Intimacy after Sexual Trauma: Clinical Perspectives

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Intimacy after Sexual Trauma: Clinical Perspectives

by

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MSW Clinical Research Paper

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University – University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master’s thesis nor a dissertation.
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Abstract

This research examines how clinicians address sexual intimacy with couples when one partner has experienced sexual trauma (i.e. childhood sexual abuse and/or sexual assault), including the ways clinicians incorporate sexual consent into their work. A qualitative methodology using semi-structured interviews was employed for this study. The findings highlight the relational impact of sexual trauma as well as the need for relational healing and empowerment, not only for the survivor, but also for the partner and the couple. One significant finding suggests the need for some partners of sexual trauma survivors to further examine and address some of their sexual behaviors that may be non-consensual in nature. One potential area for further research has to do with exploring the experiences of same sex, non-binary, and/or queer couples in terms of these same issues. Addressing sexual trauma and intimacy with couples is a complex clinical process, and this study shows that incorporating elements of the sexual consent model may make these discussions more explicit for all involved.

Keywords: sexual trauma, intimacy, sexual consent, clinicians, and couples
**Introduction**

In the United States, one in nine girls and one in fifty-three boys have experienced some form of sexual abuse (The Rape, Abuse, & Inced National Network (RAINN), 2016). According to RAINN (2016), there is a sexual assault every 98 seconds, and every 8 minutes the victim of sexual violence is a child. These are only estimates of the actual number because many incidents of sexual violence or victimization go unreported. There is still significant societal shame, victim blaming, and stigma surrounding childhood sexual abuse and sexual assault that prevent many survivors from coming forward and reporting these incidents. Many in the sexual violence prevention field have argued that there is a rape culture in the United States. Rape culture is not about one person or group; rather it is a societal attitude that minimizes, maintains, or negates the impact of sexual violence or victimization (Peterson, 2008).

Fortunately, a sea change is occurring. Within the mental health field, one cannot read a journal article or attend a workshop without hearing about trauma or trauma-informed care. There are many interventions, therapeutic approaches, and evidence-based practices that are shown to be effective for individual trauma survivors of sexual violence. However, the research is somewhat limited when it comes to the partners of sexual trauma survivors or the healing within the couple. Many partners may be left out of the therapeutic process altogether or brought in only at the very end. Many partners of trauma survivors may not understand how trauma may be affecting the survivor and/or their relationship. In most functional relationships partners want to “do the right thing” by their mates, but many times are left to figure what that is on their own. While most would agree that the primary focus of healing from childhood sexual abuse and sexual assault should be focused on the survivor and the survivor’s needs; “the importance of a trustworthy and understanding partner should not be underestimated” (Courtois, 1997, p. 307).
As a trauma survivor continues to recover and heal, many well-intentioned partners or survivors may struggle with discussing and negotiating sexual intimacy.

The sexual consent model has been gaining in popularity over the years as one tool to address communication and sexual intimacy (Beres, 2014). While most people are familiar with consent regarding college campuses and high incidents of sexual assault or sexual violence, this tool is being used to expand conversations regarding active consent and negotiation (Jozkowski, 2013). Active consent is no longer about the absence of a “no,” but rather a “yes” that is clearly communicated throughout a sexual interaction from start to finish (Bussel, 2008). Consent at its core is about communication, and that communication can be verbal or nonverbal. Ultimately, it is non-coercive andahistorical, i.e. not based on what happened last time (Bussel, 2008). The sexual consent model may provide a framework to help couples discuss sexual communication and intimacy, along with being a skill-building and practical tool to help build respect and trust. Sexual intimacy does not have to be defined by penetrative sex or sexual activity; rather it is a broad continuum of behaviors that could mean touching/caressing, kissing, hugging, napping, talking with or being near their partner (Maltz, 2001).

Healing from sexual trauma is not a linear journey for the survivor, partner, or couple (Courtois, 2008). In fact, as intimacy begins or returns in a relationship, there is a need for the couple to develop a strong(er) foundation of communication, trust, and mutual agreements (Maltz, 2001). Therefore, the purpose of this study was to engage clinicians in dialogue about how they address sexual intimacy when one partner is a sexual trauma survivor.

To achieve this purpose, a literature review on trauma, PTSD, secondary trauma, and therapeutic interventions will first be presented. The method chapter will be presented that
describes research methodology for this study. Next, a chapter that outlines the researcher’s lenses will be articulated. Finally, this will be followed by the findings and discussion chapters.
Literature Review

This literature review provides grounding for understanding the nature and types of trauma, Posttraumatic Stress Disorder (PTSD), and how that affects survivors of childhood sexual abuse and/or sexual assault. Next, the focus is on the concept of secondary trauma and its impact on the partners of sexual trauma survivors. The emphasis will then shift to what the literature has to say about the overall functioning of couples after a trauma, including sexual intimacy issues. Lastly, the various intervention options for treating individuals and/or couples will be presented. This chapter will conclude with a summary and the research question guiding this study.

Trauma

The word “trauma” has become ubiquitous within the mental health field and popular culture and has even become a buzz word for any unpleasant or difficult situation people encounter. Even though this word can be thrown around somewhat casually and at times carelessly, for those living with or loving someone impacted by traumatic exposure, the effects are real and can be long lasting: “Being traumatized means continuing to organize your life as if the trauma is still going on – unchanged and immutable-as every new encounter or event is contaminated by the past” (van der Kolk, 2014, p.53). Trauma exposure does not discriminate; and traumatic events or experiences can potentially affect anyone regardless of age, race/ethnicity, socioeconomic status or educational background (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014). In the United States, research suggests that over half of the population has experienced a traumatic exposure (Goelitz and Stewart-Kahn, 2013).
Types of trauma. Trauma can be categorized as Type I or Type II. Type I traumas are usually a single event incident such as a car accident, natural disaster, combat exposure, sexual assault, unexpected death or illness, witnessing or surviving a terrorizing or violent act (Basham, 2016; Nelson & Wampler, 2000). Type II (or more complex) traumas are ongoing experiences that usually occur in childhood such as abuse or neglect, witnessing intimate partner violence in the home, or pediatric illness (Basham, 2016; Goelitz & Stewart-Kahn, 2013). It should also be noted that adults can experience Type II trauma based on long-term intimate partner violence (Basham, 2016). It stands to reason that the short or long-term impact of trauma on an individual, child, or group of people is not an exact science; everyone will respond differently based on history and meaning making of the experience (Herman, 1997; SAMHSA, 2014).

Adverse Childhood Experiences (ACES). Extensive research on ACES has been conducted to understand the long term physical, emotional, psychological and mental impact of adverse experiences or events during childhood (Centers for Disease Control and Prevention (CDC), 2016). The ACES study addressed issues ranging from childhood experiences of neglect, emotional, physical or sexual abuse to a host of difficulties within the home i.e. substance use disorders, domestic violence, and suicide attempts to name a few. Over 17,000 adults were surveyed about their childhood experiences throughout the mid-1990s. ACES are relatively common. In fact, well over half of those surveyed identified at least one ACE, and one in five respondents identified more than three. The greater the number of ACES reported for an individual, the higher the likelihood is for poorer health outcomes and/or increased chances of engaging in riskier behaviors that could potentially lead to illness, chronic disease or premature death. The ACES study gives practitioners, clinicians, and researchers a context when working with many clients including those who have experienced childhood sexual abuse.
Posttraumatic Stress Disorder (PTSD)

Not everyone who experiences traumatic event(s) will develop PTSD. Whether or not someone develops PTSD is based on how an individual processes or integrates the traumatic event(s). PTSD is a cluster of symptoms that last for more than a month, and the intensity or length of the traumatic event or experience is usually heightened for the individual impacted (Basham, 2016). PTSD is a group of specific symptoms that include intrusion, arousal, avoidance and negative cognition and mood (American Psychiatric Association, 2013). According to the American Psychiatric Association, the potential risk for a PTSD diagnosis throughout the lifespan is 8.7%.

There are some important clinical terms worth noting here regarding PTSD symptoms. *Arousal* is an increase in any of these responses following a traumatic event(s): “irritable behavior and angry outburst, reckless or self-destructive behavior, hypervigilance, exaggerated startle response, problems with concentration and/or sleep disturbance” (American Psychiatric Association, 2013, p. 272). *Intrusion* has to do with the traumatic past intruding on the present moment. This intrusion is “recurrent” and “involuntary,” and can be in the form of nightmares, flashbacks, thoughts, and smells to name a few (American Psychiatric Association, 2013, p. 271; Goelitz & Stewart-Kahn, 2013). *Avoidance* has to do with trying to avoid “distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)” (American Psychiatric Association, 2013, p.271). Individuals may also avoid people, places and things that remind them of the traumatic event(s) (American Psychiatric Association, 2013; Goelitz & Stewart-Kahn, 2013). *Negative cognition and mood* refer to changes in mood or emotion, decreased interest in previously enjoyable activities, and feelings of detachment (American Psychiatric Association, 2013). *Dissociation* can be a specific symptom used to cope and
distance oneself from a traumatic event or experience (Courtois, 2008; Goelitz & Stewart-Kahn, 2013). Dissociation can be a survival mechanism at the time of the trauma event or experience to protect the self; however, it can become problematic later (Courtois, 2008). Individuals experiencing these symptoms may also struggle with self-blame or shame regarding the traumatic experience or event.

**Childhood Sexual Abuse and Sexual Assault**

Childhood sexual abuse is perhaps one of the more harrowing forms of traumatic experience. Research suggests that between 50% and 70% of women and 30% of males seen in therapeutic settings may have a history of childhood sexual abuse (Millwood, 2011; Jacob & Veach, 2005). The effects of childhood sexual abuse can have a devastating long-term impact on the survivor and their overall quality of life including an increased risk for mental health and substance use disorders (Basham, 2016). Childhood sexual abuse can be particularly damaging because it “mingles exploitation and assault with what may be evidence of love and affection” (Nasim & Nadan, 2013, p.369). For this research, childhood sexual abuse will be operationally defined “as any self-reported sexual contact experienced by a client before age 15, initiated by someone at least five years older” (Bartoi & Kinder, 1998, p.76).

Childhood sexual abuse is a Type II or complex trauma, meaning that it occurs in childhood and generally effects functioning into adulthood. Adult childhood sexual abuse survivors self-report “depression, anxiety, substance abuse, self-abusive behavior, low self-esteem, distrust, relationship difficulties, and sexual dysfunction” (Courtois, 2008; Nelson & Wampler, 2000; Sims & Garrison, 2014, pp. 17-18). Considering the overall health and well-being impact for survivors it should not come as any surprise that childhood sexual abuse will
impact every facet of a person’s functioning including intrapersonal and interpersonal relationships (Courtois, 2008).

