

Julie Sale

I had deferred my place to train as a psychosexual therapist for a year, to concentrate on my research into anxiety, and when I arrived on the first day of the course I had almost forgotten why I had wanted to qualify in sexual and relationship therapy at all. Since applying I had become immersed in anxiety-related conditions, particularly OCD, and my original motivation for taking the course – which was, I eventually remembered, to enable me to work with infertility – had faded. As I sat in my new learning group on that first day, it quickly became clear to me that I had conveniently edited out the sex (never mind the ‘psychosexual’) part of the training. On that first weekend I heard and used the words vagina and penis more than I had in my whole adult life and I learnt the names (and saw the pictures) of a painful range of sexual disorders, most of which I had never heard of before. My image of myself as liberated and well informed soon dissolved into the realisation that I was actually very married and, relatively speaking, really quite ‘vanilla’. Well, in the words of David Ribner, vanilla is still a flavour.¹

Training in psychosexual and relationship therapy is inevitably and extraordinarily personal. Nothing in my previous training hit this close to home, and I mean that literally. My learning was filtered through and understood in the context of my own intimate relationship, my own sexual experiences, and my

own life values. I found that I could face the horrors of sexual abuse and imagine working with both perpetrator and victim. I was OK with so called paraphilias, within the context of informed consent. Although the subject of STIs (sexually transmitted infections) is not inherently appealing, my only concern was how to remember the treatment protocols. And yet I burst into tears when we studied affairs. Affairs are the ‘bread and butter’ of relationship therapy and I could not tolerate the idea of them, never mind imagine how I could work therapeutically with them.

A perfectly timed self-reflective assignment allowed me to work out why affairs terrified me when paedophilia didn’t, providing me with as much therapeutic insight in 3,000 words as I had achieved in 50 hours of personal therapy and allaying my fears that I wasn’t cut out for this work. What the assignment had facilitated was the essential acknowledgement of the subjective and intersubjective nature of sexuality and, thereby, of sexual therapy, reducing the risk of this being brought unconsciously into my clinic room.²

Once I started working clinically in this field, everything shifted. It took a little time to lose the self-consciousness that came with talking about orgasms and masturbation before the watershed and to overcome my nerves about working with two people in front of me rather than one, but gradually the richness of the work overtook the inhibition. At the start of my course I

Jo Coker, Julie Sale and Krystal Woodbridge describe the blushes, revelations and rewards of training and working as psychosexual and relationship therapists

Illustration by Romy Blümel

On becoming a sex therapist



‘While the subject of sex itself is no longer particularly taboo in Western society, discussing and admitting to having problems with sex *is* taboo and often embarrassing’

struggled to remember why I wanted to do it. Now I’ve completed the course I wonder what would have become of my clinical work if I hadn’t. Clients with whom I’ve worked for years are now revealing and exploring sexual material in their sessions without knowing about my new training. My long-term interest in anxiety and obsessions has stood me in very good stead in treating sexual disorders and addictions. My two main professional trainings seemed worlds apart three years ago and now I can see that they are both essentially connected in enabling me to work with the human totality of the individuals and couples who come into my clinic, whether they bring specifically psychosexual and relationship issues or not.

Krystal Woodbridge

My own experience of couples therapy led me to retrain as a psychosexual and relationship therapist. Couples therapy had allowed me to move on from a particularly difficult relationship and begin to focus on myself once again. I consequently found that I had reached a crossroads in my career as a registered nurse. Although I loved working in the NHS, I had felt for years that the demands of the work and a lack of resources meant I was having to sacrifice to a large extent what was, in my opinion, the greatest privilege of the work – quality time talking to patients and their families, providing reassurance, sharing my knowledge and educating them about their conditions. I recognised that the medical model also left little space for the psychological and emotional wellbeing of patients, even though they were suffering from medical conditions and undergoing surgical procedures that had profound effects on their sexuality and intimate relationships.

