

Bridging Theory and Practice in Psychosexual Therapy

Bridging Theory and Practice in Psychosexual Therapy:

*Cultural and Clinical
Global Insights*

Edited by

Caleb Jacobson

**Cambridge
Scholars
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This book is dedicated to **Ms. LaTanya E. Jones**, Executive Officer of the International Association of Psychosexual Therapists, whose unwavering support and tireless efforts have been instrumental in making the 2nd International Symposium on Sex Therapy a reality.

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INTRODUCTION

CALEB JACOBSON, PSY.D., PH.D., C-PST
EDITOR

Considering that at the time in which this introduction is penned, the International Association of Psychosexual Therapists has only been legally organized for one and a half years, it is truly remarkable to consider that this volume represents the organization's second academic publication. This achievement not only reflects the rapid growth and professional momentum of the Association itself but also speaks to the extraordinary success of the International Symposium on Sex Therapy, which has quickly become a leading global forum for scholarly exchange in the field. The papers featured in this volume were selected from presentations given at the 2nd Annual International Symposium on Sex Therapy, held in Hvar, Croatia, from May 19–21, 2025.

The chapters in this volume represent a carefully curated selection of that exchange, highlighting emerging insights, diverse clinical approaches, and the continued advancement of psychosexual therapy on a global scale. Each paper was chosen for its relevance, originality, and contribution to the evolving discourse within the field.

Judi Keshet-Orr, the founder of the London Diploma in Psychosexual and Relationship Therapy, opens the volume with *The Evolution of Psychosexual and Relationship Psychotherapy in the UK*, offering a reflective account of the field's development in Britain, from its early roots to its current institutional and clinical standing. Her work not only charts historical milestones but also raises timely questions about future directions.

In *The Deconstructed Meal: Intersectionality of Body Image and Sex Positivity with Patients with Eating Disorders and Sexual Trauma*, Michelle L. Dean explores the clinical intersections between embodiment, trauma, and sexual identity. Through case-informed discussion and artwork, she presents integrative strategies for fostering healing and sexual self-acceptance in complex cases.

Chris Wilhoite's *The Biopsychosocial Impact of Medications on Sexual Functioning* reviews the multifaceted ways pharmacological treatment—particularly psychotropics—affects sexual health. The paper offers

clinicians practical insights into assessment and communication when working with clients navigating medication-related sexual side effects. It stands as one of the earliest contributions to meaningful dialogue on this critically important topic.

Professor Mark A. Yarhouse of Wheaton College, together with graduate student David O'Connor, turns attention to *Ethical Issues in Providing Sex Therapy to Conventionally Religious Mixed Orientation Couples*. Grounded in both clinical experience and ethical analysis, this paper examines the nuanced challenges of working with couples in which one partner identifies as LGBTQ+ and the other maintains conventional religious beliefs.

Mallory K. Hanfling's *Compulsory Heterosexuality and Its Role in the Formation and Clinical Best Practices with 'Fireflies'* introduces the term "firefly" as a gender- and sexuality-inclusive alternative to the label "late-in-life lesbian." The chapter explores how compulsory heterosexuality influences sexual identity development and offers clinical guidance for working with individuals who come to recognize their queer identity after entering heterosexual relationships. Hanfling provides thoughtful strategies for assessment and treatment, emphasizing the importance of affirming care within a heteronormative cultural context.

In *Reading for Connection: The Therapeutic Role of Romance Novels in Enhancing Communication and Intimacy*, Jennifer H. Greenberg explores the use of popular literature as a tool for deepening couples' relational awareness and fostering emotional and sexual intimacy within therapeutic contexts. Based on her recently defended PhD dissertation, this chapter marks a significant milestone in her academic and professional career. Its inclusion in this volume is a meaningful recognition of her scholarly contribution to the field. In which, I am most happy to offer it here.

Tommy Underhill's paper, *Minimizing the Impact of Executive Function in Relationships with ADHD*, offers targeted strategies for improving relational dynamics when one or both partners experience executive dysfunction. The paper bridges cognitive science and couples therapy in a clinician-friendly manner, one written with someone who self-identifies as having ADHD.

Laurie Betito's contribution, *The Impact of ADHD on Romantic and Sexual Relationships*, expands this discussion with a broader focus on how ADHD affects desire, satisfaction, and attachment. Drawing from both research and clinical practice, the paper underscores the importance of neurodivergence-informed sex therapy.

Bryson Kelpo offers a comparative legal and cultural analysis in *Cross-Cultural and Legal Perspectives on Involuntary Psychiatric Treatment for*

Sex Offenders: A Comparative Review of Germany and Spain. The paper explores divergent systems of psychiatric containment and their implications for ethical practice and human rights.

Finally, my own contribution, *Unrealized Experience Fixation: A Psychosexual Developmental Understanding of Minor-Attraction*, introduces a developmental model for understanding certain pathways to minor attraction, emphasizing the role of early psychosexual arrest and fantasy fixation in shaping adult sexual interests.

