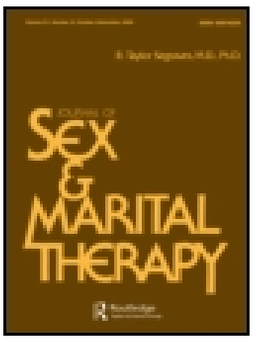

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Facilitating Erotic Connection: The Relationship Shared Values Primer (RSVP) to Sex and Relationship Therapy in the Context of Sexual Trauma History

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ABSTRACT

There are few models of sex therapy designed specifically for working with relationships in which one or more partners have a history of sexual trauma. The Relationship Shared Values Primer (RSVP) to sex and relationship therapies is a pre-sex therapy psychoeducation with the goal of promoting buy-in and reducing attrition by fostering safety and connection prior to beginning the therapeutic work through a dialogue of four key values: (1) Intimate Justice, (2) Non-linear Healing, (3) Mindful Acceptance, and (4) Erotic Empathy. We discuss research support for the rationale of the RSVP, how the RSVP can mitigate current obstacles to working with this population, and present a case study of the RSVP application.

Erotic connection, the relational dynamic in which mutual desire is expressed and received, supports sustainable sexual intimacy. While this can be conceptually and behaviorally mystifying for many individuals, for those who have experienced sexual trauma connecting erotically may be a particularly vulnerable endeavor. A more targeted and safety-oriented approach to relationship-based sex therapy for those with a history of sexual trauma may maximize the benefits of treatment for this population.

Some models of sex and relationship therapy have been shown to be effective when applied to populations with sexual trauma histories (e.g., Emotion-Focused Couples Therapy with CSA survivors; MacIntosh & Johnson, 2008; Mindfulness-Based group therapy for sexual distress in CSA survivors; Brotto, Seal, & Rellini, 2012). Other models have been modified to fit the needs of those who have experienced sexual trauma (e.g., Johnson & Williams-Keeler, 1998; Maltz, 2002). Few sex therapies have been designed specifically for those with sexual trauma histories that include all partners of the relationship and address both sexual functioning and erotic connection (e.g., cognitive-behavioral approach to couple sex therapy for sexual trauma; McCarthy, 1986; McCarthy & Farr, 2011). While the use of relationship-based sex therapies or modifications thereof are meaningful efforts to apply well-supported interventions to this population, they may not fully address the traumatic sexualization (and depersonalization) of these individuals.

Regardless of the relationship and sex therapy model used for treatment, creating a trauma-informed context for the relationship prior to beginning the therapy may be a useful approach with this population. A directive and intentional dialogue of values and expectations prior to beginning therapy may benefit relationships in which one or more partners have a history of sexual trauma. While this is a clinical article in need of empirical validation, the following primer is proposed to increase retention and the efficiency of gains for any style of sex or relationship

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therapy for these relationships. This paper looks to (1) present the primer in full along with a research supported rationale for its application, (2) review current obstacles for engaging in sex therapy with relationships in which there is a sexual trauma history in one or more partners and the way the primer may mitigate these obstacles, and (3) present a case study to demonstrate the application of the Relationship Shared Values Primer (RSVP).

The primer and its goals

The RSVP is an interactive psychoeducation intervention used as an introduction to therapy with the goal of easing apprehension and resistance to the vulnerability inherent in sex and relationship therapy, as well as providing a unified vocabulary for discussing erotic connection. Before engaging in interventions that bring vulnerability to the surface, the couple is presented with key values and skills that facilitate the safety required for erotic connection. The approach devotes the necessary sessions to naming, teaching, and exploring four key values: (1) Intimate Justice, (2) Non-linear Healing, (3) Mindful Acceptance, and (4) Erotic Empathy. Each value must be distinctly understood, if not embraced, before the next one is introduced.

Intimate justice

Intimate justice, as a value, purports that each partner in any sexual encounter is equally entitled to experience pleasure and satisfaction. This concept was originally developed by McClelland (2010) as a feminist framework for understanding sexual satisfaction and is applied here as the first key value to be introduced. She first defined the concept as "the development of entitlement to justice in the intimate domain – including both freedom from harm and coercion, as well as experiences of pleasure and satisfaction" (McClelland, 2010, p. 672). This value serves to elevate erotic pleasure from a luxury to a right for all.