Once embarked on the diploma training, my nursing background was extremely helpful in understanding the medical and physical presentations, treatments and implications of various sexual dysfunctions, and informed a pragmatic and open-minded approach to the training. My concern was that, as a therapist in my early 30s, some clients, and indeed colleagues, might doubt my competency and feel I lacked experience. I could no longer draw on my confidence in my professional knowledge and skills to demonstrate my competence, as I would as a nurse. Thankfully, my placement (with the Letchworth Counselling Centre) and excellent internal and external supervision allowed me to build my confidence, and my clients

and colleagues have consistently shown their belief in me. I am very proud to be a trustee of the College of Sexual and Relationship Therapists (COSRT) as a direct result of this.

Then there is the impact that the work has had on me personally. On the first day of the training, the tutor advised us that, if we were in a relationship, we would not be in the same relationship by the end of the course. This was true for me. For many, the exploration of our own views and those of our clients about how we define healthy relationships, effective communication and partnerships brought attention to and prompted a re-evaluation of our own relationships. Beginning to feel disillusioned, I wondered whether the goals of couples work were too idealised and unachievable until I began to witness the positive effects of therapy in my clients. This was the catalyst that resulted in the breakdown of my relationship and the subsequent establishment of a much healthier relationship based on my renewed expectations.

The reactions of family and friends to my new career have been interesting, but overall I have felt encouraged by the positive responses. In social conversations, disclosing my profession often leads either to awkward silences or to a series of questions and assumptions, often disguised by humour/banter or ‘hypothetical’ questioning, which might be interpreted as people covertly asking, for example, ‘Am I gay?’, ‘Can trust ever be restored in a relationship once broken?’, and ‘How can talking help with a physical problem?’ It would appear that, while the subject of sex itself is no longer particularly taboo in Western society (indeed, the media take the stance that sex sells, and would have us believe that everyone is having lots of good sex all of the time, which undoubtedly raises our expectations of our own sexual performance), discussing and admitting to having problems with sex *is* taboo and often embarrassing.² Maybe part of our role as sex therapists is to raise the profile of what we do so that talking about sexual problems normalises them, and to encourage the media to portray more realistic and healthy attitudes to sex and relationships. Surely this would lead to more people seeking help? To that end, I have decided to embrace the awkwardness and embarrassment! There is much work ahead and I am very excited to be involved in such an exciting and dynamic profession.

Jo Coker

I started my professional life as a registered nurse in oncology and radiotherapy, later moving into the community as a health visitor with a specialist brief to provide a health education programme for teenage mothers in inner city Leeds. During this time I became more interested in human behaviour and relationships, which led to my retraining as a counselling psychologist.

Throughout all my professional life the focus has been very 'medical model', with little, if any, attention paid to the complexity of human relationships and sexuality behind the medical presentation. Healthcare providers still commonly assume everyone is heterosexual; disabled people and people aged over 60 are routinely regarded as not having (or needing) any kind of sex life. Iatrogenic damage is seen by medical teams as justified in pursuit of a cure and improving survival rates from physical health conditions. The notion that someone might put sexuality above cure and survival is still met with disbelief.³

The scant attention paid to sex and relationships became even more apparent when I was working as a counsellor in a general practice. When patients did raise sexual issues with the medical or nursing team, they were largely dismissed. One client, a man in his 60s, who had plucked up the courage to ask his GP about his erectile dysfunction, reported to me that he was brushed aside with the comment: 'At your age you should put all that behind you and take up golf.' A young mother suffering dyspareunia after a very complex traumatic delivery was told to 'have another baby'.

I wanted to offer more constructive help to clients who suffered stress in their relationships and distress in their sex lives, which is why I signed up to train as a psychosexual and relationship therapist. In many ways my medical knowledge helped; it provided a very comfortable professional haven where it was easy to hide. However, the complexity and variation in the human experience of sexuality and practice was so much more diverse than I had ever imagined that I sometimes felt I was in a different world.

The training group contained a very eclectic mix of sexuality and gender; many were into sexual practices I had barely heard of, let alone tried. As a young nurse in the 70s I remember thinking a friend very racy for having a vibrator; that now looked very tame

in the context of my group and their experience.

