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**The construction of sex and sexuality within clinical
psychology training and practice**

Section A

The perspectives of mental health professionals on Sex and Sexuality in reference to their
professional practice and training: a review of the literature.

Word Count: 6915 (202)

Section B

The discourses around sex and sexuality within Clinical Psychology training and practice. A
Foucauldian Discourse Analysis.

Word Count 9073 (980)

Overall Word Count 17170 (1182)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2018

**SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY**

Acknowledgements

I would like to thank all of the clinicians and trainees who gave up their time to take part in this study. My supervisors Prof Margie Callanan and Dr Ian Marsh for both supporting me and for some really interesting conversations.

Last but not least I would like to thank Lorraine for encouraging me from afar and Al for listening to me and ensuring that even after a day of transcribing I could end the day laughing.

Summary of Project

This major research project is investigating the construction of ‘sex’, and ‘sexuality’ when thinking about psychological health and wellbeing. The implications for practice and training will also be considered.

Section A:

Section A presents both the theoretical and empirical understandings of sex and sexuality when thinking about psychological health and wellbeing. Literature looking at different mental health professionals’ perspectives when talking about these issues within their practice is considered and critically reviewed. Future research is then considered in the context of these findings.

Section B:

Section B looks at how the topics of sex and sexuality are constructed amongst clinical psychologists and trainees when considering their practice and training. The dominant discourse described sex and sexuality as not being spoken about and not being important for psychological treatment. When sex and sexuality were talked about they tended to be dominated by negativity and related to minority groups. This was influenced by professional, legal, cultural, societal and personal discourses. There were emerging counter discourses which positioned sex and sexuality as both important, talked about and positive.

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Section A

The perspectives of mental health professionals on Sex and Sexuality in reference to their professional practice and training: a review of the literature.

Word Count: 6915 (202)



Abstract

Background Sex and sexuality are complex issues which are impacted by culture and context. In Western society they are viewed within research and policy as important to psychological wellbeing and health. However, mental health professionals have been reported to have difficulties in engaging in conversations with clients on these topics. This literature review will first consider the background surrounding this topic, placing these topics into their current culture, social and political context. *Aim* To gain an understanding of the current findings within the literature on the perspectives and experiences of different mental health professions on the issues of sex and sexuality within practice and training. Aiming to answer the question: How are the topics of sex and sexuality thought and talked about by mental health professionals? *Method* Four electronic databases were searched, eleven papers meeting the search criteria were identified. *Results* This literature review showed mixed quality papers covering the nursing, psychologist and therapist perspectives. Papers were a mixture of qualitative and quantitative studies focusing on attitudes, values, self-efficacy, willingness, behaviour and experiences. Within the literature sex and sexuality was positioned as not a priority within mental health services, although the majority of professionals described it as important for one's wellbeing. Perspectives of whether it should be discussed more in practice were mixed, with psychologists tending to place higher value on this than other professions. *Conclusion* This literature review highlighted a number of gaps in the literature, especially with regards to the lack of qualitative studies, looking at clinical psychologists, which can offer more in-depth accounts.

Key Words: Sex, Sexuality, Mental Health Professionals, Training, Practice

Introduction

Sex and sexuality have been discussed within the context of mental health since Freud and others moved it into the psychological field in the 1800's. Since then sex and sexuality have been acknowledged as issues that can have a direct impact on one's wellbeing and are an important aspect of one's identity (e.g. World Health Organisation, WHO, 2006).

There is, however, a growing body of research which is showing that mental health professionals are not engaging with these areas in their clinical practice or training. This literature review looks at the perspectives of mental health professionals with regards to discussing sex and sexuality within practice.

The review starts by considering the main definitions and theoretical understandings around the terms 'sex' and 'sexuality'; consideration is then given to the social-historical context which mental health professionals and services are positioned within. The empirical research for why sex and sexuality could be considered important areas to investigate further when thinking about psychological wellbeing, are then presented. This is followed by current recommended professional guidelines. Finally, a rationale will be given for exploring the literature which looks at understanding the perspectives and experiences of mental health professionals talking about sex and sexuality.

Defining Terms & Theoretical Underpinning

The topics of both sex and sexuality are complex issues which have a number of factors that impact on how they are understood and viewed by professionals, research, individuals and society. It is therefore helpful to first consider some of the complexities, theories and definitions surrounding these issues.

Sexuality

The World Health Organisation (WHO) defines sexuality as:

“A central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour practices, roles and relationships.” (WHO, 2002, pg. 5)

While Poorman (1991) defines sexuality as:

“...an integral part of the whole person. Human beings are sexual in every way. All of the time. To a large extent human sexuality determines who we are. It is an integral part of the uniqueness of every person.” (pg. 633)

There are many other variations in the definition of sexuality due to its complexity and the different theoretical perspectives which emerge when thinking and discussing it. Richards and Barker (2013) question whether any adequate definition can ever be made. The main areas of contention, with regards to the theories of human sexuality, are between the essentialist biological perspectives (e.g. LaVay, 1996) and social constructionists such as Gagnon and Williams (1973; 2017) and Foucault (1979).

Essentialists believe that sexuality emerges from within the individual, believing that predetermined biological factors such as evolution, brain chemistry, hormones and genetics play a role (Bohan, 1993; De Lamater & Hyde, 1998).

Social constructionists however view ‘sexuality’ as a fluid entity that will change depending on time and place. They argue that the cultural context requires to be considered and sexuality is external to the individual, resulting from complex social interactions. They highlight the flaws within the research which highlights the role of biology such as the changing nature of sexuality and human experience (Lorber & Farrell, 1991).

Weekes (2017) describes sexuality as being more than just about the body and biological drives; believing these topics can only be understood within the context in which they are being spoken about. Weekes describes the role and impact sexuality has on everyone's lives as being influenced by various societal factors such as identity, beliefs, ideology, family structures, legal systems, gender issues, social institutions and sexual cultures.

Sex

Biological understandings of sex and sexual response have been described as the dominant way of understanding the construct of sex over psychological, social or contextual theoretical understandings (Butler & Byrne, 2010).

The Oxford English Dictionary (2018) defines sex in very simple terms:

“...involving sexual stimulation; sexual activity or behaviour, spec. sexual intercourse, copulation.”

However, this constructs sexual activity in a very limited way and there are various other definitions which construct sexual activity as a much broader issue. In considering the definition of sex, some of the same issues arise when thinking about sexuality. The definition of what sex is defined as can be seen to change over both time and place and is dependent on the group that are speaking about it. In current western society there are many exceptions to the definition of sex, with legal, moral and medical frameworks influencing what is classified as 'normal' sex, versus criminal acts or mental disorders (paraphilia's).

A Potential Middle Ground

A number of academics have highlighted the possibility and importance of acknowledging the interaction and relationship between the 'physical' and the 'social' aspects of sex and sexuality (e.g. Ussher, 2003). This gives a wider understanding of sex and sexuality, fitting well with biopsychosocial discourses of mental health and wellbeing. This is one of the main models which is advocated amongst a variety of health professionals (Kaplan & Coogan,

2005). This may be a useful way of constructing ideas related to sex and sexuality, which has both meaning to individuals who live and work within a society that comes from a more critical-realist perspective. It can also explain some of the difficulties which constructionists and essentialists have in their theoretical stances.

Summary

The purpose of this literature review is to gain an understanding of the current perspectives of mental health professionals within the literature, when talking about sex and sexuality within practice. The topics of sex and sexuality will be considered within their broadest sense and all the different theoretical perspectives discussed above held in mind.

Context

Due to the complexities which come with defining sex and sexuality it is important to consider the current mental health context which these areas are being thought and talked about in.

Over the years discourses have changed on how and when the topics of sex and sexuality are spoken about within western society and how they have been associated with mental health and wellbeing. This can be seen to be impacted by various factors including legislation, research, political and social movements.

The History of Sex & Sexuality

This 'obsession' with sex has been argued by Foucault (1978) to have emerged from the decision in the 17th century by the Roman Catholic Church, that individuals confess their sinful desires and behaviours, allowing for a discourse to emerge on previously 'unspoken' subjects. This decision by the Church can be seen to have moral, political and social implications and has been argued to act as a method of trying to control individual's private and internal lives (Weeks, 2012).

The aim of controlling the sexual lives of individuals can be seen via various legal, cultural and societal discourses. Culturally within western society it has been argued that there has been a move to a more liberal outlook on sex (e.g. Mercer et al, 2013). However, there are still various discourses around stigma when talking about certain groups having sex (e.g. those with a learning disability or older adults), taboos around what is viewed as ‘normal’ sex and moral and social judgements on what is deemed as acceptable and the ‘right’ sort of sex. Many laws still impose restrictions on certain types of sexual acts, aspects of prostitution, age of consent and ‘sexting’ (Sexual Offences Act, 2003; Audio-visual Media Services Regulations, 2014).

The change in how sex and sexuality are constructed has been influenced by various factors, including social movements such as gay rights and feminism, the introduction of the pill and sex research (e.g. Masters & Johnson, 1966; Kaplan, 1974). There is also an increased presence of sex within the media, advertisement and films (e.g. Reichert & Carpenter, 2004). The use of social media has allowed for things that were ‘unsaid’ or only said to a limited network to be public. Through the internet exposure to sexual issues are increasingly accessible to more individuals, of all ages.

The current context which individuals are placed in can be seen to have impacted on the discourses which are present around the topics of sex and sexuality within western society. Mental health professionals are therefore working within a time and context where laws and attitudes related to sex and sexuality are constantly changing, and at times conflicting.

History – Psychological Research and Sex

During the 1900’s there was a surge of research in the field of sex and sexuality, with a number of different theoretical perspectives initially addressing these issues within their psychological thinking (e.g. Freud, 1920). This move to incorporating the issues of sex and

sexuality when thinking about psychological health, was believed by some to be an extremely important move in thinking about the mental wellbeing of individuals (McCarey, 1978).

Although there was this initial influx in research and attention given to sex, sexuality and psychological health, there has been less attention placed on these issues over recent years.

Current research around these issues now tends to focus on sexual functioning (e.g. Berry & Berry, 2013; Nobre, 2010; Fruhauf, Gerge, Schmidt, Munden & Barth, 2013), rather than being incorporated into general psychological thinking.

A number of researchers have specifically discussed the decline of sex and sexuality within theoretical approaches, arguing for this to change due to these issues being core to an individual's identity (e.g. Green, 1996; Target, 2007).

Summary

How sex and sexuality are spoken about within society can be seen to be influenced and changed over the years by various factors including research, media, political and social movements.

The Importance of Sex & Sexuality to Psychological Wellbeing

Sex and Evolution

From an evolutionary perspective sex is one of human beings' basic motivational systems and drives. Various theories highlight this, such as Drive Theory (Hull, 1943), Maslow's Hierarchy (1987) and more recently Compassion Focused Therapies' (CFT) Drive System (e.g. Gilbert, 2013).

CFT's Drive System highlights how the 'old brain' aids human beings in their survival as a species. Emotions which have evolved from our threat system such as anxiety or anger are helpful in order to defend ourselves from physical or social threat, helping us to succeed as a species.

The development of our more sophisticated ‘new brain,’ includes more advanced cognitive processes and aspects of human experience. This includes self-awareness, reflection, reasoning, foresight and a sense of self based within a social context (e.g. Gilbert, 2014; Harari, 2014). This increased awareness as a social being has resulted in emotions such as shame and guilt emerging as defence mechanisms in an attempt to minimise social rejection and isolation. These emotions as well as new thinking patterns such as self-criticism have been shown to underlie many mental health problems (e.g. Gilbert, 2013). Our threat response system is increasingly activated by threats which are linked to cultural values, societal rules and how individuals understand themselves within these systems.

Based on this theory, the ‘old brain’ and ‘new brain’ have to work together. However, research and practice have reported various conflicts between our desires and emotional ‘old brain’ system and the socially contextualised, ‘thinking,’ ‘new brain.’

In considering this in relation to sex and sexuality, this opens up various difficulties and conflicts. Our basic drives have the aim of attaching ourselves to others, finding sexual partners and reducing rejection and loneliness. Yet in society we now have cultural rules and norms which perceive acting on basic motivational drives as negative, resulting in these drives needing to be suppressed. Individuals also have increased awareness and knowledge of the impact that loneliness and rejection have on their social status and lives.

If individuals are unable to negotiate these complex rules and desires or they are fearful and worry about being rejected or isolated. The threat response system will activate painful emotions.

Empirical Research

Over the years research has looked at the issues of sex and sexuality and how they are linked to psychological health and wellbeing.

Wells (2000) describes the importance of understanding an individual's sex and sexuality in order to understand their identity, relationships and emotional wellbeing. Research has shown the impact that stress can have on both male and female libido, hormone levels and reproduction (e.g. Sapolsky, 2004). A number of links between mental health difficulties and issues related to sexual functioning have been claimed (Stevenson, 2004). For example, both anxiety and depression have been shown to lead to psychosexual problems (e.g. Denman, 2004). Loss of libido or interest in sex are viewed as common symptoms of depression, with a number of measurements of depression including this within their questionnaires (e.g. Beck, 1996). Research has described negative effects on sexual functioning through the use of psychotropic medication (e.g. Higgins et al, 2005; Baldwin & Myers, 2003). There are also a number of psychiatric conditions described within the Diagnostic Statistical Manual of Mental Disorders (DSM-V) which are related to sexual dysfunctions and sexual problems (APA, 2013).

Further research has described the impact which low self-esteem and body image problems can have on an individual's sense of sexual desirability. These beliefs are claimed to impact on an individual's ability to maintain relationships due to a change in behaviour and distress (Stevenson, 2010).

There is also the emotional impact, which sexual relations can have on individuals such as abandonment, rejection and loneliness (Firestone, Firestone & Catlett, 2013.)

Sex, Sexuality & Current Guidelines

Mental Health Professionals are regulated by different professional bodies, guidelines and standards which they are expected to follow. These can be seen to have direct impact on different professional's work practices as they represent the expectations of their profession as a whole.

Documents are continually produced by the Government and professional bodies, which present key areas for professionals to keep in mind when working.

With regards to the topics of sex and sexuality these topics appear to be constructed under a very broad definition of sex and sexuality, instead of considering them as part of psychological health and wellbeing for all. Sex and sexuality were only spoken about within professional guidelines when thinking about sexually transmitted diseases, specific minority groups or issues related to trauma and abuse (e.g. Department of Health, 2001; Division of Clinical Psychology, 2012 & 2016; NHS England, 2017).

Consideration of sex and sexuality as part of psychological health and wellbeing appear to be missing from the professional guidelines. The only exception to this is from The Department of Health (2001) where the importance of sexual relations to mental and physical wellbeing within policy making is highlighted. They describe this as a key part of identity, viewing sexual fulfilment and equal relationships as important to an individual's well-being and quality of life. Despite this policies and guidelines do not seem to be considering these issues.

Client Perspective

A number of studies have looked at what mental health clients think and want with regards to talking about sex and sexuality. Research findings have shown that this is an issue which is important to them, but they are not being asked about these issues in practice (McCann, 2010a; McCann, 2010b; Waterhouse & Metcalf, 1991; Crawford & Shaw, 1998). Clients have also been reported to be happy discussing issues around sex and sexuality when professionals bring the topic up (e.g. Tharoor, Kaliappan & Gopal, 2015). Deegan (1999) claimed that individuals experiences around issues of sexuality and sex are not being discussed, leading to individuals feeling alone and distressed.

One study by McCann (2004) showed that clients expected to be asked by mental health professionals and be given support around issues related to sex and sexuality. Lewis and

Scott (1997) reported in one study that 92% of participants with a diagnosis of schizophrenia thought discussing sexuality would be helpful and they were happy to do so. McCann (2000) showed similar results, where participants were reported to be pleased about being asked questions around sex and relationships. Ostman (2006) looked at depression and sexuality, highlighting that clients and their partners felt unsupported by psychiatric services in dealing with issues related to sexuality.

Hook and Andrews (2005) however, describe a number of difficulties clients had in discussing these topics, reporting shame, guilt and a fear of being judged contributing to their difficulties in discussing their concerns around sex and sexuality. Love and Farber (2017) have highlighted the importance of therapists' responses to issues of sex and sexuality, reporting therapists' responses could aide clients in these discussions helping them to reduce shame and other difficulties clients have in discussing these topics.

Engagement with Sex and Sexuality within mental health

The World Health Organisation (1975) highlighted the importance for health professionals to be trained in the area of sexuality, and as indicated earlier they view sexuality as a core aspect of the self (WHO, 2006). As discussed above, research has reported on various links between healthy sex, sexuality and psychological wellbeing, with clients wishing to discuss these issues. Yet there are various reports of this not happening in training and practice.

A number of papers suggest that there are various barriers to these topics being addressed within mental health professionals' training and practice (e.g. Sharkey, 1997). Stevenson (2004) discusses a variety of reasons why psychiatrists are not addressing these issues, offering a number of reasons why this needs to change. Adler, Cohen and Alfonso (1997) discussed the fact that sex can be a taboo subject for both client and clinician. They describe the importance of sexual history taking and the negative impact not addressing these issues can have on clients and relationships. One recent doctorate study in Ireland (Culhane, 2015)

looked at clinical psychologists' engagement with client sexuality. This study reported that many clinical psychologists felt uncomfortable, feeling they lacked the skills to be able to address these issues in practice.

There have also been various studies completed looking at specialist fields and specific groups within the population which all show a lack of engagement and discussion in these topics. This includes forensic settings (Dein, Williams, Volkonskaia, Kanyeredzi, Reavey, & Leavey, 2016) as well as specific groups such as psychosis (e.g. McCann, 2010) and schizophrenia (e.g. Nnaji & Friedman, 2008).

Discrepancies between Research & Practice

These topics appear to be less talked about and engaged with than other aspects of psychological health and wellbeing. This is despite research and clients suggesting this is an important aspect of psychological health and wellbeing. It is also interesting that professional guidelines only appear to be present when issues relate to legality, rather than constructing sex and sexuality as an important aspect of an individual's psychological wellbeing generally.

When considering any work which takes place with regards to sex and sexuality, Shaw (2010) has highlighted that all clinicians and therapists will be impacted by the social discourses which they are part of. This will impact how clinicians work with and view these topics, influencing what does and doesn't get talked about.

Wright and Pugnaire (2010) have argued that both beliefs and attitudes of clinicians need to be looked at in order to address these discrepancies.

Rationale

In considering the above findings both the theoretical and empirical research claim that sex and sexuality are important for individuals' psychological health. Sex and sexuality are described as being linked to various mental health difficulties, a basic human drive and core to identity and self-esteem. The NHS value evidence-based practices (NICE, 2018) and

clients are reported to value discussions on these topics. However, mental health professionals do not appear to be including sex and sexuality within their assessments, formulations or training.

If clients are not being assessed on this topic, then information that is important to the client, their presentation and formulation may be being missed. There are also missed opportunities to address negative emotions which may be underlying some problems, such as shame, guilt and a fear of judgement (Love & Farber, 2017). If clinicians do not ask clients about these questions they can be seen to inadvertently be telling clients that these issues are not important for therapy and cannot be discussed in the therapy room. If clients do not discuss this aspect of their life and identity, there is also no way of knowing if and how much of a problem issues related to this topic may be.

The aim of this review is therefore to gain more of an understanding of how these topics are being discussed and engaged with by different mental health professionals within practice and training. Literature looking at the current attitudes and experiences around talking about the topics of sex and sexuality by different mental health professionals will be looked at.

This area is important as the discourses which are present can be seen to impact on how and what is thought and talked about. Social and professional discourses can be seen to have the power to influence what is brought into the therapeutic work which takes place. This may impact on clinical practice and the quality and effectiveness of work.

Understanding the perspectives of professionals may help give insight into some of the discourses that are present when clinicians talk about sex and sexuality. This may help in understanding the discrepancies between the empirical and theoretical research.

Methods

Methodology for Locating Papers

A review of the relevant literature was completed by searching a number of electronic databases: PsychInfo, Web of Science, MedLine and PubMed. A variety of search terms were used to ensure that a wide scope of papers were found that related to sex, sexuality and mental health professionals perspectives talking about this topic.

- Mental health Professionals OR Mental Health Staff OR Psychologist OR Therapist OR Psychiatrist OR Nurse.

AND

- Attitude OR Perception OR Perspective OR View OR Belief OR Discourse OR Experience OR Comfort OR Willingness

AND

- Sex*

A large number of papers were found during the initial search, the majority were excluded as they did not meet the inclusion criteria (Table 1). There were a number of inclusion and exclusion criteria, this was due to this paper looking specifically at how sex and sexuality were spoken about with regards to psychological health and wellbeing, rather than when this process has been disrupted (e.g. abuse).

Papers which looked at Specialist services were also excluded due to this paper looking to focus on how the topics of sex and sexuality are addressed when assessing psychological health of sexually active age-groups, rather than looking at difficulties that are presented in relation to sexual functioning. In other words, the attention paid to sexuality when the primary presenting issues are ‘apparently’ unrelated.

This resulted in 11 papers being included in the review. Further details of the search procedure can be viewed in Figure 1 below.

