Sex in Counselling

Lecture Transcript

Thank you to Rory and Colette and Counselling Tutor, just to begin with. We've got quite a lot to go through so let's get straight into it. There are some trigger warnings with this so everyone watching, please do pay attention to them. We'll be talking about sexual practices with some explicit descriptions and I'll be expecting you to imagine some scenarios so it might get a bit uncomfortable. We will briefly be talking about sexual assault, only briefly but it's worth mentioning that we will go into that and we'll be talking about shame quite a lot. Now, hopefully, most of you will be comfortable talking about shame, but I know how triggering shame can be within itself. So, if any of those are a concern to you, you might want to step away when they come up in the presentation.

The main aims and objectives for today are to empower you to explore sex more in therapy, to give you an introduction to sexual terms. So, this is an introduction, it won't give you everything, but it will give you a good start. Then to expand your views of sex and sexuality away from the heteronormative model, to give you a brief introduction into cognitive behavioural, psychodynamic and person-centred approaches to sex in therapy, to offer you a greater understanding of areas of shame linked to sex and why it's so important and to give you a list of personal development takeaways and also therapeutic takeaways when working with clients.

Now you know what to begin with. A large portion of people experience issues with sex and sexuality. It's very well evidenced and very well researched. Within the mental health professionals and within medical professions there is a huge lack of training around sex and sexual issues, and that goes for therapists as well and yes, sexual problems can contribute to depression, anxiety, trauma, eating disorders, substance abuse, pain disorders, etc., etc. Yet still it remains fairly unaddressed in a therapist's

office. There is some good research that I quoted there by Buehler from 2016, if you want to check that out.

I want to test you with some of those terms. I'm not going to go into all of these today, but if you do not know what they are, I advise you go away and start learning some of these. I'll read some of them out. Kink, I think hopefully most people would know that. BDSM, which we'll explore a bit later. CBT and I'm not talking about cognitive behavioural therapy, age play, furry play, material play, object sexuality, voyeurism, frottage, pup play, rubber play, cottaging, polyamory and consensual non-monogamy. We will explore some of those today. If there's any that you are thinking, 'what on earth is that?' Go and find out. Be careful what you Google. I'm just going to give you some advice there, but I'd suggest you need to start understanding some of this stuff if you're going to work with clients and sex.

The therapist - I don't know what training was like for you as a counsellor, but I know for myself we're rarely given the opportunity to explore sex in training. One of the biggest reason's professionals do not discuss sex is because of a lack of education, a lack of knowledge and also discomfort. If you are a therapist and you want to work with sex and how it tends to work at the moment is that you have to have specialist training and I'll mention that in a minute. So, again from Buehler 2016 and this first sentence says it all to me, 'therapists' silence about sex in the therapy room sends many messages, but perhaps the loudest is please don't talk about sex!' There's some vignettes below and I just described two of them, but these are actually from clients within this research. 'Since the therapist never asked about sex, the client got the message loud and clear that sex is not spoken here'. The second one, 'a couple couldn't bring themselves to tell their uptight therapist that they enjoyed swinging in their early marriage'. Clients will pick up discomfort from you and if you're unwilling or unable to talk about sex, they will pick this up. I've seen this many, many times.

We're going to do a quick exercise. What I'd like to do is close your eyes and then I'm going to describe some scenarios. Now, these might be a little bit uncomfortable, so bear with me as I go through them. I have my own discomfort when I'm describing these scenarios. I want you to pick up every time I add to the scenario or change it, where is your discomfort at and has it changed? Is it becoming intolerable to go through this scenario? Is it okay? Is it pleasurable? Is it shaming? I'll start reading through them. Close your eyes and see how it feels. The first scenario; imagine a woman on her own in her bedroom. Nice and simple. Next one; a woman on her own masturbating in her bedroom. Are you feeling uncomfortable yet? Is that okay? Now imagine a man instead on his own masturbating in his bedroom. Is there a difference between a woman and a man in that scenario and did you have a discomfort change between the two? Next, a