Professional support while training is paramount and this was provided by my training institution and COSRT. As much of the training is experiential, it requires great sensitivity on the part of the trainer to ensure the trainees feel 'safe' while being challenged. As a group we were well supported and I was able to challenge with little discomfort my self-concept about my own sexuality, history and assumptions as they came under scrutiny. Many questions begged to be answered... How did I know I was a heterosexual woman? What were the messages that had told me this? Where had I learnt about sexual practice? Which practices were OK and which were not? After the rigidity of much of my training, it was like being offered a smorgasbord of rich foods to taste, and this experience has informed my understanding of sexuality and relationships in a way that my other trainings, which barely mentioned sex, have not.

So what have been the highlights of working as a psychosexual and relationship therapist? Perhaps this is best illustrated by two very different vignette case studies from my clinic.

Ann's story

Ann was 28 and, by any standards, a very attractive woman who would not look out of place on the catwalk. However, her style of dress was rather old fashioned and dull, and I was conscious of feeling, 'What a waste of such a great body'. As we talked, she explained that she dressed that way partly because of her work, but also because it deflected unwanted attention. Ann was a successful litigation lawyer; she worked long hours and often had to sleep over at work, in one of the company's 'pods', when they were working under pressure. She had little time for a social life outside professional networking and, because she worked so hard, was professionally very successful.

Ann was tense and nervous about seeking help. When she had previously consulted her GP, he dismissed her anxiety. She had been prompted to come to therapy by the birth of her brother's baby. She wanted to have a relationship and children but she feared it was too late and she would not be able to catch up. My heart ached for her as she started to sob. It is hard for young women today, balancing the pressures of developing a career and the biological clock. The 'nurse in me' wanted to reach out and

touch her hand to offer comfort. Instead I passed her the tissues and gave her some space for her grief.

Ann said she had never had a relationship, although she found men attractive, and had only had sex once, while at university, in a drunken one-night stand. The sex was rough and it left her sore and bleeding and not wanting to repeat the experience. She used tampons easily and could put her fingers up her vagina with no discomfort. She said she had not had any relationships since that experience, partly out of fear but also because she had little time. She had a good male friend from school who was gay but not 'out' and who often escorted her to family events and parties. Most people probably thought they were an item.

Her background was privileged: her father was a lawyer and her mother a paediatrician. She was one of three children, all successful: one brother was a lawyer and the other an accountant. All had attended top public schools and universities. The family was very competitive: there was a general ethos and expectation of excellence and hard work; failure was not an option. This saddened me as failures can facilitate great learning.

Ann worked hard throughout her childhood and university, with little time for fun. As a teenager she kept aloof when friends talked about boys and sex, as she did not have the sexual experiences of her friends. Because of her good looks, most people assumed she had relationships and was simply being discreet. Men often approached her but she put them off by playing cool.

She told me she rarely tried to masturbate and had never had an orgasm. She was very ill informed about sexual repertoire, sexuality and, strangely for such a well-educated woman, anatomy. This baffled me and left me feeling sad and angry that such a clever woman was so ill prepared for adult life.

In order to have a relationship with others we first need to be able to relate to ourselves. So the first part of Ann's therapy focused on this. Her dysfunctional assumption was: 'I have to be the best', 'I cannot fail'. We explored what it felt like for her not to be best, and what 'best' meant for her.⁴ We also looked at how she dealt with learning difficult new skills. We uncovered her fear of not being best that not only limited her sexual functioning but also meant she did not try new things if she felt there was a long learning curve or risk of failure.

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Case studies

The case studies included in this article are composites and do not describe any individual client.

We found evidence outside the sexual arena that if she had a bad experience, she tended not to try again.⁵ Ann felt a lot of shame around her failure to enjoy her first sexual experience and we normalised this by looking at other people's experiences⁶ – after all, how many of us are lucky enough to immediately have a great experience with sex? She found this surprising but reassuring.

Ann had little language to articulate her emotions (alexithymia) and a very poor sense of what felt good, as became clear when we tried out some tactile exercises. She was also very controlled and uncomfortable with some of the exercises. We tried touching different foods and comparing sensations – what felt good on her hands and what did not. We also tried comparing the sensation of different fabrics. She found this easier as it wasn't so messy, which was interesting as sex is a messy business and to lose oneself in sex requires a certain tolerance of mess.

