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**Title: Brief psychosexual therapy: reflections on the provision of a time-limited therapy service in a sexual health clinic**

**Abstract**

Time-limited psychological therapy is increasingly the norm in publically funded healthcare systems. Although brevity of treatment is a characteristic of modern sex therapy, many practitioners would nevertheless consider the provision of effective psychosexual therapy in six or fewer sessions to be a daunting prospect. In this paper we reflect on the challenges, opportunities, and changes to practice associated with the development and delivery of a brief psychosexual therapy service within a specialist sexual health clinic in England. We endeavour to integrate our experiential learning with relevant research findings and principles from the fields of psychosexual therapy and brief psychological therapy. We also explore some of the broader issues associated with the development and provision of brief psychosexual therapy, including the possible implications for the education and training of psychosexual therapists.

[130 words]

**Key words:** brief therapy; psychosexual counselling; person-centred; sexual problems

## **Introduction**

Brief therapy is increasingly the norm within the fields of counselling and psychotherapy, although what constitutes ‘brief’ therapy may vary depending on therapeutic modality. The landmark dose-response analysis of Howard, Kopta, Krause and Orlinsky (1986), suggests a negatively-accelerated response curve, indicating (1) the number of sessions required for a sizable number of clients to experience clinical improvement, and (2) ‘diminishing returns’ in terms of clinical benefit as the duration of therapy exceeds this minimum number of sessions. This is now commonly referred to as the dose-response model. However, this analysis is contested. First, a greater degree of linearity has been observed between ‘dose’ and ‘response’ in subsequent studies (Shapiro, et al., 2003). Second, an alternative interpretation of the negative-accelerated curve – known as the ‘responsive regulation model’ – suggests that in actual practice the duration of therapy is regulated by both client and practitioner and that therapy therefore tends to end when clients have improved to a good enough level (Stiles, Barkham, Connell & Mellor-Clark, 2008). Such responsive regulation may involve adjusting the length of therapy to reflect rapid positive change in clients, adjusting the focus and level of engagement with therapy in response to the available time, or a combination of both of these factors (Stiles, et al., 2008). Indeed, it has been suggested that rate of therapeutic change may be accelerated when a time limit is placed on therapy (Eckert, 1993; Reynolds, et al., 1996).

The most efficient use of limited resources is particularly pressing in publically funded healthcare services, where what Shapiro et al. (2003) term ‘ultra-brief

therapies' (i.e. therapies consisting of six or fewer sessions) are increasingly the norm. A survey of psychological therapy services in primary care settings in the UK found that most service providers offered up to 8 sessions (Barnes, Hall, & Evans, 2008). In England, the *Improving Access to Psychological Therapies* initiative (IAPT) has extended the 'stepped care' model of therapy provision for people experiencing anxiety and/or depression, in line with guidance issued by the National Institute for Health and Clinical Excellence (Department of Health, 2008). 'Stepped care' models comprise different levels of empirically supported treatments, which vary in terms of intensity (that is, type and duration of intervention). In stepped care services clients are initially offered the 'least restrictive' form of treatment that is likely to be effective, and treatment is 'stepped up' or intensified if this level of intervention proves ineffective. Whether such models provide an efficient method of delivering psychological therapy services has still to be established (Bower & Gilbody, 2005; Richards, et al., 2012).

An emphasis on brevity of treatment is one of the characteristics of modern sex therapy: Hawton (1995) suggests that 'standard sex therapy', which has been strongly influenced by the work of Masters and Johnson (1970), consists on average of between 8 and 20 sessions delivered over a period of 3 to 9 months. The intensive, dyadic and predominantly behavioural approach to treating sexual symptoms outlined by Masters and Johnson (1970) marked a significant shift from the longer-term psychotherapy for sexual problems, which characterised its psychodynamic predecessors. Subsequently, as Donahey & Miller (2001) note, there has been a proliferation of different models and techniques (see Almås & Landmark, 2010), with little evidence of differential effectiveness, and a growing medicalization of the

management of sexual problems. Donahey and Miller suggest that these developments in the field of sex therapy mirror those of psychotherapy generally. Further evidence of this ‘mirroring’ is provided by the development of brief forms of sex therapy. While some of these brief sex therapy formats have emerged within approaches traditionally associated with longer-term therapy (e.g. Bianchi-Demicheli & Zutter, 2005), many are located within postmodern approaches which are strengths-based and solution-focused (e.g. Green & Flemons, 2004; Trepper, Treyger, Yalowitz & Ford, 2010).