Figure 1: Flowchart of Search Procedure

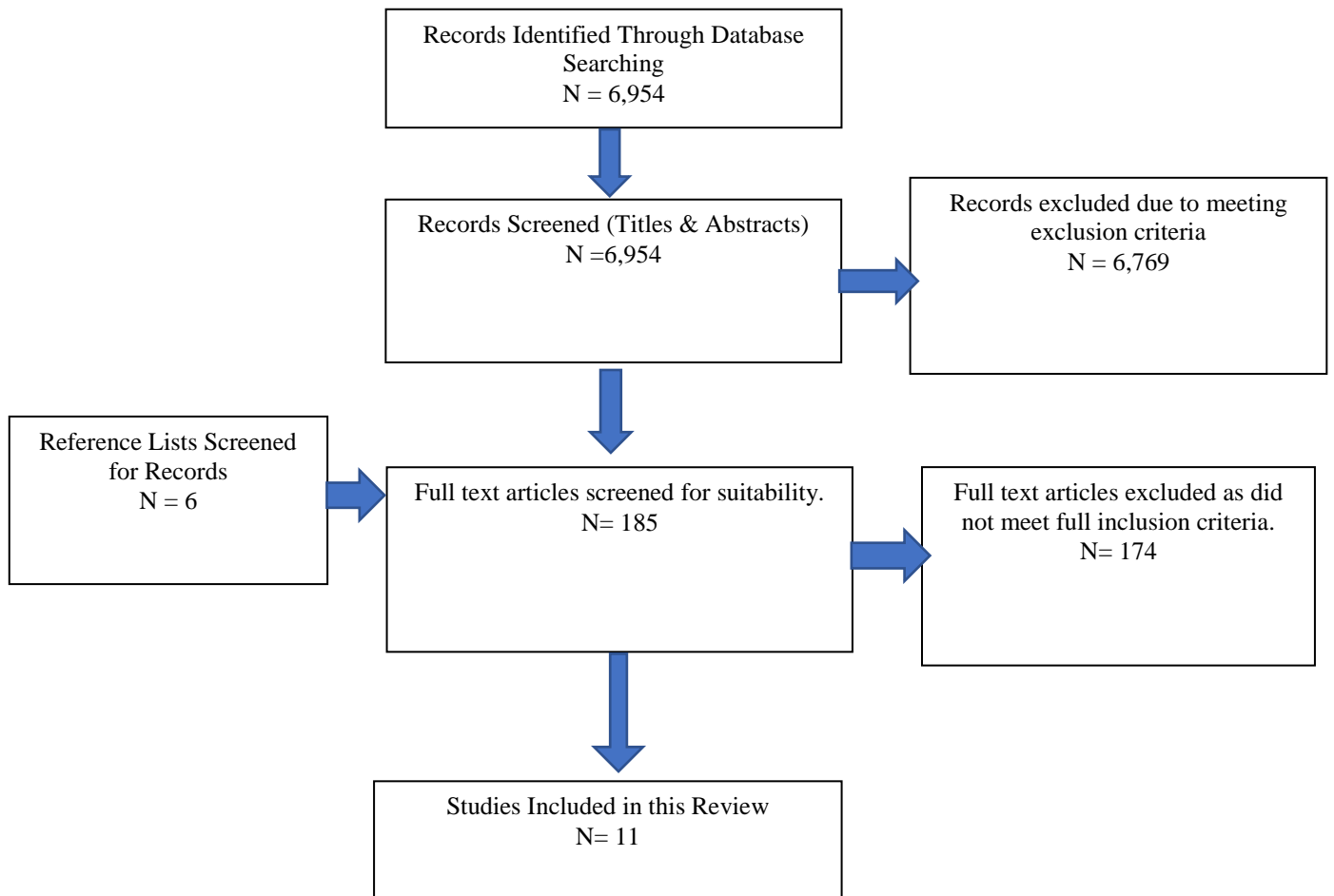


Table 1: Inclusion & Exclusion Criteria for Review

Inclusion Criteria	Exclusion Criteria
1.) Looking at perspectives, views, attitudes, experiences, beliefs and discourses by clinicians or trainees.	1.) Not written in the English language
2.) Any mental health profession.	2.) Looking at physical health rather than mental health.
3.) Looking at research, training or practice.	3.) Views of sex therapists or specialists in the field.
4.) Within mainstream primary or secondary mental health settings. (i.e. not specialist services or specific groups)	4.) Looking at a specific group
	5.) Looking at when healthy sex and sexuality have been disrupted.
	6.) Implementing an intervention

Identified Literature

Eleven papers that looked at different mental health professionals' perspectives of talking about sex and sexuality were identified. One of the papers, a content analysis of counselling psychologists research (Hargons, Mosley, & Watkins 2017) was slightly out of the remit of the inclusion criteria, but it was decided that it would help answer the review question and was therefore included. The identified papers were used to answer the following question:

- 1.) How are the topics of sex and sexuality thought and talked about by mental health professionals?

Quality of the Papers

A variety of different types of papers were included in this review including quantitative and qualitative studies as well as one content analysis. Depending on the method of the study, different quality criteria checkers were held in mind when reviewing the papers.

Qualitative papers in this study were reviewed using the Critical Appraisal Skills Programme (CASP, 2018) Qualitative Checklist (See Appendix A). All of the quantitative papers in this review were cross-sectional studies, therefore the AXIS Cross-Sectional Studies tool (Downes, Brennan, Williams, & Dean, 2016) was used (See Appendix B).

Review of the Papers

The aim of this review is to gain an understanding of mental health professionals' perspectives on the issues of sex and sexuality. It was therefore decided that the papers would be divided by professional group. The mental health nurse perspective will be considered first, followed by the psychologist perspective. The final two papers looked at therapist perspective, for one of these papers the core professions were not known, while the second paper, participants consisted of either psychologists or psychiatrists, whose interviews were based on their psychoanalytic work with clients.

A summary of the key features of these papers can be seen in Table 2 below. This included author, year, participants, focus of paper, design/method, findings, critical review and limitations. The main themes which emerged from the paper were also identified.

Table 2: Main Features of Reviewed Studies

	Authors/Year	Country	Participants/ Setting	Design/Method	Focus of Paper	Findings	Themes	Critical Review/Limitations
1.	Higgins, A. Barker, P. & Begley, C.M. (2008)	Republic of Ireland	27 mental health nurses. 10 males, 17 females. Community setting.	Qualitative: Grounded Theory. One to one ‘in-depth’ interviews focusing on response to issues of sexuality. Data collection stopped once theoretical saturation reached.	How do MHN’s respond to issues of Sexuality coming up in practice	‘Veiling sexualities’ Values and views formed early via social discourses. – culture of conservatism, negativity, taboo, shame, privatization, At school anatomy, physiology and reproduction emphasises and Biomedical Dominance via Nursing education. Avoidance and silence around topics. Downplaying value of sexual functioning to clients. Belief that protecting ‘vulnerable’ clients by being silent. Conversations taking place by chance/client initiating. Belief that work with clients should be asexual. Professional myths offering explanations to why not being addressed.	Silence Taboo Biomedical Lack of competence/co nfidence/comf ort Protection Discrimination Prejudice Unawareness	Minimal Demographic Information Minimal Situating of Sample No analyst triangulation Based in only one service in ROI – may be specific to culture or team or Irish culture differences around sex. Strengths: Overall this was a good study in considering CASP guidelines only 1/10 not met = positioning of the research did not take place.
2	Ziliotto, G.C. & Maracolan, J.F. (2013)	Brazil	7 nurses and 11 nursing assistants. Experience ranged from 1-16 years. Aged between 27- 47.	Qualitative: Social Representations Theory. Interviews and semi- structured interview.	MHN’s perceptions around sexuality in those with a mental health problem.	‘Human sexuality was viewed as either a 1.) need 2.) Preference/option/related to sexual orientation 3.) Disease 4.) How individuals behave/appearance 5.) Minimal Therapeutic input 6.) Hospital Environment inappropriate for expression 7) Surveillance, control, punishment, 8) Feel lack of authority to stop 9.) Matched	Negativity Risky Authorative Biomedical.	All heterosexual. Mostly female. Unable to identify Social Representation Theory not explained/described. Unclear how staff were approached/recruited. No positioning of researcher. Data Analysis was poorly reported – no details of how the analysis was completed or any

			Community & Inpatient Setting.			Gender care 10) Professionalism.		<p>methods to check/critically examine own input.</p> <p>Quality of paper questionable: Only half of the CASP checklist were met. However still offers helpful insights esp as a number of quotes were included for reference.</p>
3	Hargons, C., Mosley, D.V. & Stevens-Watkins, D. (2017).	n/a	Articles between 1954-2015 Counselling Psychologist and Journal of Counselling Psychology	Qualitative Content Analysis	Looked at sexuality research within Counselling -What topics discussed. -if discourses were neg/positive or neutral	<p>6 main topics covered (in order of amount):</p> <ol style="list-style-type: none"> 1.) Sexual Orientation, Identity, Minorities. (38%) 2.) Sexual abuse, objectification, victimization (24.8%) 3.) STI's and Sexual Risk (15.6%) 4.) Sex Education, Counselling, and Therapy 5.) Functioning, Satisfaction and pleasure. 6.) Health Communication, Attitudes & Values. <p>How many Sex Positive: Sex negative discourses = 70% Neutral Topics = 25% Sex Positive = 5%</p>	Negativity LGBT	<p>No positioning of researchers.</p> <p>Using the CASP Qualitative study checklist this can be seen as a good study meeting all but one of the criteria.</p>
4	Cort,E.M., Attenborough, J. & Watson, J.P. (2001)	UK	122 Mental health nurses (majority CPNS's or CMHN's). 111 – generic workers 5 – substance misuse	Quantitative – descriptive statistics presented and some statistical tests completed. 4-page survey: Choice of anonymity. 30 questions Likert scales used.	Views of MHN on wide range of topics related to sexuality.	<p>Clients are sexual beings - 62.3% Felt people with mental health problems should be encouraged to have intimate relationships.</p> <p>Views around relationships and sex tended to be more liberal: - 92.5% felt appropriate to live together before being married.</p>	Important. Clients are sexual beings. Mixed responses	<p>Questionnaires used had not been tested for reliability and validity – although rationale for use given.</p> <p>Males and females were nearly equal – this is not very rep of MHN profession. Response rate unknown due to method of data collection. Ethical approval not mentioned.</p>

			<p>6 – older adults Females (52.5%) Males (47.5%)</p> <p>Community Setting</p>			<p>There were still a few individuals who held more conservatist views: - 5 participants agreed/strongly agreed that homosexuality indicates an abnormal personality - 4 participants believed females should be a virgin at marriage.</p> <p>Taking a sexual history - 52.4 agreed should be in routine assessment. (26.3 neither agreed or disagreed.)</p> <p>Handing out condoms - 30% disagreeing with this. - 34% were neither agreed nor disagreed. There was also a theme that clients would bring issues related to sexuality up if they wished to speak about it.</p>		<p>Due to the results being mainly descriptive stats with some stats and only 1 or 2 questions asking about a specific area. The number of conclusions drawn is a little optimistic.</p> <p>Also states in the conclusion the study was specifically looking at sexual history talking. However, this was not mentioned earlier. There is also only 1 question which asks about this.</p> <p>Using the AXIS tool for cross sectional studies. Overall the paper has a number of strengths. However, there are a few methodological issues and lets itself down in the interpretations and conclusions that are able to be drawn.</p>
5	Traeen, B. & Schaller, S. (2013)	Norway	1064 Psychologists	Quantitative Survey	Behaviours, attitudes and beliefs around issues related to sex and sexuality	<p>Most common topics discussed - negative sexual experiences, sexual problems, sexual function and sexual orientation 1 in 5 reported always/often talking about these topics. Age, supervision and clinical supervision – impacted on how much spoken about. Beliefs that client will bring up and desire not to intrude. Beliefs topic would not come up in isolation. Insecurity and discomfort. Lack of training.</p>	<p>Negativity</p> <p>LGBT Individual Diffs</p> <p>Sensitive</p> <p>Discomfort</p> <p>Training</p> <p>Experience mattered</p>	<p>Type of Psychologists role unknown. Issues over generalizability due to unknown variables of population of psychologists being surveyed.</p> <p>No reliability and validity of survey.</p> <p>Less than 50% returned (46.6%) – could be a bias in the sample of who returned. Ethical approval not mentioned.</p> <p>Using the AXIS Tool for cross sectional studies this can be seen as a good quality paper.</p>

							Impact of attitudes and beliefs.	Limitations on the whole discussed and placed in context.
6	Hanzlik, M.P. & Gaubatz, M. (2012)	U.S.A.	138 Clinical psychology trainees	Quantitative Cross Sectional 3-page survey	Comfort levels when discussing sexual issues.	Increased amount of discomfort when discussing specific sexual concerns over global issues. Gender difference – specific only to females having increased discomfort when talking to males about these issues. Prior sexual training and attitudes – positive impact on comfort. Clinical Experience and General training – no impact on comfort levels.	Gender Differences Discomfort Specific Training	No information on how the trainees were recruited although sample characteristics that matched Clinical Psychology trainees were given. Ethical approval not discussed. Using the AXIS tool for cross sectional studies. This study can be seen to be a good quality study.
7	Miller, S.A., & Byers, E.S. (2012)	U.S.A. & Canada	110 clinical (83.6%) and counselling (16.4%) psychologists who had completed all of their training program. 64.5% Females Aged Between 27-78	Quantitate Cross sectional study. Questionnaires - Demographics - Post Internship Sexual Intervention Education and Training Questionnaire. - Sexual Intervention Education and Training Questionnaire. - Post Internship Verbal Persuasion Questionnaire	The continuing education that is engaged in on issues of sex and sexuality. Including motivation, behaviour and knowledge related to sexual interventions.	Average clinician was fairly liberal and reported feeling comfortable in discussing sexual concerns. However self-efficacy was low. 40% of psychologists asked at initial assessment about sexual concerns 22% Therapy clients – treated for sexual concern. Older clinicians and those with more experience were happier and more willing to treat clients rather than refer on.	High Comfort Low self-efficacy Low willingness Training Specific factors	Number of measures new – no information on reliability and validity. Response rate was low. Completion rate also low – questionnaire took approx. 30-40mins to complete. Using the AXIS tool for correlational studies despite some limitations this paper can be seen as a good quality paper.

				- Willingness to treat Sexual Issues Questionnaire. - Sexual Knowledge Questionnaire.		Training and sex education did not impact on comfort levels.		
8	Miller & Byers (2009)	Canada & USA	105 clinical and counselling psychologist Min 1 year experience Aged between 27-78 63.6% females 95.2% White	Quantitative Cross sectional Questionnaires	Impact of training on dealing with sexual issues. Willingness, knowledge, current practice.	76.2% interested in additional training. 85.7% Believed important or very important for psychologists to receive sex education and training. In past 4 weeks: 21% of psychologists had asked their therapy clients about sexual concerns. 40% had asked at an initial assessment. 21% of psychologists had treated clients for sexual concerns or probs. Somewhat more likely to treat than refer on. Training focusing on sexual problems not healthy sexuality.	Problems Important Training Don't ask.	Due to method of recruiting difficult to estimate a response rate but response rate was known to be low. Due to exclusion criteria out of the 339 people who completed questionnaire only 105 were included in analysis. Some of the questionnaires were new and therefore reliability and validity not fully tested. Psychologists had to accurately remember what training had taken in. Ethical approval not discussed. Using the AXIX tool for cross sectional studies. Overall this study can be seen as a good quality study despite some methodological limitations.

9	Miller & Byers (2008)	Canada & USA	172 trainee Clinical Psychologists 70.3% female 88.4% white	Quantitative Cross sectional study. Questionnaires Exploratory Study.	Sexual intervention self-efficacy Including willingness to treat.	Sexuality Education – poor – very limited amount attained. On avg. Students not confident in their skills for addressing sexual issues (somewhat disagree). However Sexual knowledge little higher (somewhat agree) and comfort fell between somewhat agree to agree. Factors which impacted on this: Liberal attitudes, Undergrad training, independent sexual ed, more practical experience = higher self-efficacy, comfort and lack bias. Students with conservative attitudes were least comfortable and unbiased when treating sexual issues, even if they had undergrad training, practical experience and felt comfortable and confident in their skills.	Attitudes Discomfort Training	Response rate was low 14.8% return for Canadian schools, 11.7% for American. Highlighted this has previously been shown to be typical with this methodology - could result in a return bias. Some measures used relatively new and reliability and validity limited. Ethical approval not discussed. Using the AXIS tool for cross sectional studies. This paper can be considered a good quality paper. Despite having some flaws these were discussed and the authors highlighted these and did interpreted the results with caution.
10	Ford & Hendrick 2003	U.S.A	314 Therapists – members of American Psychological Association (APA) or Association of Marriage and Family Therapy (AMFT)	Quantitative. Cross sectional study Questionnaires.	Sexual Values of therapists & potential impact on therapy.	Therapy is not value free. Sex in later life valued more than in adolescents. Gender, religion, political affiliation = impacted on comfort with working with certain sexual issues. Degree of comfort rather than being unable to work with person.	Liberal Comfort	Participants were not demographically representative. Low response rate. – bias in who is responding, individuals who feel they are addressing these issues? Ethical approval not discussed. Impact of limitations not fully discussed.

			<p>Average age 50.95years</p> <p>Average years in practice 17.66years</p> <p>54% females</p> <p>96% White</p>			<p>Value conflict = either referred clients on or consulted with peer, supervisor, colleague.</p> <p>Therapists aware of personal values and use strategies to prevent negative impact.</p> <p>Therapists tended to hold liberal values.</p>		<p>Results showed not really any problems – are implications for practice justified?</p> <p>Using the AXIS tool for cross sectional studies overall this study can be seen to be of good quality however, the main area of weakness was the discussion and implications.</p>
11	Shavlev & Yerushalmi 2009	U.S.A.	<p>10 clinical psychologists & Psychiatrists (who are psychoanalytically orientated psychotherapists)</p> <p>4 males 6 females</p> <p>Age 36-59</p> <p>6-30 years' experience</p>	<p>Qualitative</p> <p>Grounded theory</p> <p>Semi-structured Interviews</p>	<p>Understanding the attitudes of psychoanalytic therapists on the role of sexuality in human functioning.</p>	<p>4 Major Themes:</p> <ul style="list-style-type: none"> - Sexuality Is central to human motivation. - Dealing with sexuality should be in advanced stages of therapy and rarely reached. - Focus on sexual intercourse as sexuality rather than sexuality in its broadest sense. - Discomfort of therapist or/and client. Shame of client. <p>All were reluctant to engage in conversations around sexuality. Wish to avoid. Not important to therapy. Instead believing that dealing with issues of sexuality a defence against more difficult underlying issues. Belief that sexuality and relationships are different.</p>	<p>Discomfort</p> <p>Not Important</p> <p>Avoidance</p> <p>Narrow definition of Sexuality.</p>	<p>Unclear how the therapists were recruited. No information on why stopped at 10. No information on whether analysis was checked/discussed with a another. Researcher did not position themselves</p> <p>Ethical approval not mentioned.</p> <p>Using grounded theory but no theory developed – would thematic analysis been more appropriate?</p> <p>Using the CASP guidelines for Qualitative Studies. This paper can be seen to have a number of methodological flaws in it. However, it provides some useful insight into an area which had not been previously investigated and with use of quotes and refs to cases discussed the reader is able to gain some useful insight into the results.</p>

The Nursing Perspective

Four papers in total were looking at mental health nurses' (MHNs') views on issues related to sex and sexuality (Higgins, Barker, & Begley, 2008; Zillotto & Maracolan, 2013; Cort, Attenborough & Watson, 2001; Quinn & Browne, 2009.) Two of these papers were qualitative (Cort, Attenborough & Watson, 2001; Quinn & Browne, 2009), one employed grounded theory (Higgins, Barker & Begley, 2008), the other applied Social Representation Theory (Zillotto & Maracolan, 2013). The quantitative paper was a cross sectional study using a survey to illicit feedback via Likert scales. All of these papers were looking at MHNs' attitudes, perceptions or experiences related to sex and sexuality within their clinical practice.

The paper by Higgins, Barker and Begley (2008) was based in the Republic of Ireland focusing on one specific 'urban area.' In-depth interviews were completed until theoretical saturation was reached. This resulted in a total of 27 MHNs' being interviewed, the initial focus of this study was on MHNs' working within the community. However, the authors reported that nurses within day hospitals, rehabilitation settings and acute community hospitals were also interviewed. Results from the analysis showed a number of themes emerging, which suggested a number of social discourses and early experiences to be influencing their views. MHNs' appeared to respond to sexuality with conservatism, negativity and shame. Sexuality was viewed as a taboo subject which was private, avoided and silenced. There was also a tendency to 'downplay' the value of sexual functioning within clients and a desire and belief that staff were protecting the more vulnerable clients by remaining silent.

Zillotto and Maracolan (2013), completed semi structured interviews with both

mental health nurses and assistants. This was across both inpatient and community settings in Brazil with 18 MHNs' and assistants.