We moved this exercise on to applying these sensations to her body between sessions. What did it feel like to use body cream, oils and a different bath scrub? Which fabrics felt good and how did she know this? What was it like to touch her body non-sexually and sexually with these items? She finally plucked up the courage to have a body massage with aromatherapy oil, which she was surprised she enjoyed. I nearly cheered out loud when she told me – physical contact that was enjoyable... we were on our way!

Our biggest breakthrough came with an exercise that involved reading erotic literature. Using her intellectual side, which was easy for her to access, I set some reading homework between sessions. Ann felt sexual arousal, and was relieved and excited. She learned that, when aroused, you are lubricated and therefore sex and vibrator use is more comfortable. As a young girl I learnt much about sex from books that were passed between friends, and we had tremendous fun turning down the corners of the relevant pages in order to skip to the 'good bits' quickly. I felt sad that Ann had missed this camaraderie and the learning it facilitated.

We moved on to sex education and vibrators. Ann began to feel less inhibited about using a vibrator and enjoyed the sensations; now occasionally she would orgasm. We also worked on developing a lighter side to her personality. Laughter is great therapy used appropriately and, as Ann progressed, she was able to be less

serious and take life more lightly and put into perspective her first sexual experience. We looked at her work-life balance and she realised that she often volunteered to take on more work to avoid a social life. She began to make some changes and joined an exercise class and a film club.

Colleagues and friends noticed a difference, and I noticed that her sexual side was now showing through in what she wore and how she wore it. Instead of letting her clothes contain her, she began to really wear the outfits she chose, and her style became more glamorous. In fact she was looking fabulous. I no longer felt her wonderful figure was wasted and hidden. At this point I felt like a very proud mother, and identified with her comments about her mother's pride in her as a teenager. This left me feeling guilty as, of course, our clients are not there to please us.

While she did not yet feel ready to accept any invitations to date, she no longer put people off and began to make friends. We did a lot of work on relationships and social skills and her confidence grew, she began to make me laugh and I looked forward to her sessions and the changes that were occurring.

Ann finished therapy at this point, having made excellent progress. Six months later she emailed to say that she was dating a male friend she had met at the film club. While sex was very awkward at first, her partner was very understanding and it was getting better, and she had even managed an orgasm and felt she was on the way to good sex.

Yvette's story

Yvette came to see me for short-term counselling. Her GP said he was referring her after she consulted him about vaginal irritation that was caused not by infection but by sex. He said he had tried to discuss this with her and had suggested oestrogen cream to help, but she had refused it and would not open up to him. So he had given her some KY jelly and referred her to me.

When she entered the room I was immediately struck by her natural grace and poise. Yvette was 75, short and rounded in a voluptuous way, but she moved with fluidity. Her silver-grey hair was cropped and she was dressed in a bohemian manner with dangly earrings and lots of bracelets, which rattled as she moved and gesticulated – which she did a lot. I immediately warmed to her; she was the sort of person to whom I would be drawn outside the counselling room.

Yvette had two daughters, 38 and 40 years old, and seven grandchildren ranging from six months to 14 years in age. She had been widowed seven years ago after 43 years of marriage, which she described as happy but not without difficulties. The sex, she said, was enjoyable but pedestrian, and she laughed as she said this. Despite my cool, professional psychosexual therapist stance, I was amazed by her unsolicited candour about sex in our first session; I am ashamed to say that I assumed it was because of her age.

She coped with the loss of her husband by throwing herself into hobbies, friends and her daughters' lives, supporting them by helping with childcare while they went to work and generally running errands for them. Life, she said, was very busy and rich, though lacking intimacy. She looked sad when she said this and then looked me in the eye: 'You see I do enjoy sex and have never lost my drive. I do wonder if this is abnormal.'

I spend so much of my life with women who struggle with low sexual desire that I found it refreshing to meet a woman who has a vibrant sexuality, especially at Yvette's age – although again I was conscious of my implied judgment by even thinking this.

