“Will I be asked to have sex in the therapy room?”

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Background
In the July 2012 issue of this Journal I reported back on the experiences of psychosexual therapists. Their voices clearly and movingly described their motivations, their training, their challenges, their magic moments – and their hope for a deeper connection between the medical and therapeutic worlds when it comes to acknowledging and actioning psychosexual support for our patients. In so doing, I hope I helped show Journal readers that such support is a ‘Good Idea’ and – by inference – that we can confidently refer patients to it.

But hold on. Do patients themselves have any idea what ‘psychosexual support’ is? In this follow-up article, I explore the questions patients might raise, particularly the one that – whether they admit it or not – is underpinned by sheer terror.

Because, however fully practitioners may be at ease with the concept of professional sex therapy, patients being referred to it will not only feel the normal wariness surrounding the idea of any kind of counselling: “Will I be expected to hit cushions?” (probably not) … “Will I have to drag up the painful past?” (not always) … “Will it be confidential?” (yes, absolutely). They will also tap into a whole extra layer of fear based on the natural human need for safety when talking about intensely personal matters.

If we are able to confidently answer patient questions about what sex therapy means and what it involves, that process not only informs but also calms and reassures. Crucially, it also makes it much more likely that patients will proceed down the therapy road and profit as much as possible on their journey.

The basic question
So what are these patient queries, the ones we are likely to face once we’ve uttered the “Have you considered therapy?” suggestion? The first and most obvious question is a simple one: “Is it right for me?”

Typically, sex therapy is appropriate if the patient has had their problem for 6 months or longer, if medical solutions have been considered but haven’t proved relevant or effective, and if they have already unsuccessfully tried to solve the problem themselves or in conjunction with medical help (Boxes 1 and 2).

What patients – and we practitioners – also need to know is that sex therapy may not be the most effective solution if the presenting symptom is down to a tangential problem. Low libido triggered, for example, by a death in the family may best be helped not by sex therapy but bereavement counselling. Erectile dysfunction occurring as a result of an in-crisis marriage won’t be patched up by psychosexual support but will need in-depth relationship help. Plus, the therapist themselves will often refer right back to more general or relationship counselling if it seems clear that before they can even start to do good work, clients need to sort out their couple dynamic.

A final point about suitability and effectiveness. Like all counselling, sex therapy will only ‘take’ if the client is willing. If there’s real resistance, it’s pointless for the client – and a burden on psychosexual services – to refer on.

The practicality questions
The next set of patient queries that typically emerges – perhaps because it is the least embarrassing – concerns the practicalities.

“How often will I need to go?” Of course answers vary and anything but an estimate will almost certainly be wildly inaccurate, but most sessions are weekly
or fortnightly, up to 50 minutes long, but with added ‘at home’ work.

“How long will it take?” Patients may expect to see a therapist anything from half a dozen times upwards, though typically won’t be facing years of work but rather months. That said, while patient concerns are usually around not spending too much time, some may instead want reassurance that they won’t spend too little, that they won’t be rushed to a conclusion but can take as long as they need in exploring the issues. (Taking time is also vital because at the heart of successful therapy is relearning – relearning time and time again that sex can be enjoyable.)

“How much will it cost?” Again answers will vary according to local and national resources and to referral choice. Such choice is likely to be four-fold: an in-house, practice-based sexual therapist; a centralised therapy service such as that based at a regional hospital; private psychosexual counsellors; and private counselling organisations or networks, such as (in the UK) Relate or the College of Sexual and Relationship Therapists that offer psychosexual services (Box 3). The first two choices listed are likely to be free or heavily subsidised but have a longer waiting list; the last two choices are likely to be fee-paying but available more quickly. An informed practitioner can help their patient here by guiding them according to the urgency of their need and the resources that are available.

“Who will I see?” Typically one therapist. Occasionally two: one working with each partner then both conferring on a joint treatment plan. As I explained in my article1 in the July 2012 issue of the Journal, it’s usual for therapists to have originally trained in more general counselling techniques then specialised, or to be medical practitioners who have had extra therapeutic training. Clients attending alone can typically choose to work with a counsellor of their gender of choice.

“Do we both need to go?” If a client is partnered, it’s usually preferable for both partners to attend even if the problem seems to affect only one individual; sex itself is a reflection of relationship state that the therapist needs to see and work with the whole partnership dynamic. That said, if the patient reports that their spouse would need to be dragged kicking and screaming to the therapy room, it’s still worthwhile proceeding; a good counsellor can work wonders even with just one client, who can then perhaps transmit details of ‘homework tasks’ to the absent partner. (And, of course, with tact and time, successful therapy with one partner can be the most powerful persuader to get both partners to attend.)

The activity questions

“What will happen?” It’s usual for the therapist to spend the first session with a client defining the problem and then talking about what they want to achieve. The next step is the taking of a detailed history, typically with each partner on their own.