Results suggested that MHNs' viewed sexuality as a human need, with sexual orientation being a choice people made around the sex of their partner. Mental health clients' sexuality was viewed as having a focus on disease, with displays or expressions of sexuality being viewed as part of a client's problems. Hospital settings were not viewed as a place to express sexuality and those who did not fit societal 'standards' and 'norms' were viewed with more prejudice.

The cross-sectional study by Cort, Attenborough and Watson (2001) surveyed 122 MHNs' within the UK on their views on a range of topics related to sexuality. This study reports that MHN's are encountering issues related to sexuality within their practice, with only one participant reporting never encountering this. Many MHNs' viewed their clients as sexual beings, believing that having a sexual relationship should be encouraged (62.3%), with 33% having a neutral stance on this. Participants tended to show liberal attitudes around the topic of sexuality. However, there were mixed responses around how much MHNs' should involve themselves, with 52.4% of participants agreeing sexual history taking should be included in an initial assessment but 26.3% disagreed. While 41% thought that clients would be happy being asked questions about their sexual history, a further 21.3% disagreed.

All three of these studies were based in different countries and how generalisable the results are to different cultures is questionable, especially when considering the impact cultural context can have on issues related to sexuality (Butler & Byrne, 2010). However, interestingly the results from the studies by Higgins, Barker and Begley (2008) and Zillotto and Maracolan (2013) showed similar themes related to silence and negativity around these issues and a biomedical and disease focused

approach. Cort, Attenborough and Watson (2001) appear to show some contradictions to these studies offering more liberal and mixed responses. This may be accounted for by the cultural differences or the fact that this study was looking at attitudes generally, not just when specifically thinking about their clients. This study also had a number of methodological flaws which may impact on the reliability and validity of the findings, including the use of Likert scales which are arbitrary measurements.

The Psychologist Perspective

Five papers were looking at psychologists' perspectives around sex and sexuality within mental health practice. Three of these papers were quantitative cross-sectional studies by the same authors Miller and Byers (2008, 2009, 2012). Both the 2009 and 2012 papers looked at counselling and clinical psychologists in America and Canada, while the 2008 paper focused on trainee clinical psychologists. The fourth paper (Traeen & Schaller, 2013) was based in Norway and was also a quantitative cross-sectional study looking solely at clinical psychologists. The final paper (Hargons, Mosley & Stevens-Watkins, 2017) was a content analysis of articles featured in *The Counselling Psychologist* and *Journal of Counselling Psychology*.

The first paper by Miller and Byers (2008) looked at 172 trainee clinical psychologists' self-efficacy, comfort, bias and willingness to treat sexual issues. Trainees reported low self-efficacy for engaging with sexual issues and very little sexuality training within their practice. However, they did feel their ability to convey knowledge on these issues was better. There were a number of factors which were shown to impact on self-efficacy and comfort, including more liberal attitudes, having undergraduate training and more practical experience. Even when taking these factors into account trainees with more conservative attitudes were least comfortable and more biased.

Miller and Byers (2009) looked at the impact of training on psychologists' engagement and knowledge related to sexual interventions. One hundred and five psychologists completed an online survey related to psychologists' views around sexuality and sex. It showed that in the previous 4 weeks, 40% of psychologists reported asking about sex and sexuality within an initial assessment, with 21% reported treating a sexual concern.

The majority of participants believed it was important to receive training on issues related to sex and sexuality (86%), with 76% of participants reporting they would be interested in doing more training. It was also noted that the focus of training, which psychologists had received was around sexual problems over healthy sexuality.

Millers and Byers (2012) followed on from the above studies by focusing on qualified psychologists' comfort levels and willingness to discuss and treat sexual issues in practice. A number of questionnaires were filled in by 110 psychologists asking about a variety of sex and sexuality related factors.

This study replicated Miller & Byers' (2009) findings relating to engagement with these issues at assessment (40%) and treatment (21%). This study also replicated findings that were observed regarding trainee psychologists, indicating that the average clinician was comfortable discussing issues related to sex and sexuality. Self-efficacy to do so was however low, with the average clinician only feeling somewhat confident in having the ability to give information about these topics or address these issues via 'techniques.' Self-efficacy for relaying information was observed to be significantly higher than self-efficacy of skills. On completing a sexual conservatism scale, the average clinician was found to be liberal in their views on topics related to sex and sexuality. This may have an impact on the results as psychologists' beliefs about themselves may have resulted in a bias in answering the questions. They may

subconsciously view their practice as more liberal and comfort levels may be perceived as less of a problem. It is also interesting that this finding of clinicians having a liberal outlook was also shown in the UK based study which looked at nurses' perspectives (Cort, Attenborough & Watson, 2001).

All three papers replicated findings that clinicians reported feeling comfortable in addressing issues related to sex and sexuality. This is interesting as not all clinicians appeared to be asking or addressing these issues within their practice.

One of the main limitations of the above papers is that the response rate from the questionnaires was very low throughout all of the studies, which may have resulted in a bias in the sample. There were also a number of the measurements, which had not been tested for validity and reliability. All three of these papers were from the same authors and although had the benefit of building on previous studies and replicating findings, this only allows interpretation from one perspective with the design methodology being similar throughout and potential biases present from the researcher in analysing and replicating findings.

The third paper (Traeen & Schaller, 2013) was methodologically similar to Miller and Byers' (2012) study, however they received 1064 responses (46.6% returned) back from an online survey. This was less than they had hoped and a bias is possible, however this was a much higher response rate than the previous studies described above.

Traeen and Schaller (2013) showed that one in five psychologists either 'always' or 'most often' ask their clients about sexuality. A number of psychologists (58.6%) felt they did not have enough knowledge to address these issues, with age and clinical experience impacting on this belief. Results showed that when sexual topics were discussed they tended to be about sexual problems, negative sexual experiences, or

sexual orientation rather than positive sexual experiences or satisfaction. Females and younger psychologists with less experience were more likely to ask about negative sexual experiences. A factor analysis was completed suggesting five dimensions that could explain 62.8% of the variance. These were

- 1.) Lack of sexuality training
- 2.) Insecurity and Lack of comfort when topics arose
- 3.) Best to wait for clients to bring up
- 4.) Lack of conversations in supervision
- 5.) Sexuality should not come up in isolation.

The final paper (Hargons, Mosley & Stevens, 2017) was a content analysis of counselling psychologists' journal articles. Articles from between 1954-2015 were selected and analysed looking at what topics were discussed as well as reviewing whether the literature was 'sex positive', 'sex negative' or 'neutral'. The literature was also found to be predominantly based on ethnically white groups.

There were 6 topics which were mainly covered in the Counselling psychology literature

- 1.) Sexual orientation, identity and minorities (38%).
- 2.) Sexual abuse, objectification and victimisation (25%).
- 3.) Sexual risk and STI's (16%).
- 4.) Sex education, counselling and therapy (12%).
- 5.) Functioning, Satisfaction and pleasure (6%).
- 6.) Health communication, attitudes and values (3%).

In analysing the literature to whether it was 'sex positive', 'negative' or 'neutral', there were significantly more articles within the 'sex negative' discourse (70%), with 'sex positive' discourses only accounting for 5% of the papers.

These results can be seen to show similar findings regarding what is happening in practice with Traeen and Schaller (2013), showing psychologists tending to talk more about 'sex negative' topics. This was also seen in two of the three papers looking at the nursing perspective (Higgins, Barker, & Begley, 2008; Zillotto & Maracolan, 2013; Quinn & Browne, 2009.)

The Therapist Perspective

Two papers looked at the therapist's perspectives (Ford & Hendrick, 2003; Shavlev & Yerushhami, 2009.) The first paper looked at the sexual values of therapists and the impact this can have on clients who may not share the same values. This was a quantitative cross-sectional study, which surveyed 314 therapists who were registered with either the American Psychological Association (APA) or the American Association for Marriage and Family Therapy (AAMFT). There were 22 questions which were answered using a Likert scale (strongly agree to strongly disagree.) Nine of these statements were about general sexual values, while the other 13 statements were about areas that may cause discomfort when working with a client and discussing sex and sexuality. At the end of the questionnaire there were two open ended questions. The first asked therapists how they dealt with uncomfortable situations and the second asked about the most difficult situation they had faced regarding their sexual values and practice.

Results suggest that therapists tended to hold liberal values and therapy sessions were not 'value free'. Therapists reported that they would take value conflicts to supervision, a colleague or pass the case on. On the whole therapists reported that their discomfort would not result in them being unable to work with a client.

However, gender, religion and political affiliation were shown to impact on comfort levels in dealing with these issues. There was however no data provided on how often

therapists were incorporating the issues of sex and sexuality within their practice and how often they were providing treatment on these topics. This would have been helpful for a comparison between therapist beliefs and what happens in practice.

The second paper (Shalev & Yerushalmi, 2009) was looking specifically at therapists who were psychoanalytically orientated psychotherapists. All 10 participants had a background in either clinical psychology or psychiatry. This was a qualitative study using a grounded theory approach with semi-structured interviews.

Results showed that therapists were reluctant to have conversations on the topics of sex and sexuality and generally tried to avoid talking about these issues where possible. Therapists tended to believe that sex and sexuality were merely a defence against underlying issues. They therefore felt these issues were not important in therapy.

Four major themes emerged from the analysis:

- 1.) Sexuality does not determine behaviour
- 2.) Dealing with sexuality should be in advanced stages of therapy and rarely reached.
- 3.) Sexuality not viewed very broadly but only about sexual intercourse
- 4.) Avoiding Sexual issues due to Discomfort of Client/Therapist.

This study can be seen to replicate some of the previous findings from the papers discussed above, suggesting that these topics are uncomfortable; however, interestingly it presents a perspective that these issues are not believed to be important in the therapy room with sex and sexuality being constructed as unimportant for psychological wellbeing. There were a number of methodological issues with this study, however, it offers interesting insights into a group who have traditionally come from a field where sex and sexuality were spoken about and viewed as important for psychological wellbeing.

Overall Critique

It is interesting that despite sex and sexuality increasingly being described from a social constructionist or critical-realist perspective, that only one of the studies considered using a methodology that took account of social and cultural factors (Ziliotto & Maracolan, 2013).

None of the literature that has been presented positions the researcher within their study (qualitative) or discusses external rigor checks to the analysis (quantitative), which is problematic when considering the quality of the papers.

There is limited diversity within the samples, with the majority of the studies including only white participants' and only a few mental health professionals represented. For example, no literature was found for occupational therapists or social workers, only two papers were related to therapists' perspectives with the psychiatric perspective only present in the context of those who have been trained psychoanalytically.

A number of the papers also offer conflicting results with sex and sexuality being constructed as both 'important but not', 'clinicians being willing but not able'; 'having a liberal outlook, yet a conservative approach', 'a desire for training, yet not being trained,'. One key theme which appeared consistent throughout the majority of the literature was the uncomfortable feelings which this topic evoked. Different literature placed this discomfort in different things as well as the extent of the problem being different for different professionals. For example, psychologists were positioned as having the willingness, some knowledge, yet lacked self-efficacy and knowledge in certain areas.

Discussion

The findings of the literature review above will be discussed within the wider context.

The implications for the clinical psychology profession will then be considered and gaps in the literature and future research discussed.

Overview of Findings

This paper aimed to try and understand some of the current perspectives which are around when mental health professionals discuss, engage with and talk about sex and sexuality within practice and training.

There were only 11 articles found that met the inclusion criteria, covering a mixture of qualitative and quantitative studies.

The nursing perspective covered three different cultures across the three papers. On the whole sex and sexuality was presented as problem focused, negative and not spoken about with nurses having a conservative outlook. The study based in the UK was an exception to this where nurses' values were assessed as more liberal and there were mixed results on how much engagement with these topics should take place, but discomfort around these issues was present.

The therapist papers looked at both accredited therapists and more specifically psychoanalytical therapists (Ford & Hendrick, 2003). While the second paper (Shavlev & Yerushhami, 2009) reported that the therapists believed talking about sex and sexuality was not relevant to most of the work which they were doing. Both papers highlighted discomfort in talking about these issues, however the therapists did not perceive this as a problem for different reasons.

The psychologists' perspective looked at self-report measures of self-efficacy, willingness and current engagement in discussing sex and sexuality by both clinicians and trainees. Interestingly, they showed overall a willingness and comfort to discuss

these topics, but lack of efficacy and training with engagement with these issues in assessments and therapy was low. The majority of the research looking at psychologists to date has been from one author and all were quantitative cross-sectional studies. They had low response rates, a number of the questionnaires had no measures of reliability or validity and many were arbitrary in nature where by responses were given on Likert Scales.

Implications

The research looking at the area of sex and sexuality amongst mental health professionals can be seen to be very limited. This literature review highlights the current perspectives amongst mental health professionals, with a number of themes emerging from the papers. Clinical psychologists and other mental health professionals are positioned as groups who are finding it difficult to engage with the topic of sex and sexuality within their practice and training.

This is despite service users highlighting the importance of these issues and psychological theory indicating these issues to be a core aspect to human experience and psychological thinking (e.g. Hull, 1943; Gilbert, 2013; Poorman, 1991; WHO, 2002). If these issues are not considered when working with clients, opportunities may be missed to address key areas which can impact on distress levels and psychological wellbeing.

Implications for Practice

This review supports previous findings that there is a lack of engagement with these topics within mental health services. There are also mixed beliefs around the importance of discussing these issues with clients, with psychological health and wellbeing not tending to be present within conversations and thinking.

In considering both the theoretical and empirical research as to the importance of these topics. MHPs' need to review whether their current practice and policies are meeting the needs of clients and supporting both DoH (2001) and WHO (2006) recommendations.

Implications for Training

A number of the papers showed clinicians either wanting more training or the researchers suggested this within their concluding remarks. This is interesting as one of the papers highlighted a finding from their analysis that although knowledge appeared to play a role in whether these topics would be discussed, there were other factors that counteracted the impact the training. Therefore, the content and purpose of any training may need to be considered carefully.

Implications for Future Research

There is a large gap in the literature looking at the issues related to how, what and when sex and sexuality are being addressed in practice (or not addressed as the literature suggests). Despite MHPs including a variety of roles, only a few professions were represented within the literature. It would be interesting and beneficial to understand what views are present amongst all MHPs', considering what may impact on differences as well as similarities between professions.

There is also very limited literature around how these topics are discussed within different professions training, with only one paper looking at this within the clinical psychology paper.

None of these studies have considered using a discourse analysis approach, despite the complexity of the topics and discussion around sex and sexuality being caught up within culture and context. It is important to understand the wider factors which may be influencing the current context when thinking about sex and sexuality.

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Section B

The discourses around sex and sexuality within Clinical Psychology training and practice.

A Foucauldian Discourse Analysis.

Word Count: 9073 (980)

Abstract

Background Literature to date claims that sex and sexuality are a core aspect of individuals' psychological wellbeing. Literature also claims that Clinical Psychologists' (CP's) are not engaging in talking about these issues in their practice or training. Sex and sexuality are complex topics and argued to be impacted by social, cultural, historical and political discourses. Looking at the discourses within the profession may provide helpful insight in understanding current practice.

Aim The aim of this study was to investigate how sex and sexuality was constructed by clinical psychologist and trainees when discussing training and practice.

Method Semi-structured interviews were completed with 6 practicing CP's and 4 trainee CP's, 2 focus groups were also completed with trainees from 2 different universities. A Foucauldian Discourse Analysis (FDA) approach was used to explore professional and trainee's discourses around the topics of sex and sexuality.

Results Six discourses were identified during the analysis consisting of 'Let's not talk about sex'; 'Dangerous for Clients, Professionals and Society'; 'Social and Political Movements' and 'Culture and Contextual Discourses.' Two counter discourses also emerged: 'Let's talk about sex' and 'Sex and Sexuality are Positive and Healthy'.

Conclusions Various wider discourses can be seen to be impacting on clinical psychologists' decision making when talking about sex and sexuality within practice and training. Constructions of what is expected from clinical psychologists in the therapy room appear to be reinforced by dominant social, political and cultural discourses. Counter discourses were present, bringing these alternatives more into the forefront could be beneficial for clients.

Key Words: Sex, Sexuality, Discourse Analysis, Clinical Psychologist, Trainee

The discourses around sex and sexuality within Clinical Psychology training and practice. A Foucauldian Discourse Analysis.

Introduction

“The question I would like to pose is not, Why are we repressed? but rather, Why do we say, with so much passion and so much resentment... that we are repressed? By what spiral did we come to affirm that sex is negated? What led us to show, ostentatiously, that sex is something we hide, to say it is something we silence?” (Michael Foucault, The History of Sexuality, Vol 1)

There are various claims in research around the links of sexual functioning and sexuality to an individual’s psychological health and wellbeing. This relates to various topics such as self-esteem and body image (e.g. Stevenson, 2010) and depression (e.g. Denman, 2004). Despite these ideas being present within research and practice, there is a discourse around the lack of emphasis placed on these topics in mental health services within the U.K.

The literature claims that mental health professionals are not engaging in this topic area and when discussed the emphasis appears to be on risk and negativity (e.g. Zilotto & Maracolan, 2013; Hargons, Mosley & Stevens-Watkins, 2017), rather than healthy sexuality, pleasure and enjoyment.

Research to date in understanding this, has focused on therapists, psychologists and mental health nurses (e.g. Higgins, Barker & Begley, 2008). The research which looks at Clinical Psychologists (CP’s) has been qualitative in nature, focusing on the self-efficacy and lack of training which takes place within the profession (e.g. Miller & Byers, 2012). One recent qualitative study, based in Ireland looked at CP’s engagement with these issues (Culhane, 2015). This study found CP’s lacked training, knowledge and felt discomfort when discussing these issues. It also showed a number

of factors impacted on this including culture, training, supervision and work experience.

Relevance to Clinical Psychologists

CP's as a professional group, describe using formulation driven interventions to aide understanding of individuals and the distress which they experience (Division of Clinical Psychology; DCP, 2011). Although many CP's may have a particular theoretical preference, constructions of clinical psychology suggest that most work from an integrative, evidence-based approach, which has a biopsychosocial emphasis (Plante, 2011). Their role is described by their professional body to include elements of consultancy, reflective groups and team formulations (DCP, 2011). They, therefore, appear well positioned to be discussing issues related to sex and sexuality within their work.

There are various claims from research that clients are bringing topics related to sex and sexuality into the therapy room. One study by Di Giulio and Reissing (2004) claimed 78% of CP's reported being asked about sexual concerns by clients. There have also been various studies claiming that mental health clients want to discuss these issues, yet they are reporting they are not being asked (e.g. McCann, 2010). Based on the above claims it could be assumed that CP's would be trained in these areas, talk about these issues and value the topics of sex and sexuality within their practice. Yet, this is contradictory to the claims which are being made in research that indicates CP's are not engaging in these topics; they lack self-efficacy, feel unprepared for practice, and do not have a basic knowledge of human sexuality (Regus, 2011). Little research to date has looked to explore this discrepancy.

The Profession's Stance

In 2007 the British Psychology Society (BPS) through the DCP initiated a working

party on issues around sex and sexuality. This could be viewed as an attempt to position these topics more at the forefront of practice.

This working party however was initiated following concerns around equality and diversity issues, which may account for the fact the working party focused on issues related to Lesbian, Gay, Bisexual and Transgender issues (LGBT), rather than covering broader aspects of sex and sexuality such as healthy sexual functioning.

Social, Cultural, Political & Historical

Theoretical History

Freud (1920) can be seen as one of the first to position sex and sexuality in the psychological domain. This led to therapeutic approaches looking at desires, repressed thoughts and feelings. This was followed on by researchers such as Masters and Johnson (e.g.1966) who studied the human sexual response. In considering this early positioning of sex and sexuality, essentialist perspectives can be seen to dominate. However, over the years the positioning of sex and sexuality can be seen to have changed from a more essentialist perspective to a social constructionist one. This can be seen to have emerged from writings such as Foucault's History of Sexuality (1978) and social and political movements such as Feminism and LGBT rights. Sexology researchers bridged this gap via critical realist approaches, claiming that to understand sex and sexuality, biological, social and cultural contexts need to be considered (Butler, O'Donovan & Shaw, 2010).

Society, Culture & Political Context

CP's are faced with an ever-changing and complex world when it comes to the social, cultural and political positioning of sex and sexuality. More liberal laws, policies, and a move away from essentialist to social constructionist positioning, have an influence

on how these issues are constructed within society and by the clinical psychology profession.

Within society there have been emerging discourses related to the importance of equality and the desire to reduce prejudice and stigma for sexual minorities (e.g. The Marriage Bill, 2014; Equality Act, 2010). Legally there have been a number of recent changes, this includes laws relating to revenge porn (Citron & Franks, 2014) and changes in perceptions around what constitutes sexual assault (Sexual Offences Act, 2003).

These discourses related to abuse, victimization and policies to reduce stigma and prejudice, all sit against the back drop of the construction of western society being increasingly liberal and sexually free. There is easy and free access to pornography (e.g. Spink, Wolfram, Jansen, & Saracevic, 2001), and an increased presence of sex within advertisement, film and music (e.g. Reichert & Carpenter, 2004). This has not been the case for previous generations who were not presented with various constructions of sexuality. Butler, O'Donovan and Shaw (2010) claim that this freedom inevitably results in restrictions, allowing those in authority to keep power, with sex and sexuality being both liberal on one hand yet repressed and restricted on another.