Sexual assault or rape is another form of traumatic experience, “1 in 6 women and 1 in 33 men have experienced an attempted or completed rape in their lifetime” (RAINN, 2016). Most likely this number is drastically underreported in the general population given it is estimated that 80-95% of sexual assaults are not reported to law enforcement (Tambling, 2012). Sexual assault is typically a one-time event, and understood as a more Type I trauma. However, given the rape culture and lack of consent education in the United States, the reality of a person experiencing multiple sexual assaults is not unheard of or uncommon. Childhood sexual abuse survivors also have an increased chance of experiencing other forms of sexual victimization such as sexual assault throughout the life span (Courtois, 1997). For this research, sexual assault will be operationally defined as any unwanted sexual activity by a known or unknown perpetrator to the victim (Tambling, 2012). In many cases, the perpetrator of sexual assault is known to the survivor (Tambling, 2012).

Secondary Trauma

Thus far, the focus of this research has been on the survivor of either childhood sexual abuse or sexual assault. However, childhood sexual abuse and sexual assault not only affect the survivor but may also impact loved ones i.e. family, friends, and intimate relationships (Mills & Turnbull, 2004; Remer, 2013) Secondary trauma has been studied in a variety of populations such as family members of veterans, therapists, loved ones of Holocaust survivors, and emergency response workers (Henry et al., 2011; Maltas & Shay, 1995; Remer, 2013; Wiersma, 2003). Those who are suffering from secondary trauma do not necessarily experience firsthand the traumatic exposure but are nonetheless impacted (Anderson & Miller, 2006; Henry et al.,
According to Goff-Nelson et al. (2006), “Often the problems experienced by people close to a trauma survivor mimic the survivor’s trauma symptoms” (pp.451-452; Nelson & Wampler, 2000; Schwerdtfeger et al., 2008). Maltas and Shay (1995) proposed a term called “trauma contagion,” which can 1) activate the stress-response within the partner 2) challenge the partner’s view of self, survivor and partnership and 3) potentially engage in traumatic enactments with the survivor (Jacob & Veach, 2005; Maltas & Shay, 1995).

**Partners.** Partners of persons who have experienced trauma may also experience similar PTSD symptoms, but usually to a lesser degree than the survivor (Goelitz & Stewart-Kahn, 2013; Maltas & Shay, 1995). Some common PTSD-like symptoms partners may express are trouble sleeping, intrusive thoughts of survivor’s abuse, feeling helpless or powerless to stop abuse, anxiety and/or depression (Goelitz & Stewart-Kahn, 2013). Partners may be at particular risk for secondary trauma given the close interpersonal relationship and proximity with the survivor such as those in marriages, partnerships, co-habiting couples or dating relationships (Mills & Turnbull, 2004). Partners risk becoming entwined or enmeshed with the survivor and may not focus on their own needs, which can ultimately impact overall health and wellbeing (Jacob & Veach, 2005). The potential for secondary trauma is especially possible if the healing process for the survivor is just beginning or underway. Remer (2003) “secondary victims are usually recognized not for their own problems, but rather as needing help in order to provide resources necessary for primary victim healing or because their actions and reactions can interfere with that healing process” (p. 52). Ultimately, these secondary trauma survivors may require their own interventions for healing (Remer, 2013; Wiersma, 2003).

**Dual-trauma couples.** The chance for secondary trauma is especially true for couples where both people have experienced some form of trauma in their history (Chen & Carolan,
Chen and Carolan (2010) examined couples and the importance of not only taking into consideration trauma but the survivor and partners’ overall developmental history. Development history may include issues such as substance use disorders, mental health, attachment style, family background, socioeconomic status and educational background to name a few (Chen & Carolan, 2010; Nelson & Wampler, 2000). Understanding the survivor and partners’ developmental and trauma histories can be imperative when deciding on intervention strategies and treatment approaches (Chen & Carolan, 2010).

**Impact of Trauma on Couples**

Human beings are social creatures. This is evident in the need for most individuals to look for and find a mate and to create some form of short or long-term partnership. For survivors of sexual abuse, “their trauma has been a ‘violation of human connection’…” in the most basic sense (Johnson, 2004, p. 494). This most basic violation may impact the survivor’s ability to trust, be vulnerable, and to feel safe and secure with another person even a partner (Johnson, 2004). Dyadic couples that have at least one partner with a history of child sexual abuse “have higher rates of psychological distress and interpersonal dysfunction compared to a non-sexually-abused group” (Chen & Carolan, 2010, p. 407; Nelson & Wampler, 2000).

**Enactments.** A particular concern for couples is the potential for enactments of the abuse or abuse dynamics that can play out in the relationship (Maltas & Shay, 1995; Maltz, 2001; Nasim & Nadan, 2013). These enactments can be unconscious or “fragments of sensory and motor experiences” because the survivor may not consciously remember any or parts of the traumatic exposure (Maltz, 2001; Nasim & Nadan, 2013, p.369). The partner may be unaware of the enactments and the role that they may be playing in the relationship dynamic (Nasim & Nadan, 2013). The most common enactments found in the literature are: 1) “unseeing,

**PTSD.** As already noted, PTSD symptoms may include arousal, intrusion, avoidance and negative cognitions and mood which not only affect the survivor but also the partner and intimate relationship. PTSD may impact the overall functioning of the relationship because the survivor may be experiencing symptoms such as dissociation, hypervigilance, emotional numbing, detachment, and flashbacks that may make connecting and relating with a partner difficult or impossible (Goelitz & Stewart-Kahn, 2013; Millwood, 2011). Research suggests that those survivors who develop PTSD have “a 60% increased likelihood of martial instability” (Donnellan, Murray, & Holland, 2014, p. 262; Jacob & Veach, 2005). Mills and Turnbull (2004) further suggest these couples may have similar trauma reactions but may have difficulty expressing these feelings to each other. Therefore, communicating this pain to each other can be nearly impossible at times and further add to the disconnection (Mills and Turnbull, 2004).

**Isolation.** For couples who have experienced traumatic experiences, isolation can affect both the survivor and partner. Survivors and partners may feel isolated for similar and different reasons. Survivors may feel as though no one could possibly understand their experience or perhaps blame themselves for the abuse or assault. Survivors might also attempt to reach out to their social and support networks and may “feel even more alone and misunderstood when people minimize the trauma” in an effort to be helpful (Goelitz & Stewart-Kahn, 2013, p.21). Herman (1997) further highlighted that some survivors might not disclose to loved ones due to “fear that the reactions of family members will overshadow their own” (p. 65).
Partners may experience their own form of isolation due to not being able to share their survivor’s traumatic experience with loved ones for fear of shame or judgment. Partners may even feel disconnected from their partner due to communication barriers that prevent a deeper level of understanding. Partners may have feelings of helplessness because they may want to be supportive of the survivor and not have the skillset or knowledge base regarding traumatic experience and/or PTSD. Furthermore, some partners may attempt support processes and become frustrated when the survivor is still struggling and may feel as though there is nowhere to turn for support or guidance. For all these reasons, partners may need to enter individual therapy to address some of these specific concerns or join a peer support group if available.

**Protective factors.** Nelson and Wampler (2000) suggest that the dyadic relationship can be a positive and nurturing force in the survivor’s life. A supportive, nurturing partner can buffer some of the negative effects of sexual victimization (Herman, 1997). Henry et al. (2011) interviewed couples where one partner had a traumatic history and found that not all couple relationships are inherently impacted. In fact, of the 13 couples interviewed for this study, half indicted “satisfaction/nondistress” on the Dyadic Adjustment Scale (p. 329). Nelson and Wampler (2000) research suggests that in dual trauma couples there may be a further protective benefit regarding mutual understanding of the long term impact of sexual abuse. In fact, there may be a lack of greater empathy in couples where only one partner has experienced a traumatic history of abuse (Nelson & Wampler, 2000).

**Impact of Trauma on Sexual Intimacy**

There is significant research regarding the impact of sexual trauma on sexual intimacy and couple’s functioning (Anderson & Miller, 2006; Connop & Petrak, 2004; Courtois, 1997; Henry et al., 2011; Jacob & Veach, 2005; Maltas & Shay, 1995; Maltz, 2001; Nasim & Nadan,
For many survivors, sex even in the most loving, consensual and gentle, can trigger past abuse or assault:

For the survivor, the sexual situation appears to be where the most intense confusion between past and present occurs, triggering flashbacks, body memories, and otherwise dissociated states in response to feelings of vulnerability and intimacy that are linked to specific physical sensations (Maltas & Shay, 1995, p. 531).

Reid et al. (1996) conducted interviews with partners, and many felt that they “received mixed messages around sexual and other forms of interaction” (para. 36). Many of these partners self-reported feeling lost, confused and “as if they could do nothing right, that the rules changed continuously” (Reid et al., 1996, para. 36). For many partners, this uncertainty can create further anxiety, rumination, and depression in an already stressful situation for the couple. For many partners, if the sexual relationship is impacted there is a real and deep-seated loss of this intimacy and connection with the survivor (Henry et al., 2011; Maltas & Shay, 1995).

Connop and Petrak (2004) found that a few male respondents reported that their partner’s trauma history was a catalyst for examining their own sexual behaviors. In this particular study, a few males reported needing to look within themselves and “confront coercive aspects of their own sexuality” (Connop & Petrak, 2004, p. 34). This is an interesting finding given the larger societal context and messaging that males receive regarding sex, sexual coercion, and consent and how these values and attitudes may change when a loved one or partner is victimized.

Many times when people think of childhood sexual trauma survivors, the image that comes to mind is female. However, males can also be victims of childhood sexual abuse and sexual assault. A male survivor’s ability to connect both physically and emotionally with their partner can be impacted as dramatically (Jacob & Veach, 2005). In fact, males may have an even greater burden given cultural norms, gender roles, and expectations in terms of sex and the
expectation of the male as sexual initiator (Jacob & Veach, 2005). The research suggests that there may be a variety of difficulties for male survivors including, but not limited to, “an inability to form satisfying intimate, sexual relationships; expression of insecurity about how to initiate sexual relations; and confusion about the similarities and differences between love and sex” (Jacob & Veach, 2005, p.285).

