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Stephen Morris,

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Too painful to think about: chemsex and trauma

Stephen Morris

Stephen Morris is based at Her Majesty's Prison and Probation Service, London, UK.

Abstract

Purpose – Whilst chemsex is a relatively new phenomenon, trauma is not. Freud borrowed the word from physical medicine, where it was used to describe tissue damage, and applied it, for the first time, as a metaphor to a psychological process by which the protective functioning of the mind can too be pierced and wounded by events. The chemsex environment hosts a myriad of potentially traumatising scenarios and experiences, though perhaps disguised as exhilaration or excitement. The paper aims to discuss these issues.

Design/methodology/approach – The paper is a practitioner's experience.

Findings – These experiences piled on top of childhood experiences of being "less than" for being gay, can be responsible for widespread undiagnosed post-traumatic stress disorder (PTSD) among those who engage in chemsex. This paper explores this possibility and offers solutions.

Originality/value – Compounded trauma and PTSD symptoms amongst MSM who engage in chemsex has to date, not been researched.

Keywords Psychology, Drug use, Trauma, Psychiatry, Gay men, Chemsex

Paper type Viewpoint

In a myriad of ways, the word "trauma" features in daily communication the world over. However, extending an invitation for people to consider the meaning and realities associated with the word one is, more often than not, met with resistance, a wish not to know. Trauma, by its very nature, takes us to the vulnerability of the human condition. Trauma reminds us all of our fragility and the everyday potential of our demise. It is not surprising then that we prefer not to know. Those working with vulnerability will at some point encounter trauma; vulnerability and trauma share a co-existence. This paper provides an invitation to those working with the specific vulnerabilities of chemsex and its associated populations to think about trauma. To encourage this thinking, I bring together the resources that have enabled my own thinking including psychoanalytic theory, a trauma clinic intervention model and experiences of the men I work with on a daily basis in the consulting room.

Defining trauma

Whilst chemsex is a relatively new phenomenon, trauma is not. Freud (1920) borrowed the word from physical medicine, where it was used to describe tissue damage, and applied it for the first time as a metaphor to a psychological process by which the protective functioning of the mind can too be pierced and wounded by events. The early understanding of trauma recognised that the mind exists within a protective shield which is protected by its ability to maintain equilibrium by being highly selective of external stimuli. A traumatic event is one that breaks through or overrides this highly selective discriminating process and the mind becomes flooded with a degree of stimulation which is more than it can sense or manage. This feels like something very violent has happened or actually happened in the external world and results in a massive disruption, a breakdown of internal protective mechanisms.

Over the decades, the early understanding of traumatic experience has hardly changed. The awful truth is that despite our wishes and what we tell ourselves, the world is not safe and

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has never been safe. Life does on occasions massively disrupt our capacity for delusion and in doing so, we experience profound losses. Looking beyond the particular manifestation of trauma, what occurs in relation to them all is the loss or perceived loss of:

- our established way of going about life;
- our established beliefs about the predictability about the world;
- our established mental structures (i.e. our internal working models based on external influences in early development);
- our established mental structures (i.e. how we make sense of things); and
- our established defensive mechanisms (i.e. how we protect ourselves both physically and psychologically) (Garland, 1998).

When we refer to someone as being traumatised, it is these losses that they are experiencing, or perhaps more accurately, protecting themselves from experiencing. Indicated in this array of loss is the investment we all make in believing without question in the predictability of the world and in both external and internal protective functions. "Bad things happen to other people not me"; when this belief is breached anxieties and paranoid beliefs take over and life is not the same. Even when safety is restored the traumatised person is often unable to recognize this, their common statements are; "I'm not what I was", "My life has just gone to pieces", "I don't enjoy anything these days", "I don't care about anything". The main problem with trauma is that everyone else knows the incident is over but not the person who has experienced it.

Diagnosis

For many years, clinical recognition of what caused someone to experience trauma was as rigid and fixed as our protective delusions. The thinking until recently was that a diagnosis of trauma could only be considered if there had been a direct experience of a threat to life. Following much debate and a significant delay in the publication of the current *Diagnostic and Statistical Manual* of mental disorders the following criteria was approved (American Psychiatric Association, 2013):

- Direct personal experience of an event that involves actual or threatened death or serious injury.
- Threat to one's physical integrity.
- Witnessing an event that involves the above experience.
- Learning about unexpected or violent death, serious harm, or threat of death, or injury experienced by a family member or close associate.
- Memories associated with trauma are implicit, pre-verbal and cannot be recalled, but can be triggered by stimuli from the environment.
- The person's response to aversive details of traumatic event involves intense fear, helplessness or horror. In children it is manifested as disorganised or agitative behavior.