Context & the Importance of Discourse

Social constructionists view sex and sexuality as fluid entities which change over time and place with their definitions changing based on social, political, cultural and historical factors. This does not mean that nothing can be 'known' about them, but they need to be considered within the context they are spoken within.

Foucault (1972) described how discourses legitimise truth and meanings of the world through social process which can be dictated and impacted by those in positions of

power. He argues that those in power are able to influence and legitimise specific truths and knowledge while ignoring others. Foucault specifically looked at the topic of sexuality believing that there were wider social and political factors which influence how it is perceived and discussed due to the desire of Governments to control and regulate factors such as birth and death rates, life expectancy, fertility and state of the health of the nation.

Summary

CP as a professional group claim to work closely with clients on various factors which impact on their psychological health. Psychological health in western society is seen to include and value healthy sex and sexuality. There are claims by a number of researchers that these issues are missing from CP practice and training, with healthy sexual functioning receiving minimal attention. When issues related to sex and sexuality are addressed they appear to be around certain sexual minorities and sexual abuse.

Rationale for Current Study

Previous research has looked to understand different professionals' views and assumptions on the topic of sex and sexuality (e.g. McCann 2010a, 2010b; Quinn, 2009). Due to the role and position CP take within the NHS and mental health services, they can be viewed to be well positioned to be discussing sex and sexuality. Yet they are reported to lack self-efficacy, are not engaging with the topics and are not getting trained in this area (Culhane, 2015).

Exploring the discourses which are present amongst CP may allow for the dominant and subjugated discourses to be brought into awareness and considered by the clinical psychologist profession.

This may result in professionals and training providers considering the way they engage with, think about, talk about or position these topics, allowing for less dominant and subjugated discourses to be spoken about, opening up the possibilities of what is thought and known about this area. CP can then make informed choices around how they integrate these topics into their practice and training, based not on assumptions, power and unconscious beliefs but a conscious choice.

Research Questions

- a.) How are 'sex and sexuality' and 'sex and sexuality talk' constructed within clinical psychology training and practice within the UK?
- b.) What are the dominant and counter discourses within practice and training?
- c.) Do the discourses tell us anything about how sex and sexuality may be positioned within the profession and what impact this might have on practice?
- d.) What possibilities might these discourses open up and what might they close down?

Methods

Design

This is a qualitative multi-perspective, multi-method Discourse Analysis. It had the aim of gathering discourses from different CP-based groups via online questionnaires, individual interviews and focus groups, where semi-structured interviews were used. This study looked to capture the current discourses on the topic area, regarding three specific viewpoints: the trainee, the trainer and the practitioner within Clinical Psychology. Three methods of gathering different data were used: Individual interviews, focus groups and an online questionnaire.

Individual interviews have been shown to allow for more in-depth accounts to be captured (Parker, 2005), while focus groups have been highlighted as a good method

to access views with peers, as well as accessing more social discourses (Kitzinger, 1994). The online questionnaires were used to capture a brief overview of training providers' views.

The data were interpreted using Foucauldian Discourse Analysis (FDA; e.g. Willig, 2008). Sex and sexuality are complex issues, changing across time and place, and it is impossible to overlook the social, political and historical aspects when considering any research in the area. FDA looks at understanding the relationship between language and power by analysing more than just the content of the discourse, placing the discourse within its social and historical context (Parker, 1994). This can help offer insight into how certain truths come into being and how other views are excluded from the world (Yap, Byrne & Davidson, 2010). FDA therefore takes a critical look at the discourse which is being analysed.

Participants

There were three groups of participants taking part within this study using different methods of data collection. This consisted of:

- 1.) Practitioner Clinical Psychologists (6 individual interviews).
- 2.) Trainee Clinical Psychologists (2 focus groups and 4 individual interviews).
- 3.) Training Providers (brief online questionnaire completed by 3 – not part of analysis).

Recruitment

Trainees

Eight Universities within the South of England and London area were contacted via their administrative team. A recruitment email was sent to all trainee CP's enrolled on the courses (Appendix D), replies were received from trainees from 3 Universities. It had been hoped that focus groups of between 5 and 10 people from at least 3

Universities would be involved in the study. Fern (1982) reported that previous focus group research shows group sizes varying between 5 and 20. Eight trainees from one University offered to take part in a focus group, with 4 trainees from two other Universities offering their help. There were therefore only enough participants (n=8) to hold a focus group at one of the programmes.

Due to the low number of participants, Universities were asked to circulate the recruitment email again. Only one response was received from a trainee at the University that the initial focus groups was held at. Those who had offered to help initially were asked if they wished to participate in an individual interview instead, all four agreed.

While attending one of the Universities to complete an individual interview, 2 other trainees offered their help. It was therefore possible to complete a second small focus group at this University. Although this was less than initially planned for the size of a focus group (n=3), DA values different means of accessing conversations and any written or spoken language is viewed as a valuable discourse (Willig, 2008).

Demographics details of the trainees are summarised in Table 1 below. Some of the trainees within the study attended the same University as the researcher. However, due to the large size of the cohorts they were not known personally by the researcher and all had approached the researcher with interest to take part in the study.

Number of Practicing Clinical Psychologists

Recruitment took place via word of mouth and the network of known associates to the researcher. By the end of the study 6 individual interviews were completed with CP's working within the South of England. Participants represented different ages, experience and gender (Table 1). Some of the CP's were known previously by the researcher, however they were not known personally.

Training Providers

It was initially planned that a focus group would take place at a Conference where training providers attend from across the country. However, the focus group was not accepted as part of the Conference despite initial interest being indicated. An online questionnaire was therefore constructed to elicit some brief thoughts from training providers (Appendix I). An email requesting completion of this questionnaire was sent to the administrative teams at the majority of Universities in Wales and England, asking them to forward the online questionnaire to the person most appropriate to answer questions (Appendix D).

Only 3 training providers completed this questionnaire and the content was very limited. The answers have been included in Appendix P for reference but these data have not been used within the analysis.

Sample Size

When using DA there isn't a 'correct' number of required participants, with various sample sizes being used in previous studies (Wood & Kroger, 2000). Potter and Wetherall (1987) report that patterns can emerge from a small number of people, believing sample size is not as important in DA as it is in other methods.

Table 1: Participant Demographics

Category	Characteristics
Gender	Male 6 Female 14
Ethnicity	White British 17 White Other 3
Religion	Atheist 2 Agnostic 1 Christian 1 Other 1 N/A 10
Age	Between 26 and 62
Years' Experience	1 st Year Trainee 3 2 nd Year Trainee 7 3 rd Year Trainee 4 Since qualifying: Range 2-40

Inclusion Criteria

There were some inclusion criteria that participants needed to meet in order to be part of the study (Table 2). Consideration was given to whether it would be appropriate to interview individuals who were known to the researcher. It was decided that there were pros and cons to both and this will be reflected on in the discussion.

Table 2: Inclusion Criteria

Participant Group	Inclusion Criteria
Trainees	Geographically accessible Currently undertraining DClinPsych program in the UK.
Clinicians	Health and Care Professions Council (HCPC) registered Minimum 1-year Experience Working within an adult setting.
Training Providers	No criteria Who is deemed most suitable to complete questionnaire by course.

Data Analysis

DA has been chosen as the method of analysis due to the historical, social and political influences which can be seen to impact on these topics. This study is building on a previous qualitative study completed in Ireland, which explored CP's' engagement with sex and sexuality (Culhane, 2015.)

FDA and other forms of DA argue that objects and subjects of knowledge come into existence through language. This analysis is looking at how language constructs certain discourses and how this results in other discourses being limited and subjugated. In day to day life this results in certain conversations being closed down, not considered or spoken about. If only certain discourses are spoken about, then these discourses become 'truth.' Those in power can be seen to influence what is and isn't spoken about and therefore what knowledge is known within society.

Foucault challenged the notion of producing a method of how to do FDA. Instead he felt there could be a number of ways to analyse the data and felt his ideas formed more of a 'toolbox' of what to think about when undertaking DA (Cheek, 2008). A number of guidelines, however, have been produced. As a novice to DA a set of guidelines (Willig's 6 Step guide, 2008) was used when analysing the data. A summary of these steps can be seen in Table 3 below.

Table 3 Willigs 6 steps of Discourse Analysis (2008)

Steps	Description of Step
Step 1: Discursive Constructs	Different areas/objects/subjects which are spoken about are taken a note of (the constructs) within the transcripts.
Step 2: Discourses	Differences between constructs explored and thought about. Differences between constructs thought about and where sit within wider discourses.
Step 3: Action Orientation	Consideration is given to what the language is doing. What is allowed to be said/what is potentially being prevented from being said.
Step 4: Positioning	How are different subjects positioned within the wider culture and context? How are subjects positioned? (e.g. clinicians' clients, researcher, external world)
Step 5: Practice	How do the positioning of constructs and subjects impact practice?
Step 6: Subjectivity	How is knowledge/ways of understanding made legitimate/become a truth. What knowledge is legitimised, made illegitimate and which are subjugated?

Procedures

Interview schedules were constructed based on the research question and use of DA. Both supervisors were consulted during this process due to their different expertise in the area. Prior to any interviews taking place pilots were completed for both the focus group and individual interview. The interview schedule and procedures were modified based on the feedback given.

Information sheets were sent to all participants during the recruitment phase (Appendix F). On arriving for an interview, participants were asked to familiarise themselves with the information sheet, the opportunity to ask any questions was offered and participants were asked to sign a consent form and fill in some demographic data. All of the individual interviews and focus groups were audio-recorded and lasted between 37 and 65 minutes.

A short debrief took place at the end of both the interviews and focus groups (Appendix J). Those taking part in the study were offered a short report on the results of the study once it was completed. A summary of the key findings were emailed to participants at the end of the study (Appendix S).

Following all interviews and focus groups, reflective notes were made and referred to during the data analysis process. The researcher transcribed all of the recordings, taking note of any initial thoughts on this process (e.g. Appendix M). The data analysis process consisted of reading and re-reading the transcribed recordings. A coding manual was produced (Appendix O), Willig's (2008) 6 step guidelines (Table 2) was used to aid this process. The transcripts were gone through, initial notes taken and thoughts related to the different steps were taken note of. These steps were gone through on several occasions and thoughts changed over time. This resulted in 6 overarching discourses emerging at the end of the analysis.

Quality Assurance

A number of procedures were put in place to minimise biases during the data analysis process. The researcher acknowledges and discussed their own positioning towards the subject matter and reflected on how this may have impacted on the analysis. The researcher also recognises that this is one interpretation of the text and there may be other possible interpretations, depending on other researcher's positions.

Procedures were also put in place to increase the credibility of the research via means such as reflecting on own position within the research (Appendix L) use of a reflective journal (Appendix K), discussions with supervisors, and audit trail (Appendix Q). To aid the readers' understanding and increase both transparency and coherence of how discourses developed a number of quotes have been included within the result section. Discourse development and an extract from the coding book have both been included for further reference (Appendix N and O).

Ethical Approval

Ethical approval was granted by Canterbury Christ Church University Ethics Committee (Appendix C). A summary of the key findings were sent to the CCCU Ethics Committee. (Appendix S). Ethical procedures included: providing an information sheet for all participants (Appendix F) obtaining informed consent (Appendix E), outlining confidentiality and data protection issues and completing a debrief (Appendix J) at the end of interviews and focus groups.

Results

This Foucauldian discourse analysis (FDA) focused on exploring the discourses which come up when talking about the topics of sex and sexuality amongst practicing CP's and trainee CP's within the UK.

The analysis focused on what discourses emerged when trainees and clinicians discursively spoke about sex and sexuality and how they constructed how they talk about these issues.

There were four dominant discourses which emerged from the analysis: ‘Let’s not talk about sex and sexuality’; ‘Dangerous for Clients, Professionals and Society’, ‘Social and Political Movements’ and ‘Culture and Contextual Discourses’ with two counter discourses: ‘Let’s talk about sex’ and ‘Sex and Sexuality is Positive and Healthy.’

Each discourse is discussed below with a number of quotations giving illustrative examples¹. To help the reader understand how these discourses emerged from the data a segment of the coding manual as well as a summary of the development of the discourse can be found in Appendix N and Appendix O.

The analysis looked not to find one ‘truth’ but to explore how language constructs ‘truths’ based on the dominant discourses which are present. It considers how wider dominant discourses influence some knowledge while silencing others. Although the discourses are discussed as separate themes, a number of them can be seen to overlap and be linked to one another. This interpretation is accepted as only one way that the interviews could be analysed and there may be other interpretations by different individuals at different times.

‘Let’s not talk about sex and sexuality’

Overview of this Discourse: A dominant discourse around sex and sexuality talk was the avoidance and lack of conversation, desire or need to speak about these issues (‘Let’s not talk about sex and Sexuality.’) Social and professional discourses were seen to be influencing this dominant discourse. ‘Let’s not talk about sex and sexuality’ presented sex and sexuality as something that was socially difficult and

¹ Focus groups = Transcript 11 and 12, participant number indicated as P1-P8

awkward to talk about ('It's all a bit awkward.') and it was professionally perceived as not needed or wanted by clients ('A desire to be sensitive and understanding').

'It's all a bit awkward'

Throughout the interviews the topics of sex and sexuality were constructed as uncomfortable, embarrassing and awkward to speak about. These conversations were viewed as sensitive, private and taboo. They were constructed as topics that should be approached with caution and not freely spoken about.

"It feels very sensitive and private in a way.... More private than just what have you had to eat, are you seeing anyone, it's an extra level, do people need to tell you that?" (Trainee, Transcript 12, P5, Line 261- 265)

"We all know it's a sensitive subject, so it also makes you think about that and it makes you think about a need to tread carefully." (Clinician, Transcript 1, Lines 38-40)

The use of the words '*We all know*' implies this view of sex and sexuality is true, widely held and 'known.' CP's are constructed as being culturally aware of the discourses around the appropriateness of talking about this subject matter within society and the British culture.

"I keep wanting to say and opening it up again, is we are British and we don't want to talk about sex. I don't know if other cultural backgrounds, if it is a lot easier to think about or not. But [I] know not many English people find it naturally easy to talk about sex, unless their parents were incredibly open which in that case it's a great thing. But as society we are so repressed anyway that's feeding in from every direction." (Trainee, Transcript 12, P6, Lines 341-347)

This construction of sex and sexuality through this discourse, presented external reasons for many clinicians and trainees not engaging in these conversations. The difficulties were positioned within society, legitimizing the silence on these issues, whilst reinforcing wider conservative discourses that sex should not be on show. Not talking about these issues may also be impacted by wider professional discourses related to issues of appropriate professional talk and boundaries, minimising the chance of conversations being opened up. One trainee spoke about their attempt to bring these issues up in the therapy room.

“An example is em, on a referral that I had em, my last placement em, on the referral form, it explicitly talked about some of the issues about client’s sexuality. I saw this guy for 12 sessions and not once did we talk about it. Em and every session eh you know it just didn’t come up and em it didn’t, it didn’t and part of that was me and part of that was the conversation that em, I co-constructed with them that didn’t allow for that to happen. I had every intention of it happening, but it was still very difficult.” (Trainee, Transcript 12, P5, Lines 90-96)

This shows how dominant the silence and awkwardness can be, even when someone is actively trying to work against it. This extract emphasises this difficulty and acknowledges how the way sex and sexuality were constructed in the therapy room, disallowed a dialogue on the subject taking place.

A desire to be Sensitive and Understanding

The lack of talk that occurred around sex and sexuality was also constructed as a professional choice. This was constructed through the understanding that the role of a psychologist is to *be sensitive* to clients’ needs; create a therapeutic relationship and not cause any undue distress.

“I would probably tread, I’d probably tread more carefully when I’m professional role around the client because that’s our job to do that. To be sensitive.” (Clinician, Transcript 1, Lines 40-42)

“I think it can be a fear of embarrassing somebody, a fear of putting somebody in a difficult position. I think that’s why I would probably only ask about these issues once I got to know somebody...” (Clinician, Transcript 5, Lines 513-517)

The above quote not only constructs CP as caring of clients but also highlights a discourse around the importance of relationship building within CP professional role. A number of interviewees constructed the therapeutic relationship as an important aspect of the work which they do. To speak about sex and sexuality prior to this was constructed as intrusive and insensitive.

Initially the discourse around CP being respectful to clients’ wishes appears to position clients as having the power in the therapy room.

“I don’t tend to encounter a lot of people who are struggling with their sexuality and sometimes what I do find, especially with the younger generation is that they are fine about their sexuality ...they are frustrated that all clinicians are, ask about their sexuality.” (Clinician, Transcript 4, Lines 93-98)

Clinicians and trainees are positioned as doing the ‘right’ thing, being understanding and person centred to what is important and a priority for clients. The lack of conversation is legitimised based on decision making by CP’s that this is the client’s wishes, they will bring it if it is important and responsibility is passed to the client. However, instead of giving clients power via this responsibility, this can be seen to reinforce their position as powerless. CP’s power in the therapy room and the silence

and avoidance around these issues disallows conversations to be opened up.

Legitimizing a ‘truth’ to clients that these are unsaid things that are not to be brought into the therapy room.

Let’s Talk About Sex

Overview of Discourse: A competing discourse compared to the above ‘Let’s not talk about sex’ was present (Let’s talk about sex). This counter discourse constructed sex and sexuality as being important to CP work and psychological health (Of course it’s Important). Certain individuals and theoretical stances were constructed as finding this easier (Natural for Some). There was also an emerging construct around CP’s questioning the more dominant discourse of ‘Let’s not talk about sex’ (Questioning the Silence.)

Of course, it’s Important

There were a number of examples where interviewees would describe times when they had spoken about sex and sexuality in sessions and this appeared to be valued by clients and viewed by the clinician or trainees as an important piece of work.

“I think it’s quite an important part of our work, like I certainly, in a longer piece of work in first year that was a key part of what was going on for someone. What did we talk about, lack of sexual pleasure, another person wanted to talk about ehh a man not being able to get an erection...I think it can be really important. ” (Trainee, Transcript 12, P7, Lines 268-271)

This was an interesting contradiction to the avoidance and status which these issues appear to be expressed in the ‘Let’s not talk about sex and sexuality’ discourse, especially since the majority of some interviewees would express both discourses within their interviews. Through these conversations, CP were constructed as

knowledgeable and willing to address these issues and sexual health and functioning were positioned as important for psychological health.

Natural for Some-Sometimes

Not many interviewees expressed finding talking about sex and sexuality as ‘normal’ and unproblematic but there was one interviewee who did feel this was the case, constructing this as something which was different to the clinical psychology profession as a whole:

“I think it’s quite normal to ask about it, it’s just been interesting that maybe that’s not shared through the course and the profession than I thought it might be...” (Trainee, Transcript 11, P2, Lines 38-39)

A number of interviewees reflected upon clinicians they had observed who appeared to approach this topic differently, feeling it was more natural for some therapists. This was especially the case for those who had a psychodynamic background.

“I find that when psychotherapists, particularly in a psychodynamic context. It’s such as fluid, that actually it becomes really natural and it doesn’t feel awkward at the and they are so comfortable about it, particularly if they are doing really sort of candid reflections.” (Trainee, Transcript 12, P8, Lines 498-502)

Considering the history of sex and sexuality emerging in psychology from psychoanalytic and psychodynamic approaches, discourses in this field still appear to be present.

There is currently a power struggle in mental health services amongst different therapeutic approaches being legitimized as evidence-based interventions which can be offered to clients. This construction of psychodynamic therapists as experts, places more value on their expertise, increasing their position within CP’s discourses. There

also appears to be subjugated discourses related to the benefits of other therapeutic approaches in this field such as CBT based approaches, which were viewed as a therapy that would not include this.

“...what you said about your protective factor, you would never put down your sexual life, I’m thinking about theory and I went into CBT and behavioural activation. Behavioural activation would never be about go out, have a fun evening.” (Trainee, Transcript 12, P3, Lines 665-667)

This may be due to discourses around what CBT ‘does’ being influenced by Government and political agendas to focus on ‘techniques’ and therapies which help get people back to work, rather than focus on psychological health. The Government has the power to invest money into what they perceive as most helpful and if services and clinicians are not able to give the Government the outcomes in certain areas, then funding will be reduced.

Questioning the Silence

During the interviews a number of individuals started questioning how both they and their practice were positioning sex and sexuality as silenced and avoided issues. There was reflection by interviewees about the amount of questioning which they do around sex and sexuality; highlighting the fact that if they don’t ask ‘how can I know how much of an issue it is for people’ (Clinician, Transcript 2, Lines 474-475). One interviewee acknowledged their effort to actively not collude with current systems.