woman on her own masturbating in a hotel room. Does it change again? Does that feel less acceptable to you? A woman masturbating in a hotel room with one man. How does that seem? A woman masturbating in a hotel room with two men watching. Is it feeling okay? Is it feeling unacceptable? Is it feeling unsafe? Is it feeling exciting? Then finally, a woman tied up with two men masturbating being filmed. Have you reached any discomfort? Have you noticed that? What I'll ask you to do to take that exercise further is go and reflect on when your discomfort starts to creep, if it did and if anything felt uncomfortable and unacceptable, you didn't want to imagine it and you wanted to stop doing the exercise or maybe it was all okay. You can reflect on that.

We're going to look at some definitions now of sexual wellbeing, and this will form a really good basis for you as a therapist when working with clients. What I want you to start thinking about then critically, which we're going to come onto later, is the heteronormativity of these kind of definitions, i.e., sexual wellbeing. The WHO has a good definition, I'd say it has improved and I'll read that out 'sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality. It is not merely the absence of infection, dysfunction or infirmity'. We're moving away from just the physical aspects of sexual wellbeing. I'm going to move on to number two. 'Sex is influenced by biological, psychological, social, economic, political, culture, legal, historical, religious and spiritual factors'.

Then we've got some of the definitions and I'm not going to read through all of them, but I really want you to pay attention here to where is heteronormative and not heteronormative. I'm going to give an example, here at number three, physical and psychological. Martin, 2017 talks about the need for there to be physical and psychological well-being in terms of sex and if you don't have both these factors, without it you will have poor sexual wellbeing. You need the physical aspect, and you need the psychological aspect to be well. It's great as a concept and it works overall, but where I want you to think a bit more critically as a therapist with this terminology, especially the physical, is that this is based on heteronormative relationships and it's based on penis and vagina and it's based on functioning sexual organs and that is the definition Martin goes into in terms of the physical aspects. Now, we need to start thinking slightly outside of this box because not everyone has physical or well-functioning sexual organs. Some people are born that way and grow to accept it and other people may have physical injury, disease, etc., which means that they'd have to adapt to sexually function in a different way. I've worked with clients with alternative sexual organs that have sexual wellbeing. In terms that definition of you must have a well-functioning sexual organ in order to enjoy sexual pleasure, it's just not true anymore and that's what we need to start get clients to understand that there are alternatives, particularly if there's sexual function.

This is where you need to start challenging things with a therapist as well. So, start challenging these models you might be reading about. As some examples, this might include challenging views of partners for example, does it have to be a partner? Can it just be self-pleasure, and can it be multiple partners? Sexual organs I've talked about. Physical and non-physical sex. So, people practice tantric sex and nonphysical. It may just involve self-pleasure, but it also doesn't necessarily include orgasm. Penis/vagina, trying to move away from this idea of intercourse as the only form of sex. Then relationships, a lot of different types of relationships these days, not just monogamy, a lot of different formats and moving away from heteronormativity. What a difficult word to say.

You may have heard of something called the Charmed Circle. Here's an example of this, developed by Rubin in 1984. This starts building on that non-heteronormative model. In the centre of the circle, if you can see, it's very tiny writing I'm afraid. I just noticed that so I'm going to read some out. In the centre of the circle is the charmed element. Basically, what that means is that it's okay and it's acceptable by society. Bear in mind, this is 1984, but some examples in the middle are what's acceptable is marriage, heterosexual, bodies only so not using any objects, at home, coupled, etc. As you move away from the centre of the circle, away from the charmed circle, and you can apply this today, the further you move away, the less acceptable things become. I guess the lesser view society has on them and the higher the distress starts to rise if you are experiencing such desires. Some examples on the outside of the circle are pornography. What else have we got, in the park so public sex, being promiscuous, seeing more than one person.