Together, these chapters represent a meaningful contribution to the psychosexual therapy literature, capturing the diversity, depth, and expanding global scope of the field. It is a true honor to present them in this edited volume, as they reflect the intellectual rigor and clinical relevance showcased at the International Symposium on Sex Therapy. What makes this collection particularly compelling is its practical orientation—these are not merely theoretical reflections, but clinically grounded insights that can inform real-world practice.

One of the defining strengths of the symposium is its commitment to fostering dialogue between emerging voices and established leaders in the field. This intentional blend of experience and innovation enriches the discourse, challenges assumptions, and propels the field forward. The papers gathered here reflect that spirit—grounded in research, shaped by lived clinical experience, and infused with fresh perspectives that continue to expand the boundaries of psychosexual therapy.

It is with great hope that the symposium continues to flourish, serving not only as a gathering point for knowledge exchange but as a catalyst for shaping the future of psychosexual therapy. Through the efforts of the symposium and the publication of volumes such as this one, we aim to inspire, equip, and elevate the field—affirming its place as a vital and indispensable domain within behavioral and relational health care.

May this volume offer insight, utility, and encouragement to those who read it. And we warmly hope you will join us in person in the years to come, as we continue to build a community devoted to advancing the art and science of psychosexual therapy.

THE EVOLUTION OF PSYCHOSEXUAL AND RELATIONSHIP PSYCHOTHERAPY IN THE UK

JUDI KESHET-ORR, M.SC., C-PST
LONDON DIPLOMA IN PSYCHOSEXUAL
AND RELATIONSHIP THERAPY

Introduction

Psychosexual and relationship psychotherapy is, in and of itself, a relatively new profession in the UK. Historically, its foundations were laid in 1976 with the formation of the Association of Sexual and Marital Therapists (ASMT). The founding members included John Bancroft, Liz Stanley, Derek Jehu, and a handful of others, many of whom came from clinical services within the UK. By 1978, the founders were joined by other professionals in the field, and they were, in turn, joined by people from a variety of disciplines. The first training courses were established in 1979 and 1981, and this allowed for numbers to increase.

However, going back as far as 1921, Marie Stopes opened the first clinic for what was then called “constructive birth control,” which might now be termed contraception, advice on termination of pregnancy, and sterilization. Even further back at the end of World War I, the UK opened “venereal disease” clinics, now known as sexual health clinics, with a much broader remit. In 1948, the National Health Service was founded in England and Wales, and these services were integrated into it.

The primary function of ASMT (Association of Sexual & Marital Therapy) was to support education, ensuring that patients could avail themselves of support, help, and guidance for sexual and relationship issues. At this time, people were heavily influenced by the work of Masters and Johnson, as well as Singer Kaplan, whose book *The New Sex Therapy* arrived on our doormats, soon followed by her *Illustrated Manual of Sex Therapy* and, in 1989, *PE*, which is still used today.

The Illustrated Manual of Sex Therapy was published in 1975. Training at the Tavistock Clinic in London had evolved from the Institute of Marital Studies and was psychoanalytic in approach. The Institute of Psychosexual

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Medicine was founded in 1974, but only trained doctors, and so something else needed to be developed for those not within the medical field.

The first course was the Marital Sexual Training at the National Marriage Council in 1979-1980. It was a one-year course with eleven 24-hour residential trainings.

As identified by Margaret Ramage (UKCP Fellow, COSRT Fellow) in her paper to celebrate *50 Years of COSRT (2024)*:

All ASMT training courses set up after this had input from the experience of NMGC, and others in related fields such as psychiatry, medicine, psychology, etc. There was much collaboration between course directors and the leaders of clinics who were seeing patients with sexual dysfunction. At this time, courses were held in Edinburgh, Sheffield, St George's Hospital, London, The Maudsley Hospital, London, and Herbert Gray College in Rugby. Each course adopted its own individual approach, but basic standards of content, process, and assessment of students were agreed within ASMT.

Course Approval was in place from the outset. Student assessments were conducted internally with external "examiners" drawn from other courses. Course leaders visited each other's premises at regular intervals to evaluate content, process, and assessment outcomes. This became formalized by ASMT later, and continues to evolve, updated regularly to this day, as current trainers will know.

It is beyond the scope of this history to list all the successful Accredited Training Courses since 1981, but some have lasted longer than others. Notable among them is the London Diploma, which was instituted at the Whittington Hospital in 1997 and is still going. The Tavistock trainings have also continued in different forms, as have Relate. The Cambridge Institute for Clinical Sexology is a fairly recent addition and is ongoing.

ASMT joined as an organisational member, the British Association for Counselling, which was founded in 1977 and is now known as BACP, the British Association for Counselling & Psychotherapy. ASMT then became BASMT, adding British to its title. Only in 2009 did it change its name again, becoming COSRT, the College of Sexual and Relationship Therapy. It took some time to move from 'marriage' to 'relationship.' It is now one of the colleges within the United Kingdom Council for Psychotherapy (UKCP). The first formal registers of accredited therapists were opened in 1992, followed by a register for supervisors in 1993. Fellowship awards were introduced in 1992-1993.