In the UK, the availability of psychosexual therapy services varies greatly, with providers of such services located in the private, voluntary and statutory sectors. The voluntary sector has played a crucial role in the development and provision of services for people experiencing sexual problems, with pioneering work in this field undertaken by Relate (formerly the National Marriage Guidance Council), and, before the transfer of its contraception clinics into the National Health Service (NHS) in 1974, by the Family Planning Association (Irwin, 2009). Services for the treatment of sexual problems within the NHS have largely developed as a result of the enthusiasm and commitment of individual practitioners in the absence of any coherent policy for the planning and delivery of such services (Irwin, 2009). Sexual health clinics are one area of the NHS where there has been considerable support for the provision of psychosexual therapy services but many clinics have found it difficult to actually resource such services (Keane, Carter, Goldmeier & Harris, 1997; Kell, 2001). However, in the *National HIV & Sexual Health Strategy for England*, services for people experiencing sexual problems were identified as a requirement for all level 3 (specialist) sexual health services (Department of Health, 2001, p. 25). A recent

survey of sexual health clinic service users indicates just over of third of respondents reported experiencing a sexual problem. The majority of those who wanted help for such problems indicated that they would like treatment to be available at sexual health clinics, although a fifth expressed a preference for help to be made available at their GP practice (Shepherd, Heke, Sarner & Donovan, 2010).

Many established psychosexual services within the NHS already offer brief therapy to clients. In one NHS psychosexual counselling service located within primary care, clients are routinely offered six sessions of counselling, although an extension for further work is possible in certain circumstances (for instance, in work with survivors of childhood sexual abuse) (Penman, 2009). An evaluation by Deshpande, et al. (2013) of the Leeds Psychosexual Medicine Service undertaken over a 3-year period found that the average number of completed sessions for women was five and for men six (this was affected by a male 'outlier'). Of those who completed all their treatment sessions, 45 per cent had done so by four sessions, and 70 per cent by eight sessions. As a consequence of these findings, this service decided to change its initial therapeutic contract from 12 to 6-8 sessions (Deshpande et al., 2013).

### *Context*

Like many psychosexual therapists currently working in the UK, we completed the Relate diploma in psychosexual therapy. The therapeutic approach we were taught as part of this diploma programme was primarily developed for working with couples but could be modified for working with individual clients. Although based on the educative/behavioural model of Masters and Johnson (1970), it was also influenced

by the eclecticism of others working in this field, particularly Kaplan (1974), who advocated the use of interpretative counselling to help clients overcome any blocks encountered during treatment programmes (Relate, 2000, p. 3). This approach to the treatment of sexual dysfunctions usually entails seeing clients on a weekly basis and involves a lengthy and structured assessment process, which includes obtaining a detailed life history of sexual experiences. Only after this (and the construction and sharing of a detailed formulation), would any treatment programme start. A survey of Relate psychosexual therapy services undertaken over a three-month period in 2002 found that the number of treatment sessions ranged from one to 60, with an average of 9.4 sessions (Roy, 2004). Although this can be considered a brief therapeutic approach, it does not readily lend itself to brief psychosexual therapy comprising only six sessions.

After being appointed to work as a psychosexual therapist in a level 3 sexual health service, the challenge CP therefore faced was to develop a way of working effectively in six sessions with clients who presented with sexual concerns. RI, who provides CP with consultancy supervision (Hawkins & Shohet, 2012), had faced a similar challenge some years previously when he was employed as a psychosexual therapist in a time-limited NHS service. The issues outlined in this article are some of those we have explored, reflected on and revisited in supervision meetings over a period of four years. What follows is written solely from our perspective and is certainly not intended as a prescription for delivering brief psychosexual therapy, but we hope our experiences may be of interest to others involved in the development of time-limited psychosexual therapy services in similar contexts.