Sexual disorders. They're not called sexual disorders anymore, and I'd like you to try and go and find out a bit more about this, but I do find clients are maybe self-diagnosing a bit more and might come to you with the new definitions. Instead of sexual disorders, the DSM-5 talks about paraphilic disorders now. The simplest definition of that is 'a paraphilic disorder causes distress to the individual and it causes harm without consent'. The full explanation and definition or diagnosis in DSM-5 is a; feel personal distress about their interest, not merely distress resulting from society's disapproval to personal distress and then b; have a sexual desire or behaviour that involves another person's psychological distress, injury or death or a desire for sexual behaviours involving unwilling person or persons unable to give legal consent. There are 8 key paraphilia disorders and when I say key they're put in there because they are considered the most common and there's a ninth category saying, 'other specified paraphilia disorder'. I won't read through all of this, but just to pick a couple out, we have exhibitionistic disorder. What else have got, sexual masochism disorder, sexual sadism disorder. We also have paedophilic disorder now in the paraphilic categories. You might want to reflect on that and see how you feel. For me, I'm not sure if it should remain in the same category. I think it's maybe too close to some sexual preferences that are

acceptable but have a think about that and see what you think. We've got paraphilic disorders now instead of sexual disorders.

From the different perspectives, so different approaches and modalities, you might want to have some focus when working with paraphilias in these ways, so these are just some suggestions. If your person-centred counsellor you might look at the current experiential feelings of distress associated with the paraphilic disorder, so what distress it's causing them and hopefully learn to move to a place of acceptance with these feelings of distress and soothe with them. You might also look at exploring other ways to increase present satisfaction so they're unable to get satisfaction from that one desire, while other desires they engage with to satisfy their needs. Psychodynamic approach, you might explore stage development, unresolved and suppressed infantile perversions, which I'll talk about later. Perversion being Freud's word, not mine, and a possible fixation stages and connect to these experiences to key carer relationships. Then for CBT will be a little bit similar to a person-centred approach, maybe focusing a bit more on the behaviours that result from the emotional impact and then exploring triggers around the paraphilic disorders and maybe triggers that push people to engage in certain activities.

What I've also done to go into a bit more detail with the different approaches, with person-centred I've overlaid some of Roger's key theories and tried to create some of my own, so I hope it's helpful. We can look at things like personal development theory, which hopefully most of you should know, but when we're looking at self-image, ideal self and self-worth, we can overlay them with sex. So, for example, your sexual self-image, and that will be how we see ourselves sexually, good or bad, ugly, beautiful, body image, which are really important sexual satisfaction and how this influences our feelings and behaviours. We have the ideal sexual self. The sexual person we would like to be, this is forever changing. This is also influenced by things such as porn so it can change our ideal and make it may be quite unrealistic in terms of sexual expectations. Sexual self-worth, what we think about our sexual yourselves, childhood influences and child formation. I also added a fourth circle, I have always done this, and this is societal self because I believe there's quite a heavy societal influence, especially with sex, on how we think society sees what we should be doing if that makes sense. Societal sexual self gets influenced by the society around us, community, culture, religion, etc.

You can also overlay this with the five characteristics of fully sexually functioning person. This is really useful to do when working with clients and it might not be something explicitly you do with them in the counselling session, but you might reflect on this afterwards to see how fulfilled they are and how much further they need to go at that exponential curve. You might look at things like open to experience and overlay it

with sexual tones and look at it like being opened to lean into positive and negative feelings and therefore being able to recognize when they occur and understanding what sexual experiences are positive or negative, pleasurable or not. Existential living, not judging our own and others' sexual experiences, being able to enjoy sexual experiences in the present and in the moment, not necessarily always looking back at past sexual experiences or looking forward to a future sexual experience. Again, you're hopefully now getting the idea of overlay sex with the other categories as well. Trusting the feelings, that's really important and it ties with sexual dysfunction, which I'll talk about more later, but being able to trust what your body is telling you in the moment about what is enjoyable, what isn't and what's okay, what's not, and make the right sexual choices. Creativity so being able to be sexually creative, absolutely integral to reducing shame levels as well as being able to be creative with sex. Number five, fulfilled life, being happy and satisfied with our sexual choices, which can include no sex and different forms of sex, i.e., being asexual. That is a valid choice or way of being orientation.