The causes of trauma

This wider criterion makes it possible for clinicians to consider the full impact of vulnerabilities such as: harassment, abandonment, abusive relationships, rejection, co-dependence, physical assault, sexual abuse, partner battery, employment discrimination, police brutality, judicial corruption and misconduct, bullying, paternalism, domestic violence, indoctrination, being the victim of an alcoholic parent, the threat or the witnessing of violence (particularly in childhood), life-threatening medical conditions and medication-induced trauma; catastrophic natural disasters such as earthquakes and volcanic eruptions, large-scale transportation accidents, house or domestic fire, motor vehicle accident; mass interpersonal violence like war, terrorist attacks or other mass victimisation like sex trafficking, being taken as a hostage or being kidnapped; long-term/short-term exposure to situations such as extreme poverty or other forms of abuse, such as verbal abuse; committing crime and involvement with the criminal justice system.

The symptoms of trauma

Clinicians confronted with the above can then assess the reported situation in conjunction with the following symptoms:

- re-experiencing of the event (intrusive recollections involving images, thoughts or perceptions, recurrent distressing dreams, reliving, illusions, hallucinations, dissociative episodes);
- avoidance (persistent avoidance, numbing of responsiveness, efforts to avoid thoughts, feelings or conversations that act as a reminder, efforts to avoid activities, places or people that arouse recollections, inability to recollect an important aspect of the trauma, marked diminished interest or participation in significant activities that used to be pleasurable, feeling of detachment/estrangement from others, restricted range of affect, sense of foreshortened future);
- arousal (increased arousal not present before the trauma including difficulty falling or staying asleep, irritability and outburst of anger, difficulty concentrating, hyper-vigilance, exaggerated startle response); and
- life disrupted (significant distress or impairment in social, occupational or other important areas of functioning).

Sexuality and vulnerability

Application of this criterion specifically to men involved in chemsex is yet to become the subject of research. There is evidence indicating that the risk for incidents of post-traumatic stress disorder in the general population is 4 per cent for men and 10 per cent for women. In the LGBT population, the risk increases to 9 per cent for men and 20 per cent for women (Koenen, 2012). When considering other mental health statistics in relation to the LGBT community, the vulnerability to trauma is apparent and summarised in the following statement. "LGBT people subconsciously perceive that they are fundamentally defective and develop extremely low self-worth, manifesting in depression, suicidality and other negative feelings" (Todd, 2016). The Stonewall Gay and Bisexual Men's Health Survey provides further indication to the levels of vulnerability; in x1 year 3 per cent of gay men and 5 per cent of bisexual men attempted to take their own life compared to just 0.4 per cent of heterosexual men. In the same period, 15 per cent of gay and bisexual men self-harmed compared to 7 per cent of heterosexual men. In total, 50 per cent of gay and bisexual men felt that life was not worth living compared to 17 per cent of heterosexual men. One out of seven gay men experience moderate to severe symptoms of depression and anxiety compared to 2 per cent of heterosexual men.

Significantly, and specifically in recognition of the causal factors for high levels of substance use within the gay male population, Felitti (2006) states that "Chronic recurring humiliation is the most damaging of all childhood trauma's, 15% above all other trauma including sexual abuse".

Chemsex and trauma

For those who regularly sit with gay men involved in chemsex in the consulting room, be that in a specialist counselling service, sexual health, substance use service or criminal justice context the above statistics will not come as a surprise. Within the last year, slightly different versions of the following clinical examples have presented themselves to me on repeated occasions. The first example indicates a pre-existing unresolved historical trauma and the self-medicating impact of chemsex. The second example of trauma is less complex, but caused by unpredicted events taking place in the chemsex setting.

Example (1)

Anton (fictitious name) has been in the bar for about 10 mins and has started to feel uncomfortable; so much so that he is finding it difficult to keep still. He has almost finished his drink and his reaction to the thought of going to purchase another one is an indicator that he should leave. He is shaking. Now the venue has become quite crowded and he knows what will

start to happen next, especially if someone pushes against him. The last time this happened it had triggered nightmares that had continued for two weeks, the same nightmares that had haunted his childhood and reminded him that even in his sleep there was no escape from the abuse he experienced from his father. He had sought help for these feelings of “claustrophobia” as that is what it seemed to be, but nothing had worked. Now, as if to confirm that, he pushed his way to the exit and as he reached the outside breathed in the cold air suddenly feeling he was about to faint. Leaning up against the wall, he pulled his phone grasped in his hand and searched frantically for the nearest chillout (chemsex environment). With the assistance of an Uber, in an hour he could hardly recall this feeling of vulnerability and suffocation. After an extra-large bump (measure of drugs), he was flying and feeling like he controlled the world. In the months to come, Anton makes no further attempts to visit any bars and instead became a regular at local chillouts. He eventually seeks intervention; not in relation to his childhood experiences but because he has become increasingly paranoid and has stopped going to work. He only feels safe now when he has slammed (injected drugs) and that is most days.

