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# What is sober sex and how to achieve it?

Remziye Kunelaki

## Abstract

**Purpose** – *The purpose of this paper is to provide the first definition of sober sex and recommendations for health care professionals who work therapeutically with patients who struggle with intimacy after experiencing chemsex.*

**Design/methodology/approach** – *The recommendations are based on the clinical experience of a psychosexual therapist working with men having sex with men (MSM) in a Sexual Health clinic in central London.*

**Findings** – *The paper concludes that having a clear definition of sober sex and specific tools, such as healthy masturbation exercise, could prove helpful for health professionals who work with this cohort of patients.*

**Originality/value** – *This paper provides the first definition of sober sex and a clear set of guidelines for health professionals based on the clinical experience of the author.*

**Keywords** *Chemsex, Intimacy, Mindful masturbation, MSM, Psychosexual therapy, Sober sex*

**Paper type** *Viewpoint*

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## Introduction

This paper has emerged from the recent increase of patients referred for issues with intimacy to the psychosexual service of a central London sexual health clinic. According to Stuart (2018), “chemsex” is the link between three specific drugs – crystal methamphetamine, mephedrone and GHB/GBL used in sexual contexts, specifically by gay men.

In literature, there are references as to the motivations and values associated with drugs (“chemsex”) amongst gay men in London (Weatherburn *et al.*, 2017). There are also papers focused on the relationship between sexual health and drug use of gay men and other men who have sex with men (MSM) (Kane *et al.*, 2017). Bowden-Jones *et al.* (2017) studied the patterns of drug use in a cohort of MSM attending a drug club clinic and their relationship with HIV status. In total, 407 patients who attended the drug club clinic were studied by providing measures from clinical interviews and the National Drug Treatment Monitoring System Data tool. The findings concluded that majority of attendees (73.3 per cent) to the drug club clinic used drugs to facilitate sex and there was an association between HIV status, methamphetamine, mephedrone, intravenous drug use, older age and Hepatitis C Virology status.

As health professionals, we understand why MSM patients practice chemsex and the possible implications for their health. However, there is no evidence in the literature on how to help MSM to achieve sober sex after exposure to “chemsex”. In the absence of evidence, this paper will define sober sex and a suggested approach to working with intimacy issues within the context of time-limited therapy in sexual health services.

**Objective:** this paper provides the first definition for the concept of sober sex and a list of recommendations for health care professionals in helping their patients achieve it. The definition and the recommendations are based on the clinical experience of a psychosexual therapist working with men having sex with men with sex (MSM) in a sexual health clinic in central London.

**Definition:** the definition of sober sex has developed gradually and organically through the clinical experience of the author. The patients who have been presenting with the need to achieve

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sober sex, usually report feeling disconnected, unable to remain still, distracted, in need of consistent and varied stimulation. The author's clinical observations were then combined with the literal meaning of the phrase sober sex. This was achieved by looking at the meaning of the words in the context of this cohort of patients. According to the Cambridge Dictionary (<https://dictionary.cambridge.org/dictionary/english/sobering>), sober is defined as not drunk or affected by alcohol. According to the Oxford dictionary (<https://en.oxforddictionaries.com/thesaurus/sober>), some of the synonyms for sober are dry, serious, sensible, down to earth, realistic, self-controlled among others. According to the same dictionary, sex is defined as sexual activity with synonyms of making love and sexual intercourse:

SOBER = NOT DRUNK/REALISTIC,

SEX = SEXUAL ACTIVITY/MAKING LOVE,

SOBER+SEX = NOT DRUNK/REALISTIC+SEXUAL ACTIVITY/MAKING LOVE,

REALISTIC+MAKING LOVE = PRESENT SEX,

ATTEMPTED SYNONYMS OFSOBER SEX: INTIMATE SEX, REALISTIC SEX.

*Sober sex is defined as present sex where no drugs (chemsex) or fantasies are involved, and the connection between body and mind is maintained*

Sexual fantasies can be used to help patients with specific psychosexual presentations, such as delayed ejaculation. However, in the group of patients that this paper is focused on, that is not the case. Maintaining a sexual fantasy or watching pornography does not allow the presence required by the definition of sober sex or the maintenance of body and mind connection.

At the point of assessment consultation, the author aims to have clarity of a working goal with her patients. If the ultimate goal is to achieve sober sex, then that is usually a clue that the patient wants to work towards a place of intimacy. If the patient attends individual therapy, then the goal is translated as achieving internal intimacy, knowing oneself, accepting oneself. If the patient would like to work in a partnership, then the goal is extended to achieving interpersonal intimacy once the internal one is fulfilled.

Some patients might want to achieve sober sex but decide it is not for them or the timing is not right. The health care professional would then give advice on ways that the patient remains safe within their sexual practice.