The history of PRT is therefore relatively short. Training standards have evolved significantly and continue to do so. Eligibility to undertake substantive training in PRT has become more rigorous and challenging. It

is now widely accepted that those wishing to train need a solid foundation in psychotherapy and/or counselling, along with considerable clinical experience. This, of course, excludes many who, like those who trained in the past, come from diverse backgrounds.

Additionally, the language defining psychosexual presentations has also changed. For example, the term ‘impotence’ is no longer used, we now refer to it as erectile dysfunction (ED), ‘frigidity’ is seen as inhibited sexual desire or a sexual arousal disorder, ‘sexual dysfunction’ might be termed as a sexual difficulty and ‘premature ejaculation’ is now known as rapid ejaculation, thereby removing the inappropriate pejorative aspects of the prior terminology. In 2000, Rosemary Basson described a different model of female sexual response in the *Journal of Sex & Marital Therapy* (26:51–65), which has been very well received by the PRT community.

What Is PRT?

Some training organisations took it upon themselves to divide sex and relationships into distinct fields of study. This created a need for therapeutic alliances between those practitioners more equipped to handle one side of the relationship than the other, signposting couples in different directions. Other training providers saw the patients more holistically and trained people to work with all aspects of the relationship.

The curriculum of the trainings themselves also went through significant changes. As stated by M. Berry (2013):

Sex therapy has developed against the backdrop of two important elements: a scientific model of sexual behaviour and sexual functioning, and a psychological understanding of human sexuality that links sex to cognitive and emotive processes (thoughts and feelings). The relatively recent development of these fields means that the specific and targeted use of psychotherapy in treating sexual problems is itself a relatively recent phenomenon.

It is my experience that students of PRT themselves tend to lean towards either sex or relationships, which may be seen as a bias. If, for example, one has a background in medicine, psychiatry, nursing or otherwise aligned medical professions, there is a tendency to gravitate towards the ‘physical’ or organic issue at stake for which medication may prove helpful. If, however, one comes from a more therapeutic background, the organic may not be at the forefront, and non-organic issues will be addressed more readily. As such, the ‘therapeutic home’ of the practitioner gives them more comfort. Either of these may mean that the practitioner misses something important, and as training providers, it behooves us to ensure that students

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have a degree of competence to work with both organic and non-organic issues.

In the 1970s and 1980s, patient heterosexuality and monogamy were assumed by default. The field has changed considerably since then, with a greater appreciation of diversity and inclusivity. As noted by Meg-John Barker (2013):

One example of social constructionist and feminist informed sex therapy can be found in Barker, where the author describes their work with a young woman who had been diagnosed with ‘vaginismus’. Rather than focusing on the sexual problem, the therapist explores the wider worldview of the patient – within the context of prevailing discourses - and how sex fits into this. Through shared understandings of the popular ‘Bridget Jones’ view that it is vital for women to find a romantic relationship, the patient and the sex therapist are able to see the sense in the patient’s continued engagement in painful sex, as well as exploring the taken-for-granted assumption that failing to do so would result in their male partner breaking up with them. This situation is situated within a wider context of the patient attempting to embody a conventional femininity which involves pleasing everybody else and being a good daughter, good friend, and good girlfriend. Frustration at the restrictions this places around her enables the patient to tune in more to her own desires and goals, and to consider whether this relationship is good for her, rather than focusing only on the desires of her partner.

The debate about the validity of a purist approach to PRT continues: can it be seen as a distinct and specialist form of psychotherapy or is it something else? Can one train purely as a PRT practitioner or not? Is it political, with a small ‘p’? Is it about social justice? And who is attracted to the profession? These are all questions that training providers need to address.

It is my view that as a modality of psychotherapy, it differs in many ways. In the first instance, it is more openly dialogic than some other forms of therapy. It may be psychoeducational, it may require collaborative relationships with other practitioners such as psychiatrists, urologists, gynaecologists, or sexual health practitioners in addition to IMAGO experts, and in some cases, where the jurisdiction and the lead body allows it, surrogates, and sex coaches. It could be suggested that the need to work with couples, whether regarding relationship or sexual difficulties, requires particular and definable skills and knowledge. This does not usually fall within the domain of the generalist psychotherapist.

It can be said that in order to achieve competence within the work, one must have a more pluralistic and creative orientation. Whilst I accept that some of my colleagues will reside in one primary or preferred modality of

therapy, and indeed in the UK the training providers will often promote themselves as, for example, psychodynamic, behavioural/CBT, humanistic, systemic, or biosocial, it is my view that whatever any of us say, we are in service to the patient and as such we need to offer therapy in a way that reaches them and does not marginalise or confuse. Equally, a Eurocentric model of therapy in a multi-cultural society does not work. In the UK, a country of almost 70 million people, 18% of the population of England and Wales, excluding Scotland and Northern Ireland, are from black, Asian, mixed, or other ethnic groups, according to the 2021 census. The census also identified 19 different ethnic groups residing in England and Wales. It must be acknowledged that for many individuals within those groups, English may not be their first language, and sexual terms and language and relationship terminology may not fit. I suspect this is no different in other parts of the world.

