Psychosexual and Relationship Service

A unique service specialising in the management and treatment of people with sexual dysfunction, sexuality or intimate relationship problems.

www.national.slam.nhs.uk/psychosexual
Contents

Service overview 4
Our philosophy 5
Who is our service for? 6
Interventions 8
Our care model 10
Our care pathway 12
Outcomes 14
Our facilities 16
Our team 18
Case studies 22
Referrals 26
Service overview

Our service has been helping people overcome their sexual problems for more than 20 years. We are a multidisciplinary team, with a comprehensive knowledge of intimate relationships, sexuality and sexual dysfunction.

Our therapists help people to understand, overcome or adjust to their specific problems. We treat individuals and couples using simple educational interventions, highly specialised cognitive behavioural therapy (CBT), systemic and psychodynamic therapies, and medication.

We provide a variety of collaborative, evidence-based treatment options which are in line with the British Association of Sexual and Relationship Therapists, the Institute of Psychosexual Medicine and the British Society for Sexual Medicine’s recommendations.

» It was really easy to speak to the therapist right from the beginning. He’s not like my doctor, who knows me and my family. « Jane, 35
Our philosophy

We view sexuality and its expression as something as individual as the human fingerprint. Our therapists adopt a neutral and non-judgemental therapeutic stance when treating people. We help people understand their sexuality and express it in a way that is enjoyable and harmonious with others.

We believe everyone has the potential to overcome their sexual and relationship problems and improve their quality of life, irrespective of their gender, sexual orientation, age, culture or religious beliefs.

» Would I recommend the service to others? Yes. Of course, it can be difficult to talk about something so private. But the therapist made things more comfortable and it was certainly a useful experience for me. «  Jane, 35
Who is our service for?

Our clinic provides a confidential and understanding service for people who experience difficulties in their sexual lives, their intimate relationships or problems associated with hormonal change.

Eligibility

› 18+ years
› Male or female
› Individuals or couples experiencing sexual and relationship difficulties
› Relationship and sexual problems in the context of physical or psychiatric difficulties like depression, anxiety, jealousy or personality difficulties, or as a result of medication
› People experiencing sexual problems arising from fetishism, transvestism or gender identity disorder
› People experiencing psychosexual problems associated with sexual development or sexual orientation
› People experiencing physical and psychological problems associated with hormonal change, including premenstrual or menopausal symptoms, or following surgical or medical intervention

Exclusion

› Current acute mental illness requiring treatment
› Current alcohol or substance dependence requiring treatment in its own right
› Severe personality disorder as the main problem, requiring treatment in its own right
› Recent history of violence (sexual or physical), or harm to others that cannot be safely managed within the clinic
› Sexual problems arising from criminal or violent behaviour or disturbing or damaging behaviour
Interventions

Our interventions are designed to address a broad range of difficulties faced by our patients.

We offer:

› Assessment with a view to clarifying diagnosis
› Comprehensive formulation taking into account biological, psychological and social factors
› Specialist assessment with a view to pharmacological treatment and medication management
› Specialist psychodynamic therapy
› Behavioural systems couples therapy
› Specialist cognitive behavioural therapy
› Behavioural interventions
› Relaxation training
› Communication training
› Reciprocity negotiation
› Psychosexual education
› Progress follow-up

» After a while, it was like talking to a friend in the pub, though someone who understands the experiences you’re having. «  Trevor, 29
National Services: Psychosexual and Relationship Service
Our care model

**ASSESSMENT**
- Assessment of physical causes for sexual dysfunction
- Assessment of underlying psychological processes
- Comprehensive formulation, taking into account biological, psychological and social factors
- Designing an individual treatment programme

**TREATMENT**
- Evidence-based
- Synchronised multidisciplinary approach
- Tailored to address specific needs of the individual or couple
- Specialist cognitive behavioural, systemic and psychodynamic therapies
- Ongoing evaluation, feedback, and follow-up

**PATIENT**
- Person-centred approach
- Neutral and non-judgemental therapeutic stance
- Promoting psychosexual health and well-being
- Optimal therapeutic outcomes
- Improving intimate relationships
- Healthy lifestyle promotion

**EDUCATION**
- Unassuming and sensitive approach
- Clarification of biological, physiological and psychological aspects of sexual intimacy
- Dispelling unrealistic expectations and sexual myths
- Introduction to new ways of thinking, more effective coping strategies and sexual practices
- Clarification of the role of biological, psychological and social factors influencing premenstrual and menopausal symptoms

**PARTNER**
- Interventions to understand the problems and needs of the patient
- Help identifying and addressing sexual difficulties of partner
- Developing effective adaptive strategies
- Promoting psychosexual well-being
- Improving intimate relationships

**PHARMACOLOGY**
- Evidence-based practice
- Development of optimal medication regime
- Medication monitoring, long-term recommendations and follow-up
Our care pathway

» It really helped to be able to talk. My mentality has completely changed. It’s difficult to describe, but my way of thinking has changed tenfold. «  
Trevor, 29
Outcomes

Outcomes are good in the majority of sexual dysfunction cases, particularly those where medication is used in addition to psychosexual therapy.