**Therapeutic Interventions**

Research strongly suggests the need for individual therapy for the survivor (Reid et al., 1996). The survivor needs to focus on their healing and trauma work. Individual therapy for the partner is also advised (Nasim & Nadan, 2013). According to Maltas and Shay (1995), some partners may not seek therapeutic intervention due to “fear of being identified as an abuser because their needs may be experienced by the survivor as abusive demands” (p. 535). This is a particularly compelling comment especially as it relates to conversations and dialogue around sexual intimacy. Furthermore, there can be significant avoidance around addressing the impact on the sexual relationship in regards to both the survivor and partner (Mills & Turnbull, 2004).

**Individual therapy.** There may be specific and separate concerns for both survivor and partner that need to be addressed and processed in an individual therapeutic setting. This is particularly true if the partner has a sexual or traumatic history that may need to be addressed. Furthermore, the partner’s journey of awareness, acceptance, and healing may rely heavily on where the survivor is in the process of addressing their sexual trauma (Remer, 2013). However, partners need to be able to identify their own needs, coping mechanisms, and self-care strategies to ensure they do not become overwhelmed or depleted by the needs of the survivor (Remer, 2013).
Male partners, in particular, may need to examine their own belief systems and values in regards to sex, sexuality, sexual violence, and consensual interactions (Connop & Petrak, 2004). Given societal messaging and the concept of rape culture, male partners may hold views that may unintentionally victim blame or shame their partner for the sexual trauma (Connop & Petrak, 2004). These attitudes and values may need to be addressed in individual counseling sessions to avoid further harm to the survivor (Connop & Petrak, 2004). Courtois (1997) touches on the aspect of psychoeducation for the partner and learning ways to process their own feelings and emotions about their partner’s sexual trauma history including learning to be sensitive and supportive without taking over or trying to control sexual intimacy.

**Sexual consent model.** The topic of sexual intimacy will most likely surface for partners of sexual trauma survivors or within the couple relationship at some point in therapy. As already noted, the sexual consent model is being used as a tool to negotiate sexual boundaries and mutual agreements between partners. Incorporating a more active, ongoing consent model may be one tool used to expand these conversations and to provide specific education with the partner or the couple to help ensure the comfort of all involved (Tambling, 2012). The active consent model is more than a “yes or no” answer to whether someone wants to engage in sexual activity (Bussel, 2008). Rather, it is an ongoing dialogue among and between partners that can take place before, during and after sexual intimacy. It is not a one-time event or conversation. It is not just for new relationships and can be for long time lovers. The sexual consent model can support partners in creating an overall atmosphere of safety and clear boundaries regarding general comfort with many forms of touch and sexual intimacy (Troost, 2008). It can also be used more narrowly regarding particular sexual acts or ongoing as a way to continue to build trust in sexual interactions. Bussel (2008) makes a poignant point that: “There is a lot more that goes on during
sex than simply saying yes and no, and in the silences, unspoken doubts, fears, mistrust, and confusion can arise” (p. 46). Beres (2014) highlighted that gender may play a factor in which “evidence suggests that men are more likely than women to see consent as an event, rather than a process” (p. 375). The active sexual consent model is really an invitation to ongoing conversations among and between partners about sexual intimacy that keeps the lines of communication open. The focus of the active sexual consent model is making these conversations between partners more explicit and clear so everyone can feel safe, comfortable, respected, and understood (Troost, 2008).

**Couples therapy.** Dyads will enter couples counseling for a myriad of reasons: communication issues, infidelity, parenting concerns, sexual intimacy or dysfunction to name a few. Many times dyads first express concern around communication issues as the main reason for beginning therapy (Anderson & Miller, 2006). The majority of dyads who enter couples therapy may not disclose concerns around childhood sexual abuse history at the onset (Anderson & Miller, 2006; Reid et al., 1996). Or, some couples may not realize or acknowledge the impact sexual trauma might be causing in their current relationship when therapy begins. At times individual trauma work may need to occur before beginning couples therapy depending upon where the survivor is in the healing process.

Emotionally Focused Therapy (EFT) is one empirically-supported therapeutic approach used with couples that is an attachment based (Johnson & Denton, 2002). EFT focuses on emotional processing, bonding, and vulnerability with the couple (Young, 2008). There are various levels of work within the couple context, but ultimately the therapist is attempting to create a greater emotional connection between the individuals. Often, there may be attachment injuries that have occurred throughout the course of the relationship and these injuries need to be
addressed and processed. Attachment theory focuses on the “quality of an intimate relationship, a bonded relationship, is all about emotional accessibility and responsiveness” (Young, 2008, p. 265). For many couples, including those struggling with sexual trauma, there can be a lack of emotional accessibility and responsiveness within the relationship dynamic. EFT works to repair the emotional connection and support the couple in gaining greater accessibility and responsiveness to each other both in and out of therapy (Young, 2008).

Narrative therapy is another approach used by clinicians in the literature. Nasim and Nadan (2013) focused on the concept of “witnessing” in couples counseling where the partner for the first time may hear the survivor’s story of sexual abuse (p. 371). By way of creating a safe space or container both the therapist and partner will be supportive of the survivor through the telling of their story and help “integrate the events...into a continuous, whole narrative” (Nasim & Nadan, 2013, p. 371). The childhood sexual abuse is then put into context and “externalized” from the survivor (Nasim & Nadan, 2013, p. 371). The therapist then works with the couple to address relationship issues without blaming or shaming the other and begin to examine ways to address the externalized problem together (Nasim & Nadan, 2013).

Sex therapy can be a specific form of individual or couples counseling. Couples often times will enter sex therapy for specific sexual issues such as: lack of sexual desire, sexual dysfunctions, change in sexual desire, arousal, and intimacy, or recognition of past sexual abuse or assault (Tambling, 2012; Yehuda et al., 2015). Courtois (1997) cites research that suggests that the long-term impact on “sexual dysfunction” may be more likely regarding childhood sexual abuse compared to sexual assault (p. 299). However, this is not a given. For some couples, the issue of sexual trauma may not be the reason the couple is seeking therapeutic intervention (Barnes, 1995). After a thorough history, past sexual trauma may surface and the
intervention strategy may need to shift to individual intervention for the survivor at that time. Sex therapy or couples counseling may not be the best therapeutic approach if someone is starting to address and acknowledge sexual trauma for the first time.

Barnes (1995) states that if the couple proceeds with sex therapy and the “female victim is merely acquiescing to the wishes of her partner, there is considerable risk that the sex therapy will fail and will create for the woman an experience of revictimization” (p.357). In the above comment, the survivor is female, but it speaks to the concerns of creating an atmosphere of sexual intimacy that is non-coercive for the survivor. In this way, the sexual consent model can create a starting point to discuss concerns around mutual agreements, boundaries, and expansion of what sexual intimacy means to each partner.

Sexual trauma not only impacts intimacy among and between partners but also contributes to various sexual dysfunctions (Ashton, 1995; Mills & Turnbull, 2004; Tambling, 2012). However, to be clear not every person who experiences a sexual dysfunction has a trauma history. Tambling (2012) cited research in which 20% of male partners of sexual assault survivors experienced an impact on sexual functioning such as: “pre-mature ejaculation, lack of desire, fear of sex and erectile difficulties” (p. 393; Ashton, 1995). Ashton (1995) highlights that when sexual intimacy is discussed, “partners’ sexual dysfunctions also need to be addressed in treatment lest they feel that they are only part of their partner’s treatment plan and their own needs are not significant” (p. 280).

**Treatment outcomes.** The reality for survivors is that there is no timeline for healing; treatment “can last as little as a month or as long as a lifetime” (Remer, 2013, p. 60; Remer & Ferguson, 1995). Initiating honest conversations with the survivor, partner, and/or couple may be needed to ensure that all involved have at least basic, foundational information about the
therapeutic process of individual trauma work and/or couples therapy. Reid et al. (1996) focused on the “alienated partner” and issues that arise when a partner perceives being left out of the therapeutic conversation particularly when the survivor is in individual therapy (para. 22). This sense of therapeutic alienation can cause undue stress and burden on the survivor, partner, and the relationship (Reid et al., 1996). Maltz (2001) highlights that partners may have many feelings and reactions to their partner’s sexual trauma and “in response to these feelings of powerlessness, some partners may attempt to push, control, or dominate the healing efforts” (p. 212).

Unfortunately, some relationships will not survive this healing journey (Nasim & Nadan, 2013; Remer, 2013). According to Remer (2013) the issue of “commitment” and “burden” in these relationships is an ever-evolving balancing act that may reach a tipping point that ends in separation or divorce (p.53). Maltz (2001) recommends the need for a “mutual healing strategy” that will be unique to each couple (p. 202), the treatment goal being that there will be opportunities for growth and change for the individuals and the relationship during this journey, that will ultimately help facilitate and “establish new, healthy, mutually satisfying ways of relating sexually” (p.202).

**Summary and Research Question**

Sexual trauma most directly impacts the survivor. However, the effects of sexual trauma can have a radiating impact on those who love and care for a survivor. This is especially true for the partners of sexual trauma survivors who may experience many changes in the relationship including around sexual functioning. The ways and means by which partners are incorporated into therapeutic interventions will determine when or if discussions around sexual intimacy will occur. Therefore, the research question is, “How do clinicians address sexual intimacy with
couples when one partner has experienced sexual trauma?” Another area to be discussed is how clinicians incorporate sexual consent into this work.
Method

In order to answer the question, “How do clinicians address sexual intimacy with couples when one partner has experienced sexual trauma?” this study used a qualitative methodology. A qualitative method was used because this question called for a certain level of sensitivity and nuance from the researcher. Use of semi-structured interviewing allowed for an expanded dialogue that could address the complexity of clinical practice with these couples. Furthermore, this methodology allowed for follow-up and/or clarifying questions in the moment with the clinician to reduce the possibility of confusion or misinterpretation (Padgett, 2008). This researcher did not use a quantitative research design, preferring instead to engage in more comprehensive dialogue with clinicians in face to face settings (Padgett, 2008).

In order to describe the methods used for the project, this chapter will first describe sampling procedures and methods used to protect human subjects. Next, instrumentation, data collection, and data analysis procedures will be addressed. Lastly, strengths and limitation of this overall research design will be discussed.