Nonlinear healing

It is difficult to anticipate the aspects of the trauma that will be retriggered or resurface throughout different parts of the therapeutic process and over time long after the therapy process ends. The nonlinear healing value addresses the concepts that healing is messy and will have ups and downs, such that survivors of trauma may feel worse before feeling better, and have bad days even after they have felt healed. This concept is to facilitate acceptance that coping skills and skills of connection can and will continue to improve while also experiencing moments of regression or responses to triggers. Research has demonstrated that therapy facilitated change and post-traumatic growth are rarely linear and that some instability can actually aid in deeper healing (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007; Joseph, Murphy, & Regel, 2012).

Mindful acceptance

Mindful acceptance is the antidote to victim blaming. It involves acceptance of the distinction between an experience with a partner and an experience because of a partner. As the individual with sexual trauma history may be retraumatized by their own self-talk and inner dialogs, it is necessary that the partners can mutually understand that negative events, triggers, or reexperiencing of traumatic sensations during a shared experience is accepted without fault, such that no partner takes the blame for the other's internal experience. Mindful acceptance is an ongoing willingness to practice the skill of intentional acceptance and awareness of each person's

individual sexual experiences within their shared experience; the ongoing acceptance of each person's inner dialogue as a means through which to improve erotic connection.

Important to note, the current value is distinct from mindfulness models of sex therapy that focus on intrapersonal mindfulness. Mindfulness in sex therapy focuses on awareness of the present moment and focus of attention on the physical sensations within the self (Brotto, 2013; Brotto & Heiman, 2007). The value of mindful acceptance in the RSVP involves the acceptance of an interpersonal awareness (within the intimate dynamic) that is critical to supporting the development of an erotic connection.

Erotic empathy

Luterman (2018) defined erotic empathy as the "active practice of accepting that your partner can experience you in a light that you yourself do not see nor understand." The value of erotic empathy involves the principle of empathetic acknowledgement of each person's erotic experience as valid and not mutually exclusive. For instance, allowance for one person to find the other attractive despite that other person's subjective experience of unattractiveness. Erotic empathy aims to reduce the tendency to reject one's partner's sexual advances due to one's own sexual self-consciousness. This value fosters erotic connection by replacing one's spectatoring during sexual activity (Barlow, 1986; Masters & Johnson, 1970; Trapnell, Meston, & Gorzalka, 1997) with the social skill of empathetically enjoying a partner's enjoyment of you despite not receiving pleasure from yourself.

Application of the RSVP

The novel roles of therapist and partners

During the application of the primer, prior to the beginning of whichever sex therapy model is being implemented, the role of the therapist and partners are different than they are during the rest of the therapeutic process. During the RSVP introduction to therapy, the therapist takes on a role of *erotic connection educator* clarifying these values and providing a lexicon for communicating themes of vulnerability. During this phase the partners who are jointly in the role of *collaborative learners* are assessing the incoming information, determining how it fits with their current knowledge and value systems, and working with the therapist to integrate them into their broader relationship values. Notably, the RSVP should be applied in individual couple or relationship therapy and has not been applied to a group or multi-couple setting. While we propose allowing two 90-minute sessions for the RSVP, relationship-specific flexibility is understood. At the end of this value exploration phase, the therapy begins with the partners and the therapist as equal collaborators. As the therapeutic process unfolds, it is noteworthy that the therapist is mindful of their collaborative roles, promoting autonomy so as not to assume an expert stance in the relationship. In working with the RSVP, a greater sense of motivation and teamwork in the couples has been observed, along with an overall compassion for themselves and each other.

Case study: Bettie and Archer

Bettie and Archer had been married for 11 years prior to therapy. The second marriage for both; Bettie is a 47 year old white Canadian cisgender woman with no religious affiliation. Archer is 53 year old white Canadian cisgender man raised in a multiracial adoptive family. Their salaries are similar as are their generally egalitarian, liberal values. They describe little to no disagreements in the home regarding task completion and shared chores. She sent an email inquiring about therapy services, having been intrigued with the words 'erotic disconnection.' Inquiries with previous

potential therapists had led to terms like 'dysfunction' and 'general couple dissatisfaction,' neither of which appealed to this couple.