Added to this are issues of faith, the rules and mores of religion, political leanings, sexual orientation, trans issues, and relationship structures: whether consensual or non-consensual non-monogamy, forced marriage, and polygamy. This certainly was not in the frame in the late 1970s.

If one sees the spectrum of relationship work to be inclusive of intimacy, both emotional and sexual, I would suggest that they cannot be separated without disadvantaging the patients. Whichever end of the spectrum one begins addressing with the patients, be it relationship or sexuality. It is suggested that therapists need to arrive at an inclusive model of therapy which encompasses both. Heiman (2002) puts forward the idea that:

“Many successful treatments for sexual dysfunction are psychophysiological, in that physiological change circularly interacts with psychological change”

and adds:

“the prescription of a physiologic treatment which ignores the fact that human sexuality is infused with individual meaning may invite further interference with sexual functioning”.

This was certainly forward-thinking.

Hitherto, and with the new categories suggested by COSRT, there is a division. Formerly, there were only students, registered and accredited PRT Practitioners, and Fellows. As such, people may now apply within these new categories, and clearly, this changes the profession and how it is seen in the wider world.

General membership was the first identified category, open to all clinical practising members. Members had to show that they met the agreed-upon

criteria. Conferences were open to non-members from the outset. This category was dropped when the register was launched.

Registered membership was the same as general membership, and clinical practising members who wished to be registered were transferred to this category when the register was opened in 2009.

Accredited membership was launched in 1992. Members who had not undertaken an Approved ASMT Approved training had to show that they had achieved the required high standard of practice. BASMT used to hold its own examination, where necessary, a nerve-wracking experience for those who undertook that route. This option was still available until recently.

Senior Accredited membership was introduced in 2018.

Accredited Supervisor was introduced soon after Therapist Accreditation in 1993. Now there is a Registered Supervisor or Accredited Supervisor.

Student Membership was introduced around 2014-2015, and all students on Accredited Training courses had to apply. In this way they were bound by the governing documents of COSRT.

Affiliated Membership was created early on for organisations with an interest in the field of sexual and relationship therapy.

Retired Membership was brought in for members no longer actively practising but who wished to remain connected to the organisation.

Fellowship was introduced in 1992-1993 and remains in place to recognise members who have made a special contribution to ASMT/BASRT as an organisation, to the profession through publications, and to standards by virtue of teaching and training and clinical excellence. Furthermore, COSRT states:

We hold two voluntary public Registers of professionals who meet rigorous standards, one of supervisors, plus a listing of students on accredited courses.

Please note that our registrants, when working with Psychosexual and Relationship Therapies, only do so with adult Service Users. These specialist therapies are strictly talk-based and do not involve physical touch and do not entail any medical procedures or examinations.

There are two registers for practitioners and one for supervisors. The two are Psychosexual & Relationship Therapist (PRT) and Relationship Therapist (RT). So, the governing body seems to support a distinction and differentiation within the profession.

In terms of numbers and growth of the organisation, in recent years it has been somewhat slow. Whilst in 2011 there were some 400+ members, the figures over the last few years have remained relatively static. Those

with dual membership and a licence with COSRT and UKCP number around 85 today, are seemingly decreasing. In the previous few years, the numbers hovered around 103.

As an example, in 2022, the organisation had a total of 1,027 members across the board. In 2021, 1,144, encompassing all categories, and in 2022, there were 1,211. By 2023, when the two possibilities were introduced so applicants could either be PRT or RT, there were 750 in the PRT category and 457 in the RT category. These numbers do not account for the affiliate categories, those who retired in the year, or the Fellows. These numbers could be considered very low in a population of sixty million plus in the UK.

I would postulate that students who train in relationship therapy solely as a preference to PRT have an inevitable bias towards this work. It is then a matter for them and their clinical supervisors to address this and to ascertain if they think the patients are in any way disadvantaged by the exclusion of sexuality and physical intimacy within the therapeutic offering. However, many of the general public only know, if asked, of Relate (formerly Marriage Guidance), which generally offered the two-modality therapy, relationship or sex. To this end, the promotion of COSRT and PRT is essential. As stated by David Schnarch (2008), who was one of our most eminent practitioners and theorists,

The debate among clinicians, when sex therapy or couples therapy is more appropriate, has raged since the 1980s. However, this question reflects an iatrogenic problem, rather than a diagnostic conundrum. It is caused by the common state of the art of sex therapy and marital therapy, rather than characteristics of clients. Attempting sex therapy or couples therapy without the other encourage clinicians to conceptualize and practice archaically, weakens treatment of both sex and relationship problems, promotes ineffective amalgams approaches, and limits development of more effective therapies.