#### *Recommendations on how to achieve sober sex*

*A working contract.* The author recommends that there needs to be a clear therapeutic contract at the point of assessment between the patient and the health professional. The contract will set up and clarify the boundaries and will explicitly define confidentiality and cancellation policy agreements. Although this can initially feel like a barrier in the relationship, in fact it holds clear boundaries and structure for the patient, which will eventually provide the feeling of safety. Setting a clear contract right at the beginning of the therapeutic relationship can be significant for this cohort of patients, especially if they lack structure and routine in other aspects of life.

*A list of questions to enhance the assessment consultation.* Sometimes patients will attend with an intention to change because that feels the "right" thing to do. They bring to the sexual health clinics their "logical" selves. However, changing behaviours requires a more profound motivation and clarity within. The health professional could inquire further at the point of assessment with some of the following questions:

1. "What is your real motivation to change?"
2. "What are the harmful consequences of your behaviour?"
3. "Is there an investment in not being sober?"

4. "How would you manage your boredom?"
5. "What would happen to your sexual shame?"
6. "How would you look after yourself?"

*Mindfulness.* In the clinical experience of the author, the recommendation of daily mindfulness practice usually is a great starting point to the journey of sober sex, even if that means a few minutes a day. Mindfulness is usually the first stepping stone to reconnecting within. For many patients, it could feel like a frustrating approach, but the reassurance and the guidance of the health professional would be very valuable. A randomised control trial of mindfulness-based stress reduction to manage affective symptoms and improve quality of life in gay men living with HIV, resulted in reduction of avoidance, higher positive affect and improvement in depression (Gayner *et al.*, 2012).

Mindfulness practice methods are explained, and patients choose either to practice in a class environment or by themselves online or via an app. If a patient feels anxious or distracted in a session, a brief mindfulness practice with the health practitioner could facilitate their re-connection to the here and now which will then help the focus and progress of therapy.

For patients who identify with a religion of origin, in the clinical experience of the author, it is easier to return to regular prayer time, which can serve as a meditative practice. This is an excellent opportunity to attempt a deep connection within. In the author's experience working with MSM who have a religion of origin, returning to a regular prayer or religious ritual can be very healing in a spiritual context.

*Mindful masturbation exercise.* The psychosexual therapist recommends a mindful masturbation exercise to all men who present with difficulties with sober sex. The primary objective of this exercise is to attempt to reconnect within. In most cases, it seems that there are too many distractions and almost a disconnect between body and mind. In a physiological as well as psychological level, sex works when we feel connected. The idea behind banning porn and fantasy is for attempting to connect with bodily feelings again or for the first time. This does not imply that there is something wrong with either the use of pornography or fantasy for sexual arousal, this is a starting point for men who seek sober sex to try and connect with their bodies.

The role of sexual fantasy is widely reported in sex therapy. Lobitz and LoPiccolo (1972) used fantasy within their behavioural treatment method for arousal and orgasm difficulties. Perelman (2016) incorporated the use of fantasy in the treatment of delayed ejaculation for men.

The main issue with this cohort of patients in regards to masturbation arises from any potential unresolved issues of shame, internalised homonegativity and isolation which might be reinforced through certain fantasies. The author has found that sometimes the more unresolved issues within the patient, the more the likelihood for masturbation to become a "retreat from intimacy" (Schmidt, 1998). Masturbation becomes a way of escaping or disconnecting further within. "How can you remain connected with the body you touch when you are still unhappy with yourself?"

The author has often observed that especially unresolved conflicts between sexuality and religion could affect how a patient feels about the body they touch during self-stimulation. Perceptions of sin in main Abrahamic religions when it comes to masturbation are not helpful. Masturbation was named as "onanism" by physicians 200 years ago, and it became a warning for a multitude of illnesses (Bullough, 2003; Laqueur, 2003). Sometimes, discussing openly any concerns about masturbation might be the first experience for a patient, which could lead to normalising and accepting without judging the body that is touched.

The author suggests that given the time and skills of the health professional, patients could find it especially beneficial to address some unresolved issues around shame. The author encourages a neutral stance towards the body if the original one is too critical. A useful question she asks directly to her patients is "How can we move to a place where you might accept the body you have and be OK with self-stimulating it?".