## **Reflections**

### *Establishing a suitable 'frame' for a brief psychosexual therapy service*

There is some consensus in the general psychotherapy literature that the clients most likely to benefit from time-limited therapy are those who present with a clear focal problem, are ready to make changes in their lives, can function at a reasonable level in their everyday life, have a reasonable level of social support and are capable of joining in a 'good enough' therapeutic alliance (Feltham, 2006; Koss & Shiang, 1994; Mander, 2005). The requirement that there is a clear focal problem might seem easier to establish in psychosexual therapy as sexual difficulties are often seen as reasonably well demarcated. However, as Kleinplatz (2003, 2012a) observes, it is important to distinguish between sexual symptoms and the problems that underlie such difficulties, and clients' presenting problems in psychosexual therapy are often embedded in a complex mesh of historical and contemporary issues (Frith & Mohamad, 2007).

A key issue in creating a brief psychosexual therapy service is to establish a suitable 'frame' for such a service. At a foundational level, this entails establishing with the commissioners of such services what types of sexual problem the service is expected to work with, and the clear communication of this information to potential referrers. However, given the array of potential referrers and the complex psychosocial, material and health-related problems that may be associated with sexual difficulties (Frith, 2012; Mitchell et al., 2013), specifying appropriate 'caseness' may not be enough to ensure that referrals for brief psychosexual therapy are always suitable. In



the sexual health clinic where CP works, referrals to the psychosexual therapy service are reviewed and discussed at regular multi-disciplinary team meetings. This helps to identify clients who may benefit from further medical or psychiatric assessment, or might be better served by more intensive support. Clients can also be referred to doctors working within the clinic whose training with the Institute of Psychosexual Medicine emphasises a body-mind approach to the medical management of sexual difficulties and enables them to undertake a psychosomatic physical examination if this is indicated (Skrine & Montford, 2001). Sometimes, however, the complexity and severity of the problems associated with the client's presenting sexual difficulties only become apparent after they have met with the psychosexual therapist. In this situation, a specific focus and achievable goal for subsequent sessions needs to be agreed. On some occasions, this may be to use the remaining sessions to undertake a detailed assessment in order to establish the type of longer-term interventions that are most likely to be helpful to the client. Such a protracted assessment process is, however, a fairly unusual occurrence in a brief psychosexual service.

***Assessment: A person-centred, strengths-based approach***

Brief psychosexual therapy has necessitated a major change in our approach to client assessment. We had been accustomed to an assessment process comprising an initial assessment meeting, separate history-taking sessions with each individual (when working with couples), and a formulation session, in which the therapist's tentative working model of the causal factors leading to and maintaining the couple's/client's sexual difficulties is shared and goals are negotiated for further therapeutic work if this is indicated. Although this structured approach has many benefits, particularly

for practitioners who seek to diagnose, it is not an option in brief therapy comprising only six sessions. Nor is complete non-directivity possible as the early identification of the client's concerns and difficulties is essential (Feltham, 2006). The approach we take to client assessment is now less structured and more person-centred. It begins by inviting the client to identify what they feel is important for us to know about them and the difficulties they are experiencing, and what has led them to seek help. This enables clients to articulate their focal concerns. We have been surprised by how often clients, without prompting, also describe many of the troubling or distressing experiences implicated in the development of their sexual difficulties.

The use of open-ended questions early in the initial session and then transitioning to questions about specific aspects of the client's experience often encourages a feeling of being understood. The focus on the client's primary concerns and experience, which is facilitated by this less structured approach, also enhances rapport (Koerner, Hood & Anthony, 2011). It conveys that therapy is a collaborative enterprise in which both the client and therapist bring particular expertise. Furthermore, the therapist's use of open questions also communicates an 'unknowing' approach that helps to create a therapeutic space in which clients can begin to become aware of the relationship between their sexual/bodily symptoms, emotions and experiences (Penman, 1998). In our approach to brief psychosexual therapy, there is a particular emphasis on embodiment, and the idea that the body is trying to communicate (in the form of sexual symptoms) something of importance about the client's experiences and feelings. Developing an awareness of the meanings that sex and sexual difficulties have for the client is therefore crucial (Armstrong, 2006; Barker, 2011; Wells, 2000).