“It’s felt quite easy to sort of collude with this unspoken thing or well I’ve found in the past year as a trainee and to not ask about it has felt like the easier option but as I have gone over the past year in placement my supervisor has talked to me often about actually asking people about their sex lives as part of our intervention and opening up that conversation. Em. So, I think I feel that I

have to actually consciously make an effort to not collude with that I suppose discourse in society.” (Trainee, Transcript 12, P4, Lines 74-79)

There was also questioning around what topics are presented and how certain aspects of sex and sexuality were constructed as completely absent and subjugated. One interviewee highlighting the absence of sex in training and particular subjugated sexualities such as Bondage, Domination, Sadism and Masochism (BDSM)

“.....it’s only been sex negative by, by absence. You know. But even in one lecture, we did couples, family one, remember and even when you raised the issue, where the hell is BDSM in all of this. They were like oh yeah, right, we should put, emm, it wasn’t a closed answer, but it wasn’t, these sort of things are conspicuously absent,’ (Trainee, Transcript 11, P3, Lines 577-583)

From these conversations within the interviews, interviewees were shown to question the above dominant discourse of ‘Let’s not talk about sex and sexuality’. As Foucault (1978) described, questioning and bringing subjugated discourses into conversations can open up possibilities and thinking. This has the potential to both change what actions can and can’t take place as well as impact on what ‘truths’ can be known.

Dangerous for Clients, Service Users and Society

Overview of this Discourse: Another dominant discourse around sex and sexuality was the danger, risk and negativity that came with it (Sex and Sexuality is Dangerous.) This discourse presented sex and sexuality talk as dangerous for clinicians and this risk was gendered (We need to keep ourselves safe), it was viewed as bad for society and problem focused (all about the negative stuff). There was also a focus on risk and protecting clients (There is so much risk out there).

We need to keep ourselves Safe

There were a number of interviewees who constructed sex and sexuality talk as risky,

dangerous or inappropriate for clinicians to discuss. This was either constructed as something which clinicians and trainees wanted to protect themselves from or other members of the team had highlighted their concern around clinicians having these discussions.

There was a clear divide in how this risk and danger was constructed for males in comparison to females, with gender stereotypes of ‘Females as victims’ and ‘Males as abusers’ being reinforced for both professionals and clients.

There were various examples from interviewees regarding the above discourse. Male trainees and clinicians described being questioned or stopped from having conversations with clients around issues related to sex and sexuality:

“So, the one I was allowed to talk about sex and sexuality to is a guy, the one I wasn’t allowed was a young straight woman my age and that was, that was when everyone was like ‘oh hang on should *you* be talking about that [sex], talking about that to *you*?’” (Trainee, Transcript 11, P2, Line 643-647)

With a number highlighting their own reservations about bringing the topic of sex and sexuality up:

“I don’t think I would now I would tackle that [sex and sexuality] on my own. I think I would like want to seek out guidance on that and probably have someone with me to to, to approach it because it does feel like a especially on the course when they are talking about like indemnity insurance and things and it really felt like there was a real potential for allegations you know [...] that has definitely been in the back of my mind when it wasn’t really before.” (Trainee, Transcript 9, 405-414)

While females had constructed risk differently being positioned in a victimised role.

“Perhaps on the male ward, like, eh my guard was up a bit. Sometimes in relation to any sexual comments or if it was seen in like kind of inappropriate.” (Trainee, Transcript 7, Lines 320-322)

“I think there was the culture, it was a different type of risk, was someone wanting to talk about it [sex], to take advantage of you in quite a manipulative way.” (Trainee, Transcript 11, P1, 673-674)

In a risk averse NHS these discourses can be seen to maintain fear and silence on these issues. These discourses again legitimize and reinforce stereotypes and the power of males in society over females. There is an underlying implication that there is something bad and dangerous about even talking about sex and sexuality.

Maintaining conservatism and silence in this area, with professionals and clients being protected from this bad thing which needs to be controlled and repressed.

It's all about the Negative Stuff

Sex and sexuality were constructed as only focusing on the problematic aspects. This was through various descriptions of sex and sexuality being problem focused. This was demonstrated by not only the explicit use of the word ‘*problems*’ throughout the interviews but also the specific subjects that emerged through discussions such as the negative impact of porn, sex addiction and erectile dysfunction.

There were various constructions of problem focused conversations, as well as interviewees describing healthy sexual functioning and sexual health being missed from practice and talk.

“Most discussions about clinical practice that have been about sex, have been about trauma or again about problems. Rather than enjoyment and pleasure.”

(Trainee, Transcript 12, P6, Lines 542-545)

“So, em, and then, moved onto more around sexual abuse or you know, I guess more problems in that sort of area rather than fulfilling sex and sexuality. So, I guess there is like em, like the more talking to you. I’m thinking about it, it seems to be there’s not too much talk about sex and sexuality normalising, it seems to be when there is problems.” (Clinician, Transcript 4, 334-342.)

These discourses on psychological ill health rather than psychological health can be seen to position mental health professionals including CP as the experts on solving these problems, ‘the rescuer’ amongst victims. A need to fix and cure problems rather than enhance pleasure and health allows for the dominant medical model which is still present within society to be upheld. There are also wider discourses of how appropriate and professional it is for CP to be ‘encouraging’ sex. With potential moral and social discourses dictating how free individuals are to express this.

This negativity and problem focused discourse was most apparent with the constant descriptions and discussions around sexual abuse. This was something that many of the interviewees mentioned was at the forefront of their minds.

““The first thing that comes to mind when *you* think about these areas of *course* is sexual abuse, because that is one of the main ways which *we* find ourselves talking about sex and sexuality with people quite often. It’s kind of the key area that *we’d* clinically get involved in.” (Clinician, Transcript 1, Lines 33-37)

They also spoke about their awareness of the negative impact this would have on individual’s wellbeing.

“I guess we see a lot of abuse as well, don’t we? [rhetorical], sexual abuse and see the consequences of that and how that can adversely influence *victims* future relationships.” (Clinician, Transcript 3, Lines 50-51)

Through both of the above quotes there was assumptions that this was a truth where by interviewees didn’t use the term ‘I’ but instead said “*don’t we?*” and “we’d”, “we”, “you” as if representing all CP in this viewpoint. The use of the word *victims* was used on several occasions and although not always explicitly said there was an implicit sense that this was a female problem.

This problem focused perspective can be seen to position clients, especially females as powerless, victims and vulnerable reinforcing gender stereotypes. CP are positioned as the rescuer again, having power and having a role and need in services and society.

There is so much risk out there

The position of clients as vulnerable, victims and powerless when talking about sex and sexuality is legitimized further within this ‘Sex and Sexuality is dangerous’ discourse by various references to CP’s role as protectors through risk assessing, ethical and legal implications as well as discussions around the need to consider consent, capacity and safeguarding issues.

This discourse reinforces stereotypes around mental health clients as either vulnerable and needing protecting, or dangerous and needing control. These mental health discourses have emerged throughout history despite new constructions of mental health clients being resilient and empowered within a recovery and person-centred model of care. These longstanding dominant discourses are still present and can evoke fear in CP’s and services if they get it ‘wrong.’ These dominant discourses also allow

for the Government and services to ‘control’ this population with laws such as the Mental Health Act (2007) giving them power to control.

“I think sometimes, eh, eh just thinking about the ward and people expressing, just wanting to have a relationship and em, again that balance, wanting to protect someone who is very vulnerable and their right to have a relationship have an appropriate relationship I guess. People would sometimes not get address again and be like oh no they shouldn’t be saying that.” (Trainee, Transcript 7, Lines 344-366)

Sex is a good thing

A competing discourse which was much less present to the above discourse ‘Sex and Sexuality is dangerous’ was how sex and sexuality were constructed within a positive context and viewed as ‘normal’ to discuss (‘Sex is a good thing.’)

Overview of this Discourse: This discourse constructed sex and sexuality as related to positivity, viewing sex and sexuality as constructs that were part of everyday life and very ‘normal’ to the human experience and human behaviour. This included pleasure, healthy sexual identity and functioning and having ‘good’ sex (‘Sex is a good thing’).

“I guess I think it being part of life, with my friends, probably less with my family, but I see it as quite integral part of a young person. It’s quite a big focus on people’s lives and to think you’re having a good sex life is quite a goal that most people want to have. Emm. And thinking about sexuality I suppose I have lots of pictures of like pride marches and that kind of stuff.” (Trainee, Transcript 7, Lines 106-108)

This counter discourse appeared to be mainly present when CP considered their personal thoughts around the topics of sex and sexuality rather than their more

professional views. One interviewee noted this conflict with how they positioned these topics in their personal life compared to their professional life.

‘...and the importance I would give that [sex and sexuality] in people’s relationships or I suppose actually for happiness or perhaps how many problems can stem from sex and sexuality, I would say that is a really key part and how different it is to work, I’ve not really thought about the discrepancy.’

(Trainee, Transcript 11, P2, Lines 360-365)

This conflict between how some interviewees positioned and constructed sex and sexuality within their day to day life in comparison to their professional life could be understood to be influenced by a number of wider discourses. The positioning of sex and sexuality as different in ones’ day to day life compared to mental health clients has been a discourse which has been present through history. Mental health clients have been a stigmatised group who were constructed as needing either protecting or control. This discourse of ‘Us and Them’ maintains the discourse of silence, as sex and sexuality talk in day to day life is constructed differently and with greater importance. The discourse of ‘Positivity, healthy and good’ sex and sexuality appear to be subjugated within this context.

Context: Social and Political Issues

Overview of Discourse: A discourse related to sex and sexuality talk being both political and social issues were present within a number of the interviewees’ discussions. Sex and sexuality talk were constructed by a number of interviewees as an issue related to minority groups, diversity and representation – primarily LGBT issues (Social and Political Issues). This discourse included positive changes which were perceived to be taking place and CP’s sometimes feeling they should be actively initiating change (Equality, Change and Social Movements). This discourse also

included sex and sexuality remaining unequal, containing prejudices and constructing certain groups as 'us and them' (Inequalities & Concern.)

Equality, Change and Social Movements

There was a discourse of a positive change in representations and equality which was perceived to have emerged within this area. These were generally related to the area of sexual orientation and the LGBT movement.

“I think it’s quite powerful to, to see people in a really mainstream way, em, and yeah I think think sexuality is becoming a more mainstream thing and in just looking at how Pride has changed. It’s becoming much more mainstream event.” (Trainee, Transcript 9, Lines 237-239)

“I think its possibly in my experience that thinking of people years ago and I’m talking about 30 years ago, who were struggling with being gay, that would be, there would be more of that than there is now, much more of that. So that’s talked about less, I think because it’s less of an issue out there.

[laughs]” (Clinician, Transcript 3, Lines 147-150)

Past prejudices around sexual orientation were generally constructed as less of a problem, with inequalities being overcome and less need to discuss this area within practice.

A few interviewees constructed views related to their professional or personal responsibility as CP’s to bring social issues into the forefront.

“It’s kind of activated almost some sort of protective or kind of social justice part of me. That actually it’s not ok to let these things slide and we should be there for people to try, try and engender some sort of change in that world, otherwise it then crosses over into the professional and I’m not sure if I hadn’t had those, wonder if I hadn’t had those professional experiences. I’m

wondering if I would have, might have been more passive member of the world. But yeah and to challenge it and em and wonder if my role professionally has given me more power in being able to do that.” (Clinician, Transcript 6, 163-173)

These discourses can be seen to construct CP’s as socially and politically aware. Professional discourses around equality in practice and personal discourses around the role of CP’s as social activist who have a responsibility to work against prejudices position CP’s as liberal and moral in their stance. This discourse as noted by the above quote produces power in advocating for those who are powerless.

Inequalities & Concern

This discourse of sex and sexuality talk being positioned as ‘social and political issues’ was constructed as an area of concern. This was related to issues related to inequalities and ‘us and them’ positioning. This was primarily related to sexual orientation (including transgender issues), during the interviews sexuality was on the whole viewed by professionals as sexual orientation. The positioning of talk related to sexual orientation was viewed by a number of interviewees as ‘us and them.’ With one interviewee describing their frustration of training around sex and sexuality positioning it this way.

“There was no like what are the similarities here, it was like this is your tour of the gays, this is how the gays work.” (Trainee, Transcript 11, P2. Lines).

There was also concern that as these issues became more ‘normalised’ whether bringing these issues into the therapy room was making an issue of something that was no longer a problem.

Talking about issues related to ‘difference’ was constructed as potentially negative to the personal and professional self who did not wish to come across as prejudiced.

“I sometimes find myself, still unsure of, there is difference but do you want to make it an issue or not. So, for them it might not be an issue at all. And I think also for me it’s only really an issue. Em, so does it make it seem a bit more judgemental. So, we are different in this way, so does this make it a problem and things like that.” (Trainee, Transcript 7, Lines 293-300)

Building on these concerns was an awareness of how language can construct truths and power. Interviewees described how their concern about getting their language ‘wrong’ would result in them avoiding talking about these things or being in a politically correct culture would evoke anxiety and concern on talking. CP’s are faced with an ever-changing environment which they have to adapt and change with.

“Because of that, it makes people anxious and sensitive about that and whenever you are in a pc culture, you know a politically correct culture, around you get around all of these subjects [sexuality, sex, race, religion, politics]. It makes people very nervous about their language.” (Clinician. Transcript 1, Lines 265-268)

Context: The NHS Culture

Overview of Discourse: Throughout the interviews a discourse related to the wider cultural and contextual factors which were at play when talking and thinking about sex and sexuality emerged. This discourse including issues related to the priorities and restrictions which are in place when CP’s are working within the NHS and how services run.

NHS Culture

There were various discussions around the external factors which influenced how CP’s worked with and thought about the issues of sex and sexuality. Many interviewees felt the decision on what was brought to session was influenced by

external factors and limitations in what they could offer, rather than their professional opinion and expertise.

“I guess we all adapt to the context we’re in, to a certain extent and it’s not part of what we do at this point in time. I would imagine if we were maybe doing longer term work privately where you were seeing people for much longer potentially...Clinical psychology is very NHS based isn’t it. I think if the culture was different we would respond accordingly.” (Clinician, Transcript 3, Lines 192-195)

Sex and sexuality was typically described as not being a priority within services and there was even concern at time that talking about sex and sexuality was inappropriate within this context.

“I suppose partly, maybe partly an awareness that you are spending NHS funds, which doesn’t mean and therefore shouldn’t include sex, but if it does then it should be purposefully and part of the formulation, part of clinical work.’ (Trainee, Transcript 11, P3, Lines 354-356)

There was also a number of references to other more specialist services with a number of trainees highlighting the fact that these issues tended to get ‘compartmentalised’ and thought of as separate rather than integrated into practice.

This may give certain areas and people more power and also reinforce the problem focused discourse that when you have something wrong you need to be ‘treated’ rather than viewing the individual in a holistic way.

Comparisons

It was interesting that when looking at any differences within the discourses which emerged between qualified clinical psychologists and trainee psychologists no

obvious differences were present. This was also the case when comparing individuals interviews and focus groups where the same themes emerged.

Discussion

The aim of this research was to explore how CP's and trainee psychologists constructed sex and sexuality in their conversations. This analysis found that there were a number of dominating discourses which were present. However, there was some counter discourses which constructed sex and sexuality in different ways, opening up possibilities of how these topics can be spoken about that are different from the dominating discourses.

The Main Discourses

Compared to previous Findings

The dominant discourses, constructed these issues as not a priority for clinical practice, training and services, they were constructed as risky, negative and problem focused. This has been seen in previous research that looked at mental health professionals' perspectives on issues related to sex and sexuality (e.g. Traeen, & Schaller, 2013).

LGBTQ+:

It is interesting that within the interviews, nearly all individuals discussed LGBTQ+. This was despite the research question asking about sex and sexuality within the context of psychological health generally rather than asking about sexual orientation. Many individuals perceived sexuality as being sexual orientation, rather than encompassing other aspects of sexuality. This may be representative of the lack of training as well as indicate the dominant discourses within the profession of what does and doesn't get spoken about.

Previous research has shown sexual orientation is commonly talked about when asking about sex and sexuality amongst mental health professionals. This may reflect the growing discourses within society around equality, the 'LGBTQ+' movement. It may also reflect the discourses which were present within this research around CP's more liberal views and concern about inequalities and stigmatising minority groups.

Gender

There were clear differences within discourses from males and females within the interviews. Males within the interviews described the negativity and risk which others felt about them working with especially female clients. While females spoke about the potential risk themselves and their clients were at.

It is interesting that there has been an increased media coverage over the past couple of years with regards to feminists' movements, equality and the power which males have within society as well as the use of their power. These discourses may be reflecting these current wider political and social debates and movements which are going on outside the therapy room.

The Absent Discourses

The way in which these topics were constructed, resulted in alternatives being silenced and opportunities to open up conversations lost. The counter discourses where sex and sexuality were constructed and viewed as appropriate, healthy and 'normal' was not at the forefront of clinicians and trainee's minds. Contextual, social, political and professional discourses impacted on what was spoken about with certain 'truths' being maintained by those in authority and with power. Historically the importance of sex and sexuality within psychological thinking was viewed as a 'truth' through various theoretical models (e.g. Freud, 1920). At this time those in power used this knowledge to control and treat individuals. The changing economic climate,

NHS culture and increased liberalism in certain context and presence of sex and sexuality within the public sphere has resulted in a change in what ‘truths’ are thought and talked about.

There were a number of areas which had either very limited presence or they were not mentioned at all (subjugated discourses). This included constructions of the importance of wider issues related to sex and sexuality such as healthy sexual functioning, sexual health, a positive outlook on sex and sexual minorities other than LGBT (e.g. BDSM, asexuality), biological views on the topic and certain therapeutic approaches being used within this field.

One discourse which was not present when interviewees constructed what they felt was missing from the discourse was biological understandings of sexual functioning and sexuality. This is interesting based on the professional construction of CP’s as holistic in their understanding of psychological health (e.g. DCP, 2011). This may be due to more dominant discourses emerging in the profession regarding social constructivist positions and attempts to address inequalities and prejudices within society and mental health services.

A biological approach may have become the ‘thing’ that cannot be talked about, due to more recent constructions of sex and sexuality. Essentialist views may be constructed as outdated due to conflict with gender fluidity ideas and transgender issues, which are at the forefront of clinicians thinking. To place sex and sexuality within a biological framework, may be viewed as essentialist by the profession and society and viewed as ‘un-pc’. This appears to have inadvertently resulted in the broader areas of sex and sexuality such as healthy sexual functioning being out of the remit of CP’s work. Previous studies have claimed clinical psychologists tend to hold

more liberal values (e.g. Miller, & Byers, 2012). Therefore, dominating professional and social liberal ‘truths’ may result in biological discourses being closed down.

It is interesting that through conversations counter discourses emerged where clinicians began to question their own practice and the importance which they place upon these issues as well as highlighting times where they had questioned the dominating discourse.

Links to Psychological Theory

In considering the absent discourses within current psychological thinking, it is interesting that despite compassion focussed therapy ideas increasing in popularity (Leaviss & Uttley, 2015) and clinical psychologists training coming from biopsychosocial and life span approaches (DCP, 2012), the core biological drive of sex is currently missed from clinical psychology practice and training.

Implications for Clinical Psychologists

It is important for CP’s to question current practices to determine if they are being dictated by unconscious discourses or informed practice. This could be done in supervision, through extra training or reflective practice. Opening up conversations to elicit personal and professional understandings with regards to these issues will enable clinicians to consider different positions, considering how they construct these truths and how these ‘truths’ have come to be. CP’s could then make informed choices about how they wish to practice and why they ask what they do, when they do, rather than choosing other paths.

In Practice

Due to the role which many CP’s have within teams, they would be ideal candidates to help bring thinking related to these topics into reflective practice groups and meetings. This would help create a space where other mental health professionals

along with CP's could think about asking questions around sex and sexuality within their own practice. Allowing for conversations to be opened up, questioning what obstacles and challenges are present. By opening up a dialogue, concerns and counter discourses which are currently restricted can have a place to be explored.

In Training

It may be useful to have the topics of sex and sexuality integrated into all aspects of the training program. Rather than having lectures that teach on specific sex and sexuality topics, which could have the impact of reinforcing the fact this topic is not core, all lecturers could be asked to consider these topics within their lecture material. Through supervising trainee CP's and trainee CP's shadowing qualified CP's it is vital that modelling takes place. This would help a new generation of CP learn this is what CP's ask about as part of their practice.

Future Research

Discourse Analysis can be seen to offer a helpful way to understand and explore subjects such as sex and sexuality due the contextual and cultural influences which impact on them. It would be interesting to follow up this study by looking at other sources of discourse in different groups. Based on this study mental health clients, the general public, mental health teams, NHS management, Commissioners, supervisors, lecturers were all constructed as impacting on how discourses around these issues were formed. Understanding these discourses may help open up conversations on some of the subjugated discourses within practice and training. Use of interviews and focus groups is only one way of accessing these discourses and the option of analysing lectures, media (e.g. tv programs, news), supervision, therapy sessions would all be alternative methods offering access to different discourses.

Limitations

As with many qualitative approaches, DA within psychological research has become more popular over the years, offering more in depth and richer data to analyse (Marks, Marks & Yardley, 2003). However, discourse analysis still has a number of criticisms related to its methodological rigor and the potential for multiple interpretations. To counter some of these concerns this study has tried to ensure that their analysis is as transparent as possible by including quotes, extracts from a coding manual as well as positioning the researcher within the study.