Sampling Procedures

Purposive, professional networking sampling was used to recruit licensed clinicians (Monette, Sullivan, Dejong, & Hilton, 2013; Padgett, 2008). In order to reach a sampling pool of approximately 50 licensed clinicians, I conducted a multi-prong sampling approach. Participants were first identified through this researcher’s professional knowledge of clinicians who work with this population. Participants were also identified through professional networking with other mental health clinicians in the field. I further utilized professional email listservs to access participants that may have specialized training and knowledge regarding this population. Lastly, additional participants were identified on public websites based on their professional biographies.
indicating that they met eligibility criteria. Recruitment fliers were also posted on a public social media site for social workers. As a result, five participants were recruited.

The recruitment flier listed the research question, pre-screening eligibility requirements, and contact information for the researcher if participants were interested in self-selecting into the study (See Appendix C). Eligibility requirements for participants included: 1) being a licensed mental health clinician 2) working with couples where one partner has experienced sexual trauma 3) having experience addressing sexual intimacy concerns with couples 4) having at least minimal familiarity with sexual consent. The researcher ensured that participants met eligibility requirements before scheduling an interview.

**Protection of Human Subjects**

Prior to the interview, the researcher discussed the consent form with participants to ensure they understood the purpose of the study, procedures, risks and benefits and how confidentiality would be protected. The consent form was approved by the University of St. Thomas Internal Review Board (IRB) (see Appendix A). The consent form was reviewed with the participant the day of the interview and signed by both parties before beginning the interview. Both researcher and participants received a copy of the consent form for their records.

The researcher assured confidentiality of data by securing all materials (including audio recordings) on a cloud-based storage system (Google Drive), and on a password protected laptop. All paperwork was secured in a locked file cabinet. Only the researcher and the transcriber had access to audio recordings. The professional transcriber signed a confidentiality agreement before work began on this project, and deleted audio files after the transcripts were completed. After transcription had been completed, the transcripts were further de-identified to
protect the confidentiality of participants. The researcher made sure no identifiable information was used in the final report.

To ensure that participation was voluntary, participants contacted the researcher directly after reviewing the recruitment fliers so that no one else knew who participated in the study. Participants were also informed that they could chose not to answer any question without providing an explanation, or even withdraw from the study without consequence. Every participant received a $5 gift certificate for partaking in the study. There were no known risks and no direct benefits for participation in this study.

**Instrumentation, Data Collection and Analysis**

An interview schedule of questions was created and informed by the literature. The interview schedule had 12 open-ended questions. The interview schedule was reviewed by the researcher’s committee and University of St. Thomas Internal Review Board (IRB) to ensure face validity of interview questions. The interview schedule began with questions related to clinical and professional experience working with individuals and/or couples in which one partner has experienced sexual trauma. The next two questions asked the participants to share clinical cases (without divulging client information) that went well or did not go well from the participant’s perspective. The remaining questions addressed therapeutic approaches concerning sexual intimacy and how sexual consent was used in their work with clients (See Appendix B for interview schedule). Interviews averaged 48 minutes in length and were a free flowing exchange between interviewer and participants. Occasionally I would ask a follow-up question or provide clarifying information as needed throughout the interview. The semi-structured interviews were conducted in a highly systematic and uniform manner to ensure the reliability of procedures.
among and between participants. The researcher did modify question number one for clarity after the second interview, but this modification did not change the actual content of the question.

Data were collected via interviews conducted in the setting of the participant’s choice. Four participants chose to meet in a private office, and one participant requested to meeting at home. All settings were private, comfortable, and quiet.

The interviews were audio recorded and transcribed verbatim. Transcripts were reviewed and edited for accuracy, and then prepared for data analysis by saving electronic and hard copies.

In qualitative research, the researcher is the instrument of data collection and analysis (Patton, 1990). Given my ten year experience in human service, I had the ability to interact comfortably with a wide-range of clinicians and to pay attention to both verbal and non-verbal communication. I further describe my professional knowledge, training, and experience that demonstrate my credibility as an instrument in the lenses chapter.

A thematic analysis of transcripts was completed using a process of open coding, sorting into categories and eventually identifying themes (Padgett, 2008). The thematic analyses of transcripts were conducted in a systematic and rigorous process to ensure that all interviews were analyzed with the same, uniformed procedures. Once all five transcripts were transcribed, I read all transcripts in their entirety in one sitting. Next, all responses were read for each particular interview question. During these two steps the researcher did not mark or make notes, and both steps were repeated twice to ensure a certain level of absorption in the raw data (Graham, 2016). I then re-read each individual transcript and began to make initial notes of important words or phrases. I then began to look for “preliminary categories” and ultimately reduced the number by combining categories to identify preliminary themes. I then re-read each transcript again, this time looking for the themes that had been identified. The need to be rigorous and systematic
throughout data analysis was imperative to reduce bias and seek to find multiple meanings or explanations in the data (Graham, 2016).

**Strengths and Limitations**

A semi-structured interview format allowed for greater flexibility, more in-depth probing, and overall engagement with participants in a face to face setting. Furthermore, my own knowledge and training provided a certain rapport with participants that allowed me to probe for deeper clinical knowledge and identify nuances in their practice experiences. This knowledge was obtained by asking follow-up questions as necessary during the course of the interview (Padgett, 2008). Since participants were practicing clinicians with a wide range of clinical experience, I was able to have a highly interactive dialogue throughout the interview. Utilizing this research method allowed me to further explore the ways that participants engage with couples and/or individuals in real world therapeutic settings. The participants were able to share the complexity and layers of this therapeutic work using clinical cases and examples throughout the interview, which may not have been as robust utilizing another methodology.

Another strength was that the sampling procedures recruited a variety of clinicians not contingent upon one particular licensure. In fact, some participants had highly specialized training and certification, which provided further complexity, depth, and special considerations for the population under study.

Utilizing a purposive sample of clinicians, however, limits my ability to make generalizations to the larger population of clinicians (Patton, 1990). This sample was also limited to clinicians practicing in the Twin Cities metropolitan area. The sampling and recruitment procedures resulted in a total of only five participants, and two kinds of licenses. Therefore, this study is not representative of even one clinician license, let alone the broader population of
mental health clinicians. Hence, while there is some breadth of clinician experience, there is also a lack of depth with respect to any one particular license.
Lenses

Researchers, like everyone else, have lenses in which they see the world. One’s lens or worldview may inadvertently be brought into our research. I am no different. Since I conducted a qualitative research design, I am essentially the instrument, and it was ever more imperative to outline my lenses that may have ultimately impacted the reliability and validity of my research (Patton, 1990). Therefore, to be a transparent and trustworthy researcher I have articulated the theoretical lenses below that have influenced this research and my thinking along with my own professional and personal biases. The theoretical, professional, and personal lenses have influenced the ways in which I have conceptualized and theorized this research study.

Theoretical Lenses

Attachment theory. Most people have at least minimal familiarity with attachment theory as it relates to parents and children (Collins & Feeney, 2010; Karris & Caldwell, 2015). The need for ongoing love and security does not stop in childhood (Collins & Feeney, 2010). Rather this need for safety, security, and emotional intimacy continues throughout one’s life (Collins & Feeney, 2010). Attachment theory can also be applied to relational styles of attachment between romantic partnerships. Adults can form both secure and insecure attachment styles within romantic relationships. For survivors, especially survivors of childhood sexual abuse or more complex trauma, the impact on adult romantic relationships may be significantly impacted. For these survivors, the significance of this trauma is “a violation of human connection” (Johnson, 2004, p. 494). Sexual trauma and the aftermath, including PTSD symptoms, may make it more difficult for a healing and secure relationship among and between partners (Johnson, 2004). Attachment theory is one organizing way to look at the survivor,
partner, and couple and how the aftermath of sexual trauma may impact all three. Attachment theory is one lens through which I viewed this research study.

**Active sexual consent model.** I believe sexual intimacy is a conversation between partners. This conversation does not necessarily have to be verbal. However, there can be confusion, misunderstanding, or safety concerns when this conversation is entirely non-verbal.

The active sexual consent model is not a “contract” for sex or sexual intimacy as some may provide as a critique. In fact, it is quite the opposite. Rather it provides a framework or real-world tool for negotiating sexual intimacy and boundaries that value engagement, safety, and comfort for all involved (Bussel, 2008). For some survivors of sexual trauma this model may be imperative even to consider engaging in sexual intimacy after experiencing sexual victimization or abuse even with a long-term partner. There is work underfoot by sexual violence prevention educators promoting the idea that consent is not a one-time event but rather an ongoing communitative process (Beres, 2014). I believe this expanded idea of sexual consent moves away from simplistic notions of sex, sexuality, or particular sex acts, rather it expands possibilities regarding what intimacy and communication can be among and between partners. It is not about hearing a “no” but rather a clear, “direct yes” from a partner that moving forward with whatever activity is agreed to by all. Furthermore, a clear, direct yes is not a carte blanche but rather an agreement between partners that anyone can stop, slow down or further communicate if one is uncomfortable at any point. Sometimes people will use a safe word or may have a non-verbal cue to stop or slow down. Intimacy in its many forms can be vital and life-giving: “Sexual intimacy, embodied affection, physical contact: These are as intrinsic to our human well-being as are fresh air, clean water, wholesome and nutritious foods” (Amato, 2008, p. 222).
I think, for the general population, discussing sexual intimacy can be a difficult or near impossible conversation. For many partners of sexual trauma survivors, there may be real concerns, confusion, or fear when it comes to even bringing up the topic of sexual intimacy. Not communicating sexual consent around sexual intimacy, however, can lead to further re-victimization. A more active sexual consent model may provide an educational tool that supports partners in understanding the complexity of negotiating sexual interactions or intimacy with a survivor. It does not have to be “wooden” or formulaic; in fact, it is a better tool when people use their own language or verbiage that is most comfortable to all involved. I had a sense that this model may be under-utilized in the mental health field. Therefore, part of this research study was to explore how clinicians may or may not use sexual consent in real-world practice settings.

Professional Lenses

As a health educator for twelve years, I have provided education about healthier relationships, sexual intimacy, and how to engage in sexual consent conversation using active consent. Some of my work has been with the partners and/or survivors of sexual trauma. I have extensive knowledge, training, and education concerning trauma, consent, and negotiation of sexual boundaries with a wide range of populations. I am aware of current national discussions and debates around the affirmative consent model as it relates to sexual violence prevention on college campuses. As a health educator, I have seen participants begin to further understand and connect to a more active and ongoing conceptualization of consent, as a way to further enjoy sexual intimacy by making sure everyone involved feels safe and respected. However, having this experience educating about active sexual consent required me to continually evaluate and examine my own biases to ensure there was no untoward influence on research findings (Padgett,
2008). Investigator responsiveness and reflexivity principles were used throughout this research project (Padget, 2008).