Example (2)

In the early hours of a cold December morning, Primack (fictitious name) runs out into a deserted London street. He is naked, clutching his clothes in his hands. Aware of his vulnerability, he stops and hurriedly gets dressed looking around to check if anyone has seen him. He is shaking and trying not to cry. He is a little high; the mephedrone was ok but nothing too potent. The images that filled his mind were not the symptoms of paranoia or delusion, they were real. He had seen them only moments before. Worse than the images were the sounds which he just could not forget. He manages to dress himself and by the time he reaches the police station he is thinking clearly and determined to make sure the police take him seriously. They do; three months later he is visited by a police liaison officer who promises to support him once he has provided his evidence to the court. He does and later that week the owner of the house he ran from that December night is sentenced to three years imprisonment for the possession of indecent images of children. But that was three months ago and still Primack is not sleeping, still those images fill his mind and the sounds of the child whimpering he cannot get out of his head. He cannot bring himself to hook up with anyone; he is not enjoying life at all. Primack has always enjoyed life, has had good friends and has maintained regular contact with his family but now his motivation to do this is low.

Simple intervention

Recovery for both of these men is possible but each will require a different response. For Primack, it is possible to recognize that his trauma takes places in the context of an established lifelong secure experience of the world. Witnessing painful and distressing material broke through his safe view of the world and for a few moments confronted him with a different reality. The loss of safety, the loss of trust in others and the loss of his ability to understand resulted in his internal equilibrium becoming disturbed and unbalanced. The aim of intervention in this case is to re-establish the capacity to cope and to do this by mobilising the individual’s own resources. Men like Primack do not come for intervention wanting years of analysis. They come wanting help with an overwhelming external event and wanting things to be restored to how they were before. This is achievable by the intervention focussing on the external event, by talking about it, by gaining a perspective about it and to mourn the loss of a previously held view of the world. In relation to his use of chems, help, if he chooses, may then be required to address causal factors of the original vulnerability so as to enable choices informed by awareness and self-care. This work is possible within a four-session therapeutic consultation as established at the internationally renowned Tavistock Clinic Trauma Unit (Young, 1998).

For Anton, his experience of the world is very different and founded in experiences of insecurity and the trauma of childhood abuse. Anton learned early in his development to push pain away, to be fearful of intimacy and connection and, although hardwired as we all are to seek connection, he learned a series of self-management techniques to manage it, avoid it and keep it at bay. But repression of such basic needs did not remove his yearning for it. This cycle of yearning and pushing away is informed by the repeated vulnerability of unaddressed psychological pain.

For Anton and other gay men like him, the experience is of a double vulnerability rooted in experiences associated with growing up gay in a hetero-normative world and which include:

- disrupted or unavailable secure base because of parental rejection;
- searching for connection regardless of risk;
- childhood experiences of exclusion;
- repeated humiliation;
- daily homophobia;
- shaming, rejection, social isolation; and
- repetition of abuse.

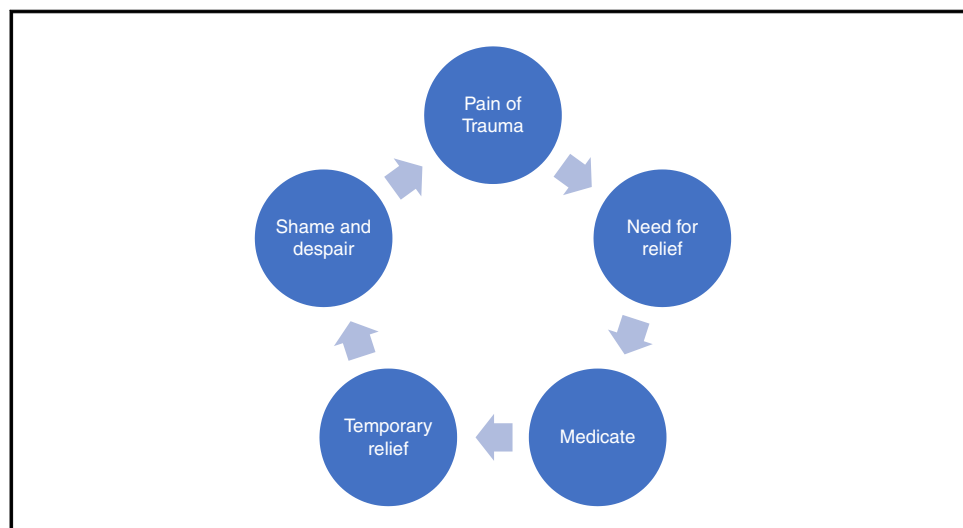
These common experiences create an urgent need for relief. Creative defences established in early development, although mentally draining, initially serve us well in managing the daily stressors. But when the cause is not addressed and the defences are still required in adulthood greater effort and more powerful means are required. Consequently, the means of relief become a dependent feature of daily life and regardless of its cost. Ironically these repetitive cycles (Figure 1) serve only to take us back to the very thing we are seeking to avoid in the first place.