In relationship problems, the outcome depends partly on the nature of the underlying problem, but in most cases there is an improvement in the relationship, and adjustment can be achieved and maintained.

For premenstrual and menopausal problems, psychological symptoms are likely to improve following six to eight sessions of CBT. Physical symptoms, including hot flushes and night sweats, can also be helped with CBT. For moderate to severe adjustment issues or depressed mood, long-term therapy of between 12 and 16 sessions is often required. In some cases, the desired outcome is a better psychological adjustment to the permanent alteration of the person's physical functioning.

We measure people's improvements using clinical outcomes in routine evaluation and paired diagnosis specific questionnaires.

Research

A cognitive behavioural intervention has been shown in our preliminary trials to be effective in reducing hot flushes and night sweats, as well as mood and quality of life in women going through the menopause transition, and for women who have symptoms following breast cancer treatments.

In a randomised comparison, CBT was found to be as effective as anti-depressant medication in the reduction of premenstrual symptoms, and the psychological treatment had better long-term effects.1

Our facilities

Our service operates from two sites in London, at the Maudsley Hospital and Guy’s Hospital. Patients can be referred to the site most convenient for them.

The historic Maudsley Hospital is internationally renowned for excellence in research, treatment and teaching in mental health. The hospital is based in South London and has close links to public transport.

Located at London Bridge, Guy’s Hospital has been in existence for almost 900 years. It is one of London’s most well-known teaching hospitals and delivers high quality treatment, education and research.

Training and consultancy

We provide clinical and educational supervision to training grade psychiatrists, clinical psychologists and qualified therapists wanting to specialise in psychosexual therapy. Senior members of our team deliver teaching on sexuality and sexual dysfunction to medical and psychology students. For more information about our training services, please contact Dr Popelyuk, dmitri.popelyuk@slam.nhs.uk
Our team

Our specialist team includes doctors, nurses, psychotherapists, counsellors and clinical psychiatrists and psychologists, who have specific expertise and are trained to help people with psychosexual, relationship and hormone related problems.

Dr Martin Baggaley  MB BS, FRCPsych
Consultant Psychiatrist

As well as being a consultant psychiatrist at the service, Dr Martin Baggaley is also the Executive Medical Director at the Trust.

Other roles
He is a member of the Gender Recognition Panel.

Background
Dr Baggaley qualified from St Bartholomew’s Hospital in 1984. He served in the British Army between 1985 and 1997, training in the army and at Guy’s Hospital.

He has been a full-time psychiatrist since 1986 and a consultant since 1993. He worked as Senior Lecturer in Military Psychiatry for four years and was Head of Division at the Defence Services Psychiatric Centre, Catterick, for two.

When he left the Army in 1997, he was appointed as Consultant Psychiatrist at the Trust and Senior Lecturer in Psychiatry for the Guy’s, King’s and St Thomas’ School of Medicine.

He was Clinical Director of Adult Mental Health in Lewisham for five years and Clinical Lead for London on the National Programme for Information Technology for two years.

He has worked at the Psychosexual and Relationship Service at Guy’s Hospital since 1990.

Research
His special interests include erectile dysfunction and gender identity disorder.
Professor Dinesh Bhugra  MA, MSc, MPhil, MBBS, PhD, FRCPsych
Honorary Consultant | Professor of Mental Health and Cultural Diversity

In addition to being an Honorary Consultant at the Trust, Professor Dinesh Bhugra is also Professor of Mental Health and Cultural Diversity at the Institute of Psychiatry, King’s College London.

Other roles

In 2008, he was elected President of the Royal College of Psychiatrists.

Research
Interests include cultural psychiatry, sexual dysfunction and service development.

He has been instrumental in developing training packages for health service professionals and strategies for psychiatric education. He was one of the editors of Workplace-based Assessments in Psychiatry, published by the Royal College of Psychiatrists in 2007, and has developed teaching modules and short courses for medical students and psychiatric trainees covering cultural psychiatry, and cinema and psychiatry.
Our team continued

**Professor Myra Hunter**  PhD, C Psychol, AFBPS  
Consultant Clinical Psychologist | Professor of Clinical Health Psychology

Professor Myra Hunter is a Consultant Clinical Psychologist and Professional Lead for Clinical Health Psychology at the Trust.