It was decided that the RSVP was an appropriate approach to starting therapy. It was explained that the RSVP is designed for those struggling with erotic disconnection, not an absence of love. Conversations about sexual needs and wants were described as both awkward and somehow cumbersome by this couple and were mutually avoided. Neither came without attachment injuries and significantly unpleasant emotional reactions to instances in their relationship. Additionally, Bettie reported a history of sexual trauma.

A brief synopsis of the couple's family dynamic and history is included here, in order to conceptualize the case. In practice, the history of each member of the couple may be taken post primer.

Archer grew up in a conservative, non-religious family with a father that was very authoritarian. Archer was determined to not exhibit tyrant-like traits in his own relationships. His mother, he emphasized, "Did not advocate much for her kids, she had enough on her plate." Archer's first wife believed that sex was inherently filthy, often shaming him for his desire and even his sexual humor. Archer offered awareness that his attempts at not coming across as domineering conveyed a, nonetheless, coercive and needy quality to Bettie. He realized that although at times his wife might need him to take more initiative, "I know that when I initiate, I haven't figured out how to be arousing or, I suppose, erotic. I am open to learning how to do that."

Bettie's parents are still married; however, their marriage is defined as loyal rather than happy. Bettie explained that she was praised for being quiet as she grew up, including the time her uncle touched her underneath her clothes. When she finally told her mother, it was dismissed and attributed no importance. Bettie experienced multiple coercive experiences and one sexual assault in college at age 20. After lengthy internal debates, she never did report any of her sexual traumas. One of her most recurring internal dialogs of sexual shame and conflict arose from her desire for male attention and validation without any desire for sexual follow through. Labeled a tease in high school, she described, "I don't feel I have changed much." Need assertions cause her significant anxiety and guilt.

Bettie describes a tendency to withdraw and freeze, unable to assert her sexual needs. Archer recounted times of impatience and frustration with himself when not knowing what to say when Bettie withdraws. When they first began therapy, their sexual frequency had become seasonal at best. They were more likely to have sexual relations on vacation or on special occasions. Sexual interactions consisted of him requesting to play, usually already aroused, and explaining how long he felt it had been since the last time and why he deserved some 'help.' She would eventually oblige him manual stimulation until orgasm after which the couple would share intimate cuddling, affection, and mutually stated feelings of attachment and connection. She would, however, feel a wave of sadness at the first inkling of her husband's request for sexual action. Despite feelings of attraction for her husband, she reported no feelings of mental or genital sexual arousal during their sexual encounters. Although, she volunteered having felt a distinct pulsation genitally while reading an interaction in a novel of a woman invited to dinner by an older man who was unbothered by the prospect of being rejected. She enthusiastically pointed out how fantastic it would be to feel the same sexual interest as him rather than feeling responsible for his sexual needs. Bettie explained, "I see myself, almost like in a little movie, confidently follow him into the shower in the morning. I want to be that person, and make him happy, but if I do, he will expect that from me and I don't want to have to do it all the time." She is fearful that by wanting to have sex she will lose the absolute boundary of 'never' that has been established.

Archer is used to taking care of his own sexuality but every once in a while needs acceptance, he explained. "There is so much love between us", they both agreed, "but sex, not so much." Archer identifies unchanged attraction to Bettie and determination to make it work. He has, however, noticed a decrease in his confidence and assertiveness more generally. His tendency to

repress his sexual desire out of shame and fear of being seen as a consumer or predator of her sexuality is a theme they agreed to address in ongoing therapy.

In order to optimize conditions for vulnerable discussions ahead, it was explained that their mutual arousal would thrive only as much as they each bought into their right to enjoy it. The value of *intimate justice* begins the primer.