One of the main practical difficulties in this study was recruitment. Previous quantitative studies around sex and sexuality have shown difficulties in recruitment via surveys. However, qualitative studies did not report on these difficulties, with a previous thematic analysis (Culhane, 2015) reporting on the ease and response rate in recruiting for interviews and focus groups. This was conducted in Ireland though and the cultural differences may have played a role, CP's may have felt it was more important to address these issues where there are more conservatist, religious and legal implications. The lack of uptake in this study may also indicate the current positioning of these topics within the profession within the UK.

It was interesting that despite significantly less males (12% in 2016) entering the clinical psychology profession (CHPCC, 2018), over 30% who took part in this study were male. This therefore may impact on how topics were constructed, especially how gender related discourses emerged through the analysis.

Some of the participants were also known to the researcher. Due to the nature of the topic area this may have limited the freedom and anonymity that participants felt when discussing their thoughts during the interview. This was considered during the recruitment phase of the research and analysis. It was felt that there could also be

advantages to this, where instead of limiting what was said, this instead could create a more informal and freeing environment for participants to feel able to express their opinions.

The analysis that was completed was one interpretation of the data and it is recognised that different interpretations of the data are possible. Therefore, it is important to remember this research is not looking for answers and truths but instead to consider the data within its current context and time.

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Section C
Appendices

Appendix A: CASP Qualitative Checklist

Section A

1.) Was there a clear statement of the aims of the research?

Yes Can't Tell No

2.) Is a qualitative methodology appropriate?

Yes Can't Tell No

Is it worth continuing?

3.) Was the research design appropriate to address the aims of the research?

Yes Can't Tell No

4.) Was the recruitment strategy appropriate to the aims of the research?

Yes Can't Tell No

5.) Was the data collected in a way that addressed the research issue?

Yes Can't Tell No

6.) Has the relationship between researcher and participants been adequately considered?

Yes Can't Tell No

Section B: What are the results?

7.) Have ethical issues been taken into consideration?

Yes Can't Tell No

8.) Was the data analysis sufficiently rigorous?

Yes Can't tell No

9.) Is there a clear statement of findings?

Yes Can't Tell No

Section C: Will the results help locally?

10.) How valuable is the research?

Appendix B: AXIS tool for cross sectional studies

Introduction

1 Were the aims/objectives of the study clear?

Methods

2 Was the study design appropriate for the stated aim(s)?

3 Was the sample size justified?

4 Was the target/reference population clearly defined? (Is it clear who the research was about?)

5 Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?

6 Was the selection process likely to select subjects/participants that were representative

of the target/reference population under investigation?

7 Were measures undertaken to address and categorise non-responders?

8 Were the risk factor and outcome variables measured appropriate to the aims of the study?

9 Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?

10 Is it clear what was used to determine statistical significance and/or precision estimates? (eg, p values, CIs)

11 Were the methods (including statistical methods) sufficiently described to enable them to be repeated?

Results

12 Were the basic data adequately described?

13 Does the response rate raise concerns about non-response bias?

14 If appropriate, was information about non-responders described?

15 Were the results internally consistent?

16 Were the results for the analyses described in the methods, presented?

Discussion

17 Were the authors' discussions and conclusions justified by the results?

18 Were the limitations of the study discussed?

Other

19 Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?

20 Was ethical approval or consent of participants attained?

Appendix C:

This text has been removed from the electronic copy'

Appendix D: Recruitment Letters

D1: Clinical Psychologist

Dear [Clinical Psychologist]

My name is Charlotte Rennie and I am a trainee clinical psychologist from Canterbury Christchurch University.

I am doing my doctorate research project on the discourse around sex, sexuality and psychological health within clinical psychology practice and training.

I would therefore like to invite you to take part in an interview on this topic. The interview is looking at your views on this topic in general, primarily focusing on your work and professional experiences. It is not looking at your own personal sexual experiences. It should take approximately 1 hour to complete. If you think that you may be interested in taking part in this study, then please read the attached information sheet for further information.

This project has been approved by Canterbury Christchurch University research ethics committee. Once you have read the information sheet if you would like to participate then please could you contact me via my University email address: c.l.rennie409@canterbury.ac.uk.

I look forward to hopefully hearing from you soon. In the meant time if you have any questions or comments, then feel free to get in touch via the email above.

Thanks in advance,

Charlotte Rennie.

Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells,
Kent,
TN3 0TF

D2: Trainee Focus Group

Dear Trainees

My name is Charlotte Rennie and I am a trainee clinical psychologist from Canterbury Christ Church University.

I am doing my doctorate research project on the discourse around sex, sexuality and psychological health within clinical psychology practice and training.

I would therefore like to invite you to join a focus group on this topic. The focus group is looking at your views and experiences of working and training. It is not looking at your own personal sexual experiences. The focus group should take approximately 1-1.5 hours to complete. The focus group will be with other trainee clinical psychologists that are currently studying at your University. If you think that you may be interested in taking part in this study, then please read the attached information sheet for further information.

This project has been approved by Canterbury Christ Church University research ethics committee. Once you have read the information sheet if you would like to participate then please could you contact me via my University email address: c.l.rennie409@canterbury.ac.uk.

I look forward to hopefully hearing from you soon. In the meant time if you have any questions or comments, then feel free to get in touch via the email above.

Thanks in advance,

Charlotte

Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells,
Kent,
TN3 0TF

D3: Training Provider Focus Group

Dear Training Providers,

My name is Charlotte Rennie and I am a trainee clinical psychologist from Canterbury Christchurch University.

I am doing my doctorate research project on the discourse around sex, sexuality and psychological health within clinical psychology practice and training.

I would therefore like to invite you to join a focus group on this topic. The focus group is looking at your views and experiences of working and training. It is not looking at your own personal sexual experiences. The focus group should take approximately 1.5 hours to complete. The group will be with other training providers.

If you think that you may be interested in taking part in this study, then please read the attached information sheet for further information.

This project has been approved by Canterbury Christchurch University research ethics committee. Once you have read the information sheet if you would like to participate then please could you contact me via my University email address: c.l.rennie409@canterbury.ac.uk.

I look forward to hopefully hearing from you soon. In the meant time if you have any questions or comments, then feel free to get in touch via the email above.

Thanks in advance,

Charlotte Rennie.

Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells,
Kent,
TN3 0TF

D4: Training Provider – online survey

Dear Training Provider,

My name is Charlotte Rennie and I am a trainee clinical psychologist from Canterbury Christchurch University.

I am doing my doctorate research project on the discourse around sex, sexuality and psychological health within clinical psychology practice and training.

I would therefore like to invite you to complete a questionnaire on this topic area. I am also looking for a few people to complete some individuals interview if they would be interested in doing so (this can be wither via phone or skype.)

If you think that you may be interested in taking part in this study, then please read the attached information sheet for further information. This project has been approved by Canterbury Christchurch University research ethics committee.

Once you have read the information sheet if you would like to participate then please click on the link. There are 10 questions in total: <https://www.surveymonkey.co.uk/r/WBDQJ6B>

If you have any questions then please feel free contact me via my University email address: c.l.rennie409@canterbury.ac.uk.

Thanks in advance,

Charlotte Rennie.

Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells,
Kent,
TN3 0TF

Appendix E: Consent Form



Salomons Centre for Applied Psychology
Faculty of Social and Applied Sciences

Centre Number:
Study Number:
Participant Identification Number for this Study:

CONSENT FORM

Title of Project: The discourses around sex, sexuality and psychological health, within clinical psychology practice and training in the UK.

Name of Researcher: Charlotte Rennie

Please Initial box:

By signing this form you are agreeing to the following statements:

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.
3. I understand that relevant sections of data collected during the study may be looked at by the lead supervisor Professor Margie Callahan. I give permission for these individuals to have access to my data.
4. I agree that anonymised quotes from my interview may be used in published reports of the study findings.
6. I agree to take part in the above study.

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

Appendix F: Research Information Sheets

F1: Practicing Clinical Psychologists



Salomons Centre for Applied Psychology
Faculty of Social and Applied Sciences

Participant Information Sheet: Individual Interviews Practicing Clinical Psychologists

Study Title:

The discourses around sex, sexuality and psychological health, within clinical psychology practice and training in the UK.

This research study is being sponsored by the Salomons Centre for Applied Psychology at Canterbury Christ Church University (CCCU) and conducted by Charlotte Rennie.

Overview:

Hello,

Thank you for taking the time to read this invitation to take part in a research study. My name is Charlotte Rennie and I am a trainee clinical psychologist at Canterbury Christ Church University. I am conducting my research project in the area of sex, sexuality and psychological wellbeing under the supervision of Professor Margie Callanan and I would like to invite you to take part. Before you decide it is important that you understand why the research is being done and what it would involve for you.

This information sheet is divided into two parts:

Part 1: Tells you the purpose of this study and what will happen to you if you take part.

Part 2: Gives you more detailed information about the conduct of the study.

Part 1:

What is the purpose of the study?

To gain insight and understanding into the discourse on sex, sexuality and psychological health within the UK. This study is particularly looking at how clinical psychology as a profession is viewing this area within practice and training.

Why have I been invited?

This study seeks to gather a broad representation of different views within clinical psychology. The study is capturing views from a number of different

sources. Individual interviews are being completed with practicing clinical psychologists. While focus groups are being used to capture the views of both trainee clinical psychologists and clinical psychology training providers.

You have been asked to take part in this study as you are currently practicing as a clinical psychologist within the UK.

To Participate in the Research, you must:

Be an HPC registered clinical psychologist.

Currently be working in the UK as a clinical psychologist.

Have been qualified for at least 6 months.

Not be working solely within a child and adolescent or learning disability service.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form and fill in some demographic details. You are free to withdraw at any time, without giving a reason up until the interview is anonymised.

What will happen to me if I take part?

This study will involve participating in individual interviews with myself. There will be a number of open questions asked around the topic being investigated. There are no right or wrong views. This study is interested in what you think on a number of different issues.

The interview is not expected to take longer than 1 to 1.5 hours and will take place over one episode. The interview will be audio-recorded using audio-recording equipment.

Expenses and payments

No payment will be received for taking part in this study.

What will I have to do?

Prior to the interview taking place you will be required to sign a consent form and complete a form asking you some demographic information.

The interview will be asking you to answer a number of open questions on your views and beliefs relevant to the study question.

What are the possible disadvantages and risks of taking part:

This study does not seek to ask you about your own personal sexual experiences. Instead the questions are looking to capture an overview of your beliefs about certain aspects related to sexuality and sexual activity with a focus on practice and training in clinical psychology.

Disclosure:

The usual limits to confidentiality apply with this study. If any information is disclosed that puts yourself or others at risk, then this will be disclosed to the relevant people.

If you have any questions or concerns about this, then please do not hesitate to ask.

What are the possible benefits of taking part?

This study seeks to build insight, understanding and knowledge.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 below, before making any decision.

Part 2:

What will happen if I don't want to carry on with the study?

Your participation in this study is voluntary and you have the right to withdraw from the study at any time prior to the interview being anonymised.

Will my taking part in this study be kept confidential?

All data and personal information will be stored securely in accordance with the Data Protection Act and the University's own data protection requirements. This includes the data being anonymised. After completion of the project the data will be stored securely and kept for 5 years after which time it will be destroyed.

Interviews will be collected via audio-recording equipment. These recordings will be stored on either password protected USB sticks and/or a password protected computer. Transcribed audio-recordings will be anonymised. The use of a transcriber may be used to assist in the transcription task. They will be required to follow confidentiality and data protection guidelines. They will not be given anyone's personal identifiable information.

The only people who will have access to identifiable data will be myself and my supervisor, Professor Margie Callanan.

All information which is collected about you during the course of the research will be kept strictly confidential except in circumstances linked to disclosure as described in part 1. You have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?

I will be writing up the findings into a formal report that will be submitted to CCCU as part of my training to become a clinical psychologist. It is intended that the results of the study will be published within an academic journal. The findings will also be shared with psychologists, training providers and other interested parties to help relevant groups gain more understanding into this area.

Who has reviewed the study?

This study has been reviewed and given approval by Canterbury Christ Church University Research Ethics Committee.

Complaints & Problems

If you have a concern or problem about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions via the contact details below.

If you remain unhappy and wish to complain formally, you can do so by contacting our Research Director, Professor Paul Camic, on paul.camic@canterbury.ac.uk.

Further information and contact details

Please note that you will be given a copy of this information sheet for your records and a signed consent form to keep.

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01892 507673. Please say that the message is for me Charlotte Rennie and leave a contact number so that I can get back to you. Alternatively, you can send me an email at c.l.rennie409@canterbury.ac.uk or write to me at:

Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells, Kent TN3 0TF

Thank you for taking the time to read this information sheet.

Best Wishes,

Charlotte Rennie, Trainee Clinical Psychologist.

F2: Focus Group Information Sheet



Salomons Centre for Applied Psychology
Faculty of Social and Applied Sciences

Participant Information Sheet: Focus Groups Trainee Clinical Psychologists

Study Title:

The discourses around sex, sexuality and psychological health, within clinical psychology practice and training in the UK.

This research study is being sponsored by the Salomons Centre for Applied Psychology at Canterbury Christ Church University (CCCU) and conducted by Charlotte Rennie.

Overview:

Hello,

Thank you for taking the time to read this invitation to take part in a research study. My name is Charlotte Rennie and I am a trainee clinical psychologist at Canterbury Christ Church University. I am conducting my research project in the area of sex, sexuality and psychological health under the supervision of Professor Margie Callanan and I would like to invite you to take part. Before you decide it is important that you understand why the research is being done and what it would involve for you.

This information sheet is divided into two parts:

Part 1: Tells you the purpose of this study and what will happen to you if you take part.

Part 2: Gives you more detailed information about the conduct of the study.

Part 1:

What is the purpose of the study?

To gain insight and understanding into the discourse on sex, sexuality and psychological health within the UK. This study is particularly looking at how clinical psychology as a profession is viewing this area within practice and training.

Why have I been invited?

This study seeks to gather a broad representation of different views within clinical psychology. The study is capturing views from a number of different sources. Individual interviews are being completed with practicing clinical psychologists. While focus groups are being used to capture the views of both trainee clinical psychologists and clinical psychology training providers.

You have been asked to take part in this study as you are currently training as a clinical psychologist within the UK.

To Participate in the Research, you must:

Be a current trainee clinical psychologist studying within the UK.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw up until the focus group takes place, you do not have to give a reason for doing so.

What will happen to me if I take part?

This study will involve participating in a focus group where there will be a number of open questions asked around the topic being investigated. There are no right or wrong views. This study is interested in what you think on a number of different issues.

The focus group is expected to take approximately 1 to 1.5 hours to complete and will take place over one episode. The focus group will be audio-recorded using audio-recording equipment. The number in the group is expected to be between 5-10 participants. All other participants in your group will be clinical psychology trainees from your University.

Expenses and payments

No payment will be made to participants for taking part in this study.

What will I have to do?

Prior to the focus group you will be required to sign a consent form and complete a form asking you some demographic details.

The focus groups will be asking you to answer a number of open questions on your views and beliefs, which are relevant to the study question.

What are the possible disadvantages and risks of taking part:

This study does not seek to ask you about your own personal sexual experiences. Instead the questions are looking to capture an overview of your beliefs about certain aspects related to sexuality and sexual activity linked to training in clinical psychology.

Disclosure:

The usual limits to confidentiality apply with this study. If any information is disclosed that puts yourself or others at risk, then this will be disclosed to the relevant people.

If you have any questions or concerns about this, then please do not hesitate to ask me.

What are the possible benefits of taking part?

This study seeks to build insight, understanding and knowledge.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 below, before making any decision.

Part 2:**What will happen if I don't want to carry on with the study?**

Your participation in this study is voluntary and you have the right to withdraw from the study at any time prior to the focus group taking place.

Will my taking part in this study be kept confidential?

All data and personal information will be stored securely in accordance with the Data Protection Act and the University's own data protection requirements. This includes the data being anonymised. After completion of the project the data will be stored securely and kept for 5 years after which time it will be destroyed.

Interviews will be collected via audio-recording equipment. These recordings will be stored on either password protected USB sticks and/or a password protected computer. Transcribed audio-recordings will be anonymised. The use of a transcriber may be used to assist in the transcription task. They will be required to follow confidentiality and data protection guidelines. They will not be given anyone's personal identifiable information.

The only people who will have access to identifiable data will be myself and my supervisor, Professor Margie Callanan.

All information which is collected about you during the course of the research will be kept strictly confidential. You have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?

I will be writing up the findings into a formal report that will be submitted to Canterbury Christ Church University as part of my training to become a clinical psychologist. It is intended that the results of the study will be published within an academic journal. The findings will also be shared with psychologists, training providers and other interested parties to help relevant groups gain more understanding into this area.

Who has reviewed the study?

This study has been reviewed and given approval by Canterbury Christ Church University Research Ethics Committee.

Complaints & Problems

If you have a concern or problem about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions via the contact details below.

If you remain unhappy and wish to complain formally, you can do so by contacting our Research Director, Professor Paul Camic, on paul.camic@canterbury.ac.uk.

Further information and contact details

Please note that you will be given a copy of this information sheet for your records and a signed consent form to keep.

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone

line at 01892 507673. Please say that the message is for me Charlotte Rennie and leave a contact number so that I can get back to you. Alternatively, you can send me an email at c.l.rennie409@canterbury.ac.uk or write to me at:

Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells, Kent TN3 0TF

Thank you for taking the time to read this information sheet.

Best Wishes,

Charlotte Rennie, Trainee Clinical Psychologist.

F3: Training Provider Information Sheet



Salomons Centre for Applied Psychology
Faculty of Social and Applied Sciences

Participant Information Sheet: Training Providers

Study Title:

The discourses around sex, sexuality and psychological health, within clinical psychology practice and training in the UK.

This research study is being sponsored by the Salomons Centre for Applied Psychology at Canterbury Christ Church University (CCCU) and conducted by Charlotte Rennie.

Overview:

Hello,

Thank you for taking the time to read this invitation to take part in a research study. My name is Charlotte Rennie and I am a trainee clinical psychologist at Canterbury Christ Church University. I am conducting my research project in the area of sexuality and psychological health under the supervision of Professor Margie Callanan and I would like to invite you to take part. Before you decide it is important that you understand why the research is being done and what it would involve for you.

This information sheet is divided into two parts:

Part 1: Tells you the purpose of this study and what will happen to you if you take part.

Part 2: Gives you more detailed information about the conduct of the study.

Part 1:

What is the purpose of the study?

To gain insight and understanding into the discourse on sex, sexuality and psychological health within the UK. This study is particularly looking at how clinical psychology as a profession is viewing this area within practice and training.

Why have I been invited?

This study seeks to gather a broad representation of different views within clinical psychology. The study is capturing views from a number of different sources. Interviews, focus groups and questionnaires are being completed with practicing clinical psychologists, trainee clinical psychologists and clinical psychology training providers.

You have been asked to take part in this study as you are currently a training provider for clinical psychology within the UK.

To Participate in the Research, you must:

Be an HCPC registered clinical psychologist.

Be currently working in the UK providing training to clinical psychologists.

Have been working within this field for at least 6 months.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, then completing the online questionnaire will constitute your consent to this part of the study. If you are happy to take part in an individual interview you will be asked to sign a consent form. You are free to withdraw at any time, up until the interviews/questionnaires are anonymised.

What will happen to me if I take part?

This study will involve completing a questionnaire online with a number of questions around the topic being investigated. If you choose to also complete an individual interview this will have a number of open questions asked around the topic being investigated. There are no right or wrong answers. This study is interested in what you think on a number of different issues.

The individual interview is expected to take approximately one hour to complete and will take place on one occasion. The interview will be audio-recorded for the purpose of transcribing.

Expenses and payments

No payment is offered for taking part in this study, though all participants will be sent a short report of the study's outcomes.

What will I have to do?

You will be sent a link to an online questionnaire and have a number of questions to complete. If you choose to take part in an individual interview you will be required to sign a consent form and complete a form asking you some demographic details. You will also be asked a number of open questions on your views and beliefs which are relevant to the study question.

What are the possible disadvantages and risks of taking part:

This study does not seek to ask you about your own personal sexual experiences. Instead the questions are looking to capture an overview of your beliefs about certain aspects related to sexuality and sexual activity with a focus on training in clinical psychology.

Disclosure:

The usual limits to confidentiality apply with this study. If any information is disclosed that puts yourself or others at risk, then this will be disclosed to the relevant people.

If you have any questions or concerns about this, then please do not hesitate to ask me.

What are the possible benefits of taking part?

This study seeks to build insight, understanding and knowledge that could enhance approaches to training or practise in clinical psychology.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 below, before making any decision.

Part 2:

What will happen if I don't want to carry on with the study?

Your participation in this study is voluntary and you have the right to withdraw from the study at any time up until the interviews/questionnaires are anonymised.

Will my taking part in this study be kept confidential?

All data and personal information will be stored securely in accordance with the Data Protection Act and the University's own data protection requirements. This includes the data being anonymised. After completion of the project the data will be stored securely and kept for 5 years after which time they will be destroyed.