**Other roles**

Professor Hunter is the Trust’s lead for implementing National Institute for Clinical Excellence (NICE) guidance on depression and chronic illness. She is part of the National Cancer Research Institute’s subgroup on treatment-related symptoms and part of the medically unexplained symptoms core group, run jointly by Healthcare for London and Commissioning Support for London.

She wrote *Psychological Services to Obstetrics, Gynaecology and Maternity*, the British Psychological Society’s briefing paper for commissioners, and has delivered presentations at conferences on women’s health, menopause and other related topics.

**Background**

After training as a clinical psychologist, Professor Hunter carried out research on pain at the Institute of Psychiatry, King’s College London. She then worked for eight years as a clinical psychologist at King’s College Hospital, during which time she completed a PhD with King’s College London (1988).

She combined research and clinical work at United Medical and Dental School (UMDS), Guy’s Medical School, King’s College London, University College London Hospital (UCLH) and Camden & Islington Community NHS Trust. Specialising in clinical health psychology and women’s health, she was Joint Head of Health Psychology Services at Camden & Islington Community NHS Trust, and a Senior Lecturer and Clinical Director of the Women’s Health Research Unit at University College London.

**Research**

Professor Hunter’s main research interests are clinical health psychology and women’s health. Her work has focused primarily on understanding and developing interventions for people with physical and emotional problems related to women’s health (PMS and menopause), cardiology and oncology. She has been involved in studies on fertility, assisted reproduction, antenatal screening, postnatal mental health, premenstrual problems and menopause and midlife.

Professor Hunter is currently working on two randomised controlled trials to evaluate psychological interventions for menopausal symptoms experienced by women who have had breast cancer (MENOS1) and for well women in the community (MENOS2).
Dr Dmitri Popelyuk  MD, MRCPsych
Consultant Psychiatrist | Clinical Lead for the Psychosexual and Relationship Service

Dr Dmitri Popelyuk is a Consultant Psychiatrist for the service, specialising in psychosexual therapy and sexual dysfunction.

Other roles
He is involved in clinical work, training, supervision, teaching and consultation.

Background
Dr Popelyuk completed his Doctor of Medicine (MD) degree in 1999 at Odessa Medical University, Ukraine. Moving to London, he trained in adult psychiatry and mentalization-based therapy on the Royal Free and Guy’s & Thomas’ Higher Training Schemes.

He became a Member of the Royal College of Psychiatrists (MRCPsych) in 2005, and received a Certificate of Completion of Training in General Adult and Rehabilitation Psychiatry in 2009.

He was introduced to clinical psychosexual work during an academic placement with the Royal Free Hospital's Department of Psychiatry and Behavioural Sciences. In 2006, he completed a Diploma in Psychosexual Medicine at the Institute of Psychosexual Medicine, London. And, in 2009 he was received as a General Member of the British Association for Sexual and Relationship Therapists.

Research
Interests include the impacts of sexual well-being on mental and general health.

He is currently developing a mentalization-based treatment programme for people experiencing psychosexual difficulties.
Jane

“Since having the boys, I just completely went off sex”

I’ve been with my husband for 10 years now and we have two little boys. Since having the boys though, I just completely went off sex.

It felt like my husband was trying it all the time, and it’s not that he was being forceful or anything – it was a natural thing for him to do – but the more he tried, the less interested I was really. I felt under pressure. It was like I should be fulfilling my wifely duties but couldn’t.

“The thing is, it’s never been anything to do with my husband. I love him to bits”

It’s never been because I don’t fancy him. I told him that Brad Pitt could have walked in the room and have been offering it to me on a plate, and I really wouldn’t have been interested. He was really understanding even though things were difficult. I felt a prude mainly. I don’t want this to sound bad, but I felt like an old age pensioner. I was so disgusted by the idea of sex and, as a woman of 36 years old, that just didn’t seem natural to me.

I spoke to quite a few of my friends who had their own children. Most were tired, but none of them had the same feelings as me. That convinced me to speak to someone.

“My doctor felt I might be suffering from postnatal depression, so he referred me to the Trust”

I actually thought I had postnatal depression, but I was always under the impression it came after my second child. My oldest boy is six years old and I had my youngest two-and-a-half years later. After my first, I just thought it was a first-time mum thing... I wasn’t sleeping that well so I was probably just tired. But I’ve come round to the idea that I had depression back then too.