As a third year MSW student, I have had significant clinical education and training on trauma and trauma-informed practice regarding childhood sexual abuse, sexual violence, and PTSD. I have studied the impact of secondary trauma as it relates to persons who work with, are close to, or love a trauma survivor. My professional background has influenced my theoretical and analytical approach to this research and made me a credible instrument for this study.

**Personal Lenses**

I have had a few close personal friends disclose to me over the years that their significant other has a history of sexual trauma and that there has been an impact on their overall relationship including sexual functioning. The impact of sexual trauma is a very complex and personal subject. However, I do think that involving the partner, if the relationship is relatively healthy and functional, can provide some relief for the survivor and the couple. Not addressing sexual intimacy in some capacity with the partner can take a toll on all involved and the relationship. I have seen firsthand the sadness, confusion, and frustration expressed by the partner when left out of the therapeutic conversation all together.

Trauma work is a complicated process. There are no clear-cut timelines for healing (Courtois, 2008). Survivors may be struggling with the hard work of recovery for months or, more realistically, years (Remer, 2013). And partners simultaneously may be experiencing their own secondary trauma to the sexual abuse or assault of their loved one. Sexual trauma can affect every aspect of a person’s functioning including the ability to engage whole heartily into sexual intimacy with another person. Ultimately, the topic of sexual intimacy will need to be addressed in therapy, and it may rise to the surface at unexpected or inopportune times. As clinicians, I
believe we obviously have to consider the survivor as primary, but we also need to make sure the partner is receiving good quality care as well (Remer, 2013). Sexual intimacy is a natural and healthy part of a relationship so the reality is that even though the partner or survivor may not expressly verbalize the topic, it most likely is on at least one of their minds. My bias is that there are ways the partner can be more integrated into the therapeutic process. If the partner is a source of support, at the bare minimum the partner should receive some psychoeducation on the general trajectory of trauma work and the impact of sexual abuse or assault on long-term health and well-being including sexual functioning. My theoretical lens leads me to believe that partners can learn more about and utilize active sexual consent as a way to be a more supportive, caring, and informed partner to the survivor when it is therapeutically appropriate to begin addressing sexual intimacy concerns.
Findings

This chapter begins with a brief description of participants that will include licensure, years of clinical experience, specialized certification and demographic information. Next, observational data will be reported. Lastly, seven themes emerged from data and will be presented: role of clinician, relational impact, empowerment, relational healing, sexual consent, partner sexual behaviors and differences among queer couples. These themes and additional subthemes will be presented along with supportive documentation from interview data.

Description of Participants

Five participants were interviewed for this research project. Two participants were Licensed Marriage and Family Therapists (LMFTs) and one was a Licensed Associate Marriage and Family Therapist (LAMFT). The remaining two participants were Licensed Independent Clinical Social Workers (LICSWs). Of the five participants, two were Certified Sex Therapists (CSTs), and another was working toward that certification. Another participant was certified in Emotionally Focused Therapy (EFT). Two participants were certified in Eye Movement Desensitization and Reprocessing (EMDR), and another participant was in the process of obtaining that certification. One participant also had a doctorate in Psychology.

Four participants practiced in outpatient settings, and one clinician was not in a counseling setting at the time of the interview. There was a range of clinical experience among the participants from 2 ½ to 15 years. Three clinicians were female identified, one was male-identified, and one was transgender male-identified. All participants were based in the Twin Cities metropolitan area.
Observational Data

All participants appeared to be highly self-reflective and knowledgeable clinicians as evident by their ability to share multiple clinical case examples without divulging any identifying information in the process. Three participants shared perspectives on the overall frequency and rates of sexual trauma among clients and within the greater population. In fact, one participant estimated that 50-75% of clients may have a sexual trauma history. Another participant stated that *inevitably most clients have that [sexual trauma] somewhere in their background.* All five of the participants had at least minimal familiarity with the sexual consent model. Two participants spoke of sexual consent as an integral part of their work with couples around sexual intimacy. Each participant spoke to the overall relational impact of sexual trauma that harkened back to the research literature.

Role of Clinician

Three participants explicitly or implicitly discussed a particular therapeutic bias, and all five participants described how their education and professional training influenced their therapeutic approach and practice knowledge when working with couples. For example, two participants explicitly state therapeutic bias in terms of trauma-informed care, attachment theory and Emotionally Focused Therapy (EFT):

*I think I’m really biased but I think everybody working in mental health should be trauma informed. I’m really biased again but I really love the EMDR way of looking at things. The attachment way of looking at things... but everything is trauma so if we process or if we don’t, everything that hits us is trauma and I think having an understanding of how that works and how it affects our bodies and the way we are in the world is just such a foundational aspect of our work.*

*It’s pretty rare that I’ll refer to another therapist unless they’re an EFT therapist. Because most individual therapists will undermine a couple relationship. The biggest source of divorce for women...college educated women is if they go into individual therapy. And I think I wanna support the relationship and the healing.*
Two participants spoke about more implicit bias around the importance of addressing sexuality and eroticism in therapy:

...there can be a lot of hopelessness with sexual trauma. And I think a lot of clinicians...and maybe this is me being somewhat blind or not seeing all the evidence or whatever but, stop the work at the catharsis and the processing of the actual sexual trauma and not think about sex after the trauma. And sex actually being a really healing part of the work...Eroticism should have just as much space in the therapy room as anything else that comes in. And my hope would be that although not everyone needs to be a sex therapist, at least sex can come into the therapy and doesn’t need to be pathologized or shut down...So if we come in and say, this [sexuality] is pathological, this is inappropriate, this is not fit with the morals of our culture...we’re taking away from them again.

I’ve had people come to me and they’re like, “I was doing EMDR with someone around my trauma and it was sexual trauma. And then once I wanted to start rebuilding my sexual relationship, they referred me to you.” And so I know that there’s a bunch of people out there that are really good at doing EMDR and really good at working with sexual trauma but when it comes to like, “Now let’s try to make your sex life what you want it to be.” They’re like, nope not my deal.

One participant addressed the importance of clinician self-awareness:

I think as the case of any work you’re doing as a clinician the need to be as self-aware as you can be and to do that ongoing work for yourself around you own stuff...have a good therapist or supervisor to bounce things off of. When you bring up issues around sexual intimacy that can trigger therapists too; I mean things can come up. So I think really being mindful of that and working on yourself continuously and that’s what makes this job, this work so challenging at times.

Lastly, one participant addressed the role that gender identity and/or sexual orientation may play in clients’ perceptions of aligning with one partner over another in therapy:

... and it’s tough because I’m a [cisgender]male...like if it’s a female who was sexually victimized or experienced sexual trauma... she might think that I’m gonna push her to have sex. That I might be aligning with the partner more than with her. Or even in the case of a same sex couple, like where it’s two men and one of the men was sexually traumatized. I’m aligning more with the partner who wants to have sex than I am with the very strong presence of their fear. And that does come into the room and I do my best to address it, but I know that I can’t always change the way people hear me...At the same time, like I identify kind on the queer spectrum here. So like sometimes like I’ll have a heterosexual male think I’m aligning more with his female wife who doesn’t wanna have sex...like I’m being too gentle and not pushing her enough...I’m not being manly enough to push her. So there’s all sorts of things that come into the therapy space but I do my
Relational Impact

All five participants spoke to the relational impact of sexual trauma on the survivor, partner, and/or couple. Some participants addressed to the impact of trauma and symptoms on sexual functioning, others on the role of fear, or the impact of enactments or attachment wounds:

I think what makes it challenging...is when the trauma is more complex. Where you know these old attachment wounds start from a really young age and where maybe the sexual abuse is happening in the home. And there’s just an ignoring of the pain and suffering of the people and how that then sets up these relational ways of being that can oftentimes leave a person stuck in that for a big part of their life.

...so sometimes they [survivor] get in relationships with people that they genuinely care about and genuinely care about them but those people [partner] are very used to, kind of the [sexual] boundaries that person has set while they’re in trauma mode. Like, “oh, my comfort doesn’t matter as much.” Or maybe a fear of addressing their own wants, so they’re kind of just like going with what their partner wants because they’ve never been allowed to address their own wants.

...if they’re a partner with a person with sexual trauma, because of sometimes the complexity and the feelings like they’re a perpetrator, that they’re victimizing their partner... you know they’ll start to experience sexual dysfunction like erectile dysfunction, delayed ejaculation, anorgasmia... or arousal disorders, things along that line as a result of what may happen in the encounter. That is absolutely something that I’ve seen and will work with people to address and I just create space and try to create a lot of empathy for the fact that these things may have emerged in this dynamic.

Empowerment

All five participants discussed the overarching theme of empowerment in working with couples. Empowerment emerged in relation to the survivor of sexual trauma, the partner, and also in relation to the couple.

Survivor empowerment. Four participants discussed empowerment of the survivor. For example, two participants discussed empowerment in terms of survivors learning, identifying, and setting personal boundaries around sexual intimacy and self-identity:
Well if you’re [a survivor] not ready to talk about it [sexual intimacy], then we’re not gonna talk about it.” And I really am good about like, good for you for having boundaries. Good for you,...we’re gonna make sure you’re really super comfortable cause it’s not okay. Like good for you for...you need to be comfortable talking about it [sexual intimacy], when you’re ready. You get to decide when you’re ready.

Oftentimes it helps them [survivors] strengthen their... their boundaries and their ability to kind of put themselves out in the world and stand up for themselves sometimes. Definitely, I witness a lot of sexual transformations of like, how do we get you to the point where you feel really in control and empowered by your sexual experiences? And you know that you don’t have to do sexual things that you don’t feel in control of or empowered by. Because once you’ve had a traumatic experience, it’s really easy for you to think, “Well that’s what sex is.” And to keep going with that even in loving relationships where no one’s intending to traumatize because you’re just like, “Well this is the way sex has always been. Why would it be any different?”

Two other participants spoke about the role of advocacy and self-disclosure of sexual trauma that were described as empowering experiences for survivors.

But the change in the female partner [survivor] has been dramatic... dramatic...She has really taken on a lot of ability to speak up for herself and ability to advocate for herself, and ability to advocate for others and a lot of strength in her convictions that have been really, really powerful for her.

...she always called this the unwanted sexual experience. And by the end...we did a ton of EMDR around it, and then she started to tell people she was raped. And this is what that was and this was after the rape and it felt very empowering for her...I mean helping the one person, the survivor, get through it and then helping her to disclose kinda what she needed in healthy way to her partner.