Thereafter subsequent sessions will typically involve talking – about thoughts, experiences, feelings – that shed light on the problem. Sometimes it’s relevant to delve into childhood memories, sometimes the problem is much more based in the here-and-now; often exploration reveals that what seemed like a sexual problem is something deeper, a relationship issue that needs to be resolved. Clients will be expected to talk about their sexuality, but only within

Box 1 For what conditions might sex therapy prove useful?

<table>
<thead>
<tr>
<th>Conditions</th>
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<tr>
<td>Sex therapy may benefit any condition that affects a patient’s sex life</td>
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<td>and for which medicine has done all it can. Note, though, that if the</td>
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<td>problem is down to communication or relationship problems – or any</td>
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<td>problem that needs general counselling – this needs to be done before</td>
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<td>sex therapy is possible.</td>
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<td>For her: pain during intercourse, vaginismus, anorgasmia.</td>
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<tr>
<td>For him: erectile dysfunction, problems controlling ejaculation,</td>
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<tr>
<td>anorgasmia.</td>
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<tr>
<td>For both: loss of desire, sexual identity issues, inhibition, boredom,</td>
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<tr>
<td>communication, fear, sexual difficulties caused by ill health, medication</td>
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<td>or disability.</td>
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Box 2 What self-help resources are available?

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<td>There may well be a waiting list for local – even private – psychosexual</td>
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<td>services. Hence it is useful to suggest that patients explore self-help</td>
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<td>methods – to resolve their sexual difficulties or to strengthen their</td>
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<tr>
<td>relationship – while they are ‘on hold’. The following resources may help.</td>
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<tr>
<td>Sexual Advice Association (<a href="http://www.sda.uk.net">http://www.sda.uk.net</a>).</td>
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<tr>
<td>The Orgasm Answer Guide by Barry R Komisaruk, Beverly Whipple, Sara</td>
</tr>
<tr>
<td>Nasserzadeh and Carlos Beyer Flores (The Johns Hopkins University Press,</td>
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<td>November 2009, £11.00) – in-depth advice from a worldwide panel of</td>
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<td>experts.</td>
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<tr>
<td>Overcoming Sexual Problems by Vicki Ford (Robinson Publishing, July 2005,</td>
</tr>
<tr>
<td>£9.99) – information and practical step-by-step advice on resolving</td>
</tr>
<tr>
<td>sexual problems like vaginismus.</td>
</tr>
<tr>
<td>The Relate Guide to Sex in Loving Relationships by Sarah Litvinoff</td>
</tr>
<tr>
<td>(Vermilion, March 2001, £8.99) – Relate’s guide to sexual</td>
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<td>fulfillment.</td>
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<tr>
<td>Sleeping with ED by Victoria Lehmann and Mike Kirby (National Services</td>
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<tr>
<td>for Health Improvement, July 2008, £6.00) – guide to coping with erectile</td>
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<td>dysfunction.</td>
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</table>

Box 3 Where can one get more information about sex therapy?

<table>
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<th>Resources</th>
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<tr>
<td>The College of Sex and Relationship Therapy (<a href="http://www.cosrt.org.uk">http://www.cosrt.org.uk</a>)</td>
</tr>
<tr>
<td>The Institute of Psychosexual Medicine (<a href="http://www.ipm.org.uk">http://www.ipm.org.uk</a>)</td>
</tr>
<tr>
<td>The Porterbrook Clinic (<a href="http://www.porterbrookclinic.org.uk">http://www.porterbrookclinic.org.uk</a>)</td>
</tr>
<tr>
<td>Relate (<a href="http://www.relate.org.uk">http://www.relate.org.uk</a>)</td>
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their own comfort zone; if that is narrow, then the
counsellor may well use that very fact as a starting
point for work.

“Won’t the therapist be shocked?” The patient may
need to be reassured that any therapist will, truly,
have heard it all before, that they won’t judge or criti-
cise and, once again, that everything said in therapy is
absolutely confidential.

“What will I be expected to do?” As the therapist
and the client(s) start to understand why problems are
happening, action plans will start to emerge. Often
what’s needed is not directly sexual. Clients may be
helped to relax, to lower anxiety levels, to gain confi-
dence and self-belief. If lack of knowledge – perhaps
about the biology or the mechanics of sex – is at the
root cause of their problems, they may be offered
additional information. They may be helped to think
and feel differently, to rework their beliefs about sexu-
ality, body image, gender roles and what really works
in bed.

Particularly when both partners are involved in the
therapy, clients may be helped to communicate better
about their needs and wants, to encourage sharing of
fantasies or, crucially, to develop a common vocabu-
lary that lets them talk more comfortably about sexual
issues. Or, with problems that stem back to earlier
trauma or sexual abuse, sometimes specific techniques
will be used; there is, for example, a growing interest
in trauma resolution through eye movement desensiti-
sation (EMDR).