Not only does this more person-centred approach help to create a strong working alliance, but it also conveys the therapist's belief in the client's competence and capabilities, that is, the client's capacity to make positive changes in their relationship with self and/or others. This is further amplified by another aspect of assessment in brief psychosexual therapy, the identification of the client's strengths and psychosocial resources that can be recruited to facilitate positive sexual and interpersonal functioning. The importance of strengths-based assessment and early resource-activation is increasingly recognised in all forms of therapy, but is crucial in brief therapy formats (Gassmann & Grawe, 2006; Flückiger & Holtforth, 2008; Rashid & Ostermann, 2009).

### *An emphasis on relationships*

The positive association between the quality of the therapeutic relationship and psychotherapy outcomes is consistently reported in the empirical literature (Norcross, 2011; Wampold & Imel, 2015). In the context of therapy with people who present with sexual concerns, Donahey & Miller (2001) suggest two specific therapist behaviours that can enhance the therapeutic relationship: accommodating therapy to the client's readiness for change, and tailoring therapy to fit with the client's view of the therapeutic alliance.

Individual consultations are the norm in healthcare settings for adults, and this is also true for the brief psychosexual therapy service in which CP works. Sexual concerns, however, are problems of the interpersonal realm and brief psychosexual therapy services need to be able to work with referred individuals and their partners. We have

observed that within a healthcare setting the invitation to attend with their partner (when clients have partners) often has a powerful effect on clients even if the subsequent work continues on an individual basis as it helps to (re-) introduce a more contextualised, dyadic view of their sexual concerns (Benson, McGinn & Christensen, 2012; Bor, Miller, Latz & Salt, 2000; Wincze, 2009). However, the relational focus within brief psychosexual therapy is not only on the client's relationships with others but also their relationship to self and whatever is troubling them. As Flemons and Green (2004) observe, the transformation of a problem can only be achieved by helping people change their relationships to it. We have found that where clients are survivors of neglect or abuse, or feel unsafe or insecure in their current relationships, this often entails helping them to reframe their sexual problem(s) as something that is psychologically functional (Maltz, 2012).

Many of the clients referred to psychosexual services complain of sexual pain and/or sexual difficulties that may in part be the consequence of physical health problems. Such clients have often had many consultations with different medical specialists and, in some cases, have undergone repeated, invasive medical examinations and investigations, some of which they may have found embarrassing, uncomfortable or distressing. An important aspect of psychosexual therapy in a sexual health clinic (where examination of the 'private' parts of the client's body is the norm) is to provide clients not only with the opportunity to process such experiences, but also a space where their body boundaries are inviolate (Girard, 1988). This literal 'hands off' approach offers the client the opportunity to experience a different type of relationship with a health professional, which in turn opens up the possibility of exploring different ways of thinking about and relating to their problems.

### *The spacing of sessions*

Brief psychosexual therapy does not mean that the therapist's relationships with clients are invariably fleeting. In her work at a sexual health clinic, CP's caseload normally comprises fifty or more 'active' cases, and whenever possible CP allows clients to decide on the spacing of their therapy sessions. Clients are not usually seen on a weekly basis, indeed as therapy progresses several weeks or even months may elapse between sessions. So, although the number of sessions may be limited to six, work with most clients takes place over several months.

This 'irregularity' of consultations in brief psychosexual therapy is something CP initially found quite disconcerting, and, in the context of working within a sexual health clinic, can add to the 'culture shock' sometimes experienced by psychosexual therapists who have never previously worked in the NHS. From a more general psychotherapeutic perspective, the irregular spacing of sessions could be seen as undermining important functions of the therapeutic frame, such as predictability and containment that help to provide clients with a secure base (Gray, 2000). However, we have noticed that a more flexible approach to the spacing of sessions can have certain advantages. First, the client retains greater control over the therapy process – this appears to be particularly important for individuals who have experienced or are living in abusive relationships (Maltz, 2012). The responsiveness of this approach to clients' attachment styles also means that for some clients (particularly those with an avoidant attachment style) it may be easier to stay in a therapeutic relationship. Indeed, a flexible approach to the provision of therapy may be more acceptable to

clients who have ambivalent feelings about engaging in work around their sexual experiencing. The possible adaptive value of a client's sexual difficulties in their life and relationships needs to be kept very much in mind (Lo Piccolo, 1994, p. 6).