Partner empowerment. Three participants spoke about empowering the partners of sexual trauma survivors. Each of them discussed the importance of partners empowering themselves by learning more about sexual trauma, and how that can change their worldview, awareness, or feeling less alone:

But we also have secondary victims...But that person [partner] is also tasked with the job of supporting this person [survivor]. They’re like the number one support in a sense. And that takes just as much I think work, especially if somebody really has no idea what sexual violence is. It’s just a huge, shitty hill to climb over. So yeah, that’s why it can be really helpful...to have them have their own space as well. ‘Cause a lot of times it can be... it can feel like it’s all focused on... the survivor.
I watch partners grow in awareness of...what does abuse or sexual violence look like? How does it affect the person? How can people grow and change through healing? And I think that I watch a lot of partners view the world differently almost...you know...and like advocate for people more.

So...working with partners to kind of understand what that [sexual trauma impact] looks like and how to help them help their partners in ways that don’t look necessarily like enabling but yet are still supportive...on a broader level too...it helps people feel less alone and like they’re not the only one dealing with this [sexual trauma] and with a partner who has some of these problems or issues or struggles.

One participant addressed that sometimes ending the relationship is a successful outcome and can be empowering for the partner:

So he [partner] found a better partner for himself...So it was kind of a successful scenario, I think...Sometimes people think the only success is the couple staying together, and that isn’t always the case.

Couple empowerment. All 5 participants discussed empowerment of the couple in some way. For example, one participant spoke about empowerment via the therapeutic process, how individual and couple sessions are organized:

...sometimes I’ll say, “I think we should do EMDR with this person for a while and we’ll do a couple sessions of that. And then we’ll check back in with the two of you as a couple and see what you’re noticing from this process and maybe what’s come up that maybe you need help with.” I feel like people figure it out more for themselves. They feel like at first a lot of the time they want me to tell them who I want to see and after they’ve been seeing me for a while, I’ll get a call from someone being like, “yes I know I need to come in for my own thing.” Or “something came up and we definitely need to come in as a couple.”

Another participant addressed the importance of letting couples be in control of the therapeutic process:

I think also just even in just the more practical sense of letting couples/people be their own master. And I say this with everyone, but like, if I think we need to meet every week, I’ll say that. But also, you get to decide ultimately you know...because there’s scheduling, there’s finances...Yeah, just trying in every aspect to make...to give them the power essentially.

Relational Healing
All participants spoke to the overall theme of relational healing for couples where one partner has experienced sexual trauma. Three subthemes emerged from the data: repairing the bond, intimacy, and partner support behaviors.

**Repairing the bond.** Two participants discussed this subtheme in terms of the survivor sharing or disclosing sexual trauma history with the partner, and having the partner receive this in a healthy and healing way. Both participants spoke to this healing as *connection, shared experience, positive, and rewarding*:

> I think it’s really about repairing the bonds. I think it’s pretty intimate for them [couple] to be able to talk about it [sexual trauma]. I think what they [partners] do is, they’re respectful... “is it okay if I hug you? Is it okay if I hold your hand? Is it okay if I feel comfortable with you?”... I think that we heal in a relationship and to be able to turn to your partner and say, this thing [sexual trauma] happened to me and you’re gonna be there for me. That attachment figure’s in the room. And it’s really lovely when that happens. And it [healing] changes relationships too - usually in positive ways. I mean sometimes it changes them enough, the relationships don’t stay together, but a lotta times, people’s relationships are so much more positive and connected after they go through this process together...So she [survivor] came in as an individual and now her partner’s just sitting there holding her hand while she’s dealing with her sexual trauma]... And it’s like at the end I’m like, “what is it like to hear her[to the partner]say this?” You know... tears, it’s like really lovely work.

So we’ve [couple and therapist] *really been working hard on how you [partner] stay connected to somebody [survivor] when they’re gonna do something [have trauma symptoms] like this? Because if you continually leave and say basically, “call me when you feel better.” You’re not... that’s not gonna build trust and that’s not gonna build that kind of bond between the two of you where she feels supported.

One participant, for example addressed the fact that there can be a shared experience of uncomfortable *sexual experiences* even though one partner may not ultimately identify it as sexual trauma:

> ...he [cisgender male partner] was like, “well what... a girl did sexual things to me, why wouldn’t I have wanted that?” So, we were able as time went on to be able to work with that and say, “Well you’ve had sexual experiences where you didn’t feel comfortable, or where you had confusing feelings afterwards.” And even without naming it as trauma, then there was the kind of shared experience between the two of them [couple], you know?
**Intimacy.** All five participants spoke about emotional or sexual intimacy as a healing aspect between the couple. They reported that intimacy is both sexual and emotional in nature.

One participant described intimacy as going beyond *sex and/or sexual body parts*:

*Part of the way I might address it is to talk about intimacy being more than just sex. Intimacy being around touch, intimacy being around conflict, intimacy being around the things you share together. And start to create the sense that intimacy is more than just sex. And to allow for the idea that intimacy isn’t just involving sexual body parts. It is hugs, it is holding hands, it is eye gazes. It’s a lot more than just sexual activity.*

Two participants discussed sexual intimacy as one way to be *connected to a partner*. They further discussed sexual intimacy as being *fun, exciting, arousing, desirable*, and *connecting it to pleasure*. All the while supporting partners to become more aware and notice trauma responses and reactions in their partner during sexual interactions:

*Let’s make this [sexual interaction] something that’s fun and exciting and arousing and desirable. Not, let’s shut down and be distant from each other….it’s reclaiming sex from the trauma and making it you and me [couple] and what’s happening between us. And I may have responses that shut me [survivor] down but that doesn’t mean we [couple] need to stop our connection. And that I think is the most important part in doing work with sexual trauma, staying connected to a partner rather than dissociating.*

*I’m [therapist] usually like, “Look, if you want to have pleasurable sexual experiences with your partner where you feel really connected and wanted, you have to pay attention to their reactions and you have to go off their reactions. And if you don’t, you’re not gonna have the sex you want to have or the relationship you want to have.*

One participant stated that there may be times when one or both partners may not be able to handle the sexual intimacy topic at the current therapeutic juncture and some of that work may need to be addressed in individual counseling:

*… if the issue [sexual intimacy] came up, we would talk about that in the couple...about are we ready to go there in this context [couple’s therapy] and if the other partner who’s triggered or can’t handle it, then I would recommend that we kinda pull back from that in the couple, focus on other things and let me have some time talking with the individual who needs to talk about it, the partner in our individual session.*

**Partner support behaviors.** Two participants discussed the role of the partner’s support...
behaviors in the relational healing of the couple. One participant discussed the partner’s behaviors that help support the survivor’s healing process:

*The best of them [partners] really are slow... “does this feel bad, how does this feel?”...and they just stop the action and their [partners are] very loving about it. The worst of them don’t...A lot of support. A lot of love. And also helping with her shame, like you didn’t do this. You didn’t make her [female perpetrator] do this. There was a lot of helping her get through that shame.*

One participant discussed the importance of the partner *witnessing* the survivor’s process during therapy to better understand the impact of the traumatic experiences:

*Sometimes people want their partners there, even during sessions that maybe feel a little more individual because they, 1) want their partner there for support and then also, 2) they kinda want their partner to know what they’re going through and what they’re processing through. And having someone in the room who hears them and like witnesses that can be really powerful...I’ve noticed with partners that a lot of times they experience rejection. That feeling of like, you don’t want to be sexual with me or it can be scary to watch someone get triggered. Or maybe dissociate, or have a panic attack. And even if part of the partner’s logical mind is saying, “I didn’t do anything bad here, this wasn’t because of me.” Having that happen while you’re being sexual with somebody can be really traumatic; can be really scary and so witnessing a partner’s process and being able to be the support through that...*

**Sexual Consent**

Sexual consent was addressed by each participant since this topic was related to the research question and item(s) on interview schedule. Two participants described sexual consent as *foundational* to their work. Two sexual consent subthemes emerged from the data: explicit conversations and techniques.

*Explicit conversations about consent.* All five participants discussed sexual consent in some capacity with couples and/or individuals. The participants discussed engaging couples in in-depth, explicit conversations around sexual consent and “unpacking” the concept together in therapy. One participant talked about expanding the consent conversation with couples to include family of origin messaging around hearing *No* or *Yes:*
And then more directly just asking, “like how do you guys [couple] disagree?” And I don’t think it’s always about disagreement but like how do you know something’s not okay? Like what are you looking for? How do you know something is okay? Do they have conversations? ... is the one looking for words and the one is looking for body language? You know looking at like how did you know something wasn’t okay when you were growing up? How did you hear No? How did you hear Yes? When did you really... when were you able to do something and really own it and feel like that was yours and when did the opposite happen? So it doesn’t always have to be explicitly sexual, just kinda talking about what are those things? What are... what are you okay with? What are your boundaries? What... a lot of times you won’t think about those things.

One participant connects the topic to communication and asking permission not only during sexual intimacy but with other behaviors as well:

I sometimes say, “It’s sexy to talk about sex during sex. Do you guys talk about what you like, are you communicating and how are you communicating? And what are you talking about?” Yeah, I encourage people to ask permission... “Is it okay if I hold your hand? Is it okay if I hug you? Is it okay...?”

One participant discussed sexual consent as not being a one-time event and that it can change over time or evolve; that is part of the reason why this participant thinks it should be a more explicit conversation:

I think there is the idea that just because you’re in a couple, you give one-time consent and that it’s...that’s said and done. I mean I think that it changes just like any couple evolves over time. And also what people’s...what they’re comfortable with in terms of language used, how their bodies are touched, all those things certainly does change over time or evolve.

Two participants shared that even individuals within the couple may have different ideas or perceptions about sexual consent and the importance of having specific and explicit discussions:

I guess what the couple is comfortable with [sexual negotiation], how they’re comfortable conveying consent and what does that look like for the couple and each individual person in the couple. The idea of consent can be very different and so you know if that’s the case, both partners have a very different perception of consent and what’s consensual for them, then we’d have to talk about that.

... some people are looking for verbal consent and some people are looking for like signs. And so that could mean like just not stopping somebody is a sign. And so I will slow it down a lot and say, “How do you know that consent is happening? Like what are the nonverbals that you look for? Do you look for verbals? If not, let’s talk about how you
can.”... Or if you’re working with someone who doesn’t notice any of that then you get that feeling of like, ooh they’re not noticing. Okay so we need to like work on how do we make it important for them to notice? How do we make them understand that that is a crucial part? And I usually connect it to pleasure.