This further underlines and supports the notion that psychosexual therapy offered within relationship therapy is seen as the most effective modality of therapy. However, it appears that the trajectory of the profession within the U.K. is to support and validate a separation between sex and relationships for those practitioners who lean more towards a one-focussed offering.

It is important to consider what any prospective patient may be seeking, and how many who request PRT may even be aware of it as a modality of psychotherapy. The first point of contact from a patient, anecdotally, is to say “our relationship is struggling,” or something similar. Further exploration during the assessment phase may reveal an issue with intimacy or sexuality. It is my view that the totality of the relationship needs to be

seen as a whole and not segmented, in order to truly be of service to the patient(s).

In one paper published in 2023 entitled *Barriers to Seeking Treatment for Sexual Difficulties in Sex Therapy* by Zoe Sever & Laura M Vowels, through the *Journal of Couple & Relationship Therapy* (tandfonline), they stated:

Findings from the GSSAB (Global Study of Sexual Attitudes and Behaviors) within Britain and continental Europe identified the main barriers to seeking help for a sexual problem as 1) not viewing it as serious (71.3% of men and 61.1% of women), 2) a belief that it was normal/being comfortable with things as is (64.2% of men and 58.2% of women), and 3) not viewing a sexual problem as a medical matter (48.6% of men and 46.9% of women).

This may explain why at the first point of contact, sex is mentioned far less often than relationship issues. PRT is offered from a multimodal position that incorporates psychoeducation, advanced CBT, and psychoanalytic understanding, to name but a few. However, the figure below addresses what PRT therapy is today. A trusted colleague, E. Soutani, developed this model to show what the work is now.

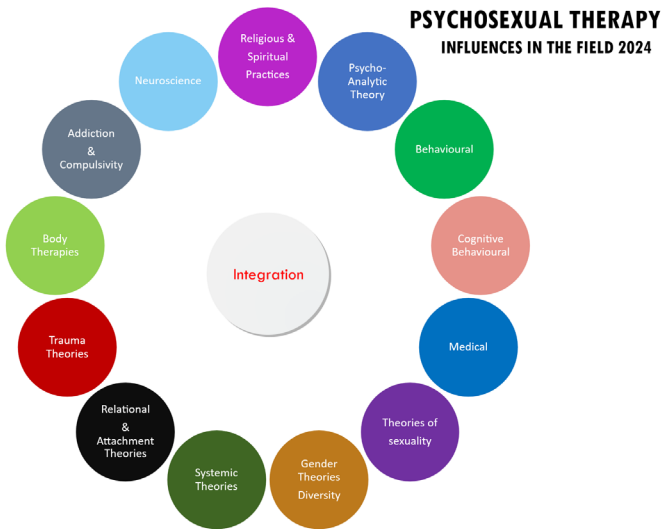


Fig. 1-1

Bearing the above in mind, we need to consider that practitioners often use the word “intimacy”, which itself can be a euphemism for sex but can also be seen as emotional closeness. The work can often be about the inter linking of the two, a cycle of one leading to the other. This, I suggest, may be an argument for the need of those working purely from a relationship perspective missing the often interdependence between the two in a relationship. This is demonstrated in the figure below by PRT therapist J. Miller:

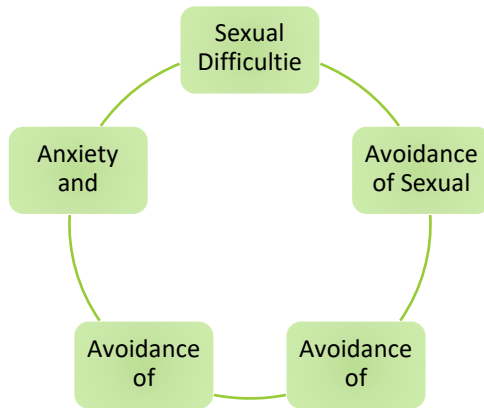


Fig. 1-2

PRT therapists now often regard themselves as psychotherapists with an additional and significant area of specialism. The undoubted importance of thorough assessment to include evaluation of the influences shown, is key to the work.

The assessment of a relationship/couple is now considerably more in depth and far-reaching than it was at the outset many years ago. Practitioners need knowledge in both organic and non-organic presentations alongside how to signpost and refer on as required and as would be professionally wise and ethical. The exploration of the patient’s sexual map and the identification of trauma, both past and present, informs the practitioner. We also need to address the transcultural, GSERD, and other aspects of the relationship in its broadest sense. Assessment needs to take a biopsychosocial view of the patient/s, leading to a nuanced and multifactorial formulation. This underlines what a wide-ranging speciality this is, and how much a responsible practitioner needs to know. It cannot, in my view, be underestimated. The future of PRT work in the UK is in some flux. In the BMJ (2023), they stated:

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Integrated sexual health (ISH) services commonly manage individuals requiring psychosexual therapy (PST). Sexual problems may cause significant psychological morbidity and frequent attendance at clinic through overt or covert presentations. Demand on the service prompted an existing sexual health clinician trained by the Institute of Psychosexual Medicine (IPM) to start a psychosexual service in 2018, at one of our four clinics across an urban inner city. Referral was by direct email internally, from GPs and other specialties. The service was rapidly overwhelmed with waiting times of over 6 months, prompting the need for expansion and optimisation.