Histories of sexual trauma often entrench a belief that one's sexuality is not one's own, that their bodies are not their own (van der Kolk, 1994; Young, 1992; Zoldbrod, 2015), but for someone else's desire, making assertiveness and self-advocacy particularly challenging. Having sexual partners intellectually embrace the value of intimate justice provides both the reassurance and empowerment necessary to facilitate reclaiming the sexual self after sexual trauma in the context of a relationship. One of the first steps to reclaiming the sexual self involves interpersonally asserting one's sexual needs. This involves a commitment to having ongoing attention to the cues of partners' affective states, such as negative affect during sexual activity (Meston, Rellini, & Heiman, 2006), as well as clarification of the distinction between consent and want (Peterson & Muehlenhard, 2007), desire and arousal (Althof et al., 2017), and arousal nonconcordance (Chivers, Seto, Lalumière, Laan, & Grimbos, 2010; Meston & Stanton, 2018). Intimate justice as a value, therefore, requires an agreement to maintain sexual integrity and acknowledge the necessity of the honest communication of sexual cues. Conversations regarding intimate justice for this couple may include: hesitation around the importance of one's sexual pleasure, habitual pleasure inequalities in relationships, low expectations with regard to sexual pleasure, and shame around sexual likes and dislikes. Interestingly, this discussion covered numerous difficult emotions for both members of this relationship. They each have a history of putting others before themselves as well as a history of desperately hoping to feel satisfied by their partner. They agreed that they would work to assert their individual needs during treatment. Intellectually they were able to grasp an understanding of the concept of intimate justice. Bettie was even enthusiastic about how obvious the concept is and in the same breath recognized how consistently she has not been able to put it into practice. By not expecting pleasure, she even tolerated pain. Archer, similarly, acknowledged he felt guilty just for feeling desire and offered an understanding that this needs to be worked on.

The second piece of intimate justice entailed a discussion of sexual integrity and the promise to be as honest and transparent as possible when relaying cues during intimacy. The couple agreed that future sessions would need a focus on Archer's tendency toward silence, as well as her tendency toward vocalizations during sex that came from a place of duty or expectation. Archer offered, "Sometimes I think that you aren't really enjoying what we are doing as much as you make it sound like you are. As hot as it is sometimes, I want to trust how you sound to know what you like." The embracing of intimate justice for this couple served to illuminate inequity in their sexual script and encouraged accountability.

The second value introduced at the end of the first session was the *non-linear processing of healing*. The focus of the dialogue around this value is to correct the myth that healing is an upward linear trajectory that results in flawless and unshakable interpersonal resilience. A goal of this discussion is to facilitate the understanding that therapy does not fix a person "broken" by trauma, but is an ongoing process that requires informed expectations in each partner that will lead to greater intra- and interpersonal empathy over the course of relationships. Nonlinear healing as a value involves subscribing to the notion that while the traumatic experience cannot be erased; it does not need to be a directive voice in the relationship's dynamic. The value of nonlinear healing cultivates acceptance for the process of acquiring skills for emotion regulation and coping throughout the healing process. It is the value that gives people the determination to work through disappointment when they feel they have temporarily regressed.

Both Bettie and Archer welcomed the idea that ups and downs are nonetheless forward moving. They were encouraged to notice all-or-nothing thinking and mitigate overgeneralizations as

they navigate difficult moments. Here, the couple shared an instance in which Bettie was triggered quite severely during a couple's therapeutic Swedish massage organized for their anniversary. During the massage, when the male therapist utilized his elbows, a technique she had experienced countless times before, his weight and a scent she could not pin point brought her back to a distinctly terrifying moment from her childhood sexual abuse. Though it took weeks for them to resume intimacy after this event, this temporary cessation of sexuality contributed to a learned, deeper sense of supportive intimacy and connection. The therapist pointed out that though this experience brought about tension and arguments, they were ultimately able to foster mutual vulnerability about that incident. Archer was able to feel heard about being devastated that she was struggling in the room next door while he was relaxed in his massage. Bettie was able to validate Archer's feeling helpless to her struggle.

As is the case with reeexperiencing symptoms (Ehlers et al., 2002), triggers and/or activations of previous trauma can be unanticipated regardless of how connected and sexually satisfied the couple is at that moment. The couple offered that awkward sexual moments have left them feeling hopeless. The value of non-linear healing intends to uphold realistic expectations and aid emotion regulation skills in times of disconnection.