Interviews will be transcribed via audio-recording equipment. These recordings will be stored on either password protected USB sticks and/or a password protected computer. Transcribed audio-recordings will be anonymised. The use of a transcriber may be used to assist in the transcription task. They will be required to follow confidentiality and data protection guidelines. They will not be given anyone's personal identifiable information.

The only people who will have access to identifiable data will be myself and my supervisor, Professor Margie Callanan.

Anonymised quotes from questionnaires/interviews may be used in published reports of the study findings.

All information that is collected about you during the course of the research will be kept strictly confidential. You have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?

I will be writing up the findings into a formal report that will be submitted to Canterbury Christ Church University as part of my training to become a clinical psychologist. It is intended that the results of the study will be published within an academic journal. The findings will also be shared with psychologists, training providers and other interested parties to help relevant groups gain more understanding into this area.

Who has reviewed the study?

This study has been reviewed and given approval by Canterbury Christ Church University Research Ethics Committee.

Complaints & Problems

If you have a concern or problem about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions via the contact details below.

If you remain unhappy and wish to complain formally, you can do so by contacting our Research Director, Professor Paul Camic, on paul.camic@canterbury.ac.uk.

Further information and contact details

Please note that you will be given a copy of this information sheet for your records and a signed consent form to keep.

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01892 507673. Please say that the message is for me Charlotte Rennie and leave a contact number so that I can get back to you. Alternatively, you can send me an email at c.l.rennie409@canterbury.ac.uk or write to me at:

Salomons Centre for Applied Psychology
Canterbury Christ Church University
Broomhill Road
Tunbridge Wells, Kent TN3 0TF

Thank you for taking the time to read this information sheet.

Best Wishes,

Charlotte Rennie, Trainee Clinical Psychologist.

F4: Trainee Individual Interview



Salomons Centre for Applied Psychology
Faculty of Social and Applied Sciences

Participant Information Sheet: Individual Interviews Trainee Clinical Psychologists

Study Title:

The discourses around sex, sexuality and psychological health, within clinical psychology practice and training in the UK.

This research study is being sponsored by the Salomons Centre for Applied Psychology at Canterbury Christ Church University (CCCU) and conducted by Charlotte Rennie.

Overview:

Hello,

Thank you for taking the time to read this invitation to take part in a research study. My name is Charlotte Rennie and I am a trainee clinical psychologist at Canterbury Christ Church University. I am conducting my research project in the area of sex, sexuality and psychological health under the supervision of Professor Margie Callanan and I would like to invite you to take part. Before you decide it is important that you understand why the research is being done and what it would involve for you.

This information sheet is divided into two parts:

Part 1: Tells you the purpose of this study and what will happen to you if you take part.

Part 2: Gives you more detailed information about the conduct of the study.

Part 1:

What is the purpose of the study?

To gain insight and understanding into the discourse on sex, sexuality and psychological health within the UK. This study is particularly looking at how clinical psychology as a profession is viewing this area within practice and training.

Why have I been invited?

This study seeks to gather a broad representation of different views within clinical psychology. The study is capturing views from a number of different sources. Individual interviews and focus groups are being completed with practicing clinical psychologists, trainee clinical psychologists and clinical psychology training providers.

You have been asked to take part in this study as you are currently training as a clinical psychologist within the UK.

To Participate in the Research, you must:

Be a current trainee clinical psychologist studying within the UK.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw up until the interview takes place, you do not have to give a reason for doing so.

What will happen to me if I take part?

This study will involve participating in an interview where there will be a number of open questions asked around the topic being investigated. There are no right or wrong views. This study is interested in what you think on a number of different issues.

The interview is expected to take approximately 1 hour to complete and will take place over one episode. The interview will be audio-recorded using audio-recording equipment.

Expenses and payments

No payment will be made to participants for taking part in this study.

What will I have to do?

Prior to the interview you will be required to sign a consent form and complete a form asking you some demographic details.

The interview will be asking you to answer a number of open questions on your views and beliefs, which are relevant to the study question.

What are the possible disadvantages and risks of taking part:

This study does not seek to ask you about your own personal sexual experiences. Instead the questions are looking to capture an overview of your beliefs about certain aspects related to sexuality and sexual activity with a focus on training and practice within clinical psychology.

Disclosure:

The usual limits to confidentiality apply with this study. If any information is disclosed that puts yourself or others at risk, then this will be disclosed to the relevant people.

If you have any questions or concerns about this, then please do not hesitate to ask me.

What are the possible benefits of taking part?

This study seeks to build insight, understanding and knowledge.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 below, before making any decision.

Part 2:

What will happen if I don't want to carry on with the study?

Your participation in this study is voluntary and you have the right to withdraw from the study up to the point of the interview being anonymised.

Will my taking part in this study be kept confidential?

All data and personal information will be stored securely in accordance with the Data Protection Act and the University's own data protection requirements. This includes the data being anonymised. After completion of the project the data will be stored securely and kept for 5 years after which time it will be destroyed.

Interviews will be collected via audio-recording equipment. These recordings will be stored on either password protected USB sticks and/or a password protected computer. Transcribed audio-recordings will be anonymised. The use of a transcriber may be used to assist in the transcription task. They will be required to follow confidentiality and data protection guidelines. They will not be given anyone's personal identifiable information.

The only people who will have access to identifiable data will be myself and my supervisor, Professor Margie Callanan.

All information which is collected about you during the course of the research will be kept strictly confidential. You have the right to check the accuracy of data held about you and correct any errors.

What will happen to the results of the research study?

I will be writing up the findings into a formal report that will be submitted to Canterbury Christ Church University as part of my training to become a clinical psychologist. It is intended that the results of the study will be published within an academic journal. The findings will also be shared with psychologists, training providers and other interested parties to help relevant groups gain more understanding into this area.

Who has reviewed the study?

This study has been reviewed and given approval by Canterbury Christ Church University Research Ethics Committee.

Complaints & Problems

If you have a concern or problem about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions via the contact details below.

If you remain unhappy and wish to complain formally, you can do so by contacting our Research Director, Professor Paul Camic, on paul.camic@canterbury.ac.uk.

Further information and contact details

Please note that you will be given a copy of this information sheet for your records and a signed consent form to keep.

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01892 507673. Please say that the message is for me Charlotte Rennie and leave a contact number so that I can get back to you. Alternatively, you can send me an email at c.l.rennie409@canterbury.ac.uk or write to me at:

Salomons Centre for Applied Psychology

Canterbury Christ Church University
Broomhill Road
Tunbridge Wells, Kent TN3 0TF

Thank you for taking the time to read this information sheet.

Best Wishes,
Charlotte Rennie, Trainee Clinical Psychologist.

Appendix G: Demographics

G1: Clinical Psychologist

Demographics: Practicing Clinical Psychologists

Participant Name.....

Sex:	Female	Male	Other_____	Prefer not to say				
Age:	19-24	25-34	35-44	45-54	55-64	65-74	75+	Prefer not to say
Ethnicity:	white/British – white/Irish - white/Caribbean - white/African- white/Asian - white/other – Indian – Pakistani – Bangladeshi – Asian other – Caribbean – African - black other – Chinese – other – Prefer not to say							
Religion:	Christian	Catholic	Buddhist	Hindu	Jewish	Muslim	Sikh	Other_____
	Prefer not to say	NA						

Country of Undergraduate Degree: _____
Any other Qualifications other than DClIn Training? _____

Preferred Models*: Cognitive/Behavioural Psychodynamic Systemic
Community Integrative Other

Service setting*: Community Primary Care Secondary In-
patient/Residential

Area of Work (e.g. CMHT; Sexual Health) _____

Have you worked in any other areas? If yes can you give details (areas/length of time):

How many Years since Qualified?

Country Undertook DClIn Training?

Any Specific Training in Sexuality/Sexual Functioning?

* Tick each category that applies

G2: Demographics

Demographics

Participant Name.....

Sex:	Female	Male	Other_____	Prefer not to say				
Age:	19-24	25-34	35-44	45-54	55-64	65-74	75+	Prefer not to say
Ethnicity:	white/British – white/Irish - white/Caribbean - white/African- white/Asian –							
	white/other – Indian – Pakistani – Bangladeshi – Asian other –							
	Caribbean – African - black other – Chinese – other – Prefer not to say							
Religion:	Christian	Catholic	Buddhist	Hindu	Jewish	Muslim	Sikh	Other_____
	Prefer not to say	NA						

Country of Undergraduate Degree: _____
Any other Qualifications other than DCLin Training? _____

Year of Study:	1st Year	2nd Year	3rd Year
University Currently Studying at:	CCCU	Southampton	Royal Holloway
	Oxford	Surrey	

* Tick each category that applies

Appendix H: Interview Schedules

H1: Clinical Psychologists

INTERVIEW SCHEDULE FOR CLINICAL PSYCHOLOGISTS

QUESTIONS

- 1.) I am interested in hearing about whether there are any reasons that you chose to take part in this particular study today?
- 2.) What thoughts come to mind when you think about sex and sexuality within the context of your professional role?
- 3.) What are your thoughts on psychological health within the context of your professional role?
- 4.) Within your professional role when you think about sex, sexuality and psychological health together what comes to mind?
- 2.) What thoughts come to mind when you think about sex and sexuality?
- 3.) What thoughts come to mind when you think about psychological health?
- 4.) When you think about sex, sexuality and psychological health together what comes to mind?
- 8.) What are your thoughts and experiences of asking questions around these issues within a typical psychological assessment?
- 9.) Are there any specific contexts that you would choose to discuss sex and sexuality in the therapy room?
- 10.) Are there contexts when you would choose not to talk about sex and sexuality in the therapy room?
- 11.) When was the last time you spoke about these issues with a client and could you give a brief summary of what you spoke about?

- 12.) Do you have any reflections or thoughts about how you position these topics within your own practice?
- 13.) Have your views on this topic changed over time and if so what do you think has influenced this?
- 14.) What are your thoughts on how the topic of sex and sexuality is positioned within the clinical psychology profession?
- 15.) Do you think there are any aspects of sex and sexuality that get more attention within practice or training?
- 16.) Do you think there are any aspects of sex and sexuality that are particularly missed or not spoken about within practice and training?
- 17.) Thinking about what does and doesn't get attention what do you think influences this?
- 18.) In practice do you think these topics should be positioned more, less or do you think it's about right?
- 19.) What are your thoughts on clinical psychologists addressing issues related to sex and sexuality within the therapy room?
- 20.) What do you think influences your views on this topic as a professional?
- 21.) What are your thoughts on how you see sex and sexuality positioned within mental health services?
- 22.) Do you have any other views about this area which you feel haven't been covered?

H2: Individual Interview Schedule 1st Year Trainees

INTERVIEW SCHEDULE FOR TRAINEE CLINICAL PSYCHOLOGISTS 1st years

QUESTIONS

- 1.) I am interested in hearing about the reasons that you chose to take part in this particular study today?
- 2.) What thoughts come to mind when people think about sex and sexuality within the context of your role as a trainee?
- 3.) What about your thoughts on psychological health within the context of your role as a trainee?
- 4.) Within your professional role when you think about sex, sexuality and psychological health together what comes to mind?
- 5.) What thoughts come to mind when people think about sex and sexuality in day to day life?
- 6.) What about when you think about psychological health in day to day life?
- 7.) When you think about sex, sexuality and psychological health together what comes to mind?
- 8.) Had you thought about sex and sexuality being part of what would be covered in your training?
- 9.) Did you have any thoughts on how the topics related to sex and sexuality are positioned within your training program before you started the training program?
- 10.) What have your experiences been so far on the course of these topics in training?
- 11.) Do you think there is particular areas that would have been useful to know about at this early stage of your training with regards to sex and sexuality?
- 12.) What do you think influences what has or hasn't been covered so far?

- 12.) What about your thoughts on how topics related to sex and sexuality are positioned within practice?
- 13.) Do you think there are any aspects of sex and sexuality that get more attention within practice than others?
- 14.) Do you think there are any aspects of sex and sexuality that are particularly missed or not spoken about within practice?
- 15.) What do you think influences what does and doesn't get attention?
- 16.) With regards to sex and sexuality are there times in practice that you feel you have inadequate training?
- 17.) Can you tell me about the sort of times you feel this is the case?
- 18.) Do people have any specific examples from practice that you can recall that you can tell me about?
- 19.) Has any of your views on this topic changed during the course of you gaining experience to get on to the clinical psychology training or since you have started the course?
- 20.) If so, what do you think has influenced this?
- 21.) What do you think influences your views on the topic of sex and sexuality as a clinical psychology trainee?
- 22.) Do you have any other views about this area which you feel haven't been covered?

H3: Individual Interview Schedule - Trainees

INTERVIEW SCHEDULE FOR TRAINEE CLINICAL PSYCHOLOGISTS

QUESTIONS

- 1.) I am interested in hearing about the reasons that everyone chose to take part in this particular study today?
- 2.) What thoughts come to mind when people think about sex and sexuality within the context of your role as a trainee?
- 3.) What about your thoughts on psychological health within the context of your role as a trainee?
- 4.) Within your professional role when you think about sex, sexuality and psychological health together what comes to mind?
- 5.) What thoughts come to mind when people think about sex and sexuality in day to day life?
- 6.) What about when you think about psychological health in day to day life?
- 7.) When you think about sex, sexuality and psychological health together what comes to mind?
- 8.) What are your thoughts on how the topics related to sex and sexuality are positioned within your training program?
- 9.) Do you think there are any aspects of sex and sexuality that get more attention within your training program?
- 10.) Do you think there are any aspects of sex and sexuality that are particularly missed or not spoken about within training your training program?
- 11.) What do you think influences what does and doesn't get attention?

- 12.) What about your thoughts on how topics related to sex and sexuality are positioned within practice?
- 13.) Do you think there are any aspects of sex and sexuality that get more attention within practice than others?
- 14.) Do you think there are any aspects of sex and sexuality that are particularly missed or not spoken about within practice?
- 15.) What do you think influences what does and doesn't get attention?
- 16.) With regards to sex and sexuality are there times in practice that you feel you have inadequate training?
- 17.) Can you tell me about the sort of times you feel this is the case?
- 18.) Do people have any specific examples from practice that you can recall that you can tell me about?
- 19.) Has any of your views on this topic changed during the course of clinical psychology training so far?
- 20.) If so, what do you think has influenced this?
- 21.) What do you think influences your views on the topic of sex and sexuality as a clinical psychology trainee?
- 22.) Do you have any other views about this area which you feel haven't been covered?

H4: Focus Group Interview Schedule – Trainees

INTERVIEW SCHEDULE FOR TRAINEE CLINICAL PSYCHOLOGISTS **QUESTIONS**

- 1.) I am interested in hearing about the reasons that everyone chose to take part in this particular study today?
- 2.) What thoughts come to mind when people think about sex and sexuality within the context of your role as a trainee?
- 3.) What about your thoughts on psychological health within the context of your role as a trainee?
- 4.) Within your professional role when you think about sex, sexuality and psychological health together what comes to mind?
- 5.) What thoughts come to mind when people think about sex and sexuality in day to day life?
- 6.) What about when you think about psychological health in day to day life?
- 7.) When you think about sex, sexuality and psychological health together what comes to mind?
- 8.) What are your thoughts on how the topics related to sex and sexuality are positioned within your training program?
- 9.) Do you think there are any aspects of sex and sexuality that get more attention within your training program?
- 10.) Do you think there are any aspects of sex and sexuality that are particularly missed or not spoken about within training your training program?
- 11.) What do you think influences what does and doesn't get attention?
- 12.) What about your thoughts on how topics related to sex and sexuality are positioned within practice?
- 13.) Do you think there are any aspects of sex and sexuality that get more attention within practice than others?

- 14.) Do you think there are any aspects of sex and sexuality that are particularly missed or not spoken about within practice?
- 15.) What do you think influences what does and doesn't get attention?
- 16.) With regards to sex and sexuality are there times in practice that you feel you have inadequate training?
- 17.) Can you tell me about the sort of times you feel this is the case?
- 18.) Do people have any specific examples from practice that you can recall that you can tell me about?
- 19.) Has any of your views on this topic changed during the course of clinical psychology training so far?
- 20.) If so, what do you think has influenced this?
- 21.) What do you think influences your views on the topic of sex and sexuality as a clinical psychology trainee?
- 22.) Do you have any other views about this area which you feel haven't been covered?

Appendix I: Online Survey

Before completing the following questions please make sure you have read the information sheet about this research study. By continuing with this questionnaire, you are consenting to understanding and agreeing to the information within the information sheet. When questions refer to sex and sexuality. Please include all elements such as sexual functioning, attraction and desire NOT JUST sexual orientation.

1. Which University are you a training provider at?
2. What elements relating to sex and sexuality are included in your training programme?
3. In your teaching in Assessment and Formulation do you include topics related to sex and sexuality?
4. Do you consider sex and sexuality key dimensions to psychological health?
5. What are the key elements to psychological health according to the philosophy of your training programme?
6. How is both sex and sexuality positioned within your training programme?
7. Do you think the training you provide on sexual functioning and sexuality is sufficient for sound psychological assessments?
8. In general do you think that sex and sexuality are positioned within clinical psychologists thinking?
9. Do you think more attention to sex and sexuality would aid clinical practice?
10. Please leave any other comments on the topic that you would like to offer in the box provided. If you would be interested in taking part in an interview on this topic. (This can be via phone or Skype.) If you would like to take part then please also leave your email in the box provided.

Many thanks for your time.

Appendix J: Debrief

Debrief

The following questions will not form part of the transcribed data analysis but I wanted to check that you/everyone is happy with the process so far and if there is any feedback which would be helpful for me to think about in future focus groups/interviews.

- 1.) Do you have any questions or comments about the focus group/interview which you have taken part in today?
- 2.) Do you have any concerns or anything that you think would be helpful to change?

If anyone would like to discuss any aspect of the study on an individual basis, then please feel free to stay behind. Alternatively, you can contact me at a later date via the details on the information sheet.

As stated in the information sheet if you have any complaints that you would like to make then you can contact myself or use the alternative details provided in the information sheet.

Once again thank you for your time.

Appendix K: Abridged Research Diary

Research Diary

Meeting with external Supervisor

Met with external supervisor, who has an interest in DA, for the first time today. Had the aim of discussing ideas and ask a number of questions about the DA approach.

Was really interesting, have been given some suggested reading and making me think about what philosophical perspective I believe, why I have come to believe this and what perspective I wish to come to the study from.

Have planned to work on interview and focus groups questions and to then discuss again in the context of doing DA.

I am also aware that I need to decide which DA approach I wish to use, find this idea quite overwhelming as there seems to be quite a few and on initial readings it appeared difficult to unpick some from the other.

Pilot Focus groups/Interviews

Really enjoyed trialling out both the focus group and the individual interview, got some really useful feedback which has helped me think about both the questions, ordering of the questions and general feelings on the topic. Feeling optimistic and looking forward to getting started.

Feel a bit more nervous about interviewing training providers than the other groups but have planned to complete the focus groups for trainees first as feel more comfortable interviewing my peers.

Initial Recruitment

Little concerned at how difficult it has been to recruit participants for the trainee focus group as thought this would be an easy group to recruit too as planning especially as planning on going to Universities to make this as convenient as possible for people.

Thought the topic would be viewed as interesting but now wondering if the topic might put people off, or maybe it is just because everyone is very busy, as aware other trainees are having difficulties recruiting.

I am also surprised at some of the barriers to reaching students due to procedures for accessing students. However, those Universities that have been happy to send out emails, have been really helpful which is making life a bit easier.

Hopeful the Conference application will allow for me to reach a good number of training providers from different Universities at the same time. Will also be glad that due to the timing of the Conference I will hopefully have built my confidence up with interviewing and the focus group format by completing the majority of the trainee and clinicians by then.

Later Recruitment

Managed to get 8 people from 1 University to complete a focus group, this went really well and was pleased at how many participants I managed to get from here in the end.

Have however had to extended the number of Universities I am asking, due to the poor recruitment, with no more than 2 people from 2 other Universities offering their help.

Surprised despite extending this, no response from the majority of Universities.

I am going to have to speak with supervisor on how to go forward. Think I will need to convert to individual interviews instead, if the trainees who offered to do focus group would be happy to do an individual interview.

At least have found recruiting of practicing's clinical psychologists was easier than I thought and have had 6 clinicians offer their time. Just have to plan suitable times venues as some of the interviews are quite far away from my home base. Have

contemplated doing Skype or phone due to this, but on offering options, all clinicians have requested a face to face.

The Initial Interviews

Really enjoyed the first focus group, time was a little pressured as I was aware people had to get back to lectures. However, felt everyone got a chance to talk and felt some interesting points came up. Surprised at how many males were in the group (nearly half) as males – something to think about in the discussion.

Was difficult to know how many further questions to ask. Interested in further points but felt reluctant to interject as didn't want to lead the conversation down a path I think is important rather than the interviewees. Also noted that people interpret the questions very differently and many people seem to equate sexuality as sexual orientation. Need to think about whether I try and highlight the fact I am encompassing all areas of sexuality and this is something to think about. However, it seems interesting in itself that this is what people think of when they think about sexuality and are not considering other aspects.