Additional staff: an experienced COSRT therapist was employed in 2021. Two ISH nurses had commenced IPM training in November 2018.

Access from January 2022: exclusively via a routine appointment with an ISH clinician completing a standardised cross-site, detailed electronic referral form. The latter included recommended pre-PST investigations to exclude physical causes, to be requested through their GP. Electronic patient records in year 1 were analysed.

Results: 103 patients were referred in the first year. Some had multiple diagnoses. 4 did not meet service criteria. 44 were male, 57 female and 2 non-binary. Age range was 17 to 72 years. Waiting times ranged from 3 to 16 weeks. 10% did not attend (DNA) a first appointment.

COSRT declares itself as:

COSRT is the UK's only professional body dedicated to Psychosexual and Relationship Therapies. Set up 50 years ago, the organisation has been at the forefront of developing these specialised disciplines.

As a registered charity, COSRT's work is focused on providing benefit to the public. This is enshrined in the organisation's charitable objectives to set and monitor professional standards, provide and support training, and promote research.

This then means that although generic counsellors and psychotherapist may proclaim some experience or competence in the field of PRT if they are not registered or accredited, they cannot carry any emblematic badge to state so.

Their strategic priorities as stated in 2024 are:

- Improving awareness of therapies – so that Psychosexual and Relationship Therapies are better understood by the public and those responsible for delivering services.

- Increasing the impact of evidence – so that all stakeholders have better access to relevant, high-quality evidence on what services work, why they work and why they are needed.
- Spreading professional standards – so that it is only acceptable for practitioners to deliver specialist therapies with the proper training and accreditation.
- Improving professional training – so access to and the quality of Psychosexual and Relationship Therapy training is increased for the benefit of all.
- Reinforcing COSRT's position – so that we build our visibility and understanding to maximise impact and reach.

Now in 2025, in the UK many organisations are working towards or within the SCopEd framework, which is described as:

The SCopEd framework is a ground-breaking shared standards' framework, developed by six Professional Standards Authority accredited bodies representing over 75,000 counsellors and psychotherapists including our Registrants.

It transparently sets out the core training, practice and competence requirements for counsellors and psychotherapists working with adults.

We have come a long way from the outset, some 50 years ago. Some may posit the idea that we are now over-regulated and the creativity within the work may be lost. That psychotherapists may operate from a place of more caution rather than originality and a dynamic or idiosyncratic way of working. A debate remains concerning the division between being a PRT therapist (Psychosexual & Relationship Therapist) or an RT (Relationship Therapist).

My position is clear: we work with the couple/relationship, they are 'the patient,' and failing to address either the relationship or sexuality does them a disservice. It is contrary to a holistic view of the work and the totality of the relationship experience. It is therefore not uncommon for people to say in the consulting room, "our last therapist did not talk about sex and intimacy, so that is why we are here."

There is little doubt that psychosexual and relationship therapy has its critics, and the proclamation that it is a specialisation is denigrated and perhaps even ridiculed and marginalised.

For example, in 2009, Binik and Meana discussed this in *The Future of Sex Therapy: Specialization or Marginalization*:

Sex therapy's claims to specialization may be exaggerated and ultimately damaging to the integrated treatment of sexual dysfunction. In fact, sex therapy does not have a unified underlying theory, a unique set of

practices, or an empirically demonstrated efficacious treatment outcome. Paradoxically, the practice of sex therapy has gained widespread professional and popular acceptance since the publication in 1970 of *Human Sexual Inadequacy* by Masters and Johnson. Consequences of the widespread acceptance of this supposed specialization include the marginalization of sex therapy from other forms of treatment and the perpetuation of the notion that sex therapy is a special form of therapy requiring highly specialized training. This specialization focus also helps to perpetuate societal discomfort with sexuality.

Would one agree with this today in 2025? It may be true that some, and some faith or cultural groups, have a degree of discomfort in openly discussing and addressing intimacy and psychosexual issues, alongside an awkwardness in using some terminology or not having a word for a particular sexual activity. Nevertheless, a diverse range of patients present in the therapy room who want to avail themselves of speaking and being with a practitioner who is competent within this area of work.

Training organisations now have a greater degree of inclusion and trainees come from a variety of cultural backgrounds, including all sexual preferences and diversities, faith groups, and those with disabilities, seen or unseen.

Relate, which was familiar and publicly known, went into administration in 2024 as stated in *The Guardian* newspaper (2024):

Britain's biggest relationship counselling charity is on the verge of insolvency after failing to overcome financial difficulties caused by a collapse in funding from NHS, school and local authority contracts.