Mindful acceptance, the next value introduced, is the intention to practice attunement to one's partner's cues across time. Bettie reminded Archer about the time she pulled away during intimacy that resulted in a misinterpretation by Archer. He quickly apologized without knowing what he was apologizing for, assuming he had harmed her in some way. Bettie was simply changing positions with no problem in mind at all. The skills of mindful acceptance will be central to ongoing treatment as the couple strengthens their ability to communicate desire for one another in the context of boundaries with erotic empathy.

To a person who has experienced sexual trauma, concrete boundaries may be a survival mechanism. Yet, this seemingly protective distance can be maladaptive when generalized to all erotic moments. By mindfully accepting that the trauma survivor is not to blame for lower levels of sexual interest, the couple can become more resourceful and strategic with regard to enhancing sexual interest as a couple. Sexual encounters are encouraged to be postponed until conditions are met for both partners to be erotically present. Mindful acceptance maintains non-judgment for intermittent lack of sexual interest by holding space and choosing curiosity. Lack of sexual interest is not necessarily pathology, but can provide insight into the wisdom of unmet needs (Kleinplatz et al., 2018).

Erotic empathy is the skill of empathizing with how your partner is inclined to feel erotically fulfilled. By venturing into a discussion of erotic empathy, a greater part of the therapy process ahead is unveiled. In just this introductory discussion, the couple discovered that Archer does not, in fact, only want to orgasm quickly with Bettie. He reduces his desire to what he believes will least bother her, thereby stripping their potential intimacy of elements of erotic approach that Bettie needs. The couple was asked to paraphrase their pre-therapy understanding of each other's needs and wants, and in so doing were able to begin to see how each of their responses were reactions to incorrect preconceived assumptions. They discovered that Bettie has difficulty receiving oral stimulation, and previous experience has taught her that men do not like to provide it at length; whereas Archer feels like he has pleaded with her to not see him as she sees other men. She expressed maintaining a cautious openness to exploring it with her husband. Archer volunteered to demonstrate erotic empathy by reassuring her that "she can have all the time she'd like" the next time they engage in cunnilingus in an attempt to help her with her inner dialogue to the contrary.

Meanwhile, Archer had created a narrative that led him to believe he did not deserve to provide his wife with oral sex because he either was not good at it or was not worthy for some other reason. Bettie in disbelief of his statement of unworthiness stated that she would do her best to erotically empathize that he wanted to pleasure her without interfering. She stated, "I don't have

the right to tell you that you don't want me, when you feel you do." The therapist offered how you can tell him what you want - you cannot tell him what he should not want. The goal of acquiring the skill of erotic empathy is to be able to make space for each partner's shameless sexual enjoyment, without feeling threatened or distracted by the incongruence from one's own experience. Erotic empathy, the couple paraphrased "is deciding to be careful to not dismiss [invalidate] the other," their erotic needs, or erotic narrative.

A list of important themes and follow-up discussions emerged and were jotted down, effectively creating a mutually established table of contents for future sessions. While the impact of the primer on long-term sustainability of erotic connection is beyond the scope of this manuscript, observed changes in the couple's cohesive dynamic included: increased eye contact while speaking, more physical affection in session, closer seating on the couch, and less safety behaviors (e.g., grasping throw pillows, sitting close to arms of the couch). The couple continued to meet biweekly for six sessions and has since maintained monthly refreshers for the last four months.

Obstacles for sex therapy when working with sexual trauma histories

Obstacle 1: trust and safety

A recent review of common factors of effective psychotherapies highlighted the importance of relationship factors in the therapeutic process including: the therapeutic alliance, empathy, goal consensus and collaboration, positive regard/affirmation, and congruence and genuineness (Laska, Gurman, & Wampold, 2014). While there are certainly common factors that underscore the effectiveness among the primary models of sex and relationship therapy, there is also a common factor that may relate to obstacles in treatment efficiency and treatment plateaus: a lack of safety. In work with individuals with trauma history, one of these obstacles is the posttraumatic fear of abandonment or retraumatization in the therapeutic process that can interfere with early rapport building. Individuals with interpersonal trauma have reported difficulty in building rapport with therapists (Cobia, Sobansky, & Ingram, 2004; Elmone & Lingg, 1996). By beginning the therapeutic process with the RSVP, each member of the couple is given the opportunity to arrive safely through active learning and listening before entering into the emotionally vulnerable beginnings of therapeutic work. One of the goals of the primer is to have a psychoeducational dialogue around important relational values to create a safe therapeutic space allowing for an easier transition into vulnerability.