For men who present with a sexual dysfunction or difficulty, masturbating on their own appears to be “fine”, but that does not translate to partnered sex. The main difference for men seeking sober sex is that the relationship with fantasy at the point of the presentation is one that is likely to be an unhelpful one. The idea behind banning fantasy for this cohort of patients is not in any way to shame or judge but to provide an opportunity to dismantle habitual conditioning. For many men, masturbating regularly to porn or fantasy is not necessarily a sign of their true libido. The decision to masturbate does not derive from any bodily clues, but it is established all in the mind. The body rarely plays a part in this type of masturbation, and that is fine if one is planning a solo sex life. The difficulty arises, and that is the experience of the author when one tries to have partnered sex:

1. banning the use of pornography or fantasies;
2. listening to the body's needs;
3. only self-stimulation if the body shows signs of arousal, e.g. morning erection; and
4. reconnecting body and mind with no distractions, similar process to mindfulness meditation.

*Links to existing theoretical models.* The phenomenon of sober sex is relatively new and understudied in the therapeutic setting. There may be many theoretical approaches that could apply to the working framework of sober sex, but there are currently no links in literature. The author has found that transactional analysis works best for the needs of this cohort of patients of this paper. Transactional analysis is easy, visually accessible and suited in time-limited therapy settings. The psychosexual therapist has found it straightforward to explain to her patients, and the response is usually one of clarity, and due to the visual graph attached to the different ego states, it can facilitate further reflection in between sessions.

According to transactional analysis (Berne, 1964), we all have three sets of ego states. Those are parent, adult and child. Within the parent ego state, there is the positive parental voice, which is the nurturing one, the one that usually tells us we worked hard today and we should be heading home early, have a bubble bath and cook a chicken soup (or a veggie one). The parent also has a negative section which is the critical parental voice. That is easily recognised as the voice that is never satisfied with how much one has done and demands more.

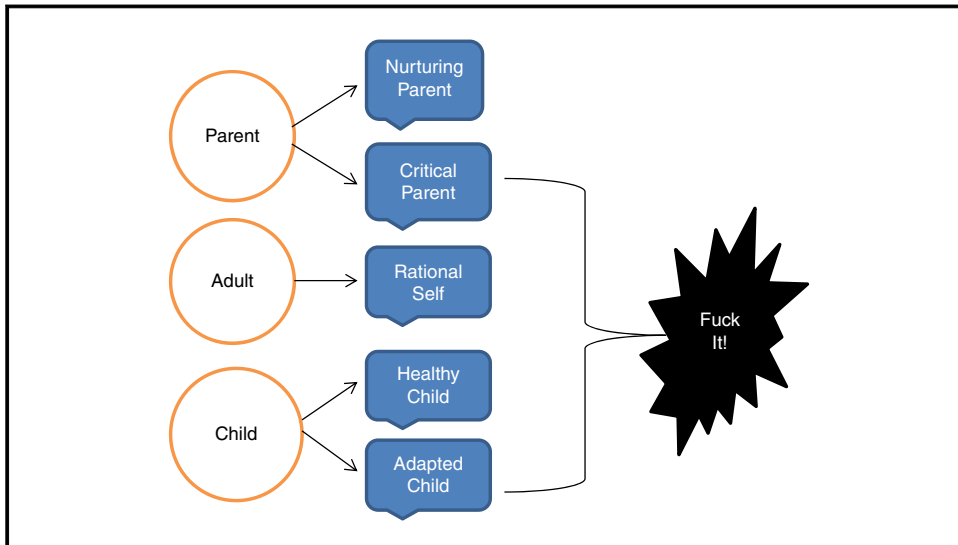
The adult ego state usually represents the logical, the rational self. We are more likely to make decisions from the adult place. This is the state where we put all the options in front of us, and we decide according to what is the best one for us, rationally.

The child ego state also has two branches, the positive and the negative. The positive child is the one who benefits from all the positive qualities such as being creative, playful, forgiving and intuitive. The negative child, otherwise known as the adaptive child, is the one that spends all his purpose in life in trying to please the critical parental voice. The adaptive child usually neglects its own needs in order to keep everyone else happy.

The author has found transactional analysis to offer a beneficial theoretical model in understanding why it is difficult to achieve sober sex for some patients. In the psychosexual therapist's experience with working with this group of patients, there is usually a “hook” between the critical parental and adaptive child ego states. That is the strong link between the critical voice that is never satisfied no matter how much one tries/does and the inner child that is continually trying to please that demanding voice. As a result of that hook between the two ego states, the therapist has noticed that there is minimal opportunity for the adult ego to develop and that is usually symbolic of patients who cannot decide what is right for them or make a decision.

The psychosexual therapist often observes that patients who are stuck in this hook eventually get tired because they can never satisfy the critical parental voice and they have consistently neglected their needs. At that point of realisation usually, there is an accumulation of anger and resentment the most likely response is: “Fuck It!”. The “fuck it” place is when this group of patients do not any longer care about themselves or any consequences of their behaviour, and they are more likely to take sexual risks and return to chemsex (Figure 1).