Furthermore, some clients seem to require differing amounts of time in which to process the work they has been undertaken in the therapy room. The strength of the working alliance is an important factor here: investigations of the process of internalising therapy, which occurs largely outside of participants' awareness during the time between sessions, suggest an association between positive emotions when thinking about one's therapy and therapist between sessions and a good therapeutic alliance (Hartman, Orlinsky & Zeeck, 2011).

#### *Sustaining the therapeutic alliance*

One practical aspect of this irregular pattern of sessions is the need to re-engage quickly with the client and attend carefully in each session to the state of the therapeutic alliance. In therapy generally, the development of a 'good enough' alliance early in therapy is considered vital for success (Horvath, Del Re, Flückiger & Symonds, 2011). Although fluctuations in the strength of the alliance may occur between sessions, in forms of therapy where sessions are regularly spaced and reasonably close together the building and maintenance of the working alliance tends to be a more cumulative process, and any 'alliance ruptures' can be promptly addressed. In brief therapy in which sessions are irregularly spaced, the strength of the therapeutic alliance needs to be reviewed and revitalised at each meeting. The importance of strengths-fostering micro-behaviours on the part of the therapist should not be underestimated in terms of sustaining the therapeutic alliance (Duff & Bedi,

2010). Furthermore, it is particularly important when the pattern of session spacing is irregular, that the therapist acknowledges ‘missed’ sessions, perhaps in the form of a letter (where permitted) to a client who has not attended.

### ***The power of expectations***

Therapists communicate their attitudes and beliefs to clients in subtle and various ways: a belief that the number of sessions available to the client is insufficient to bring about meaningful and positive change is likely to become a self-fulfilling prophecy (Gibbard, 2008). A therapist’s belief in the effectiveness of brief psychosexual therapy is likely to instil a sense of hope and expectancy of change in the client (Wampold & Imel, 2015). This is particularly important given the levels of demoralization often experienced by clients when they initially present for help (Connor & Walton, 2011; Frank, 1974). Fostering hope, or ‘re-moralization’, is also associated with marked improvements in subjective wellbeing (Howard, Lueger, Maling & Martinovich, 1993; Stulz & Lutz, 2007). The therapeutic models and techniques used by therapists can also help to generate hope and expectancy of change in clients and enhance the ‘common factors’ associated with positive outcomes in therapy (Donahey and Miller, 2001; Wampold & Imel, 2015).

### ***What is lost in brief psychosexual therapy?***

The therapeutic approach that provided the foundation for our initial practice in psychosexual therapy was based on the work of Masters and Johnson (1970). This approach involved negotiating with couples for them to undertake a series of

behavioural ‘homework’ tasks, usually starting with non-genital touching (sensitive focus exercises), progressing to genital touching before sometimes incorporating specific techniques for the direct modification of sexual response and (abandoning an agreed prohibition on sexual intercourse) reintroducing forms of penetrative sexual activity. As Bancroft (1997) observes, this graduated behavioural programme has two important functions. For some couples, its anxiety-reducing effects and the expanded repertoire of ways of being intimate it encourages, are sufficient to facilitate enjoyable sexual interaction. The second important function provided by the treatment programme is that the ‘blocks’ couples encounter when carrying out ‘homework’ tasks often help to identify relevant interpersonal and intrapersonal issues and dynamics that inhibit enjoyable sexual interaction (Bancroft, 1997). While aspects of this approach have been criticised (Kleinplatz, 2001a, 2001b; 2012b) and evaluations of its effectiveness have not reproduced the impressive outcomes data initially reported by Masters and Johnson (Hawton, 1995; Heiman & Meston, 1997), this behavioural programme does help to block the “compulsions of normal sexuality” in partnered sex, such as spontaneity, penetration, and the obsession with (mutual) orgasm, that are often implicated in the development and maintenance of sexual difficulties (Apfelbaum, 2001, p. 23).

If the structure and novelty of therapeutic models help to enhance the potency of other common factors associated with positive outcomes in therapy as many claim (Donahey & Miller, 2001; Wampold & Imel, 2015), the inability to use a graduated programme that seeks to combat a preoccupation with sexual performance and to introduce a ‘non-demand’ approach to sexual interaction, is certainly a loss for both therapist and clients in brief psychosexual therapy. However, it does make it easier to



move away from the diagnosis-treatment programme approach that characterises traditional sex therapy and to focus more on the particular individual or couple who present with sexual concerns (Kleinplatz, 2012b). Rather than seeking to match particular interventions to specific diagnostic categories, we endeavour to provide a facilitative environment in which the meaning of the client's/couple's sexual concerns can be explored and understood.