An example of the necessity of cultivating safety can be seen with Bettie and Archer. They had previously seen another therapist in the second year of marriage after Archer tugged on Bettie's hair during intercourse, at which point she became very upset and they stopped abruptly. The therapist was not comfortable facilitating a conversation about sexuality. She unintentionally conveyed judgements and concerns around non-problematic sexuality. Instead of having discussions around boundary assertion of needs and wants, she conveyed that Bettie should 'lighten up' and Archer should explore why he felt the need to engage in abusive behavior. Neither agreed this was either light or abusive. They left therapy and their issues slipped under the rug, demotivating their intimacy.

Obstacle 2: attrition and buy-in

Sexual trauma can be a source of erotic distancing between partners or can be a factor that adds to the difficulty of overcoming erotic distancing that began for non-trauma related reasons; regardless, sexual trauma is expected to be visited in sex therapy. Trauma-related therapeutic work is associated with high rates of attrition, which has in part been associated with the discomfort of revisiting traumas or the tendency to avoid trauma related stimuli that is inherent in Post-

Traumatic Stress Disorder (PTSD; Imel, Laska, Jakupcak, & Simpson, 2013; Wamser-Nanney & Steinzor, 2017). In a meta-analysis on attrition rates, which looked at 669 studies (83,834 psychotherapy clients), the average dropout rate was found to be 20% for individuals with trauma history (Swift & Greenberg, 2012). The importance of pretreatment psychoeducation (e.g., Delgadillo & Groom, 2017) and strong treatment rationales (e.g., Addis & Jacobson, 2000) in retention and gains has been demonstrated in research with a number of empirically supported treatments. For instance, Delgadillo and Groom (2017), in a 2-arm randomized clinical trial of psychoeducation and CBT (n = 49) versus CBT alone (n = 49), found significantly higher retention rates for those that received psychoeducation prior to CBT (87.8%) than those that received CBT alone (68.8%). The RSVP seeks to increase motivation to stay in the therapy process by providing evidence-based preliminary hope and psychoeducational skill building to assist future emotional conversations. In couples work using the RSVP, the first author has found that using the primer appears to help with couple cohesion that decreases tension and increases a sense of teamwork in the couples, as well as facilitating a therapeutic alliance and treatment motivation.

Obstacle 3: false expectations

In individuals and relationships seeking therapy, there can be a tendency to believe that the therapeutic work will immediately alleviate concerns. The frustration and/or disappointment that ensue when individuals feel worse before feeling better, hit roadblocks, or experience old wounds after believing they were healed can feed resentment and hopelessness. While instilling hope is one of the cornerstones of early sessions with clients, the need to impart realistic expectations is critical for the progress of healing, connection, and growth. Individuals may enter therapy already feeling discouraged. Therapists should stay attuned to times where the clients begin to feel hopeless or discouraged through treatment. The value of nonlinear healing helps prevent the idea that things just get better and provides a launching point for therapists to invite discussions of fears, disappointments, and expectations. As illustrated in the case study, it is used early on in the work to facilitate hope and provides psychoeducation that can serve to increase tolerance for distress later on (McKay, Wood, & Brantley, 2007). Additionally, the mindful acceptance value can assist clients in learning to be gentle with themselves during setbacks, triggers, or moments of discouragement. The effectiveness of therapy can stand the test of time as the processing of difficult moments helps practice skill acquisition and monitor progress. Avoiding struggles for erotic connection is not encouraged. Instead, the RSVP supports mutual discovery through struggling with imperfect sexual moments encouraging discussions of "significant moments" in session. It should be noted that the RSVP does not seek to offer avenues for perfect sexuality, nor does it suggest the acceptance of lack-lustre sexuality. Instead, the RSVP hopes to provide a tangible platform for clients to begin approaching their own goals for erotic connection.