**Techniques.** Three participants discussed specific techniques used to discuss or facilitate sexual consent with couples and/or individuals. Each participant shared some complexity of engaging couples in these conversations that are not inherently simple but rather nuanced discussions. One participant discussed the technique of *enthusiastic* and *curious* consent:

*I talk about enthusiastic consent as something to shoot for and then we talk about what would that look like?...I also talk about curious consent, when like you’re interested in trying something but maybe you’re also a little nervous about it...I mean there should always be the expectation that someone may stop in the middle but I think that that kinda helps really cement that...“I’m curious, we don’t know which way this is gonna go.”... So like proceed with excitement and also caution.*

One participant expanded the conversation of sexual consent outward to non-sexual activities such as finances that highlighted the more general concept of consent as a *foundation of trust* in the relationship:

*...consent really fuels a lot of my work with couples. To the point where we start talking about consent even when it’s not about sex. Even if it comes up around finances, it’s like “Well why is one of you allowed to make all those decisions without the input of the other?” Or “If one of you said hey let’s not buy that and the other one of you bought it, like why... how’d that happen?” So there’s a lot of things that you can do with consent before you even get to sex to kind of illustrate,...this is really the foundation of trust in your relationship. And in sex I think that’s heightened. But it’s also really important with money, or you said you’d do this thing and you didn’t do it. Or worse you said you wouldn’t do the thing and you did it anyway.*

Another participant discussed the technique of *Yes, Maybe, No* and *The Wheel of Consent*:

*...one of the easiest ones that I learned about was the Yes, Maybe, No. And how that in of itself can give people who huge amounts of permission...That there’s a space to kind of...to move within and that when something may be a No right now, actually if there’s some more intimacy, more connection, more foreplay... that it actually can sometimes move into a Yes...Another model that I use is called the Wheel of Consent...Cause I think with sexual trauma and rape, sexual assault... there are times when it’s really straight
forward. And then there are other times when it’s really, really grey. And someone isn’t sure that something may have happened or a boundary was crossed and they were talked into it [sexual activity], or they were pushed into it, or coerced into it...And to be able to help them identify reasons why that might not be right for them fit within that Wheel of Consent.

Lastly, two participants discussed how they used therapeutic modeling to demonstrate consent with their clients:

So there’s [therapeutic] modeling in a way, lots of modeling. So in a way it’s asking questions of, “do you feel comfortable in this space?... if something I say really hits you and you’re like, I don’t know about that, or if you’re offended.” Having those conversations up front kind of set the tone of, like please say that to me. Please disagree with me.

And I also, so as a couples’ therapist, a lot of times I can touch people because there’s two people in the room. So sometimes I’ll do some of this...with people. I touch feet or I’ll touch a knee or something, like with men.

Partner Sexual Behaviors

Two participants shared clinical examples with primarily cisgender men that involved examining sexual behaviors. Some partners may need to further examine their own sexual behaviors, either past or present which may not be entirely consensual in nature:

...he’s not hearing my No sometimes. He will keep going sometimes. And so then we started having couple sessions again around what’s going on with this? And what’s it like for someone to say No in the middle of a sexual experience? You know, yes that is surprising or disappointing and yes we also need to listen to it all the time.

I’m working with a couple where...one of them, the partner was coercing the other. And they [survivor]...came to that realization...that I’m being coerced...And it’s also horrifying for the other person [partner] because they didn’t understand that that’s what they were doing. But when the partner [survivor] who was coerced, recognized it and was able to say, this is how you did this... There was this horrifying acceptance that had to occur as a result of that. And...it forces them to look at...why am I doing this? Why is this something that happened?...They’re just trying to do what they think is connecting with a partner. Not understanding that the way that they’re doing it is actually coercion. And then also what do you do then after that? ...Do you go back to having sex? Do you stop?... it can be really confusing for couples who are going through that. But it absolutely forces them [partner] to kinda look inward and hopefully with my help, that they can do it in a way that isn’t so unforgiving of themselves but to take a real good look at the ways that they’re doing things and what needs are they trying to have met?
Because those needs are important but... the way you’re going about having those needs met is problematic. So... it does absolutely... create that space where they have to look at themselves.

Three participants addressed initiating these discussions even though the partner may not realize that what they are doing is coercive, manipulative or doing harm to the survivor:

...again I think somebody I would identify as coercive... it’s kinda hard to get other people to see their behaviors unless they have a fair amount of insight. So I guess that would be the challenge... working to help people gain enough insight to be able to then look at their own behaviors... because you know what I might identify as manipulative but what were perceived as manipulative, first of all it would depend on does the partner see it that way?

You know he [partner] keeps saying to her [survivor], “it’s been 9 months when are we gonna get over it?” She’s like, “you’re pressuring me, you’re pressuring me.” She hasn’t even been able to deal with her trauma at all.

I [therapist] have told people... it’s always been cisgender men. I’ve told them you need to stop having sex with your partner right now. You need to stop for a while and you need to stop having sex if they are not enjoying it, or if they don’t seem present. And that can be a really hard thing for guys to hear, especially when they are already feeling rejected cause they can tell their partner’s not into it; and maybe sex isn’t happening as often as they would hope. So they have to kind of contain their ego and like, tend to their own wounds, okay sex isn’t gonna be what I want it to be because I’m saying, like “you’re doing harm here. I know you’re not intending to but you are.”

Differences among Queer Couples

One participant spoke to differences between heterosexual and queer couples around sexual activities and differences around what sex looks like:

...one thing that I noticed that I think that queer couples really have going for them that... I’m gonna say straight couples do not... is that I noticed queer couples assume a whole lot less, which is great. There’s a lot less assuming of what might sexual activities look like? What might we be doing in any given time that we want to be sexual together? There’s a lot less assuming that we’re gonna start at one place and we’re not gonna stop until we get to this place. And I think that heterosexual people get a lot of messages around here’s what sex looks like, and here’s what that means. And if you’re not doing that from beginning to end then something’s going wrong.

The same participant noted a greater awareness in queer couples around trauma symptoms and the partner check[ing] in with the survivor if something doesn’t seem quite right:
...one advantage I’ve seen is that [queer couples] do a lot more discussing, and I think there’s a lot more awareness around trauma and like attention to if someone notices trauma symptoms in a partner. They’re like, “oh wait, hang on let’s check-in cause this doesn’t seem quite right.” And I think that’s one thing that I always wanna applaud people when I see that.

However, this participant did acknowledge some challenges in addressing trauma and the impact with cisgender gay men:

... people who are in partnerships where they’re both cisgender male [gay men]...I think that it can be hard to get people to acknowledge how intensely trauma can be symptomatic in your life. I think there’s a feeling of...you should kinda just push that aside. It’s not that big of a deal. And it’s hard to get people to give that the attention that I think it deserves based on what I’m seeing, how I’m seeing it affect their lives. I have had that happen and we’ve gone somewhere with it but I’ve noticed that I feel like male/male partnership clients don’t want to go as deeply with that. They always kinda like want it...like even if we touch on the trauma stuff, they’ll kinda wanna shift back to, “okay but the rest of this isn’t about trauma, right? Or let’s talk about... we’ve talked about that enough now let’s go into this...” And when I do have people who want to work through it, it’s usually like one of the men coming on his own to work through it. It’s a little less like both of them being there.

Once again, five clinicians participated in this research study. Three participants were marriage and family therapists and two were clinical social workers. Each participant had specialized training and certification that made them uniquely qualified to speak to this topic. The following seven themes emerged from the data: role of clinician, relational impact, empowerment, relational healing, sexual consent, partner sexual behaviors and differences among queer couples.
Discussion

The discussion chapter will begin with findings that were supported by the literature. Next, unexpected findings will be presented. Lastly, implications for social work practice and future research will be presented.

Findings Supported by the Literature

A number of findings in this research study are supported by the literature. One such finding is the prevalence of sexual trauma history within both the clinical and general population. At least three participants explicitly addressed the prevalence of sexual trauma history among clinical caseloads. One of the participants stated that between 50-75% of clients had experienced some sexual trauma, and another participant stated that the majority of clients had a sexual trauma history somewhere in background. Given the overall rates of sexual violence and abuse, it is clear that mental health clinicians are working on an ongoing basis with clients who have experienced some form of sexual trauma. The research suggests that between 50-70% females and 30% of males with a history of childhood sexual abuse are seen in therapeutic settings (Millwood, 2011; Jacob & Veach, 2005). This finding supports the ongoing and continued importance of incorporating trauma-informed care into clinical work.

Another finding supported by the literature is the impact of sexual trauma on the survivor, partner, and couple (Jacob & Veach, 2005; Malts & Shay, 1995; Mills & Turnbull, 2004; Remer, 2013). Participants in this study discussed working with the survivor but also incorporating the partner in the process to support both the survivor and relational healing. Remer (2013) indicates the importance of partners receiving individual therapeutic services as needed to cope with secondary trauma symptoms and/or to address specific personal or interpersonal issues. Participants spoke to multiple configurations, priorities, and complexity
regarding how best to work with the survivor, partner, and couple, and all five participants addressed empowerment and what it may look like for the survivor, partner, and couple as therapy occurs. Empowerment for the partner may be focused on more psychoeducational components such as trauma awareness and PTSD symptoms, personal self-care and wellbeing, along with identifying appropriate and non-enabling support behaviors. The survivor’s empowerment focus may be regarding strengthening identity and efficacy, setting personal boundaries, healthy disclosure, and self-advocacy to name a few.

A third finding that links back to the literature is the role of consent in discussing sexual intimacy with couples and partners. All participants discussed using some elements of consent in their work with couples around sexual intimacy i.e. asking permission, discussing and unpacking personal boundaries, communication around verbal and nonverbal cues, and how creating an overall climate of consent begins to build a foundation of trust in relationships. Maltz (2001) work with survivors and couples regarding sexual intimacy supports the finding of using consent elements to build trust, communication, and healing within the relationship.

**Unexpected Finding**

One unexpected finding was the explicit attention given to “relational healing” among couples where one person has experienced sexual trauma. Based on clinical case examples shared by participants, a significant amount of couples are attempting to heal their relationship, repair the bond, and work toward greater intimacy. One might have expected more incidents of separation, breaking up, or divorce within these relationships. And, participants did share clinical examples of couples also ending relationships. Most, however, reported focusing on couples working on individual and relational aspects of healing separately and together. One explanation is that at least three clinicians were either LMFT or LAMFT including one with certification in
EFT. Hence, clinicians with this licensure and certification have very specific training working with couples, dyad functioning, and attachment-based concerns. These clinicians may have more experience and comfort working with couples and viewing the dyad through a systemic lens even though there are times when they are only working with one or both partners individually.