Although our approach has become more person-centred and we consider the six conditions proposed by Rogers (1957) to be necessary for successful therapeutic work, we do not view these conditions as always sufficient to bring about positive change. As in other forms of brief therapy, we accept that a certain pragmatism is needed in brief psychosexual therapy, and this sometimes requires the therapist to occupy the role of 'expert' (for instance by providing psycho-education, teaching body-centred techniques such as progressive muscle relaxation), although in ways that are consistent with the therapeutic process (Feltham, 2006). One set of interventions CP uses in her work with many clients is designed to encourage mindfulness.

### ***Mindfulness-based interventions***

CP has incorporated some mindfulness –based techniques into her practice that are designed to increase the client's awareness of their breathing patterns and bodily sensations. Mindfulness is characterised by the regulation of attention to keep it focused on the present moment and a curious and non-judgemental approach to one's experience (Bishop et al., 2004). Interventions designed to promote greater mindfulness have been shown to offer benefits to people experiencing a range of

distressing conditions (Khoury et al., 2013; Veehof, Oskam, Schreurs & Bohlmeijer, 2011). To date, the application of mindfulness to psychosexual therapy has tended to take the form of brief interventions designed to help women with sexual function problems. Empirical studies of such interventions – delivered in both individual and group therapy formats – indicate that they are associated with a reduction in sexual distress, greater awareness of sexual arousal, and improvements in sexual function and satisfaction (Brotto, Basson & Luria 2008; Brotto, Heiman, Goff, et al., 2008; Brotto, Seal & Rellini, 2012).

Interestingly, a number of commentators have pointed to commonalities between mindfulness-based interventions and the sensate focus exercises devised and used by Masters and Johnson (Brotto, 2013; Goldmeier, 2013). Indeed mindfulness has certain advantages over sensate focus especially in psychosexual therapy with individuals (Brotto, 2013). The precise mechanisms by which mindfulness helps individuals/couples with sexual difficulties and concerns are unknown, although Brotto (2013) suggests a number of possibilities, such as helping clients to attend to sensations that are unfolding in the moment thereby shifting the focus away from negative memories and anticipated failures, and promoting greater awareness of subtle changes in body sensation through repeated practice of Body Scan exercises. Mindfulness may also enable clients to better regulate the emotional distress associated with sexual function problems. Many of the clients who present to CP with genital pain disorders, arousal problems or numbness/lack of sensation seem to find the use of mindfulness-based techniques very helpful. However, the application of mindfulness to sexual concerns is still in its infancy and, to date, only a few studies have examined its effectiveness (Brotto, 2013).

## **Discussion**

We have outlined some of the changes in therapeutic practice associated with the delivery of a brief psychosexual therapy (six or fewer sessions) service within a sexual health clinic. In the remainder of this article we focus on four broad themes that are discernible in the issues we have already discussed but have not been considered directly.

The first of these is the location of such services. As already mentioned, in England there is an expectation that level 3 sexual health services will provide services for people experiencing sexual concerns and sexual function problems (Department of Health, 2001). This policy has identified clearly a need for the development of psychosexual therapy services within the NHS. Given the funding constraints faced by the health service and the relative scarcity of psychosexual therapists, placing limits on the number of sessions offered to individual clients may be seen from a utilitarian perspective as a means of ensuring the greatest good for the greatest number (Barkham, 2009). One advantage for psychosexual therapists and their clients of being located within sexual health clinics is the ready access this provides to the expertise of a multi-disciplinary team comprising medical and other health professionals who are willing to discuss sexual matters. This is a highly unusual situation as studies consistently indicate a marked reluctance on the part of many health workers to discuss patients' sexual concerns (e.g. Kedde, van de Wiel, Schultz, Vanwesenbeeck & Bender, 2012; Lemieux, Kaiser, Pereira & Meadows, 2004; Stead,

Fallowfield, Brown & Selby, 2001), and its benefits, in terms of quality and continuity of care, should not be underestimated.