The scary question
Undoubtedly the most fear-laden question that
patients typically have – although, through embarrass-
ment, they may ask the question only in their own
minds – is the one that heads up this article: “Will I be
asked to have sex in the therapy room?” The answer is
a resounding “relax … don’t worry.” Granted, par-
ticularly where the presenting problem stems from
lack of sexual skill, clients will usually be asked to
carry out intimate exercises, but with the exception of
the rarely-used bodywork approaches I described in
my article in the April 2011 issue of this Journal2
these will always be at home.

Furthermore, any such exercises will always be only
when the patient is ready: no good therapist would
ask a client to leap into such activities without full dis-
cussion and preparation. Exercises begin from a safe
base and build session by session, as clients gain confi-
dence. They take the emphasis off performance and
onto ‘in the moment’ pleasure, because often the ori-
ginal problem began because of pressure to perform.
If there’s embarrassment, reluctance or resistance,
that’s also discussed in the therapy sessions and fully
resolved before clients are asked to go further.

What kind of exercises will the client be asked to
do? At the heart of most sex therapy is sensate focus:
gently touching each other at increasing levels of
intimacy, through genital stimulation, then masturba-
tion to orgasm and finally – again only when clients are
ready – moving on to penetration. Sensate focus
not only re-stimulates desire and interest and helps
both partners discover what excites the other, but can
also be used to address particular issues such as pre-
mature ejaculation. (In some cases, such as vaginismus,
clients may be introduced to using a dilator, though
this will happen later in the therapy and only once the
client is completely comfortable with the idea.)

The effectiveness question
“But will it work?” Of course the bottom-line ques-
tion is whether sex therapy will be effective, and it’s
realistic to give patients a very positive response here.
Sexual issues are often very susceptible to therapy and
the results can be stunning. A study conducted by the
British counselling organisation, Relate, in 1999
reported that 93% of counselling clients felt their
sexual relationship improved after using the service.
Why? Perhaps because sexual issues can be well
defined, perhaps because sex therapy techniques are
well developed, or perhaps because often the simple
fact of being able to discuss taboo issues – often for
the first time – is in itself immensely therapeutic.

That said, it’s vital to warn patients in advance that
therapy will only be as effective as the effort they put
in. Counsellors can’t – and won’t – provide all the
answers and no one is going to wave a magic wand.
Part of supporting patients in any medical setting
involves managing expectations; guiding them into
sex therapy is no exception.

The referral question
“Where do I find a therapist?” When deciding on what
kind of therapy to go for – as mentioned above, the
practitioner (National Health Service or private), the
regional clinic or the counselling organisation – of
course the final call is with the patient. However,
the first trial should, I suggest, be with the health pro-
fessional, for the more knowledgeable and specific the
referral practitioner is about the available options, the
more motivated the patient will be to take their sug-
gestions on board.

I truly believe that names, facts, figures and direct
experience here count for a great deal when it comes
to reassurance, and to lowering patient anxiety. The
health practitioner who says “I think there are services
available, look them up yourself on the web” will
surely have a lower therapy take-up rate (and there-
fore a lower rate of patient resolution) than the one
who accompanies the suggestion of treatment by
actively facilitative comments such as “The sex
therapy clinic at the hospital is on Wednesdays – it’s a
very friendly place” or “I’ve met that counsellor –
she’s very well qualified and lives near you”.

To put in the time and energy to gain such a level of
first-hand knowledge may seem daunting in these
cash-strapped, time-impoverished days, but it can make all the difference in the world to have this knowledge already at your fingertips when dealing with a therapy-nervous patient. So pop round to the local counselling service provider, or have a coffee with the in-practice therapist; such actions will bear fruit (Box 4).

As will my final suggestion: the offer of a follow-up appointment. Because the question that many patients will never ask, but often want to, is: “...and can I come back to you for further help if sex therapy isn’t right for me?” The response “Come back and see me next month and let me know how you’re getting on” is the perfect answer to that question, whether asked or not.

Competing interests None.

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References

Box 4 Do it yourself?

An alternative to the longer-term therapy described here is for the patient’s problem to be addressed within the medical context by their own (therapeutically-trained) doctor or one of their colleagues, often within the same practice.

This clearly has a number of advantages. Issues can be tackled when they arise; patient and doctor have already established a bond of trust; any necessary genital examination may well be more acceptable; and so on. In addition, the fact that solutions can often be offered on the spot may mean the patient is less likely – in the sometimes weeks-long interval before starting therapy – to wobble, or retreat!

Therapy offered as a direct result of a medical consultation is likely to have the same theoretical basis as that described in this article, but could well be more clinically-based, is typically aimed at the individual patient rather than the couple, and often tends towards briefer intervention.

The Institute of Psychosexual Medicine (IPM) offers courses to give trained doctors the qualifications and experience to provide psychodynamically-based therapy. For details of these courses – or for a list of members to whom you could refer your patients – visit the IPM website (http://www.ipm.org.uk).