When I spoke to the therapist, he said that what I had been experiencing was likely to have been a result of this depression. How can I say it... the postnatal depression takes away the sexual drive. It can be the last thing to come back.

One of the other things we established was that I’d forgotten about myself... forgotten that I was here as well. My husband works seven days a week, so I have the kids all the time. It’s not that I don’t like having them, but it can be exhausting. I’d been running around after two little boys and so sex was the last thing on my mind.

“It made it easier that the therapist didn’t know me”
It was really easy to speak to the therapist right from the beginning. He’s not like my doctor, who knows me and my family. I’m not one to get embarrassed about these kinds of things, but it did help that he was someone completely out of that picture, and he made it really easy for me to talk openly.

You hear about some people who can’t talk about postnatal depression, but I found it really helpful. I felt there was no point in hiding myself away.

I went to the first assessment on my own, and my husband was going to join me a few sessions in – something he was fine about. The therapist said we should probably expect to meet 10 or 11 times, but in the end we only needed four or five, and my husband didn’t come in.

“After a few sessions, I started to become the instigator again”

We agreed that it was OK to finish our sessions sooner because things were already changing. Once my husband backed off just a little, things became a lot easier. Before, he would always be the one to instigate things, but after a few sessions I started to be the instigator again.

The door is always open at the clinic, so I feel I can go back and ask for help if I need to... and that’s helpful in itself. I’d definitely be happy to go back if I felt I needed it.

“He pointed out that this was about us. We were here before the kids and our relationship is really important”

It’s not always perfect now, but I feel better. I don’t get the same feelings anymore and it’s not a drag – even if I’m knackered on an evening.

One thing that helps is that I have some time to myself now. My youngest is at nursery during the day, so I’m doing things I wasn’t able to do before... like shopping, or just getting out of the house. It means I’m not as exhausted, and of course it’s nice to do things for myself.

Would I recommend the service to others? Yes.

Of course, it can be difficult to talk about something so private. But the therapist made things more comfortable and it was certainly a useful experience for me.
Trevor

“My previous sexual experiences had upset things and left a few scars”

In particular, I was tentative about being seen by another person. I spoke to my GP about these feelings of insecurity, sexually, and she asked whether I’d considered psychosexual counselling. She thought it might be beneficial.

I’d always had counselling in the back of my mind, but ummed and ahhed about it. I used to speak to my partner about things – and I was probably looking for some guidance from her – but she hadn’t experienced what I was going through, so understandably it was difficult for her to know what to say.

“I’m engaged to my partner and I didn’t want past experiences to be affecting us”

The future was looking bright, but my head wasn’t really where I wanted it to be.

I’d also spoken to my uncle who had just finished counselling himself. My aunty – who was someone he’d lived with for most of his life – died last May, and counselling had really helped. He told me it was the best thing he’d ever done, so that made me think it couldn’t be a bad thing... and that it would probably help me in the long run.

“Still, I was quite apprehensive as I didn’t know what to expect”

I actually thought I’d go in, sit down and be asked lots of questions I’d have to answer. But it was very different. It was just like, talk to me.

Talking was definitely the best way, but I found it surprising at first as it felt like we were straight in at the deep end. One of the first things he said was “tell me why you’re here”. I didn’t know where to start... I thought I’d be completely silent, but I actually talked for an hour.

It did feel odd that I wasn’t getting anything back from him at first, but he clearly knew I wasn’t finished. He knew I needed to keep talking.

“After a while, it was like talking to a friend in the pub... though someone who understands the experiences you’re having”

We had eight sessions in total, and after two or three I’d just sit down and start automatically – like I’d just pressed pause on a tape at the end of the last session. I guess I was probably trying to find the right words in the first few, but it was then just like talking to a friend in the pub... though someone who understands the experiences you’re having.
He can say, “this is why this and that happened”. And it’s good to hear that something is not your fault – there are reasons for what is happening, and you’re not strange or that different from other people.

“My attitude to sex is a lot more relaxed now”

It really helped being able to talk. My mentality has completely changed. It’s difficult to describe, but my way of thinking has changed tenfold.

It was almost a sex addiction before. I’d push myself into situations I didn’t want to be in really. I was covering up the cracks somehow; then I’d blame myself when things went wrong.

He convinced me I didn’t need to feel like that, so now I’m more relaxed if things don’t completely go to plan. If it goes a certain way, it might just be because of the situation I’m in. Blame was definitely a big part of it before, but now sex is not so much of a chore or a big issue... it’s something you enjoy.
Referring to the service

Referrals are accepted from all healthcare professionals, including consultant psychiatrists, GPs, counsellors and CMHTs.

All referrals to our outpatient service require funding authorisation.

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