Psychodynamic approaches. I thought I'd start off with Oedipus, the Oedipus complex and in particular male Oedipal aggression. This isn't well evidenced, by the way that there's some good research that shows this, but there are different ways to look at Oedipus aggression and why it's a thing. This is essentially the societal influencing gender and men in particular, how they're brought up in a different society to women or different concepts of society to engage with activities that display strength to reject homosexual behaviour, to reject femininity, to take control and on the other side, the women are generally taught to be more subservient. So, you get self-esteem from other people and men to care, feelings, family. So, this is where the psychodynamic approaches might explore how formation, personality formation and gender influence actually begins to affect how we act and how gendered responses are formed around sex later on in life.

For the psychodynamic approaches, which if you're a psychiatric practitioner, hopefully you would know this now, essentially Freud thought that human sexuality is disturbed and that it was given, and its libido led so it's not often about reproduction. He talks about children having sexual desires and this is where things tend to develop. If you link this to paraphilias, I suppose if Freud was around now, he might connect paraphilias to this stage of development. He talks about infantile sexuality and how this becomes repressed into genital sex at a later stage and that's where adult sexuality emerges. Infantile sexuality, by the way, not being the same as adult sexuality. It is different, but it might have all things like being stared at or looking. I will link that more later to sexual practice in adulthood. Infantile sexuality can become the dominant driver of sex, by the way. Freud calls this perversion, which is a word I used earlier, where something like voyeurism or being watched gets fixated and moves into adulthood and becomes the

fantasy or as DSM call it, if it is causing distress or distress and harm to the people, the paraphilia. Number 6, we cannot distinguish between normal and abnormal, by the way so Freud is pretty clear in this and we have traits of both. Societies is super complex, and it will also change our views of what is and isn't normal. The stages of sexual development. We have oral, anal, phallic, latency so little or no sexual motivation and then genital penis, vagina. It's that genital stage to adulthood stage where the infantile desires then get suppressed. So, academics will work on exposing the dominant infantile desires to make sense of them and then look at when these perhaps emerge and how you resolve them. That's again, if you're psychodynamic practitioner, that's what you might do with the paraphilia.

Then cognitive behavioural therapy, I've mentioned earlier, but we're essentially looking at thoughts, feelings, physical sensations, behaviours around sex and often these cycles that get in the way. A cognitive behavioural approach and I'll give male dysfunction as an example. If one of your clients is experiencing erectile dysfunction, what you might do with cognitive behavioural therapy is look at when the issue began and look at links between events, triggers, behaviours. Behaviours that typically emerge out of male dysfunction are avoidance as well. Once the erectile dysfunction starts and avoidance behaviours kick in, in order to reduce shame levels and not engage in that, that increases shame. You might then look at goal setting. Small, immediate goals. You're not obviously going to set a goal to have an erection straightaway. That will be the end goal, but you'll work on intermediate goals, and it might be non-shaming, physical contact that isn't necessarily about erection or orgasm or even intercourse. It's just about physical contact with their partner or whoever. You choose things like talk tools and exercises, as I've just mentioned, that body contact, reducing avoidance, self-serving behaviours, self-monitoring and then possibly relaxation techniques. I wanted to give female dysfunction as an example, in contrast against similar. There's a really good model here, a fear avoidance model you might want to look. It's similar to male dysfunction. It starts when there was a penetration attempt and there was a negative experience. It could be a high amount of pain or another shaming experience, catastrophizing thoughts, fear of penetration, pain. The avoidance activity kicks in, hypervigilance and then tension. This cycle here is actually talking about vaginismus and where that might begin.