This cycle of repeated pain will be familiar to those working with vulnerable populations. The default response in recent years to this process has become referral to therapy and often without due consideration or assessment of its appropriateness. Eventually a long-term therapeutic intervention may be appropriate but, in the early stages of someone presenting as caught up in this cycle, meeting the immediate internal and external expectations of a therapy process is often not possible. To process original trauma and to relinquish established coping mechanisms requires an extraordinary degree of courage, effort and motivation. It also requires established resources of support and resilience. A therapeutic process will highlight and bring to consciousness the pain of trauma along with an acute awareness of associated despair and shame. To contain such powerful affects, a rigorous psychological confidence is required. Few men taking the initial steps to think about trauma and involvement in chemsex will not be able to do this, it is all too painful to think about.

Hope and resilience

There are other tasks to achieve before long-term intervention is considered. These tasks are not complex and are in fact quite simple. Care is needed to avoid thinking that seemingly complex

Figure 1 Cycle of trauma repetition



issues require complex responses. Complexity has the capacity to frighten people away and make professionals feel inappropriately omnipotent. In recognition of this, my plea is, not for therapy, but for the instillation of hope and the growth of resilience.

For the man whose coping mechanisms are beginning to fail or are becoming a problem in their own right, then growing and maintaining hope is crucial. All professionals, regardless of their role, have an important part to play in this crucial process. A service that is trauma aware does not require everyone to be a therapist, it requires everyone to give the same consistent messages and information both implicitly and explicitly. Such messages conveyed need to address:

- recognition – the ability to witness the reality of the person concerned;
- psycho-education – provision of basic trauma information;
- therapeutic relationship – a non-judgmental warm and open manner;
- trauma awareness – a knowledge base within the professional;
- identify impact of trauma – recognition of symptoms;
- empathy and compassion; and
- specific intervention – referral pathways to trauma clinics as required.

It is helpful to think of hope and resilience as mineral resources; they diminish and grow depending on the conditions available. Individual practitioners, ranging from receptionist to case worker, all can assist in creating the right conditions whereby even the briefest of contact will contribute to the growth of hope and resilience. Provision of the following allows for this:

- recognition of survival skills – positive regard and recognition of daily, sometimes moment by moment, survival;
- mindfulness – simple techniques can be encouraged using apps and practicing in appointments;
- reach out and connect with others – encourage awareness of the wider community;
- care and support – can be and often needs to be practical;
- pay attention to needs and setting of boundaries;
- self-awareness and self-confidence – referral to classes and other non-statutory services working with these issues;
- realistic expectations and goals – small achievable steps;
- empathy and compassion; and
- meaning and purpose – identifying areas of life that matter and have relevance.

Services should not underestimate the holding and containment they provide just by offering a warm, relaxed atmosphere and a routine process. I have heard on more than one occasion men commenting that following an appointment at their sexual health clinic they enjoy remaining in the waiting room and are not so keen to rush off as many would imagine. It is significant, if not a sad reflection on a wider society, that the prison service is sometimes referred to as the “brick mother”. For some, it offers a longed for safety and care.

Connection

It is evident in both the causal and symptomatic indicators of trauma that its main impact is disconnection. Trauma separates a person from the world around them and from the safety of their internal world. Separation and disconnection do not allow for links to be made. The failure of linking accounts for many of the symptoms of trauma (Bion, 1967). Trauma symptoms enable its overwhelming features to be broken down into temporary manageable pieces, e.g., flashbacks of isolated bits of experience. Symptoms and coping mechanisms alike, work to keep the traumatic experience out of the flow of experience and so it never becomes part of the past. To bring

someone out of the past requires safe and reassuring links and connections in the present. Chemsex provides an illusion of this process but eventually it fails miserably ending in massive disconnection. Safe connection makes it possible to think; in developing our response to chemsex-related trauma then thinking and connection need to become our essential priorities.

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Corresponding author

Stephen Morris can be contacted at: stephenburtonmorris@gmail.com

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