**Figure 1** Transactional analysis as adapted and understood by the author



*Tools to work towards intimacy*

1. saying no to sex;
2. self-care/compassion for the sexual self;
3. gaining intra-psychoic intimacy;
4. learning to be still;
5. enjoying “the cup of tea” again;
6. allowing oneself to relearn and explore;
7. mindfulness/meditation/yoga/martial arts;
8. congruence/authenticity;
9. working towards interpersonal intimacy; and
10. making time for intimacy and the other.

*Use of clinical supervision.* It is vital that health professionals who work with patients trying to achieve sober sex be in regular supervision themselves. In the author’s clinical experience, there is often a conscious or unconscious invitation from the patient for reparenting, especially in cases where there is a traumatic event in childhood or neglect. It is crucial for the health professional to recognise this invitation if possible discuss and explore with the patient and become aware of themselves as the “parent”.

In other circumstances, material that is brought to the session might feel seductive, overtly sexual in nature or even repulsive to the health professional. Clinical supervision or personal therapy can offer the space and help to understand the relational dynamic between the health professional and the patient.

Stewart (2010) stated that “sharing, in supervision or with our own therapist, the ways we get our relational needs met through our work with clients helps normalise the existence of this dynamic and support the positive aspects of it [...]. Transparency with colleagues creates the opportunity for feedback if the therapist’s needs are being met inappropriately through their clients”.

In some cases, the material brought to the sessions can be very traumatic, raw and unprocessed. The author found further training in trauma therapy particularly helpful when helping this cohort of patients. Rothschild (2006) uses the term “vicarious traumatisation” to describe the experience in the nervous system of a therapist, even if they are not involved with the client’s trauma.

The author strongly recommends that the health professional attend supervision or personal therapy and prioritises their own self-care. The mirroring with patient needs to reflect self-care and discipline. Patients can sense when a recommendation comes from a “real” and practised place and when it is just a guideline from a book.

## Results

The recommendations based on the clinical experience of a psychosexual therapist conclude that ultimately working with patients who present with issues around sober sex is about encouraging more profound and holistic ways of self-care. The positive outcome (self-reported by patients) is mainly due to changes in a deeper understanding of themselves. The recommended exercises in this paper could prove helpful tools for patients aiming to achieve sober sex. Transactional analysis can offer a visual understanding of what might be going on. Patients report that they find the model especially helpful to recognise which part of themselves they are operating from at a given time.

## Conclusions/discussion

Patients, who aim to achieve sober sex according to the clinical observation of the author, tend to have critical parental ego states. The critical parental state is based on the transactional analysis model by Eric Berne (1964). The critical voice together with any unresolved issues around shame, internalised homonegativity and the need for approval sometimes could be the contributing factors to remain in the chemsex loop. Intimacy, in those circumstances, is too painful to achieve.

Offering a holistic approach to therapy allows patients to tackle issues from the past (usually from childhood) and understand their implications in the here and now. The author’s clinical observation is that consistently patients present stuck in a “younger” and unhealthy patterns, which then cause delays in the decision making for what is best for them from an adult place. So, the journey to sober sex, for some patients could feel like a passage from adolescence to adulthood.

The good use of supervision for the therapist is required to reflect on issues of reparenting, transference (“whom do I represent to the patient?”) and countertransference (“who does the patient represent to me?”), as well as to maintain clear and safe boundaries.

The definition and recommendations of practice on sober sex might need local adaptations, but the paper aims to prove helpful to other health professionals across disciplines.

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## About the author

Remziye Kunelaki graduated with a Bachelor in Science in Psychology from Turkey in 1997 and moved to London in order to specialise in Psychosexual Therapy. She trained as a psychosexual therapist at the Whittington Hospital and completed a Master's Degree in 2001 on "women's experiences of using vibrators". She started working as a Sexual Health Adviser at St Thomas' Hospital and later at St George's Hospital as a psychosexual therapist. She has been working as Lead Psychosexual Therapist at 56 Dean Street of Chelsea and Westminster hospital since 2012, where she manages a busy psychosexual department and supervises trainees on clinical placements. Remziye is an Accredited Psychosexual Therapist and Supervisor from the College for Sexual and Relationship Therapists (COSRT). She is Committee Member of the British Society for Sexual Medicine (BSSM). In February 2016, she became a Certified European Psycho-Sexologist by the European Society for Sexual Medicine and European Federation of Sexology (ESSM and EFS). She is EFS/ESSM Psycho-Sexology Accreditation Committee Member. She is currently doing a PhD at Anglia Ruskin University with the title "how do Christian men having sex with men (MSM) experience the collaboration of sexual health professionals with the Church?". Remziye Kunelaki can be contacted at: [remziye.kunelaki@chelwest.nhs.uk](mailto:remziye.kunelaki@chelwest.nhs.uk)

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