Relate has been put into administration, with staff told that it has four to six weeks to find a buyer or merger partner if it is to stay afloat. The 26 local branches of the charity, which are each independent, are not affected.

There are fears hundreds of clients could have sessions cancelled after 80 staff – a third of the workforce at Relate's central arm – including 40 counsellors were made redundant with immediate effect.

This was devastating for the patients and staff members; however, it was bought out of administration by another charity called Family Action.

National Health Service clinics for PRT work are stretched to the limit, and sadly, due to funding cuts, some are closing. The number of PRT registered therapists with COSRT is currently very few when one considers the population of the UK, which is now over 60 million, as mentioned earlier. This means a higher usage of private clinics, third sector settings, and lone practitioners. In a parliamentary enquiry in 2019, they stated:

Witnesses to this inquiry told us that a new, national strategy is needed for sexual health, to help both providers and commissioners to deliver sexual health services to a high-quality and consistent level, in the face of the challenge of fragmented structures.

Sexual health: We recommend that Public Health England should provide clear national leadership in this area. The strategy should set out one clear set of national quality standards for commissioners to adhere to, encompassing all aspects of sexual health.

The Future

We acknowledge the struggles that have shaped the profession in the past and have brought it to where it is today, but what does the future hold? Some are less pleased than others with the trajectory taken, and clearly, there is some way yet to go, but it can be affirmed that psychosexual and relationship therapy is an honourable, educated, and thoughtful profession, one that by its very nature cannot remain static or inactive but must adapt to the times. Evolving relationship models: couples, throuples, polyamorous dynamics, and diverse sexual preferences and needs require that the field remain adaptable to change.

The makeup of those wishing to train in the field is significantly different to how it was 50 years ago. Stylistically, trainees learn in a different way. They come from advanced counselling diplomas or psychotherapy training with a smaller smattering of medics than previously applied, and among those, they tend to be from the field of psychiatry. Specialist nurses make up a proportion of trainees from clinics which did not formally exist 50 years ago.

Wherever trainees come from and whatever their previous experience and professional standing, arriving in the training room for the first time is anxiety-provoking, and trainers/facilitators need to be aware of their tendency to revert to their prior experience rather than embracing the unknown world of PRT, which they are about to enter.

Personal therapy is a given; this was not formerly the case. Training in PRT or RT by its very nature and depth may be restimulative of the trainee's own past experiences, and as such, trainees need to identify their blind spots and be aware of transference and countertransference issues in the room. The role of the 'training supervisor' thus becomes key in the development of the trainee. It is no easy task.

Is the profession at risk in the UK? The number of practitioners who are suitably qualified is not high. There are only a small number of approved training providers, some of those with very small student numbers, and of

those, not all students will qualify. In a blog in *Psychology Today* (2024), Dr. Marianne Brandon stated:

Sex technology is advancing at an astounding rate and promises to revolutionize intimacy. Chatbots, avatars, sex dolls, and VR porn are some examples of advancing sex tech that are already gaining traction– and this is just the beginning. Intimacy is the core of humanity, yet the ways we are intimate are changing fast. How future humans engage emotionally and sexually is being determined today by tech companies.

Given this rapid pace of technological and societal change, is there a danger that the specialism of PRT work will be submerged and disappear within either technology or generic psychotherapy or both?

It can be said that patients, in whatever formation of coupleship they are in, will continue to seek the openly dialogic, dynamic, and human interaction which is given within the therapy room. They will continue to seek the expertise of the clinician who has undergone a rigorous and specialist training where they have been both academically, intellectually, and personally challenged and where the standards of the profession are upheld. The professional body, namely COSRT, has an enormous task before it. Without an increase in the number of registered and accredited practitioners and with an ever-growing population in the UK, there is a risk that the profession might become marginalised and somewhat hidden from public awareness. Those who work within the UK, therefore, have a responsibility to keep the profession alive and active and continue to make contributions in various forms, be that through writing, podcasts, public appearances, or talks.

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THE DECONSTRUCTED MEAL: INTERSECTIONALITY OF BODY IMAGE AND SEX POSITIVITY WITH PATIENTS WITH EATING DISORDERS AND SEXUAL TRAUMA

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Introduction

This paper explores the intersectionality of positive body image and sex-positivity through a depth psychology lens and provides examples of innovative interventions that are art-based, imagistic, symbolic, and are grounded in embodied and relational approaches for individuals with eating disorders who have experienced sexual trauma. While the relationship between sexual trauma and eating disorders is not causation, there is evidence to show there is a correlation (Madowitz, Matheson, & Liang, 2015). Sexual trauma often precedes eating disorders (Pike et al., 2008) and thus, can be a precursor to the development of an eating disorder (Kjaersdam Tellés, Lauritsen, & Rodrigo-Domingo, 2021). Research findings provide evidence that experiencing sexual trauma is a major risk factor for multiple forms of psychological dysfunction across populations and assault types (Campbell, Dworkin, Caral, 2009; Kelley et al., 2009; Kessler et al., 1995).

