive of all gender and sexual diversities in terms of self-work and body exercises. Unfortunately, Agronin and Goodwin's book is only aimed at females, but it does contain some excellent and creative tools which can be adjusted. In this stage I observe clients being able to spend more time in their adult state, stay present during sex, and even begin to enjoy it. It's about words like 'playing' and 'having fun' and 'laughing' and 'letting go'.

Whether clients are in a long term relationship, or just starting a new sexual relationship (with themselves or other people!), they start to feel that they can relax more, even if only for a short time. In terms of attachment, people are closer, more secure, and more trusting,

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and that has a knock-on effect on their physiology: the sexual circuit starts to light up! From the perspective of my work as a sex therapist, as phase III continues, it becomes time to loosen the structure slightly – there's still safety and boundaries, but people are able to play more and explore. They don't need such a tight/clinical structure to homework tasks. They're less often in the amber zone and continually fighting that, and more able to be in the green zone of relationships and people and fun and joy. It's very rewarding to see someone move through into this stage of 'integration' where they are much more secure within themselves and able to explore their sexuality without the 'monkey brain' on high alert all the time.

A PARTNER'S ROLE IN THE PROCESS

A partner can play a pivotal role throughout the whole process, especially if he or she is educated through phase I about the role of trauma in sexual difficulties. So if a new partner comes onto the scene, or a client invites their partner to join the therapeutic space for a few sessions, couples can begin to identify what their triggers are and explore what happens in the brain and body when someone is triggered. They can begin to consider things like the trauma traffic light, and learn some grounding techniques. The partner can develop some key statements, things like, 'I'm not your dad / your brother / [whoever the perpetrator was]', 'I'm here', 'I'm with you now'. They can learn how to use paced breathing to help their partner ground, or use the techniques about colours, shapes, dates, slow walking mentioned earlier.

Lori Brotto has undertaken some research around mindfulness and painful sex. She specifically looked at how a partner's response can alter the sexual outcomes. Many partners I work with think that if a trauma survivor is triggered during sex, the best thing they can do is to just stop sexual contact immediately and back away. Brotto's research showed that actually this response was less helpful than one that was more 'facilitative'. Anecdotally, my clients seem to agree with this: they talk about how positive it is for them when their partners 'hang out with me a bit more and don't run away', 'aren't freaked out by what's coming up for me', 'are ok with me just the way I am', 'still find me sexy', 'still want me but are willing to wait a bit until I'm ok.'

I've understood from Brotto's research that a facilitative partner might say something like, 'I'm really enjoying what we're doing, but it's ok for us to just lie here for a while' or 'I'm loving everything about you – when you're ready I'd love to xyz (fill in the blanks with something from the safer/established list of things that you've done.)' They might just gently stop, hold them, and help them to ground, back into the green zone.

It's best to stay put and not run away, to keep some safe touch going, and to keep checking in, bringing the partner very very softly back into the present, and working it through. And then, if it's safe to and the survivor is no longer dissociating and is back in the green zone – if it can be firmly established that it's consensual – to continue. If the survivor needs to stop and not continue, then of course that's fine too, but at the very least they need to stay together and keep the connection intact. That connection might be going back to the basic intimacy things you did in phase I – hair brushing, breathing, head massage, hand massage or simply sitting and smiling at one another.

SUCCESSFUL TREATMENT

There is clearly a great deal of hope for recovery for clients with sexual problems following sexual abuse. Some may never experience the things I've spoken about. I'm just unlikely to meet them in my professional work! Clients can develop a better understanding of their bodies and their sexual needs. They can learn to consent, to make requests, to give feedback, and to remain present rather than dissociated. Many clients leave therapy with a different sort of sexuality than they thought they were aiming for – commonly less focused on penetration and orgasm. Pleasure and consent are always at the core of the transformations. A history of sexual trauma is not a bar to future sexual fulfilment, and it's a great privilege to work with this particular client group. •

MAJOR SYMPTOMS OF SEXUAL ABUSE

- Difficulty with becoming aroused and feeling sensations
- Sex feels like an obligation
- Sexual thoughts and images that are disturbing
- Inappropriate sexual behaviours or sexual compulsivity
- Vaginal pain
- Inability to achieve orgasm or other orgasmic difficulties
- Problems with erections or ejaculating
- Feeling dissociated while having sex
- Detachment or emotional distance while having sex, or being afraid of or avoiding sex
- Guilt, fear, anger, disgust or other negative feelings while being touched.

adapted from
www.psychotherapist.net/adultsurvivors

RECOMMENDED BOOKS

- *Woman's Guide to Overcoming Sexual Fear and Pain*, Aurelie Jones Goodwin and Marc E Agronin
- *LoveSex: An Integrative Model for Sexual Education*, Cabby Laffy
- *The New Male Sexuality*, Bernie Zilbergeld
- *Sex Happens: The Gay Man's Guide to Creative Intimacy*, Arlen Leight
- *The Body Remembers*, Babette Rothschild
- *Waking the Tiger: Healing Trauma*, Peter Levine
- *Healing the Shame that Binds You*, and *Homecoming* both by John Bradshaw
- *Shame: The Power of Caring*, Gershen Kaufman
- *Sex and the Psyche*, Brett Kahr
- *Getting The Love You Want: A Guide For Couples*, Harville Hendrix

RESOURCES AND LINKS

- Pink Therapy – training and therapy listings with GSD-friendly therapists. www.pinktherapy.com
- COSRT (College of Sexual and Relationship Therapists) – listings of sex and relationship therapists and CPD provider. www.cosrt.org.uk
- Sh! Women's Store – female sex-positive sex shop. www.sh-womenstore.com
- Café V – A safe space for women who have experienced sexual violence to learn about sexual pleasure and reclaim their body after assault. www.mybodybackproject.com/events/cafe-v/
- A Change of Scene – A free monthly forum for men to share their lives and experience. Events are open to those identified as gay, bisexual, trans and MSM. www.facebook.com/achangeofscene
- Vulval Pain Society – providing information for women who suffer from vulval pain, and their partners. www.vulvalpainsociety.org
- Carolyn Cowan – sex therapist who provides lots of free content and resources. www.theaddictivepersonality.co.uk
- Vagi-Wave – vaginal acceptance trainer. www.vagi-wave.co.uk