We're going to go into shame now, and the reason why I'm spending a bit of time on shame is because it is integral when working with sex. I'm not saying everyone will experience shame, but most people do. Shame can be a big part of sexual dysfunction, or it can just be ashamed to talk about sex with most people, including therapists. It's important to understand shame from different perspectives so I'm going to give different examples of shame and what the flavoursome is like and what you might be able to do with them. Shame and sex for women. Really good article here that I've

referenced, Gunning et al 2020, but this talks about memorable messaging and whilst this is just about women and to note this is about white heterosexual women, so it's quite a tight lens. Nevertheless, memorable messaging is important for everyone and I'm going to explain a little bit more about this. It gives examples of messages women receive when they're younger that has lasting implications on their identity, but not just their identity, it also impacts sexual activity. Where a woman might be taught, for example, to protect themselves, to start a family, to serve or give pleasure and that consequently can form to the way they relate with sex and other people. This might be because of belief bias, religious bias, moral implications, gender assumptions which I've mentioned and assumptions about sexual gratification. Key example of this is masturbation. Much more shame is experienced with women and masturbation than it is for men. Just a resource you might want to look at in case you are working women with issues around masturbation and self-pleasure, there is a brilliant podcast called 'menage a moi' that I listen to myself and I always recommend it to women, and it looks at reducing shame around particularly solo activities, but just sexual activities in general and readjusting that memorable message.

Body image. Again, this one is about women but what I'd like to mention is that this is a fast-growing issue amongst men and also particularly LGBT men. This article is a CBT evaluation of body image and I think it gives you as a therapist, a really good base point for how to look at body image and how to evaluate it. I'm going to focus on the first three categories from a CBT perspective. It looks at the client's individual values of conception, I guess, with their body image and this is how they view themselves and how they assess themselves. Then it looks affective so that is the feelings that emerge with that, so how they feel about their own body and then the behavioural. A really good example of this, and I've heard this many times from clients, particularly women, but other clients as well will be something like they want to turn the lights off all the time during sex or maybe not want to lie in a certain position because they were concerned it was showing body fat. That would be the behaviour that kicks out of the poor body image. If you're hearing things like this, lights off or lying-in particular positions, you can already get a good sense that they've got low body image and body image is directly connected to sexual satisfaction.

Just to bring some of the terms I mentioned earlier, I wanted to mention polyamory as a growing type of relationship but because the relationship discrimination, it experiences being in a primary relationship. So, this piece of research that I've quoted, the definition of polyamory is 'the assumption that is possible, valid and worthwhile to maintain intimate, sexual and all loving relationships with more than one person'. What we see more and more with polyamory, particularly as it starts to come out, is more discrimination towards it. This isn't just from society outside either, it's been well documented that therapists actually as supportive, as they might be towards polyamory,

they're often the ones that try and advise or push clients back to a form of monogamy, because they think polyamory is associated with damage and trauma. So, be really aware of this as a therapist. As I have just mentioned there the assumptions about polyamory also include lack of sexual health, emotional instability, negative personal characteristics and also trauma.

Shame and LGBT+, it really goes hand in hand. I identify as LGBT and I experience a lot of shame in my life and still do. If you're working with LGBT+ clients there will be shame, there. It's almost guaranteed and there will be shame associated with sex as well. You'll probably see more substance use with LGBT+ clients and even more substance use with sex because of shame association. So, sex parties with drugs, etc. Bear in mind this is different as well, so it depends on culture, countries of origin. I noticed with myself when I came out at a younger age, it is much more difficult at that time. Much easier now for some people to come out but there's still layers of shame and depending where people are from even more shame, some countries aren't as ahead as we are in terms of homosexuality.