A year ago she had gone on an educational cruise and met David, a fellow passenger of a similar age. They struck up an immediate rapport, having many interests in common, and both having lost their partner. By the end of the cruise they were lovers and Yvette said that, after years of grieving for her husband, she felt alive again. David felt the same and, as they lived not too far away from each other, they looked forward to continuing the relationship and seeing where it went. The sex, she told me, was far from pedestrian, and she felt alive and in contact with her femininity. However, she was experiencing vaginal irritation caused by dryness and difficulty with some positions as she had a hip replacement two years previously. But the main problem was her daughters: they were horrified when she told them and started to treat her like a naughty child – especially her eldest daughter. They said she was 'too old for sex' and that her behaviour was 'disrespectful to the memory of their father'. Her eldest daughter even suggested she was 'losing it' and that her sexual behaviour was abnormal. This upset Yvette tremendously, especially as David's son had been very kind and had seemed delighted that they had found some happiness together.

Her younger daughter had now come around, and they had long discussions about the situation, but her older daughter remained upset. Yvette suspected it wasn't just about the sex; it was that she was less engaged with the family now as her relationship with David became more permanent. She now felt torn: she adored her girls but she wanted the relationship with David. Could she have both? At this point my conscience pricked me and reminded me of a parallel process in my own life. My much loved octogenarian mother recently announced that a long-standing male friend had proposed marriage, which had me and my sister rolling our eyes and tutting. Listening to Yvette, I felt very guilty about our lack of understanding and empathy for our mother and her needs.

The first session passed quickly and I was able to help Yvette sort out more suitable vaginal lubrication to make sex more comfortable. We laughed as we tried out the different lubricants, for all the world like two girls talking about face cream. I also helped her find more comfortable positioning to avoid putting strain on her hips. As she left she thanked me for listening: 'You see, Jo, people think that us oldies should not be having sex, but let me tell you it can be just as good at my age as when you are young, just a bit more problematic.' And out she sailed, leaving me feeling very energised and with plenty to think about until our next session, including my own prejudice.

Much that is written or portrayed in the media about sex is aimed at a younger audience, and little consideration is given to the help that older folk may need to enable them to enjoy a sex life. This is particularly important today, when many people in the 50+ age group are entering new relationships, and may have special needs for help, and in particular safe sex education, as the incidence of sexually transmitted disease in this group is rising.⁷ Fortunately the trainers on my course were very enlightened in this respect, maybe because, like me, they were of a mature age themselves and experiencing the physiological changes that can impede a satisfactory sex life. Despite this I still felt a little surreal talking to Yvette about sexual positions and lubricants; I had never had such in-depth conversations with my own mother or aunts.

Over the course of the next sessions we continued to explore the relational issues and how they might be resolved. Yvette made plans to spend some quality time with her elder daughter to try and understand her resistance. She was also

determined to hold her ground with her new relationship and not let this be sabotaged. I suggested *Still Doing It*, a book about women over 60 and sex, that she could share with her daughters.⁸

At our last session Yvette was in fine form. It was a bitter winter day and she was dressed in velvet and fur and looked magnificent. Her hunch that her elder daughter's negativity was about more than sex turned out to be correct; her daughter was anxious about money and how she would manage the extra costs if Yvette were no longer available to offer free childcare. They had come to a mutually acceptable compromise: Yvette would tell her when she was available to help with childcare and when not.

The daughter had also talked about her own grief at losing her father and her fear about losing her mother to David and how lonely that made her feel. Yvette was able to tell her how much she loved her daughters and her grandchildren and how very important they would always be to her. But she had also made it clear that she had needs that could not be met by these relationships alone and that her relationship with David provided these. The book I suggested had prompted a lively and open discussion about the social prejudice that exists around older women and sex. Yvette's elder daughter had also agreed to meet David and to try to respect her mother's relationship with him.

Yvette said it had been enormously helpful to talk about sex with someone who was not shocked and did not judge her because of her age, which left me feeling a little guilty as, while I did not judge her, I had been surprised by her very active sex drive and it certainly made me reflect on my own attitudes to sex and age.

Six months later I received a letter from Yvette to say she and David were to marry and that the family had settled down well and were getting on. The letter had a PS: 'The sex is still really wonderful.' I laughed out loud. ■

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