Therefore, it is surprising that even in individual therapy the relationship is still at important focus as an important part of the healing process. This finding is significant because even though the survivor or partner may need individual therapy, this does not mean that the relationship necessarily needs to end. In fact, some of the clinical examples speak to the importance of attachment, witnessing by partners, and support behaviors that can have a profound effect on the survivor’s healing process.

**Implications for Practice**

This research raises some important implications for social work practice. These implications include clinician language around discussing sexual trauma, clinician comfort addressing sexual intimacy and sex, working with partners that may be coercive or nonconsensual in attitudes or sexual behaviors, and facilitating explicit sexual consent conversations.

One implication for social work practice is that clients may have experienced what a mental health clinician would consider sexual trauma, but the client may not identify the experience it as such or use that language. One participant shared that some partners (in particular cis-gender males) may have had *sexual experiences where [they] didn’t feel comfortable, or where [they] had confusing feelings afterward*, but may not identify or label those experiences as sexual trauma. This comment may speak to some of the complexity of societal shame and stigma particularly for cisgender males around acknowledging sexual trauma.
and the overall underreporting of sexual victimization. In any case, an important implication for clinicians is to expand or re-define the ways in which sexual trauma is addressed with clients to explore cultural messaging, shame, stigma, and/or differing gender expectations around sexual experiences.

Another implication for social work practice is the need for clinicians to be comfortable and willing to address sexuality and sexual intimacy openly with clients. There can still be a certain level of discomfort or lack of professional training around addressing sex, sexuality, and sexual intimacy in therapeutic settings. One participant encouraged students and clinicians to practice having conversations about sex and sexuality and to develop a greater comfort using both technical and client-specific language on the subject. Two participants addressed the integration of sexual intimacy for the survivor and within the couple as an integral part of the healing process and should not simply stop at processing the sexual trauma(s). This researcher would add that if clinicians are uncomfortable with addressing sexual intimacy, sexuality, or sex that there may be some personal and professional growth or training that may need to occur outside of the therapeutic setting to gain more comfort, awareness, and confidence with the subject. One participant went a step further addressing clinician self-awareness regarding this topic, which may potentially trigger the clinician and that it is imperative to utilize therapeutic support and supervision as needed for self-care, personal considerations, and countertransference concerns.

One of the more powerful findings that directly relates to social work practice is the role of sexual consent and helping partners examine sexual behaviors and attitudes that are non-consensual in nature. Four participants addressed the complexity of working with partners who are engaging in sexual behaviors that are coercive or causing harm to the survivor. These
participants discussed the difficulty in working with those who have violated someone’s consent, sometimes for years. In order, to work compassionately with these individuals and not to cause further harm, this researcher would strongly encourage clinicians to seek supervision and guidance as needed to examine biases and potential countertransference reactions that may arise in this challenging work.

Another recommendation for clinicians is to directly engage couples in sexual consent conversations. Beres (2014) suggests that “consent is a concept that is often taken for granted...without defining it explicitly, assuming a shared understanding” even within research (p. 374). Hence, clients and even clinicians may hold a multitude of factors and different ideas, cultural messaging, and beliefs around what is considered sexual consent (Beres, 2014; Beres, Herold, & Maitland, 2004). Therefore, making sexual consent conversations explicit and exploring attitudes individuals hold even within the couple relationship can be a powerful and eye-opening experience. One participant addressed ongoing consent discussions because what one is comfortable with in terms of the language used, how their bodies are touched, all those things certainly does change over time or evolve. Another participant discussed facilitating explicit conversations around noticing and naming signs or verbal/nonverbal cues that someone is sexual consenting or helping someone to begin to start noticing these things. The point being that for direct practice, sexual consent behaviors and actions cannot be taken for granted and that consent is not a one-time event even within long-term couples.

Implications for Future Research

This research suggests the need for additional research examining more diverse couples around this topic. A majority of research studies focus primarily on heterosexual couples, where the female is the sexual trauma survivor. However, there are some studies that focus on
cisgender male sexual trauma survivors or dual trauma couples. Some participants addressed special considerations and areas of strengths for same sex, transgender, or sexually fluid couples regarding overall awareness of trauma symptoms/reactions, knowledge of consent, and ongoing communication around sexual intimacy. Some queer, trans*, and kink communities may be more comfortable and aware of the potential impact of sexual trauma on intimacy, and may practice ongoing sexual consent behaviors as more the rule than the exception. These consent behaviors and practices may be opportunities to further research techniques and applications in more diverse populations. In fact, one participant discussed a consent technique that was incorporated into professional work with couples after attending training, within one kink community.

Lastly, one participant discussed the potential for transference and countertransference concerns regarding the clinician’s gender identity or sexual orientation working with survivors and partners. Since transference and countertransference is always in the therapy room, this is one area that may need to be further explored in greater depth and how this may impact therapeutic intervention and alignment issues with this particular population of couples.
Conclusion

Healing from sexual trauma is a complex and complicated process for both the survivor and partner. Navigating sexual intimacy may present further challenges for some couples. However, through the therapeutic process both survivor and partner may experience empowerment, relational healing, and potentially greater intimacy as a result of this difficult work. Elements of sexual consent are being used by clinicians as one tool to help facilitate these conversations with couples. The guidance of a clinician who is comfortable and knowledgeable in addressing and discussing sexuality, sexual functioning, and sexual intimacy is imperative. Clinician skill along with the willingness of couples to engage further into explicit sexual consent including non-consensual sexual behaviors is an important consideration for direct social work practice.
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APPENDIX A

Consent Form
974280-1 Intimacy after Sexual Trauma: Clinical Perspectives

You are invited to participate in a research study about how clinicians work with couples about sexual intimacy when one has experienced sexual trauma. You have self-identified as a clinician that works with this target population in a therapeutic setting. You are eligible to participate in this study because you are a licensed mental health clinician and have experience engaging couples in sexual intimacy discussions. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

Background Information
The specific research questions guiding this study are: “How clinicians work with couples around sexual intimacy concerns when one partner has experienced sexual trauma? Can the sexual consent model can be used in this work?” This research study will be conducted using semi-structured qualitative interviews with clinicians.

Procedures
If you agree to participate in this study, I will ask you to do the following things: 1) engage in a semi-structured face to face interview lasting approximately 1 hour in length 2) pick a location for the interview i.e. office, conference room at agency, or other appropriate location. The interview will be audio recorded with your consent, transcribed without any personal identifiers, and then analyzed for themes.

Risks and Benefits of Being in the Study
There are no known risks associated with this study. There are no direct benefits for participating in this study.

Compensation and Privacy
All participants will receive a $5 Caribou Coffee gift card for their participation in the study. Gift cards will be given to each participant at the end of the interview. All participants will receive the gift card even if you chose to withdraw from the study.

Your privacy will be protected while you participate in this study. Participants will choose the location along with the date and time to be interviewed to ensure privacy is protected. Participants will determine the amount of information to share and/or decline to answer a question(s) during the semi-structured interview. All personal identifiers will be removed from the transcript and no identifiable information will be used in the final report to ensure privacy is protected.
Confidentiality
The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include consent form, audio recording, field notes, and de-identified transcript. Written or paper research records will be kept in a locked file cabinet. I will keep the electronic copies of field notes and transcript on a cloud-based storage system (Google Drive), and on a password protected laptop. The primary investigator and transcriber will be the only ones with access to the audio recording. The transcriber will sign a confidentiality agreement prior to providing service. All transcripts will be transcribed verbatim and then de-identified by redaction after transcription occurs. The audio recording will be immediately destroyed after transcription has occurred and reviewed for accuracy. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study
Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with University of St. Thomas, St. Catherine’s University or the School of School Work. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will not be used for this research. You can withdraw by contacting Melissa Franckowiak, primary investigator. You are also free to skip or decline to answer any question(s) I may ask without providing a reason or rationale.

Contacts and Questions
My name is Melissa Franckowiak. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at 763.587.5327 or Melissa.Franckowiak@stthomas.edu. You may also contact Mari Ann Graham, Research Committee Chair at magraham@stthomas.edu if you have any questions or concerns. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent
I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study. You will be given a copy of this form to keep for your records.

__________________________________________  ______________________
Signature of Study Participant                  Date

__________________________________________
Print Name of Study Participant
Signature of Researcher

Date
APPENDIX B

Interview Schedule

Licensure:
Years as a practicing clinician:

1. In what capacity do you provide clinical services in individual and/or couple’s therapy to those who have experienced sexual trauma? (By sexual trauma I mean childhood sexual abuse or sexual assault).

2. What do you find particularly challenging and/or exciting, about working with persons whose partners have experienced sexual trauma?

3. Without divulging names or any information that would potentially identify clients, can you tell me about a clinical case with a partner (or couple) that you felt went particularly well? (Where at least one person had a history of sexual trauma)

4. Without divulging names or any information that would potentially identify clients, can you tell me about a clinical case with a partner (or couple) that you felt did not go well?

5. How do you decide whether a couple needs individual therapy, couples’ therapy or both?

6. How do you determine when sexual intimacy can be addressed in couples’ therapy?

7. How do you work with partners around sexual intimacy concerns when survivors are not ready for this conversation?

8. As a clinician, what do you think is most important to take into consideration when facilitating conversations around sexual intimacy?

9. How familiar are you with the sexual consent model? If yes, do you incorporate elements of the consent model into your work with partners? If not, why not?

10. How do you think the consent model could be used to facilitate work with partners?

11. What recommendations do you have for clinicians on this subject?
12. What would you like to tell me that I have not asked?
Greetings,

My name is Melissa Franckowiak and am finishing my Masters of Social Work at St. Catherine University/University of St. Thomas. I am conducting a qualitative research study on:

“How do clinicians address sexual intimacy with couples when one partner has experienced sexual trauma? Can the sexual consent model be used in this work?”

If you are interested in participating in this research study, I have included eligibility requirements below:

**Are you?** A licensed mental health clinician

**Do you?** Work with couples where one partner has experienced sexual trauma

**Have you?** Engaged these couples in conversations around sexual intimacy

**Do you?** Have minimal familiarity with the sexual consent model

If you are interested in participating in a face-to-face interview for one hour, please contact me at **763-587-5327** or **Melissa.Franckowiak@stthomas.edu**.

Interviews will be conducted in January at a location of your choosing.