The final thing I want you to consider with shame as well is men and masculinity. There's been a lot of change in the world in the past few years, particularly around women, really positive change and it's still moving. What we are also seeing is increased shame in men around sex. You might notice this more with clients as they come forward, and this can be categorized into different areas. Men are now experiencing more shame around sexual experience distress, masturbation and pornography, remorse. They feel more guilt and shame around that. Libido disdain, body dissatisfaction, which I mentioned earlier, which has growing amongst men, dystonic sexual actualization. This is a long term, but essentially, it's a clash between sexual self-image and sexual orientation. It might be men; it might be hyper-masculine men that are gay and coming to terms. It also might be straight men that have some urges or fantasies around sex with men but do not identify as gay and are not gay, so there's a clash between what's acceptable and not acceptable in their eyes. Sexual performance insecurity which can cause erectile dysfunction. Perceived high libido, if they've got higher levels. Sexual harassment, stereotype threat and homoerotic guardedness. You might be able to spot some of these things with male clients you work with. Finally, on shame and I'll discuss this briefly, but I put some references in there for you to go into. Kink and BDSM, and I wanted to give an example of the Grace Millane murder that you may be aware of and this happens repeatedly in our media. This is a case of a woman that was unfortunately murdered and instead of the trial and the media focusing on the murder, they focused on the fact that she had a kinky sexual lifestyle and was on BDSM sites and they try to label her as responsible because of her sexual practices in terms of what happened. That's the kind of shaming we see around kink and BDSM, that it's unsafe and it's dangerous and actually converse is absolutely the opposite, that BDSM

and kink practice is often safer. It often has less STI's in terms of sexual practice. People have safe words, they have rules, and they have discussions beforehand, but there's still this discrimination between King and BDSM. You might work with clients that have a high level of shame if they're discussing their practices around Kink and BDSM.

BDSM - just a quick bit of background information, we're talking about things like play, power, mind and sensation, and that's how it's often categorized, and it can emerge at a younger age. I mentioned it with psychodynamic theory. In terms of society's perceptions of mentioned, it tends to view BDSM as a negative thing, unhealthy and it may be associated with abuse and trauma and that's what you need to move away from as a therapist.

Fantasy and trauma. I just mentioned trauma and I wanted to throw this in because people often ask me or often associate a traumatic sexual experience at a young age with sexual fantasies at a later age. With women, in the research I've mentioned here, this might be something like women's sexual forceful fantasies. There is some evidence, but only some to suggest that an earlier sexual trauma may lead to a later adulthood sexual fantasy, but there's a lot of examples where that doesn't happen. So, as a therapist, do not assume if somebody has got a sexual fantasy, maybe a forceful sexual fantasy, that a trauma happened at the same time there might be a link because sometimes that does happen in formation.

Something I want to mention is GSRD, if you don't know what GSRD you is needed to go and find out. So, gender, sex, relationship, diversity model, and there's a link there for you to follow. This is with BACP. This was developed by Dr Meg-John Barker, brilliant writings and a website and a fantastic piece with the BACP. This is a newer model of viewing gender, sex and relationships that is no longer heteronormative, and it moves away from things like sexual dysfunction. It starts asking questions like, 'what really satisfies people? Can people have sex without orgasm? Can people have sex without intercourse?' There is a guide as well for BACP therapists and how you might look at that. Charmed circle I mentioned earlier, and I just mentioned Meg-John Barker. She developed a version to this charmed circle. I won't go through all of this now, but the link is on the website, so I'd advise you to look at the version two of the charmed circle, which reverses where the shame lies and what we should be moving towards.

My own model of sexual acceptability, which is here and it's in very small writing so you may not be able to see it, but this is starting to identify that that charmed circle in the middle, which would line up with heteronormative and acceptable section at the top. There's different layers to sexual acceptability in society now so they're not just an

accept one accept all. What we are seeing more of is that we have an acceptable stage, that's heteronormative and then it moves to a transgressive but acceptable stage beyond that, to transgressive being pushing societal norms but it's acceptable and it's considered moral pleasurable, but for most people it's unknown. This might be things like group sex. It's still considered things like homosexuality that it's acceptable, but unknown to most people. It might be the use of objects like dildos and other objects. Then the next stage is transgressive. Again, it's pushing social norms. What is deemed as unacceptable by society. It's immoral, potentially disgusting and unknown. This might be a larger group of people, so 'orgies'. It's also a transsexuality, probably sits in this category for most people, which I don't agree with but it's there. It might be for money, so it might be sex working. The final category to look at is coercive and illegal. So that, as it says is that there's no consent and its illegal practice. We're looking at things like rape, paedophilia, bestiality, etc.