Winter 2016-17

Seem to be constantly ill and trying to managed university, placement, travel and recruitment and getting started on my introduction. Really wanted to be much further ahead than I am. But feels like I am just going to have to focus on getting through this placement, submitting assignments and try and do as much as I can with my MRP.

Final Trainee Interview:

So pleased on attending a University today with the aim of completing 2 individuals interviews was able to recruit 2 more people for the same time as one of the trainees who was already attending. Small focus group but found this a really good size for having a conversation. Compared to the larger focus group, there was less pressure for

everyone speaking and felt really easy and flowing. Felt we could have talked a lot more as some interesting points came up. But again, restricted by the time limit due to trainees having to get back to lectures.

Only training providers to try and recruit now! Pleased to have reached a bit of a mile stone with the recruitment but really wished I had a plan for interviews with the training providers. Feeling a bit frustrated at this, but today relieved and pleased.

Final Stages of Interviewing:

Have decided due to time that I no longer have time to think of different ways to recruit training providers or use alternative methods to gather data. Have discussed with supervisor and decided that will just use add the small amount of data that I got from the online survey to the appendices.

Reading:

Have been trying to do some background reading on discourse analysis finding it hard to get my head around. Aware the 'doing' will probably help with this as I find that I learn better this way. Hoping what I am reading will help me in the future write up and although I don't feel I completely understand everything I am reading feel I am getting some broad understanding.

Finding the reading up on social constructivism and essentialist views all interesting, but again a different way of thinking to me who has been educated through numerous courses and training via an critical-realist perspective yet there seems a lot less literature out there on this area. Interesting considering this to me seems like a middle ground of the two approaches. Although when thinking about sex and sexuality, there does seem quite a social constructivist element to understating these areas. Have been considering if I want to do a critical realist approach to my discourse analysis.

However, this approach feels like it is more in its infancy and in thinking about

Foucauldian discourse analysis I like the more critical element to this approach and the emphasis on the political and social movements to it. I also think watching the media at the moment and how it is presenting lots of issues related to sex and sexuality does make me question who this is benefiting and what are the bigger agendas at play via those in power. Appears to be a bit of a social movement going on in these areas at the moment. Not sure how helpful some of these elements are.

Transcribing:

Have started my transcriptions, trying to complete them as and when I can. Did not realise just how long it would take. Noticed that what I hear sometimes is quite different to what I transcribe on the first listen. Does make me think what happens when we are in conversations and we think we have heard one thing but the person has actually said something a bit different. Really want to get the transcriptions completed as soon as possible. Have taken a few days off for annual leave and have booked my final few interviews so hoping I can have all of my clinician and trainee data by the end of the week and get a good amount of the transcription completed. Feel quite disheartened about how much I've got through but at least I can see some progress with it.

The Discourse Analysis Process:

Have found going through the transcripts initially really overwhelming. Thinking about forming different discursive constructs from all the ideas that have come up is bringing up lots of ideas. Have been considering using different guidelines to help with the process, especially to help ensure I keep to a Foucauldian Discourse Analysis approach as feels like a very different way of thinking and want to make sure I keep with the philosophy of this approach.

Have decided to use Willigs 6 step approach as feels helpful way in structuring. In thinking about all the different elements of this I do wonder how much further reading and awareness of political and philosophical ideas would aid with this. Feel I am restricted in how I interpret the data by my knowledge base. Questioned if I'm doing DA 'right.'

Even with guidelines I felt at times I've found I am thinking lots of thoughts and not sure how to bring them together under a few meaningful discourses. Have noticed there is some overlap between different codes and some of the quotes.

Found it difficult at times to 'let go' of ideas and think about what the meaning is behind what is being said. Seem to be wanting to hold onto certain ideas around certain discourses that I initially felt were more dominant – but had to question why this was as the further I looked at the transcripts the importance and dominance changed and meaning behind them also changed. This evolved as I went on and had to go back to my coding manual a handful of times to re-think the positioning and

Appendix L: Positioning of The Researcher

The researcher came to this study for a number of reasons. Initially when the topic area was discussed as a possible research area it was felt it would be both interesting, important to individuals and an area that was under-explored within clinical practice and training. Previous work as a Cognitive Behavioural Therapist (CBT) led to the reflection of how often the topics of sex and sexuality were brought up in sessions by individuals without any prompting. Since commencing the clinical psychology training less discussion was observed around these areas, unless it was related to risk, child abuse or LGBT issues, rather than healthy sexual functioning and the benefits of feeling sexually comfortable and confident.

This resulted in reflection on what questions were being asked in sessions, what questions may have been useful to explore earlier and what was resulting in this feeling like a difficult area to explore.

From experience there were a number of times conversations about these issues had opened up the session, resulting in new information being provided and sending the formulation and session in a different direction due to an alternative way of constructing the experiences which they were having.

Despite acknowledging this topic as an area which may be useful to explore, questions were not being asked about sex and sexuality while other topics were much more at the forefront of thinking.

Appendix M: Annotated Transcript

This text has been removed from the electronic copy

Appendix N: Progression of Developing Discourses

Discourse Development

Let's not talk about sex and sexuality

It's all a bit awkward (Social)

Sex/sexuality talk' is sensitive and private.
Sex and Sexuality talk' is taboo
Culture Influences – we're British we don't like to talk about these things.
Sex and Sexuality talk' is embarrassing,
Sex and Sexuality' talk is uncomfortable and awkward to talk about.
Sex and sexuality talk is inappropriate.
Repressed as a society
Not talked about
Not natural
Don't want to talk about it.
Evokes emotional response – going red.
Not freely spoken about
Restricts conversations
Treading carefully
Not an easy thing
It 'complicated and easier not to talk about it and mix things up.
Its difficult/awkward even when have the intention to talk about.

Professional Decision (Professional)

Clients would be offended
You would be in-sensitive just to bring it up.
Need to consider clients wishes and preferences
Sex and sexuality is just not a priority for clients
Clients choice – they don't want to talk about 'it.'
It's not relevant to the problems we are addressing
Important to have a therapeutic relationship before speaking of these things.
Trust comes before these conversations.
Only appropriate in certain contexts
Unprofessional if just bring it up.
Clients won't return if you start asking such things.
Don't want to put clients in a difficult position/feel
embarrassed/awkward/uncomfortable due to something CP's have done. – role to help
not hinder.

'Let's talk about Sex and Sexuality'

Important Work

Valued by clients
Important to relationships
Lots of different topics discussed – sexual pleasure, erectile dysfunction
Sex life affects clients
Impact of negative schemas on sex life
Sex and sexuality as the main focus of a session

Sex and sexuality are important to psychological health
The unsaid stuff being at the heart of psychological difficulties

Natural Sometimes/For Some

Normal to ask about sex
Not natural for all
Not natural for CP's as a profession
Individual differences
Certain context – it's easier
Psychodynamic therapists are good at this talk/make it look easy.
Individual differences: Person specific in the ease and amount at which it is talked about.
Theoretical differences make a difference.
Sex/Sexuality is important in CP's work - when it comes up.
It's our role to talk about the difficult stuff - And people expect this.
Clinicians are happy/no problems to talk about sex and sexuality if it comes up.

Questioning the Silence

Questioning of the silence and avoidance
Don't want to collude.
Awareness of absence of sex and sexuality.
Questioning of this silence – appears absent from everywhere.
Acknowledgment of discourse in society.
Questioning the subjugated topics.
Supervisors encouragement of this questioning.
Conversations can be opened up – sometimes help needed.
Contextual – Why does it feel so different in Personal life compared to work life?
Asking selves = Am I asking enough?
Asking Selves = How do I know if I don't ask?
Uncertainty over whether to bring it up or not to.

Sex/Sexuality is dangerous for Professionals, Clients and Society

Talking about sex and sexuality is dangerous

'Sex and Sexuality talk' is dangerous and risky for professionals.
Risk of talking is gender specific.
Language is important - Got to be careful with the words being used when talking about sex and sexuality.
Can easily offend with language being used and cause anxiety.
Contextually appropriate
Need to protect self – from perpetrator
Need to protect self from allegations
Allegations to self are increasingly a risk
Can keep self-safe by not talking about these things.
Need to be prepared - Legal implications – indemnity insurance
Teams/Others restrict conversations re: sex and sexuality due to risk
Have to be careful – don't wear certain things.
Females can be taken advantage off/abused

Can cause anxiety for CP's.

Sex is negative, 'Bad,' immoral & Problem Focused

Negative Impact of Porn.

Sex addiction

Sex and Sexuality talk is **not** about healthy sex and sexuality. (subjugated?)

Sexual abuse/ assault/allegations are at the forefront

Males as perpetrators within services.

Females as victims

Moral and ethical codes

Problem

Diagnosis and Symptoms.

Distress and Dysfunctions

Protecting Clients from Risk

Sex and Sexuality is about managing risk and safeguarding

Legal & Ethical Implications: Laws & Rules

Consent and capacity

Vulnerabilities of clients

Clients need protecting

Risk assessments

Balancing gains vs. risk

Relationships are risky

People can be taken advantage of.

Risk to professionals if don't protect.

Clients are powerless.

Sex and Sexuality as Important, healthy and part of life

Positive and good

Sex and sexuality talk can be about pleasure and fun

Presence in day to day life.

Positive aspects to sex and sexuality.

Important for people.

Good sex.

Healthy sexual identity.

Healthy sexual functioning

'Us and Them'

Sex and Sexuality as Social & Political Issues

Changes in Equality and Stigma via 'Movements'

Feminist Movement

Empowering woman

Increasing awareness of LGBT

More representation of LGBT

Opening up Conversations can challenge the status quo.

Transgender Movement at the forefront of thinking.

Cohort changes due to historical and cultural shifts.

Clinical psychologists as social activists.

Media as influencing what gets attention

Inequalities

Inequality/Stigma of LGBT

Categorising groups: LGBT and difference 'Us and them'

Sexuality is only sexual orientation

Clinicians desire not to judge individual's sex/sexuality.

'Sex and sexuality talk' as heteronormative.

No training around on any groups except LG and T - Where are other sexualities.

Us and Them – Gays and non-gays

Us and Them - Gender Differences in Presentations. – males and females

Clinicians desire not to judge individual's sex/sexuality.

Sex and Sexuality within the Current NHS Culture & Context:

Specialist - Sexual health clinics

Specialist – psychosexual counsellors

Sex and sexuality are not integrated but seen as specific individuals 'things' that are separate to other things.

Sex and sexuality and compartmentalised

Sex and sexuality is not a priority for clinical psychologist's job role.

NHS Funding.

Time Pressures/Number of sessions

Targets

Commissioning of services

Only certain things treated

Appendix O: Coding Manual

This text has been removed from the electronic copy

Appendix P: Training Providers Responses

TRAINING PROVIDER 1

Q1.) Which University are you a training provider at?

██████████

Q2.) What topics related to sex and sexuality are included within your training programme?

Occurs within various taught units - Difference and Diversity, Adult, LD - not sure about Older People

Q3.) Does your teaching on assessment and formulation include topics related to sex and sexuality?

Don't know

Q4.) Do you consider sex and sexuality key dimensions to psychological health?

Yes

Q5.) What are the key elements to psychological health according to the philosophy of your training programme?

bio- psycho-social and spiritual with a particularly strong emphasis on relationships and attachment

Q6.) How is both sex and sexuality positioned within your training programme?

Embedded rather than foregrounded

Q7.) Do you think the training you provide on sexual functioning and sexuality is sufficient for sound psychological assessments?

Probably not

Q8.) In general, do you think that sex and sexuality are positioned within clinical psychologists thinking?

Marginal unless overtly related to specialism

Q9.) Do you think more attention to sex and sexuality would aid clinical practice?

Yes, but it would remain constrained by NHS protocols

Q10.) Please leave any other comments on the topic that you would like to offer in the box provided. If you would be interested in taking part in an interview (this can be via phone or Skype). Then please leave your email in the box provided. Many thanks for your time.

TRAINING PROVIDER 2

Q1.) Which University are you a training provider at?

[REDACTED]

Q2.) What topics related to sex and sexuality are included within your training programme?

Sexual Identity, Gender Identity, Intellectual disability, discrimination, self-advocacy

Q3.) Does your teaching on assessment and formulation include topics related to sex and sexuality?

Yes, within the above

Q4.) Do you consider sex and sexuality key dimensions to psychological health?

Yes

Q5.) What are the key elements to psychological health according to the philosophy of your training programme?

Can't answer this

Q6.) How is both sex and sexuality positioned within your training programme?

Within various teaching blocks, I think

Q7.) Do you think the training you provide on sexual functioning and sexuality is sufficient for sound psychological assessments?

Can't answer

Q8.) In general, do you think that sex and sexuality are positioned within clinical psychologists thinking?

Nothing like enough!

Q9.) Do you think more attention to sex and sexuality would aid clinical practice?

Definitely. A 'sexuality blind' approach is often adopted, which means that there is insufficient consideration of experiences of difference/diversity

Q10.) Please leave any other comments on the topic that you would like to offer in the box provided. If you would be interested in taking part in an interview (this can be via phone or Skype). Then please leave your email in the box provided. Many thanks for your time.

TRAINING PROVIDER 3

Q1.) Which University are you a training provider at?

██████████

Q2.) What topics related to sex and sexuality are included within your training programme?

Assessment, formulation, intervention of sexual difficulties Communication around sexual issues Working systemically with sexual issues (couple work) Sexual assault and rape Sexual diversity Sexuality and older adults Sexuality and LD Transgender issues

Q3.) Does your teaching on assessment and formulation include topics related to sex and sexuality?

Yes - see above

Q4.) Do you consider sex and sexuality key dimensions to psychological health?

Yes!

Q5.) What are the key elements to psychological health according to the philosophy of your training programme?

See programme spec (Clearing House website)

Q6.) How is both sex and sexuality positioned within your training programme?

Seen as a central part of working with all clients, irrespective of age, sex, gender, culture, ethnicity etc

Q7.) Do you think the training you provide on sexual functioning and sexuality is sufficient for sound psychological assessments?

We try, but there is never enough time to cover everything as much as we'd like. However, we do have 3 x 3 hours dedicated to assessment, formulation and intervention specifically regarding sexual functioning and sexuality (generic) plus another 4 x 3 hours covering sexual assault and rape, sex and sexuality in older adults, in LD, and transgender....so we do what we can.

Q8.) In general, do you think that sex and sexuality are positioned within clinical psychologists thinking?

Not enough!

Q9.) Do you think more attention to sex and sexuality would aid clinical practice?

Yes!

Q10.) Please leave any other comments on the topic that you would like to offer in the box provided. If you would be interested in taking part in an interview (this can be via phone or Skype). Then please leave your email in the box provided. Many thanks for your time.

Appendix Q: Audit Trail

Halpern's (1983) 6 Categories of Information for an Audit Trail

(In Lincoln & Guba 1985, p. 319-310)²

Recommendations of using audit trails have been suggested by a variety of researchers to enhance the credibility and quality of qualitative studies (Cutcliffe, 2003³). Lincoln & Guba (1985) were one of the original authors to discuss the use of audit trails in qualitative studies and base a lot of their work on Halperns (1983) 6 categories of ‘information for an audit trail.’ This audit trail documents the different stages of this current research project.

Audit Trail Classification	‘File Type’ and ‘Evidence’
Raw data	<ol style="list-style-type: none"> 1.) Focus groups and individual interviews completed. 2.) Interviews were audio-recorded on password protected USB sticks. 3.) All interviews were transcribed by the author. Initial thoughts were immediately taken note of. 4.) Transcribed recordings were and read through.
Data reduction and analysis products	<ol style="list-style-type: none"> 1.) Transcribed recordings were read through several times. 2.) Further initial thoughts were taken note of. 3.) Initial ideas of immediate codes were written down. 4.) Codes were listed and Willigs 6 step guide for analysing data in discourse analysis was used to expand on the codes and think about them within a DA framework. 5.) Coding scheme developed. 6.) Codes and coding scheme were reviewed with supervisor.
Data re-construction and synthesis products	<ol style="list-style-type: none"> 1.) Discourse Development took place by pulling together initial codes. (Appendix N) 2.) Discourse development was reviewed with supervisor.
Process notes	<ol style="list-style-type: none"> 1.) Reflective diary written during the research process. 2.) Workshops in lectures on process of completing MRP. 3.) Discussions with peers and one specific colleague working in mental health with an interest in the area.
Materials relating to intentions and dispositions	<ol style="list-style-type: none"> 1.) Discussions with supervisor over chosen methodology. 2.) Rationale for this included in research paper. 3.) Positioning of the researcher considered and included within methods section. 4.) Discussions with supervisor at meetings around beliefs, motivations, doubts and difficulties. 5.) Reflective diary written during the research process.

² Lincoln, YS. & Guba, EG. (1985). [Naturalistic Inquiry](#). Newbury Park, CA: Sage Publications. **Note:** Full detailed account of Halperns (1983) Audit Trail in Appendix A of Lincoln and Guba (1985.)

³ Cutcliffe (2003). Expert Qualitative researchers and the use of audit trails, *Journal of Advanced Nursing*, 45, 126-135.

Instrument development information	<ol style="list-style-type: none">1.) Pilot focus group and pilot clinician interview took place.2.) Feedback from both were used to help finalise both the interview/focus group procedures and questions.3.) Research question was discussed with SAGE member during teaching session.4.) Interview schedules and drafts were discussed with two supervisors, one with a specialist interest in discourse analysis. Several drafts produced prior to final decision being made.
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Appendix R: Author Guideline for Journal of Mental Health

Checklist: What to Include (Journal of Mental Health)

1. Author details. Please include all authors' full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. [Read more on authorship](#).
2. A structured abstract of no more than 200 words. Use the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article's intellectual or technical content. Read tips on [writing your abstract](#).
3. You can opt to include a video abstract with your article. [Find out how these can help your work reach a wider audience, and what to think about when filming](#).
4. Between 3 and 8 keywords. Read [making your article more discoverable](#), including information on choosing a title and search engine optimization.
5. Funding details. Please supply all details required by your funding and grant-awarding bodies as follows:
For single agency grants
This work was supported by the [Funding Agency] under Grant [number xxxx].
For multiple agency grants
This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

6. Disclosure statement. This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. [Further guidance on what is a conflict of interest and how to disclose it.](#)

7. Data availability statement. If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). [Templates](#) are also available to support authors.

8. Data deposition. If you choose to share or make the data underlying the study open, please deposit your data in a [recognized data repository](#) prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

9. Supplemental online material. Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about [supplemental material and how to submit it with your article.](#)

10. Figures. Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, GIF, or Microsoft Word (DOC or DOCX). For information relating to other file types, please consult our [Submission of electronic artwork](#) document.

11. Tables. Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

12. Equations. If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about [mathematical symbols and equations.](#)
13. Units. Please use [SI units](#) (non-italicized).

Appendix S: End of study report for Research Ethics Committee

End of Study Report

Background

Literature to date claims that sex and sexuality are a core aspect of individuals psychological wellbeing. Literature also claimed that mental health professionals are not engaging in talking about these issues in their practice or training.

Clinical psychologist's professional body describe their role as addressing psychological wellbeing from formulation based and holistic approaches (DCP, 2011), it could be argued that they are well positioned to be addressing these topics. Sex and sexuality complex topics and argued to be impacted by social, cultural, historical and political discourses. Therefore, looking at the discourses within the profession may provide helpful insight in understanding current practice.

Research Questions

- e.) How are 'sex and sexuality' and 'sex and sexuality talk,' constructed within clinical psychology training and practice within the UK?
- f.) What are the dominant and counter discourses within practice and training?
- g.) Do the discourses tell us anything about how sex and sexuality may be positioned within the profession?

Method

A Foucauldian Discourse Analysis (FDA) approach was used to explore professional and trainee's discourses around the topics of sex and sexuality, using guidelines by Willig (2008).

Semi-structured interviews were audio recorded. Participants for the individual interviews consisted of 6 practicing clinical psychologists and 4 trainee clinical

psychologists. Two focus groups (n =7; n= 3) were also completed with trainees from 2 different universities.

Findings

Four main discourses were identified during the analysis consisting of ‘Let’s not talk about sex’; ‘Dangerous for Clients, Professionals and Society’; ‘Social and Political Movements’ and ‘Culture and Contextual Discourses’ two counter discourses also emerged: ‘Let’s talk about sex’ and ‘Sex and Sexuality are Positive and Healthy’.

Clinical and Research Implications

Various social and wider discourses can be seen to be impacting on clinical psychologist’s decision making when talking about sex and sexuality within practice and training. Constructions of what is expected from clinical psychologists in the therapy room appear to be reinforced by dominant social, political and cultural discourses. Counter discourses were present; bringing these alternatives into the forefront could be beneficial for clients.

Feedback to Participants

All participants in the study will receive a copy of this summary report.

Publication and dissemination of findings

The findings from this study will be published on the research site and the aim will be to submit to the Journal of Mental Health for publication.

References

Willig, C. (2008). *Introducing qualitative research in psychology*. Maidenhead: Open University Press.

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