Prevalence and Demographics

Sexual trauma is defined as any non-consensual or exploitative sexual behavior or activity imposed on an individual without their consent. It can encompass a variety of unwanted and nonconsensual sexual acts, including attempted or completed sexual coercion, sexual touching, and attempted or completed sexual penetration (Muehlenhard et al., 2017). Although the term typically is used with reference to any sexual contact between adults and children, sexual abuse can also occur in any relationship of trust (American Psychological Association, 2025).

It has been reported that in the United States, 17–25% of women and 1–3% of men will be sexually assaulted in their lifetime (Black et al., 2011; Fisher, Cullen, & Turner, 2000; Koss, Gidycz, & Wisniewski, 1987; Tjaden & Thoennes, 2000, 2006) and approximately, one in five college women will experience sexual assault (Muehlenhard et al., 2017). Sexual assault has the most profound impact on mental health than other forms of trauma (Kelley et al., 2009; Kessler et al., 1995), including severe psychological consequences that contribute to worse outcomes than other assaulted comparisons (Campbell, Dworkin, & Cabral, 2009; Dworkin et al., 2017). Survivors of sexual assault face increased risk of psychological distress and illness such as the development of Post-Traumatic Stress Disorder (PTSD), depressive or anxiety disorders, and suicidality, greater engagement in heavy episodic drinking, as well as weight and eating-related disturbances (Decker & Littleton, 2018; Dworkin et al., 2017; Groff Stephens & Wilke, 2016; Leone & Carroll, 2016).

The highest causes of mortality among those with a mental health disorder were those with a substance use disorder (i.e., opioid overdose) and Anorexia Nervosa. In no other mental health disorder listed in the *Diagnostic Statistical Manual-V (DSM-V)* (American Psychiatric Association, 2013) has a higher mortality rate than those with eating disorders, including those who commit suicide from depression and it is estimated that 80 percent of people with eating disorders will recover while the remaining 20 percent will remain chronic or die (Anorexia Nervosa and Related Disorders, 2015; Smink, van Hoeken, & Hoek, 2012). These high mortality risks translate into substantial (10–20 years) reductions in life expectancy (Chesney, Goodwin, & Fazel, 2014). As a result of the significant impact of sexual assault, it is an issue of major public health concern and carries implications into adulthood that impact the care and nourishment of the individual, their body, and how they may navigate relationships and intimacy.

Attachment and Relationship Disturbances

Secure attachments in the child's development when the primary caretaker adequately mirrors the child (Bowlby & Ainsworth, 2013). Attachment acts as an internal regulator between the other and the self, and plays a decisive role in people's lifelong strategies for autonomy, emotion regulation, intimacy, and relationships (Hazan & Shaver, 2017). When the caregiver is sensitive to the feelings and needs of the child and responds to those needs promptly and appropriately, secure attachment is formed. However, neglectful, intrusive, inconsistent, and intimidating caregiver behaviors

pave the way for childhood abuse and the development of insecure attachment behaviors (Aydin et al., 2024). Early childhood trauma can cause neuroendocrine responses resulting in structural and functional changes in the developing brain, causing changes in perception, language skills, regulating emotions, processing pain, and maintaining attention due to experiencing over- or under-stimulation as a result of trauma (Hass-Cohen, et al., 2014; van der Kolk, 2014). How one relates to their intimate partner is also determined by their attachment styles. The impact of traumatic experiences, especially the profound effects of sexual trauma, also influences how one feels about oneself and has an impact on intimate relationships.

Relationship to Intimacy and the Body

Eating disorders are disturbances of relationships: Relationships to others and the environment, to oneself, to one's emotions, and to one's needs, desires, and imagination (Dean, 2019), which often require a disconnection from the body. Body image is a complex psychological phenomenon that refers to how individuals perceive themselves and feel about their bodies. Body image is more than an objective visual observation of one's shape or size; it is instead an inter-action between sociocultural, psychological, and biological influences (Cash & Deagle, 1997; Slade, 1988).

Intersectionality of Body, Nurturance, and Intimacy

The image is the connector between the psyche, or soul, and the soma. The feeling tone in the body, where the belly resonates with the heart and liver, produces chemistry that is picked up by the brain (Woodman, 2009). The body and its boundaries are inexorably intertwined. The messages we tell ourselves, or receive from others, are absorbed and can define who we are and what we deserve, whether this is the quality or quantity of food, touch, pleasure, or relationships. The internalized self provides either a malevolent or benevolent kind of dialogue that extends beyond our mind's eye into how we hold ourselves and allow others to hold us.

A Body Image and Sex Positivity Approach

Understanding the contributing factors to eating disorders, including sexual trauma and relationship issues, through a symbolic and expressive means is imperative in promoting body acceptance and a sex positive life. One way that art-based, imagistic, and symbolic approaches are grounded in