Some key takeaways then, I think the best thing you can do as a therapist is to look at yourself and I want you to try and expand your understanding of sex and sexuality and do that first by gaining knowledge. A lot of things mentioned today. If you do not understand, then go away and find out. Don't expect your client to tell you. It's repeated again and again that this happens within therapy and clients do not want to do it. They'll give you limited information, but they want you to know. Then I want you to start thinking about sex, not just being penis and vagina, particularly when working with dysfunction where you have to support clients to find other forms of pleasure. I want you to explore your own sexuality. So, understand your discomforts and reflect on the exercise we did earlier and see where your discomfort kicks in. Your boundaries, your levels of disgust, because they might be there. Body image. do you have body image concerns? Will you possibly project that onto clients? Think about that. Sexual efficacy and explore this in therapy, on your own and talk to other people about it. Be honest about your phobias and isms. They will be there. We will have judgments. We will assume. You may have a lacking culture awareness, go away and discuss it again in therapy and supervision. To mention the second time, please look at that GSRD link that will start to progress you to a different way of thinking about sex.

Your key takeaways in terms of working with clients. Start to think about sexual dysfunction. The best way I can put it as sexual communication. I'm going to give the example of erectile dysfunction with a male client. We have a lot of shame involved in that and viewing something wrong as a dysfunction is not going to help. Starts with communication. What is the body telling the individual? It may be telling them there is something physically wrong and they need to go and get that checked out medically. It may be telling that there's something they're very unsatisfied with and uncomfortable with, anxious. So, consider it sexual communication and that can be a really positive way of framing it. Explore memorable messaging. I talked about that with women but

explore that with everyone. What are the messages they're telling themselves maybe about themselves in terms of body image and they might be saying they're disgusting? I hear that a lot from women but explore that more. Ask your client about sex early on. So, once the relationship is comfortable, just ask them. Clients want to be asked. If you don't ask and if you remain silent as a therapist, the client will start to assume that you are uncomfortable to talk about sex. If they're talking about a relationship, for example they might be saying they have relationship issues. Ask them, 'okay, so what's the sex like?' 'Are there issues in terms of sex?' Be curious. Be absolutely curious about everything, but please be relevant as well. Let the client lead you. Don't let your curiosity lead them. Normalize discomfort. I'm talking about yours as well as theirs. Use their language possible. This is a little bit jovial, but I'm saying it anyway, Dick means Dick. If they're saying dick, then if you can use the same word, if you're uncomfortable using that word, you don't obviously have to say it, but make sure you validate theirs. You might want to explain that 'I'm uncomfortable using that word but I'm going to use this, but I'm absolutely comfortable with you using that word.' Use that language where possible. Do not expect your client to educate you. Educate yourself between sessions. Normalize, normalize, normalize, keep doing it. Normalize sexual issues, so many people have their normal sexual dysfunctions. Gently unwrap shame. If you can start to unpack shame, you start to unpack a huge part of their sexual dysfunction, sexual issues but do it gently. Know your position also on adult and child safeguarding, it's something I advise many counsellors on and I often see, I guess, a knowing around safeguarding in terms of sex and what counsellors should do. This idea to kind of protect the relationship so much that we avoid safeguarding issues. So, please understand your positions on adult and child safeguarding and knowing what to do if something comes up.

That is everything, I hope you got what you needed. I hope that was a good oversight. Please go away and find out more about these topics.