Obstacle 4: too much too soon

A number of relational sex therapy models have been developed and implemented, with some of the most commonly used models and interventions stemming from outcome-based research (e.g., Gottman Method Couples Therapy; Gottman, 2008), empirical observation studies (e.g., Masters and Johnson's Sensate Focus Therapy; Masters & Johnson, 1970), and theoretical models of interpersonal attachment (e.g., Emotion-Focused Couples Therapy; Greenberg & Goldman, 2008). Commonly used models of relationship and sex therapy may benefit from psychoeducation in a way that primes the clients for attunement between the individuals in the relationship. Allowing room for clients to express their individual values, understand their partner's values, and explore their shared relationship and/or sexual values. For example, although some modifications of Sensate Focus exercises exist for those with sexual trauma histories (e.g., Maltz, 2002; Weiner,

1988), they begin with touch exercises. For some individuals with sexual trauma histories who may have traumatic responses to touch (van der Kolk, 1994; Zoldbrod, 2015), being introduced to the invaluable sensate focus work too early or without psychoeducation and discussions of safety and values could add an obstacle to or further delay comfort with touch. Applying the RSVP prior to sensate focus work or other sex therapy modalities, could aid in fostering safety and understanding prior to touch exercises. The application of the RSVP allows the stage to be set so that the partners are better equipped to Honor being in both a relationship with trauma history and an erotically connected sustainable relationship.

Conclusions

The RSVP was developed in response to an observed need to help foster safety in a therapeutic setting for those with sexual trauma history. The RSVP's purpose is to introduce a unified vocabulary and safe conditions in which to increase mutual vulnerability prior to relationship psychotherapy. Intimate justice, non-linear healing, erotic empathy and mindful acceptance are introduced, fostering some brief discussion from which themes emerge to be addressed later on in treatment. The RSVP validates and welcomes both the individual's and their shared experiences into the therapeutic space. It provides clients with the preparation to be able to integrate and apply the sex and relational work in a context of being understood by the therapist and their partner(s). This has the potential to strengthen rapport early on and instill feelings of hopefulness and competency.

The RSVP underscores the importance of reviewing basic and advanced nuances of boundaries in a sexual relationship. Therapeutic practitioners of the RSVP can promote the conditions for partners to speak from erotic agency, facilitating their conversational capacity for bidirectional desire. By clarifying the four values of the RSVP, the ineffective elements of the relationship's erotic dynamic are unveiled verbally, safely clarifying the themes of treatment ahead. Although the primer is brief, it can uncover concerns for both the individuals and their relationship while allowing for a shared experience of facilitated mutual vulnerability.

Important to note, not all issues presented in therapy by those with trauma histories are related to trauma. Instead, in the RSVP trauma history is viewed as a context in which relationship and erotic concerns are situated. Regardless of the prominence of the trauma in the presenting disconnect, there should be awareness and discussion of its presence in the relationship. While the RSVP may be useful for work in relational contexts beyond that of sexual trauma, the RSVP has not yet been applied outside of this context.

Limitations

A notable limitation to this article is the generalizability of the heterosexual and erotically heteronormative couple discussed in the case study. A particularly verbal, self aware, and nonresistant couple, cannot represent more than an anecdotal depiction of this therapeutic intervention. Additionally, the four values asserted may not align with individual or relationship values for the clients. An assessment of cultural and individual belief systems, prior to the application of the RSVP is recommended. While the RSVP may be useful for individuals looking to increase erotic connection and mutual eroticism, it may be not be appropriate for individuals with other treatment goals. As the RSVP has not yet been empirically examined, an additional limitation of the article is its lack of empirical evidence for effectiveness in enhancing erotic connection.

Future work will implement research utilizing the primer in cases of relationship therapy with cultural competence across diverse populations, sexual orientations, and relationship configurations. Additionally, research of the RSVP may examine if incorporating this primer promotes treatment retention and ongoing treatment efficacy. It is a hope of the authors that the RSVP

serves as a stepping-stone for further addressing the needs of those with sexual trauma histories in the field of sex and relationship therapy.

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