A second related issue concerns the availability of services for clients who (are likely to) need more than six sessions of psychosexual therapy to experience any significant clinical benefit. Increasingly, stepped care models provide the basis for planning and delivering publically funded psychological therapy services. However, the lack of qualified psychosexual therapists and the general paucity of psychosexual services in the NHS make it difficult at present to adopt this model for designing and delivering psychological therapy services for clients presenting with sexual concerns (Dixon & Adams, 2002). Currently, most providers of longer-term psychosexual therapy in Britain work in private practice or in the non-statutory sector, so identifying suitable services for clients who require or request longer-term psychosexual therapy can be a challenge. Clear protocols are needed for ‘extending’ the initial therapeutic contract in certain circumstances (for example, when working with clients who have learning difficulties), and pathways for the clinical management of clients who require a more open-ended therapeutic contract, need to be agreed. A related issue here is also the purpose of psychosexual therapy services in the statutory sector. Kleinplatz (2012b, p. xxv) has argued that psychosexual therapy should aim to optimise the sexuality of clients rather than settle for ‘fixing performance problems’. However, given the financial and resource constraints under which the NHS operates, it is likely that the latter will remain the espoused aim of many psychosexual services located in the statutory sector.

For the benefit of service users and for the continued provision of brief psychosexual therapy services, practice-based evidence of the effectiveness of such services is urgently required. But evaluating outcomes in psychosexual therapy is particularly challenging (Leiblum, 2007). A focus solely on changes in genital function or sexual performance neglects important variables such as client/partner satisfaction and quality of life. Also, the relationship between sexual distress and sexual (dys-)function is far from straightforward (Bancroft, Loftus & Long, 2003). Furthermore, it is not uncommon for the main underlying issues identified during therapy to differ from the presenting ones, making the measurement of success problematic.

Depending on the needs of clients, indicators of success in psychosexual therapy may include increased sexual and relationship satisfaction, higher levels of sexual confidence, and improved quality of life (Leiblum, 2007). A number of measures already exist that can be used to assess these outcomes (Tabatabaie, 2014). Therapists who work in time-limited practice recognise that sometimes the most important outcome for clients is to experience the possibility of change during therapy (Butler & Byrne, 2008), although significant changes in sexual well-being and sexual and relationship satisfaction may only occur after therapy has ended. This adds an additional level of complexity to outcome evaluation in brief psychosexual therapy as it suggests the need for longer-term follow-up of service users. However, the importance of monitoring and tracking the client's responses to therapy throughout the course of therapy and responding in a timely manner to such feedback has been demonstrated to improve clinical outcomes in psychotherapy (Lambert & Shimokawa, 2011). Miller and Donahey (2012) describe how this process might be incorporated into therapy for sexual concerns. Given the brevity, pragmatism and

eclecticism of brief psychosexual therapy, ensuring that such therapy is feedback-informed would seem essential.

The final issue concerns the training and supervision of therapists who work in brief psychosexual therapy services. As indicated above, the traditional sex therapy format does not lend itself to such time-limited work and in our experience working in an brief psychosexual therapy service requires a shift to a way of working that is more person-centred, flexible and based on technical eclecticism. This suggests that psychosexual therapists may not only need specific training and supervision to work in a 'brief' way, but also that the continued isolation of psychosexual therapy from the broader field of psychotherapy and its empirical data is untenable (Kleinplatz, 2012a). Although many psychosexual therapists working in the UK are trained in relationship counselling and other forms of therapy (Wylie, 2006), brief psychosexual therapy does provide challenges (and opportunities) for providers of accredited training programmes in psychosexual therapy. As previously noted, brief psychosexual therapy formats have been developed within some brief therapy approaches such as solution-focused therapy (e.g. Trepper et al., 2010). The question that arises here is whether any additional education and supervised practice is required for practitioners already trained in these theoretical orientations in order to work with sexual concerns? We think the answer to this is provided by Kleinplatz (2012a), who suggests that it is a specialist knowledge of sexuality and comfort in dealing with sexuality that distinguishes the psychosexual therapist from practitioners in other therapeutic modalities. Unfortunately, as Kleinplatz also notes, the opportunities to undertake training that facilitates the development of such specialist knowledge and comfort in dealing with sexuality seem to be diminishing.

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